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Part 1

HELP EFFICIENT, ACCESSIBLE, LOW COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2002

SEPTEMBER 25, 2002.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. SENSENBRENNER, from the Committee on the Judiciary, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 4600]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 4600) to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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The amendment is as follows:
Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2002".

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

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

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

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

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

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

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

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

(2) reduce the incidence of "defensive medicine" and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

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

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

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

SEC. 3. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

A health care lawsuit may be commenced no later than 3 years after the date of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years, except that in the case of an alleged injury sustained by a minor before the age of 6, a health care lawsuit may be commenced by or on behalf of the minor until the later of 3 years from the date of injury, or the date on which the minor attains the age of 8.

SEC. 4. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, the full amount of a claimant's economic loss may be fully recovered without limitation.

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

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit, an award for future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for non-

economic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 5. MAXIMIZING PATIENT RECOVERY.

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

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

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

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

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

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

SEC. 6. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder.

SEC. 7. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

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

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, the trier of fact shall consider only the following:

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

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

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

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

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

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

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

(c) NO CIVIL MONETARY PENALTIES FOR PRODUCTS THAT COMPLY WITH FDA STANDARDS.—

(1) IN GENERAL.—No punitive damages may be awarded against the manufacturer or distributor of a medical product based on a claim that such product caused the claimant's harm where—

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

(ii) such medical product was so approved or cleared; or

(B) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes a drug or device (including blood products) approved by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such drug or device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug or device.

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

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

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

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

SEC. 8. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

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

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

SEC. 9. DEFINITIONS.

In this Act:

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

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

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

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

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

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

(D) any other publicly or privately funded program.

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

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

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

(7) HEALTH CARE LAWSUIT.—The term "health care lawsuit" means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

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

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

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

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

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

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

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

(14) MEDICAL PRODUCT.—The term "medical product" means a drug or device intended for humans, and the terms "drug" and "device" have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

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

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

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

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

SEC. 10. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

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

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

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

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this Act shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 11. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

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

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this Act; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS.—Any issue that is not governed by any provision of law established by or under this Act (including State standards of negligence) shall be governed by otherwise applicable State or Federal law. This Act does not preempt or supersede any law that imposes greater protections (such as a shorter statute of limitations) for health care providers and health care organizations from liability, loss, or damages than those provided by this Act.

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

(1) any State statutory limit (whether enacted before, on, or after the date of the enactment of this Act) on the amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, whether or not such State limit permits the recovery of a specific dollar amount of damages that is greater or lesser than is provided for under this Act, notwithstanding section 4(a); or

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

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

This Act shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

PURPOSE AND SUMMARY

The costs of the tort system are predicted to soon swamp the national economy,[1] and already a national insurance crisis is ravaging the nation's essential health care system. Medical professional liability insurance rates have skyrocketed, causing major insurers to drop coverage or raise premiums to unaffordable levels. Doctors and other health care providers have been forced to abandon patients and practices, particularly in high-risk specialties

[1] *See* Michael Freedman, "The Tort Mess" *Forbes* (May 13, 2002) ("In the next few years, predicts insurance consultancy Tillinghast-Towers Perrin, tort costs could increase twice as fast as the economy, going from $200 billion last year to $298 billion, or 2.4% of GDP, by 2005. Since 1994 the average jury award in tort cases as a whole has tripled to $1.2 million, in medical malpractice it has tripled to $3.5 million and in product liability cases it has quadrupled to $6.8 million, according to just released data from Jury Verdict Research."). Also, according to the Council of Economic Advisers, "the United States tort system is the most expensive in the world, more than double the average cost of other industrialized nations . . . To the extent that tort claims are economically excessive, they act like a tax on individuals and firms . . . With estimated annual direct costs of nearly $180 billion, or 1.8 percent of GDP, the U.S. tort liability system is the most expensive in the world, more than double the average cost of other industrialized nations that have been studied. This cost has grown steadily over time, up from only 1.3 percent of GDP in 1970, and only 0.6 percent in 1950." Council of Economic Advisers, "Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System" (April 2002) at 1–2.

such as emergency medicine[2] and obstetrics and gynecology.[3] Women are being particularly hard hit, as are low-income neighborhoods and rural areas. Soaring premiums have also left medical schools reeling, and small medical schools are particularly vulnerable.[4] And according to the Department of Health and Human Services:

> Doctors who would volunteer their time to provide care in free clinics and other volunteer organizations, or who would volunteer their services to the Medical Reserve Corps, are afraid to do so because they do not have malpractice insurance. This makes it more difficult for clinics to provide care to low-income patients. The clinics must spend their precious resources to obtain their own coverage, and have less money available to provide care to people who need it. The proportion of physicians in the country providing any charity care fell from 76% to 72% between 1997 and 1999 alone, increasing the need for doctors willing to volunteer their services.[5]

According to the Associated Press, the current medical professional liability premium crisis has also prevented doctors from conducting charity missions.[6]

The current crisis was summarized in *TIME* magazine as follows:

> In some states, hospitals are closing entire clinics and rural communities are losing their only practitioners. Mercy Hospital of Philadelphia closed its maternity ward after annual insurance premiums for its group of four hospitals swelled to $22 million, from $7 million in 2000. In Arizona one woman gave

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[2] *See* Patricia Neighmond, National Public Radio, "All Things Considered" Analysis—High Cost of Malpractice Insurance in Nevada is Causing Some Physicians to Stop Practicing Trauma Medicine or Leave the State (April 3, 2002) ("NEIGHMOND: . . . Some doctors have stopped practicing emergency medicine because they can no longer afford malpractice insurance . . . [S]tate law requires a certain number of emergency physicians and specialists to be on call 24 hours a day 7 days a week. And if the Trauma Center can't comply, it could be shut down. If that happens [,] critically injured patients would have to be sent to trauma centers in nearby states. Dr. CARRISON: Some patients are going to die that wouldn't die, and that extra time, that's what saves lives. Time saves lives. The quicker you're at the trauma center, the better chance you have of survival.").

[3] In a March 7, 2002 release, the American College of Obstetricians and Gynecologists ("ACOG") states that "the meteoric rise in liability premiums threatens women's access to [health] care." ACOG continues that "[e]xperience demonstrates that obstetric providers—when confronted with substantially higher costs for liability coverage—will stop delivering babies, reduce the number they do deliver, and further cut back, or eliminate, care for high-risk patients, the uninsured, and the underinsured . . .".

[4] *See* Myrle Croasdale, "Rocketing liability rates squeeze medical schools," *American Medical News* (May 20, 2002) ("The University of Nevada School of Medicine in Reno could be forced to close if it can't find affordable liability insurance by June 30. In West Virginia, Marshall University's Joan C. Edwards School of Medicine in Huntington has cut its pathology program and is trimming resident class size. Pennsylvania State University College of Medicine in Hershey is cutting faculty salaries, which will make it hard to land top researchers . . . [According to] Jordan J. Cohen, MD, president of the Assn. of American Medical Colleges, . . . 'I think it's adding to the view that medicine is plagued by liability costs and is constantly on the defensive,' Dr. Cohen says. 'I wonder how many students are not even considering medicine because of the changes that have occurred.'").

[5] Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July 24, 2002) at 4 (citing Center for Health Systems Change, "An Update on the Community Tracking Study, A Focus on the Changing Health System," Issue Brief No. 18 (February 1999)).

[6] *See* "Doctors say insurance costs force them to cut charity work," The Associated Press (August 26, 2002) (Local doctors say the high cost of medical malpractice insurance is having the secondary effect of curbing their ability to do charitable work. A physicians group last month canceled an annual trip to poorer regions of Appalachia after being unable to sign up enough doctors . . . "We've gone every year for several years. We take supplies, many types of specialists, and we treat people there," said Theresa Chin, assistant to and wife of Dr. Victorino Chin of Holy Family Health Clinic. "None of the doctors want to go because they are afraid of being sued.").

birth by the side of the road before she reached the only remaining maternity ward in an area of 6,000 sq. mi. The sole trauma center in Las Vegas closed for 10 days in July, forcing critically injured patients to be helicoptered to California or treated in ill-equipped local emergency rooms.

Sommer Hollingsworth, president of the Nevada Development Authority, which works to attract employers to southern Nevada, observed that of about 350 firms his group sought to recruit over the past year, "we've never had anyone ask about the nuclear waste at Yucca Mountain, but client after client wants to know what we are going to do about the doctor situation. The quality of the medical system plays a big role for companies choosing to relocate."

Nevada has been especially hard hit because it's one of the states with the sharpest rise in malpractice costs. But those costs are climbing nationwide. According to one study, from 1999 to 2000 the median plaintiff's jury award in medical-malpractice cases increased 43%, from $700,000 to $1 million. Last year the MIIX Group, an insurer in 24 states, saw 26 claim payments of more than $1 million. This year it has faced an average of one new $1 million-plus claim every week . . .

Because their reimbursement rates are often fixed by contracts with HMOs and managed-care groups, doctors cannot readily pass on their increased costs. To pay higher insurance premiums, some doctors have cut back on staff. But others are dropping high-risk specialties or retiring early. "I would be working just to pay my malpractice costs," said Debra Wright, a Las Vegas obstetrician who took a leave of absence this spring to avoid a premium increase to $180,000, from $50,000 last year. She hopes to resume her work if rates go down. Cheryl Edwards has stopped her obstetrics practice altogether and moved from Las Vegas to Los Angeles for a gynecology and cosmetic-surgery practice. "I was getting up in the middle of the night and losing money with every baby I delivered."

Reformers point to California, where jury awards for noneconomic damages, such as pain and suffering, are capped at $250,000 and malpractice rates have held relatively steady over the past year. With tort reform, says Ron Neupauer, a vice president of Medical Insurance Exchange of California, "you don't have the emotion-laden blockbuster verdicts." . . . Even when tort reforms are put in place, they can take time to bite. In Nevada, where liability caps were passed last month, most insurers have declined to lower rates until they see the change reflected on their balance sheets, which could take years. They may have a point: courts in six states have struck down as unconstitutional limits on a jury's ability to determine damages in malpractice cases, and lawyers in Nevada are readying a case against the new limits.

While the interest groups jockey, access to the courts is less urgent for most people than access to a doctor. After calling every day for weeks, Elizabeth Gromny finally persuaded her obstetrician to handle her delivery, but only because another patient in military service had been transferred out of state. But complications have forced Gromny to visit specialists, and many specialists have also posted signs in their offices warning

> that the insurance crisis might force them to close their doors. "I'm constantly worried about what could happen," says Gromny. "When you're pregnant, the last thing you want to have to worry about is your doctor." [7]

The current crisis has been caused by increasingly escalating "mega-verdicts." According to the Department of Health and Human Services:

> The number of mega-verdicts is increasing rapidly. The average award rose 76% from 1996–1999. The median award in 1999 was $800,000, a 6.7% increase over the 1998 figure of $750,000; and between 1999 and 2000, median malpractice awards increased nearly 43%. Specific physician specialties have seen disproportionate increases, especially those who deliver babies. In the small proportion of cases where damages were awarded, the median award in cases involving obstetricians and gynecologists jumped 43% in 1 year, from $700,000 in 1999 to $1,000,000 in 2000. The number of million dollar plus awards has increased dramatically in recent years. In the period 1994–1996, 34% of all verdicts that specified damages assessed awards of $1 million or more. This increased by 50% in 4 years; in 1999–2000, 52% of all awards were in excess of $1 million. There have been 21 verdicts of $9 million or more in Mississippi since 1995—one of $100,000,000. Before 1995 there had been no awards in excess of $9,000,000. These mega-awards for non-economic damages have occurred (as would be expected) in states that do not have limitations on the amounts that can be recovered . . . Mirroring the increase in jury awards, settlement payments have steadily risen over the last two decades. The average payment per paid claim increased from approximately $110,000 in 1987 to $250,000 in 1999. Defense expenses per paid claim increased by $24,000 over the same period. [8]

H.R. 4600 (the HEALTH Act), modeled after California's quarter-century old and highly successful health care litigation reforms, addresses the current crisis and will make health care delivery more accessible and cost-effective in the United States. California's Medical Injury Compensation Reform Act ("MICRA"), which was signed into law by Governor Jerry Brown, has proved immensely successful in increasing access to affordable medical care. Overall, according to data of the National Association of Insurance Commissioners, the rate of increase in medical professional liability premiums in California since 1976 has been a very modest 167%, whereas the rest of the United States have experienced a 505% rate of increase, a rate of increase 300% larger than that experienced in California. [9] As the *Los Angeles Times* reported, "Accord-

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[7] Laura Bradford, "Out of Medicine; As premiums soar for malpractice insurance, doctors get harder to find," *TIME* (September 16, 2002).

[8] Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July 24, 2002) at 9–10.

[9] The following comments by the Democratic Vice Chairman of the U.S. Commission on Civil Rights, Planned Parenthood of Los Angeles, and the AIDS Health Care Foundation have been transcribed from a CD-ROM that includes videotaped interviews with supporters of California's health care litigation reforms, on which the HEALTH Act is modeled. The CD-ROM, entitled "MICRA: Keeping Health Care Available and Affordable," was compiled by Californians Allied for Patient Protection:

ing to data for 2000 from the National Association of Insurance Commissioners, insurers spent a smaller percentage of premiums collected—45.8%—in California to pay claims against medical providers than the national average of 80.9%." [10]

Two Stanford University economists have also concluded that direct medical care litigation reforms—including caps on non-eco-

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Comments by Cruz Reynoso, Democratic Vice Chairman of the U.S. Commission on Civil Rights (appointed by former Senate Majority Leader George Mitchell in 1993), Professor of Law at UCLA, and former Justice of the California Supreme Court:

> "Medical insurance has been going up. I think there's no question that what the legislature did and continues to do has had an influence on keeping those expenses down and that's a very important public policy obviously for the state. The litigation as I've seen it as a lawyer, and as a judge, and as a law professor is filed for its settlement value and therefore, and particularly if you have at the end of the line the possibly of punitive damages, of high damages aside from the punitive damages, there's a great incentive to try to settle the matter and so there could easily be a quite adverse ramification for the whole industry . . . Publicly-funded medical centers were very supportive of the continued protection of MICRA because if their own insurance rates would go up they would be less able to serve the poor. I think that's very much a matter in the mix that the legislature should take into account . . . I think that folks ought to have access to the courts and I think we need a balance of having access and yet in such a way that it won't be a negative for the interests of society. I personally have favored having as much access to the courts as possible, but at the same time you have to be careful that it doesn't do so in a way that is destructive, for example, in the medical field, destructive of the ability of society to respond to the medical needs of the people. I think MICRA has tried very hard to reach a balance between the interests that plaintiffs have in going into court and the public policy that we've long had in California, and in our country, and the interest of providing reasonable insurance and medical attention."

Comments by Nancy Sasaki, President and CEO of Planned Parenthood, Los Angeles:

> "A lot of times Planned Parenthood is seen as the primary provider for women . . . If the caps [on non-economic damages] in MICRA were to be increased, you actually would begin to see kind of a domino effect. One of the primary areas that would be of concern to us is how that would affect prenatal care and obstetric care. If insurance costs for the physicians go up they typically will then, as any business would, look at what services are their highest risks, which services are costing them the most, and they may no longer provide that. And that's happened in the past, where physicians have stopped providing obstetric care because of costs. If that were to happen, with our prenatal program, we would have no place to send women for deliveries. We don't do deliveries ourselves, we need a physician who's a certified ob-gyn to provide those, and if we have no place to send them, they'll end up in the emergency rooms of the hospitals delivering with no continuity of care, not knowing the doctor that they're going into, and that's another issue that we've really fought to try and reduce is emergency care for routine types of care that should be able to be provided by a physician. So in that sense, prenatal care would be affected. Our own insurance costs could possibly go up . . . so [if] our costs go up that means that we may not be able to serve as many people as we currently serve and therefore you have greater problems with access to care . . . It's a serious threat to Planned Parenthood because when I sit behind my desk the things that I'm thinking about are those things that are happening in the environment that affect our ability to provide care for women in Los Angeles county."

Comments by Donna Stidham, Director of Managed Care and Patient Services, AIDS Health Care Foundation:

> "The under-served and the unserved patients tend to be people of color, tend to be women, tend to be people that don't have the resources, and statistics are showing us that is where the [AIDS] epidemic is moving . . . They desperately need the care. [An] increase in the MICRA cap . . . would increase our premiums phenomenally. In a single clinic setting it could probably increase their premiums maybe twenty or thirty thousand dollars. For multiple physicians, I'd hate to even guess, but it'd be in the hundreds of thousands, which would take away from direct patient care because that's where our dollars go is in caring for the patients, paying for their medications, paying for their outpatient services, paying for the physicians to care for them, and the nurses to care for them. So it would directly take away from care, from the patients. You'd see us perhaps not being able to admit all types of patients. Right now we can take any kind of patient, whether they have the ability to pay or not. It would force us to look at taking patients that only have a third party insurer, maybe not even taking some of the patients that have third party insurers because their reimbursement rate wasn't high enough, such as Medicare or Medicare. We'd have to make those sort of hard decisions, and if you make those decisions you're cutting out exactly the people it's our mission to serve. And there are still large awards for patients who've been harmed. But the pain and suffering, that's where it used to be out of control here [in California]."

[10] Edwin Chen, "Curb Malpractice Suits to Fix 'Badly Broken' System, Bush Says" The *Los Angeles Times* (July 26, 2002) at A30.

nomic damage awards—generally reduce the growth of malpractice claims rates and insurance premiums, and reduce other stresses on doctors that may impair the quality of medical care.[11] By incorporating MICRA's time-tested reforms at the Federal level, the HEALTH Act will make medical malpractice insurance affordable again, encourage health care practitioners to maintain their practices, and reduce health care costs for patients. Its enactment will particularly help traditionally under-served rural and inner city communities, and women seeking obstetrics care.[12]

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[11] *See* Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," *60 Law and Contemporary Problems* 1:81–106 (1997), at 105 ("[P]hysicians from states enacting liability reforms that directly reduce malpractice pressure experience lower growth over time in malpractice claims rates and in real malpractice insurance premiums. [Also], physicians from reforming states report significant relative declines in the perceived impact of malpractice pressure on practice patterns.").

[12] The Association of Obstetricians and Gynecologists ("ACOG") recently issued a "Red Alert" on May 6, 2002, listing nine states in which obstetricians and gynecologists are leaving their professions due to unaffordable professional liability rates caused by a lack of litigation reforms:

Florida: This state has the highest average premium for ob-gyns in the nation, at $158,000 per year in 2000. But in certain areas, notably Dade County, rates can soar to $208,949. Ob-gyns in this state are more likely than their colleagues in other states to no longer practice obstetrics. The liability situation has been so chronic in Florida, that during the crisis of the 1980's, the state began to allow doctors to "go bare" (not have liability coverage) as long as they could post bond or prove ability to pay a judgment of up to $250,000.

Mississippi: Liability premiums for obstetrical care rose from 20% to 400% in 2001. Certain counties are known for being liability "hot spots," notorious for high jury awards. "Forum shopping" by plaintiffs' attorneys—to file cases in high-award counties no matter where the medical case originated—is becoming more common. Most serious of all: the state suffers from a chronic shortage of medical care in rural areas. Few cities under 20,000 have physicians delivering babies. Yazoo City—pop. 14,550—has no one practicing obstetrics.

Nevada: The St. Paul Companies, Inc., which dropped its medical liability coverage in the last year, had insured 54% of Nevada's ob-gyns. Physicians are rushing to find available or affordable insurance. The University of Nevada Medical Center may lose its medical liability coverage as of July 1. The state ranks 5th among states in the highest physician liability premium (at $94,820 per year) but only 47th out of 50 states in the number of physicians for its population. Las Vegas could lose as many as 10% of its physicians in the coming year. A survey of ob-gyns in Clark County found that 42.3% were now making plans to leave the state, if the crisis was not resolved in a few months: 6 out of 10 ob-gyns say they would stop obstetrics.

New Jersey: Three medical liability insurance companies will stop insuring NJ doctors in 2002 for financial reasons. The state's two largest medical liability insurers have stated they cannot pick up all the extra business and are rejecting doctors they deem high risk. The president of the New Jersey Hospital Association says that rising medical liability premiums are a "wake-up call" that the state may lose doctors. Hospital premiums have risen 250% over the last 3 years. Sixty-five percent of hospital facilities report they are losing physicians due to liability insurance costs.

New York: The state is second only to Florida in the cost of liability insurance for ob-gyns ($144,973 per year in 2000), and is renowned for higher jury verdict amounts. (There is no upper limit on noneconomic damages in jury verdicts.) Attempts to pass a no-fault compensation program for birth-related injuries—similar to laws in VA and FL—have been unsuccessful. According to Insurance analysts, the majority of physicians may see a 20% hike in premium costs beginning July 1, 2002. NY is presently faced with a shortage of ob care in certain rural regions.

Pennsylvania: The state is the second highest in the nation for total payouts for medical liability—$352 million in fiscal year 2000, or nearly 10% of the national total. Despite some tort reform measures passed by the state legislature this past winter, ob-gyns were disappointed the measures did not provide more relief. The state abandoned its provision of a catastrophic loss fund. South Philadelphia is losing its only maternity ward: Methodist Hospital has announced that after a century of service, its labor and delivery ward would be closing by June 30, 2002, due to rising costs of medical liability insurance.

Texas: In parts of the state, premiums have soared to $160,746 a year. Premiums can vary widely across the state, with some regions less affected than others by cost increases. The Texas Medical Association expects premiums for 2002 to increase by 30% to 200%. According to the Texas Attorney General John Cornyn, Texas doctors are two times as likely to be sued as their colleagues across the country. Preliminary results of a recent Texas Medical Association survey indicate that more than half of responding physicians, including those in the prime of their careers, are considering early retirement because of the state's medical liability problems.

Washington: In late 2001, the second largest insurance carrier in the state announced it was withdrawing from the medical liability market in Washington: the decision impacted about 1,500 physicians. In 2001, insurance premiums for many physicians increased 55% or more from the year before, and ranged from $34,000–$59,000 per year. Some Tacoma specialists reported 300% increases in premiums. Unlike California, Washington currently has no cap on noneconomic damages in medical liability cases.

MICRA's reforms, which have been the law in California for 25 years, include a $250,000 cap on noneconomic damages, limits on the contingency fees lawyers can charge; authorization for defendants to introduce evidence showing the plaintiff received compensation for losses from outside sources (to prevent double recoveries); and authorization for courts to require periodic payments for future damages instead of lump sum awards that prevent bankruptcies in which plaintiff's would receive only pennies on the dollar. The HEALTH Act also includes provisions creating a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault, and reasonable guidelines—but not caps—on the award of punitive damages. Finally, the HEALTH Act will accomplish reform without in any way limiting compensation for 100% of plaintiffs' economic losses (anything to which a receipt can be attached), including their medical costs, their lost wages, their future lost wages, rehabilitation costs, and any other economic out of pocket loss suffered as the result of a health care injury. The HEALTH Act also does not preempt any State law that otherwise caps damages.

Enactment of the HEALTH Act will not result in more medical malpractice cases being brought in Federal court. The Supreme Court has held that a "federal standard" does not confer Federal question jurisdiction in the absence of Congressional creation of a Federal cause of action. [13] Consequently, medical malpratice cases under the HEALTH Act could continue to be brought in state court.

Finally, many state supreme courts have judicially nullified reasonable litigation management provisions enacted by state legislatures, many of which sought to address the crisis in medical professional liability that reduces patients' access to health care. [14] Con-

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West Virginia: The state is known for high jury verdict awards, and unaffordable insurance rates could fuel an exodus of doctors from the state. A majority of the state is already classified as medically underserved and cannot afford to lose physicians. Yet an informal ACOG survey found that half of all ob-gyn residents and two-thirds of ob-gyns in private practice plan to leave the state if the crisis is not resolved.

ACOG has also noted that "In three other states—Ohio, Oregon, and Virginia—a crisis is brewing, while four other states—Connecticut, Illinois, Kentucky and Missouri—should be watched for mounting problems . . ." ACOG News Release, "Nation's Obstetrical Care Endangered by Growing Liability Insurance Crisis" (May 6, 2002).

[13] *See* Merrell Dow Pharm. Inc. v. *Thompson*, 478 U.S. 804, 813 (1986).

[14] **Alabama—***Clark and Halliburton Industrial Services Division* v. *Container Corp. of America*, 589 So. 2d 184 (Ala. 1991) (statute allowing for periodic payments of personal injury awards over $150,000 held unconstitutional under state constitution); *Henderson* v. *Alabama Power Co.*, 627 So. 2d 878 (Ala. 1993) (statute setting $250,000 limit on punitive damages awards held unconstitutional under state constitution); *Moore* v. *Mobile Infirmary Association*, 592 So. 2d 156 (Ala. 1991) (statute setting $400,000 limit on noneconomic damages awards in health care liability actions held unconstitutional under state constitution); *Smith* v. *Schulte*, 671 So. 2d 1334 (Ala.) (1987 statute setting $1 million aggregate limit on damages awards in health care liability actions held unconstitutional under state constitution), *cert. denied*, 517 U.S. 1220 (1996); **Alaska—***Turner Construction Co., Inc.* v. *Scales*, 752 P.2d 467 (Alaska 1988) (6-year statute of repose on suits filed against design professionals held unconstitutional under state constitution); **Arizona—***Anson* v. *American Motors Co.*, 747 P.2d 581 (Ariz. App. 1987) (2-year statute of limitations for wrongful death actions, with accrual at time of death, held unconstitutional under state constitution); *Barrio* v. *San Manuel Division Hospital For Magma Copper Co.*, 692 P.2d 280 (Ariz. 1984) (statute of limitations which required minor injured when below age of seven to bring action for medical malpractice by the time she reached age ten held unconstitutional under state constitution); *Hazine* v. *Montgomery Elevator Co.*, 861 P.2d 625 (Ariz. 1993) (12-year product liability statute of repose held unconstitutional under state constitution); *Kenyon* v. *Hammer*, 688 P.2d 961 (Ariz. 1984) (3-year statute of limitations for wrongful death claim held unconstitutional under state constitution); **Colorado—***Austin* v. *Litvak*, 682 P.2d 41 (Colo. 1984) (3-year statute of repose in medical malpractice actions held unconstitutional under state constitution insofar as the statute applied to persons whose claims were based on negligent misdiagnosis); **Florida—***Smith* v. *Department of Insurance*, 507 So. 2d 1080 (Fla. 1987) (statute setting $450,000 limit on noneconomic damages awards held unconstitutional under state constitution); **Georgia—**Denton v. *Con-Way Southern Express, Inc.*, 402 S.E.2d 269 (Ga. 1991) (statute authorizing admission of collateral sources of recovery available to plaintiffs seeking special

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damages for tortious injury held unconstitutional under state constitution); **Illinois—***Best* v. *Taylor Machine Works, Inc.*, 689 N.E.2d 1057 (Ill. 1997) (Civil Justice Reform Amendments of 1995's $500,000 limit on noneconomic damages award and abolition of joint liability held unconstitutional under state constitution); **Indiana—***Martin* v. *Richey*, 711 N.E.2d 1273 (Ind. 1999) (2-year occurrence-based statute of limitations as applied to plaintiff was held unconstitutional under state constitution); *Van Dusen* v. *Stotts*, 712 N.E.2d 491 (Ind. 1999) (same); *Harris* v. *Raymond*, 715 N.E.2d 388 (Ind. 1999) (same); **Kansas—***Farley* v. *Engelken*, 740 P.2d 1058 (Kan. 1987) (abrogation of collateral source rule in health care liability actions held unconstitutional under state constitution); *Kansas Malpractice Victims Coalition* v. *Bell*, 757 P.2d 251 (Kan. 1988) (Kansas Health Care Provider Insurance Availability Act provisions setting $1 million limit on aggregate damages in health care liability actions and provision requiring annuity for payments for future economic loss in all health care liability actions held unconstitutional under state constitution); *Thompson* v. *KFB Insurance Co.*, 850 P.2d 773 (Kan. 1993) (statute allowing evidence of collateral source benefits where claimant demands judgment for damages in excess of $150,000 held unconstitutional under state constitution); **Kentucky—***McCollum* v. *Sisters of Charity of Nazareth Health Corp.*, 799 S.W.2d 15 (Ky. 1990) (5-year statute of repose for health care liability actions held unconstitutional under state constitution); *O'Bryan* v. *Hedgespeth*, 892 S.W.2d 571 (Ky. 1995) (statute allowing admission of evidence of collateral source payments in personal injury actions held unconstitutional under state constitution); *Williams* v. *Wilson*, 972 S.W.2d 260 (Ky. 1998) (1988 punitive damages reform statute requiring a plaintiff to show that the defendant acted with "flagrant indifference to the rights of the plaintiff and with a subjective awareness that such conduct will result in human death or bodily harm" as a predicate for punitive damages liability held unconstitutional under state constitution); **Missouri—***Strahler* v. *St. Luke's Hospital*, 706 S.W.2d 7 (Mo. 1986) (statute of limitations for health care liability actions held unconstitutional under state constitution insofar as the statute applied to minors); **New Hampshire—***Brannigan* v. *Usitalo*, 587 A.2d 1232 (N.H. 1991) (statute limiting recovery for noneconomic loss to $875,000 in personal injury actions held unconstitutional under state constitution); *Heath* v. *Sears, Roebuck & Co.*, 464 A.2d 288 (N.H. 1983) (12-year statute of repose and 3-year statute of limitations for product liability actions held unconstitutional under state constitution); **North Dakota—***Hanson* v. *Williams County*, 389 N.W.2d 319 (N.D. 1986) (10-year product liability statute of repose held unconstitutional under state constitution); **Ohio—***Adamsky* v. *Buckeye Local School District*, 653 N.E.2d 212 (Ohio 1995) (2-year statute of limitations for personal injury actions against political subdivisions held unconstitutional under state constitution, as applied to minors); *Crowe* v. *Owens Corning Fiberglas*, 718 N.E.2d 923 (Ohio 1999) (limitation on punitive damages held unconstitutional under state constitution); *Gaines* v. *Preterm-Cleveland, Inc.*, 514 N.E.2d 709 (Ohio 1987) (health care liability statute of repose held unconstitutional under state constitution as applied to adult litigants who, following discovery, did not have adequate time to file actions); *Galayda* v. *Lake Hospital Systems, Inc.*, 644 N.E.2d 298 (Ohio 1994) (statute requiring periodic payments of future damages awards in medical malpractice suits held unconstitutional under state constitution), *reconsideration denied*, 644 N.E.2d 1389 (Ohio), *cert. denied sub nom. Damian* v. *Galayda*, 516 U.S. 810 (1995); *Gladon* v. *Greater Cleveland Regional Transit Authority*, 1994 WL 78468 (Ohio App. Mar. 10, 1994) ($250,000 limit on noneconomic damages awards held unconstitutional under state constitution), rev'd on other grounds, 662 N.E.2d 287 (Ohio 1996); *Hardy* v. *VerMeulen*, 512 N.E.2d 626 (Ohio 1987) (statute barring health care liability claims brought more than 4 years after act or omission constituting alleged malpractice occurred, as applied to bar claims of health care liability plaintiffs who did not know or could not have known of their injuries, held unconstitutional under state constitution), *cert. denied*, 484 U.S. 1066 (1988); *Mominee v. Scherbarth*, 503 N.E.2d 717 (Ohio 1986) (statute which required health care liability actions to be brought within 1 year from date cause of action accrued, or 4 years from date alleged malpractice occurred, whichever came first, held unconstitutional under state constitution insofar as the statute applied to minors); *Morris* v. *Savoy*, 576 N.E.2d 765 (Ohio 1991) ($200,000 limit on general damages in health care liability actions held unconstitutional under state constitution); *Schwan* v. *Riverside Methodist Hospital*, 452 N.E.2d 1337 (Ohio 1983) (statute of limitations for health care liability actions, as it applied to minors, held unconstitutional under state constitution); *Sorrell* v. *Thevenir*, 633 N.E.2d 504 (Ohio 1994) (statute providing offset of collateral source benefits received by plaintiff held unconstitutional under state constitution); *Samuels* v. *Coil Bar Corp.*, 579 N.E.2d 558 (Ohio Cm. Pl. 1991) (same as applied to wrongful death actions); **Oregon—***Lakin v. Senco Products, Inc.*, 987 P.2d 463 (Or. 1999) ($500,000 limit on noneconomic damages in personal injury and wrongful death actions arising out of common law held unconstitutional under state constitution); **Rhode Island—***Kennedy* v. *Cumberland Engineering Co., Inc.*, 471 A.2d 195 (R.I. 1984) (10-year statute of repose for product liability actions held unconstitutional under state constitution); **South Dakota—***Knowles* v. *Federal*, 544 N.W.2d 183 (S.D. 1996) ($1 million aggregate limit on economic and noneconomic damages in health care liability actions held unconstitutional under state constitution, but more limited statute capping noneconomic damages awards in health care liability actions at $500,000 remained in effect); **Texas—***Lucas* v. *Federal*, 757 S.W.2d 687 (Tex. 1988) ($500,000 aggregate limit on damages in health care liability actions held unconstitutional under state constitution); *Nelson* v. *Krusen*, 678 S.W.2d 918 (Tex. 1984) (2-year statute of limitations for medical malpractice actions held unconstitutional under state constitution); **Utah—***Berry* v. *Beech Aircraft Corp.*, 717 P.2d 670 (Utah 1985) (statute of repose barring product liability claims 6 years after of purchase or 10 years after date of manufacture of product held unconstitutional under state constitution); *Lee* v. *Gaufin*, 867 P.2d 572 (Utah 1993) (provision of Utah Health Care Malpractice Act subjecting minors to 2-year statute of limitations and 4-year statute of repose held unconstitutional under state constitution); **Washington—***Sofie* v. *Fibreboard Corp.*, 771 P.2d 711 (Wash. 1989) (variable limit on noneconomic damages awards held unconstitutional under state constitution); **Wisconsin—***Kohnke* v. *St. Paul Fire & Marine Insurance Co.*, 410 N.W.2d 585 (Wis. App. 1987) (medical mal-

sequently, in such states, passage of Federal legislation by Congress may be the only means of addressing the state's current crisis in medical professional liability and restoring patients' access to health care. Laws passed by states that have already provided for, or may in the future provide for, different limits on damages in health care lawsuits will be preserved under the HEALTH Act, as the HEALTH Act provides that "No provision of this Act shall be construed to preempt . . . any State statutory limit (whether enacted before, on, or after the date of the enactment of this Act) on the amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, whether or not such State limit permits the recovery of a specific dollar amount of damages that is greater or lesser than is provided for under this Act . . ." Some states have limited noneconomic damages in medical malpractice actions, but at levels higher than $250,000.[15] Some states place aggregate limits on medical malpractice awards.[16] Montana limits noneconomic damages in medical malpractice cases at $250,000, but its health care litigation reforms do not include other elements of the HEALTH Act.[17]

According to the Department of Health and Human Services:

> [A] major contributing factor to the most enormous increases in liability premiums has been rapidly growing awards for noneconomic damages in states that have not reformed their litigation system to put reasonable standards on these awards. Among the states with the highest average medical malpractice insurance premiums are Florida, Illinois, Ohio, Nevada, New York, and West Virginia. These states have not reformed their litigation systems as others have. (Florida's caps apply only in limited circumstances. New York has prevented insurers from raising rates, and accordingly it is expected that substantial increases will be needed in 2003.) . . . The effect of these premiums on what patients must pay for care can be seen from an example involving obstetrical care. The vast majority of awards against obstetricians involve poor outcomes at childbirth. As a result, payouts for poor infant outcomes account for the bulk of obstetricians' insurance costs. If an obstetrician delivers 100 babies per year (which is roughly the national average) and the malpractice premium is $200,000 annually (as it is in Florida), each mother (or the government or her employer who provides her health insurance) must pay approximately $2,000 merely to pay her share of her obstetrician's liability insurance. If a physician delivers 50 babies per year, the cost for malpractice premiums per baby is twice as high, about $4,000. It is not surprising that expectant mothers

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practice statute of limitations held unconstitutional under state constitution), *aff'd on other grounds*, 424 N.W.2d 191 (Wis. 1988).

[15] *See* La. Rev. Stat. Ann. § 40:1299.42(b) (1992) (limiting noneconomic damages to $500,000); Mass. Gen. Laws, Ch. 231, § 60H (2000) (limiting noneconomic damages to $500,000); Mich. Comp. Laws § 600.1483 (1996) (limiting noneconomic damages to $500,000 if certain criteria are met, otherwise capping them at $280,000); N.D. Cent. Code § 32–42–02 (1996) (limiting noneconomic damages to $500,000); S.D. Codified Laws § 21–3–11 (Michie 1987) (limiting noneconomic damages to $500,000); Utah Code Ann. § 78–14–7.1 (1999) (limiting noneconomic damages to $400,000, adjusted for inflation); W. Va. Code § 55–7B–8 (1994) (limiting noneconomic damages to $1,000,000); Wis. Stat. § 893.55 (1997) (limiting noneconomic damages to $350,000, adjusted for inflation).

[16] *See* N.M. Stat. Ann. § 41.5 (Michie 1996) (limit to $600,000, excluding punitive damages and medical care and related benefits);Va. Code Ann. § 8.01–581.15 (Michie Cum. Supp. 2000).

[17] *See* Mont. Code Ann. § 25–9–411 (1999) (limiting noneconomic damages to $250,000).

> are finding their doctors have left states that support litigation systems imposing these costs. In addition to premium increases for physicians, nursing home malpractice costs are rising rapidly because of dramatic increases in both the number of lawsuits and the size of awards. Nursing homes are a new target of the litigation system. Between 1995 and 2001, the national average of insurance costs increased from $240 per occupied skilled nursing bed per year to $2,360. From 1990 to 2001, the average size of claims tripled, and the number of claims increased from 3.6 to 11 per 1,000 beds. These costs vary widely across states, again in relation to whether a state has implemented reforms that improve the predictability of the legal system. Florida ($11,000) had one of the highest per bed costs in 2001. Nursing homes in Mississippi have been faced with increases as great as 900% in the past 2 years." [18]

Also according to the Department of Health and Human Services:

> The insurance crisis is less acute in states that have reformed their litigation systems. States with limits of $250,000 or $350,000 on non-economic damages have average combined highest premium increases of 12–15%, compared to 44% in states without caps on non-economic damages . . . [T]here is a substantial difference in the level of medical malpractice premiums in states with meaningful caps, such as California, Wisconsin, Montana, Utah and Hawaii, and states without meaningful caps. [19]

The California courts have described several purposes of California Civil Code section 3333.2, which limits recovery of noneconomic damages to $250,000. One purpose is to "provide a more stable base on which to calculate insurance rates" by eliminating the "unpredictability of the size of large noneconomic damage awards, resulting from the inherent difficulties in valuing such damages and the great disparity in the price tag which different juries placed on such losses." [20] Another purpose is to "promote settlements by eliminating 'the unknown possiblity of phenomenal awards for pain and suffering that can make litigation worth the gamble.'" [21] A third purpose is to be fair to medical malpractice plaintiffs by "reduc[ing] only the very large noneconomic damage awards, rather than to diminish the more modest recoveries from pain and suffering and the like in the great bulk of cases." [22]

BACKGROUND AND NEED FOR THE LEGISLATION

THE NATIONAL HEALTH CARE LITIGATION AND MALPRACTICE INSURANCE CRISIS IS RAVAGING THE HEALTH CARE SYSTEM

A recent survey conducted for the bipartisan legal reform organization "Common Good"—whose Board of Advisors include former Senator George McGovern, former Speaker of the House Newt

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[18] Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July 24, 2002) at 12–13.

[19] *Id.* at 14–15.

[20] *Fein* v. *Permanent Medical Group*, 38 Cal.3d 137, 163 (1985); *see also Western Steamship Lines, Inc.* v. *San Pedro Peninsula Hospital* 8 Cal.4th 100, 112 (1984).

[21] *Fein* v. *Permanent Medical Group*, 38 Cal.3d 137, 163 (1985).

[22] *Id.*

Gingrich, former Deputy Attorney General during the Clinton Administration Eric Holder, former Senator Alan Simpson, former Senator Paul Simon, and former Attorney General Richard Thornburgh—reveals the dire need for reforming health care litigation in America. What follows is an excerpt from the "Executive Summary" of the survey's findings:

> Rather than explore the number of suits, the size of jury awards, or the costs of malpractice insurance, this survey sought to explore—through interviews with physicians, nurses and hospital administrators—how the fear of litigation affects the practice of medicine and the delivery of medical care. The results are striking. Concerns about liability are influencing medical decision-making on many levels. From the increased ordering of tests, medications, referrals, and procedures to increased paperwork and reluctance to offer off-duty medical assistance, the impact of the fear of litigation is far-reaching and profound.
>
> Broadly, half (51%) of all physicians think that their ability to provide quality medical care to patients has gotten worse in the past 5 years. Further, more than three-fourths of physicians feel that concern about malpractice litigation (76%) has hurt their ability to provide quality care in recent years. All respondent groups report increased levels of concern or awareness about the risks of malpractice liability over their career and nearly one-third (29%) of physicians state that they have been interested in a certain specialty but shied away from it due to fear of higher legal exposure. These findings seem to suggest that the broad impact of the fear of litigation is significant and growing.
>
> Some of the more arresting study findings are on the impact of liability concerns on the provision of medical care. Broadly, nearly all physicians and hospital administrators feel that unnecessary or excessive care is veryoften or sometimes provided because of fear about litigation. More specifically, physicians report that the fear of malpractice claims causes themselves and/or other physicians to:
>
> - Order more tests than they would based only on professional judgment of what is medically needed. (91% have noticed other physicians, and 79% report they themselves do this due to concerns about malpractice liability)
> - Refer patients to specialists more often than they would based only on their professional judgment of what is medically needed. (85% have noticed other physicians, and 74% report they themselves do this due to concerns about malpractice liability)
> - Suggest invasive procedures such as biopsies to confirm diagnoses more often than they would based only on their professional judgment of what is medically needed. (73% have noticed other physicians, and 51% report they themselves do this due to concerns about malpractice liability)
> - Prescribe more medications such as antibiotics than they would based only on their professional judgment of what is medically needed. (73% have noticed other physicians, and

41% report they themselves do this due to concerns about malpractice liability) . . .

Not surprisingly, there is nearly unanimous agreement among physicians, nurses and hospital administrators that these extra tests, referrals and procedures contribute in a significant way to health care costs issues . . .

Conversations with colleagues appear to be impacted by the fear of litigation. While more than two-thirds of both physicians and nurses report that frank discussions of an adverse event or error at least sometimes helps them or a colleague avoid making a similar mistake in an actual medical case, many report that their colleagues are often uncomfortable having such conversations.

- Only one-fourth or fewer of physicians, nurses and hospital administrators think that their colleagues are very comfortable discussing adverse events or uncertainty about proper treatment with them.
- Even fewer—roughly 5%—think that their colleagues are very comfortable discussing medical errors with them.

Fear of liability is cited by physicians and hospital administrators as the leading factor that discourages medical professionals from openly discussing and thinking of ways to reduce medical errors . . .

The clear majority of physicians, nurses and hospital administrators all feel that malpractice claims occur mainly from adverse results rather than actual error.[23]

The survey asked physicians, "Based on your experience, have you noticed the fear of malpractice liability causing physicians to . . . ?" The results are startling. The following percentages of physicians reported that litigation fears caused them to order more tests than they would based only on professional judgment of what is medically needed (91%); prescribe more medications such as antibiotics than they would based only on professional judgement of what is medically needed (73%); refer patients to specialists more often than they would based only on professional judgment (85%); and suggest invasive procedures more often than they would based solely on their professional judgment (73%).[24] 94% of physicians think such extra tests, referrals, or procedures contribute in a significant way to health care costs.[25] When asked "Generally speaking, how much do you think that fear of liability discourages medical professionals from openly discussing and thinking of ways to reduce medical errors? Fifty-nine percent of physicians replied 'a lot.'[26] And according to the Department of Health and Human Services, 'Doctors are reluctant to collect quality-related information and work together to act on it for fear that it will be used against them or their colleagues in a lawsuit. Perhaps as many as 95% of adverse events are believed to go unreported.'"[27]

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[23] *See* Harris Interactive, "Common Good Fear of Litigation Study: The Impact of Medicine," Final Report (April 11, 2002) ("Executive Summary") at 8–11.
[24] *Id.* at 20 (Table 7).
[25] *Id.* at 21 (Table 8).
[26] *Id.* at 30 (Table 17).
[27] Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July

Doctors themselves, who are most keenly aware of the litigation threats they face, are not blaming insurance companies for high premiums because they know the problem lies in an unregulated medical litigation system.[28] 60% of America's private practice physicians, as well as dentists, hospitals, and other healthcare providers, are insured by insurance companies that were created by doctors, and which are owned and operated by doctors, and which provide only medical malpractice insurance for doctors in the states in which they are based.[29] In fact, most such insurers are mutual insurance companies, in which any "excess profits" must be rebated to the policyholders through dividends or used to offset unexpected losses and thereby hold down premiums for policyholders and potential insureds. The Common Ground survey also found that 87% of physicians stated they fear potential malpractice liability more today than they did when they started their careers,[30] and 83% somewhat or strongly disagree with the statement that physicians can trust the current system of justice to achieve a reasonable result.[31] Indeed, median awards for malpractice claims grew 7 times the rate of general inflation between 1994 and 2000, while negotiated settlement payouts grew at nearly triple the rate of inflation.[32]

As the Reagan Administration's Tort Policy Working Group reported in its seminal study of the effects of tort laws on insurance premiums:

> [Losses due to previous price decisions] are "sunk costs" which the industry cannot recoup simply by charging higher premiums. If premiums in fact are higher than the insured risks and the currently available investment return dictate, either other sources of capital . . . should offer the same insurance at a lower price, or insureds will retain these "excess profits" for themselves through self-insurance or the formation of captives. The fact that there appears to be little insurance coverage being made available by new or expanding underwriters . . . strongly indicates that recoupment of losses is not a par-

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24, 2002) at 6 (citing Maulik, Joshi, Anderson, John *et.al.*, "A Systems Approach to Improving Error Reporting," 16 *Journal of Health Care Information Management* 1)).

[28] As the chair of Our Common Good has written, "The moral authority of victims is powerful. But the resulting laissez-faire lawsuit culture means that social policy gets made, by default, at the intersection of personal tragedy and personal greed. All of society ends up victimized by the victims . . . Suing is not a unilateral right of freedom, like free speech or a property right. Those hallowed constitutional rights—the safeguards of our freedom—protect us against government power. Suing, by contrast, is a use of government power against another free citizen, coming down to that fateful verdict when the full power of government may compel the defendant to pay millions. Being sued is like being indicted for a crime, except that the penalty is money. Today in America, however, we let any self-interested person use that power without any significant check . . . Setting limits on lawsuits is not an infringement of freedom, but a critical tool of freedom. Otherwise one angry person, by legal threats, can bully everyone else. Limiting lawsuits is also a critical tool of social policy. For example, Americans cannot sue utility companies for damage sustained from blackouts, because legislatures long ago prohibited such suits to keep utility bills from skyrocketing." Phillip K. Howard, "There Is No 'Right to Sue'," *The Wall Street Journal* (July 31, 2002) at A14. As Justice Oliver Wendell Holmes wrote in the *Harvard Law Review*, the law is a "standard which we hold the parties to know beforehand . . . not a matter dependent upon the whim of the particular jury . . ." Oliver Weldell Holmes, "Law in Science and Science in Law," 12 Harv.L.Rev. 443, 458 (1899).

[29] *See* http://www.thepiaa.org/about—piaa/what—is—piaa.htm.

[30] *See* Harris Interactive, "Common Good Fear of Litigation Study: The Impact of Medicine," Final Report (April 11, 2002) at 16 (Table 3).

[31] *Id.* at 39 (Table 26).

[32] *See* American Medical Association, "Trends Report: Medical Professional Liability Insurance" (April 2002) at 7. While median jury awards and settlements for alleged malpractice grew at 18.4% and 7.4% per year, respectively, from 1994 to 2000, the rate of general inflation was only 2.5% per year over the same period.

ticularly compelling explanation for the current insurance availability/affordability crisis.

It is particularly puzzling that the proponents of this theory advocate the abolition of the insurance industry's antitrust immunity contained in the McCarran-Ferguson Act (Public Law 79–15) as an appropriate response to the asserted problem of the industry's cash-flow "mismanagement." It is hard to reconcile the argument that the current problems of the insurance industry stem from "excessive competition" with the proffered solution of removing the industry's antitrust immunity. Since the goal of antitrust law is to enhance competition, if one truly believes that the problems of the insurance industry are a result of too much competition, the last thing one would advocate is a legal change which would increase the level of competition. While the Working Group did not review and takes no position on the continuing validity of the industry's antitrust immunity, it is readily obvious that the suggestion that allegedly "excessive competition" can be cured by even more competition is patently absurd.

The reasons why the loss recoupment (or excessive pricing) theories advocated by some make little economic sense can briefly by summarized as follows:

- Insurers, like all profit maximizing companies, charge the price which maximizes their profits. Past gains or past losses are irrelevant to setting the price today which will maximize profits tomorrow. The argument that insurers are charging higher premiums to recoup past losses suggests that absent such losses their premiums would be lower—that is, that they would not be charging premiums that maximize their profits. That makes little sense.
- Even if excessive premiums were being charged by some insurers to recoup their past losses, for the reasons discussed, other insurers would offer the same coverage at lower prices reflecting the actual risk, or insureds would retain such excess profits for themselves through self-insurance or the formation of captives. [33]

As the Tort Policy Working Group also stated, "These same points apply equally well to arguments that premiums are set excessively high to recoup losses resulting from mismanaged investment portfolios. Just as past losses are irrelevant to determining the premiums which will maximize profits, investment portfolio losses should have no bearing on premiums." [34] The Tort Policy Working Group continued:

> A[n] . . . important contribution of tort liability to the availability/affordability crisis is the tremendous uncertainty that has been generated by rapidly changing standards of liability and causation. The "rules of the game" have become so unpredictable that the insurance industry often cannot assess liabil-

[33] Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability (February 1986) at 27–28. Many insurance companies are mutuals, meaning that they are owned by their policyholders. The suggestion that they are charging their policyholder-owners unnecessarily high premiums makes even less sense, since any such excess profits must be rebated through policyholder dividends.

[34] *Id.* at 29, n.20.

ity risks with any degree of confidence. This appears to have severely exacerbated the problem. [35]

Further:

The increase in the number of tort lawsuits and the level of awarded damages (or settlements) in and of itself has an obvious inflating effect on insurance premiums. To illustrate, assuming all other factors are held constant, if the number of lawsuits against a company or person doubles in 10 years, and if the average damage award (or settlement) doubles over this same period, that company or person will experience at least a four-fold increase in insurance premiums over those 10 years. As noted above, however, for both medical malpractice and product liability the last 10 years have witnessed much more than a doubling in lawsuits and average awards . . . [T]he current explosion in premiums results in large part from the fact that now that the insurance industry is facing substantial underwriting losses, it must price coverage to reflect the actual risks presented by tort law. [36]

. . .

Simply put, insurance, like other business activities, operates most efficiently within a stable legal regime. Tort law, unfortunately, over recent years has been anything but stable . . . In conclusion, the current problems of tort law can be summarized as follows:

- Too many defendants are found liable (or forced into settlements) where there should be no liability, either because they engaged in no wrongful activity, or because they did not cause the underlying injury.
- Damages have become excessive, particularly in the area of non-economic damages such as pain and suffering, mental anguish and punitive damages. And,
- Transaction costs are far too high. [37]

The ability of the tort system to deter injuries caused by medical negligence is greatly reduced by the haphazard relationship between negligent injuries and compensation through the tort system. Research of the Harvard Medical Practice Study consisted of reviews of medical tort claims filed by a specialist medical reviewer teams. The Harvard Study team concluded that "when we compared the tort claims brought by the patients in our sample with the judgment made by our medical reviewers, we found that in a substantial proportion of cases where claims were filed, our reviewers judged from the medical record that a negligent adverse event had not occurred. Thus, the tort system imposes the costs of defending claims on [health care] providers who may not even have been involved in an injury, let alone a negligent injury." [38] Indeed, the researchers found that, of the 47 medical malpractice claims they studied that resulted in litigation, [39] "[i]n 14 cases, the physi-

[35] *Id.* at 3.
[36] *Id.* at 49.
[37] *Id.* at 51–52.
[38] *See* Harvard Medical Practice Study to the State of New York, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York at 11–5 (1990).
[39] *See id.* at 7–1.

cians reviewed the record and found no adverse event. For most of these cases, the physicians examined the outcome and concluded that the cause was the underlying disease rather than medical treatment . . . In these 14 cases, our physician reviewers took a stand opposite to that of the plaintiff-patient's expert."[40] Further, the reviewers found that in an additional 10 cases an adverse event occurred, but there was no negligence on the part of the health care provider.[41] Thus, of the 47 claims filed that the researchers analyzed, less than half demonstrated any actual negligence, and many demonstrated no discernable injury.[42] Physicians will respond to the incentives created by tort law only if they believe their punishments are connected in some rational way to their negligence. But research shows that they do not believe that. They tend to see the tort system more as a random generator of punishments and rewards. A majority of physicians feel that they will be held legally liable for seriously adverse outcomes, almost regardless of the quality of care they actually provided. Physicians and risk managers are therefore moved by the threat of malpractice liability to avoid the risk of liability rather than to avoid the risk of injury.[43]

The data produced by the Harvard Medical Practice Study has been further analyzed to determine how accurately malpractice litigation leads to payment. Confidential medical records were reviewed to determine the insurers' honest assessment of the patients' injuries, and the study's findings indicate that in malpractice claims, only the severity of the patient's disability, not negligence or even the occurrence of an injury caused by medical care, was statistically significant in predicting whether a plaintiff would receive payment.[44] From its previous study, the Harvard authors identified 51 litigated claims and followed them over a 10-year period. The authors conclude, "Among the malpractice claims we studied, the severity of the patient's disability, not the occurrence of an adverse event or an adverse event due to negligence, was predictive of payment to the plaintiff."[45] As one writer on seeing these findings put it: "If the permanence of a disability, not the fact of negligence, is the reason for compensation, the determination of negligence may be an expensive sideshow."[46] This is widely understood by physicians as determined by a recent survey conducted for the bipartisan legal reform organization "Common Good," which found that 96% of physicians believe malpractice claims occur mainly from adverse results rather than actual medical errors.[47]

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[40] *See id.* at 7–33.

[41] *See id.* at 7–33.

[42] *See also* Paul Weiler, et al., A Measure of Malpractice (1993) at 71 ("[Of those 47,] 10 claims involved hospitalization that had produced injuries, though not due to provider negligence; and another three cases exhibited some evidence of medical causation, but not enough to pass our probability threshold. That left 26 malpractice claims, more than half the total of 47 in our sample, which provided no evidence of medical injury, let alone medical negligence.").

[43] *See* Harvard Medical Practice Study to the State of New York, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York at 9–34 (1990).

[44] *See* Troyan A. Brennan, et al., Relation Between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation, 335 *New England Journal of Medicine* 1963 (December 26, 1996) at 1966 ("Overall, empirical evidence does not strongly support using the negligence standard to prevent medical injury.").

[45] *See id.* at 1963.

[46] *Id.* at 1967.

[47] *See* Harris Interactive, "Common Good Fear of Litigation Study: The Impact of Medicine," Final Report (April 11, 2002) at 42 (Table 29). *See also* O'Connell, Jeffrey and Pohl, Christopher, "How Reliable is Medical Malpractice Law?," 359 Journal of Law and Health (1998) ("The evi-

The Harvard Study researchers conclude that "In the multivariate analysis, disability (permanent vs. temporary or none) was the only significant predictor of payment. . . . Neither the presence of an adverse event due to negligence . . . nor the presence of an adverse event of any type . . . was associated with payment to the plaintiff."[48]

The medical journal *Annals of Medicine* has recently detailed a series of reports of medical errors. In an editorial about the new series, Dr. Robert M. Wachter, associate chairman of the department of medicine at the University of California at San Francisco, and his colleagues wrote that the medical profession "for reasons that include liability issues"[49] has not harnessed the full power of errors to teach and thereby reduce errors.

Research has demonstrated that direct medical care litigation reforms—including caps on non-economic damage awards—reduce the growth of malpractice claims rates and insurance premiums, and reduce other stresses on doctors that may impair the quality of medical care.[50] Researchers' findings point to the stresses created by the adversarial quality of both litigation and equally adversarial pre-trial maneuvers.[51] Indeed, physicians who are under the malpractice gun are isolated from both their patients and their professional colleagues; they feel vilified by the accusations and the personal invective that litigation requires; they are distracted and engage in excessive rumination, to the detriment of timely and effective medical decision-making; and they experience a marked loss of professional self-confidence. Litigation causes stress; stress causes dysfunctional behaviors; and these behaviors can contribute to the making of additional errors.[52] Researchers have found that

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dence is growing that there is a poor correlation between injuries caused by negligent medical treatment and malpractice litigation.").

[48] Troyan A. Brennan, *et al.*, Relation Between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation, 335 New England Journal of Medicine 1963 (December 26, 1996) at 1965. Another report by the Institute of Medicine regarding medical errors states that "Preventable adverse events [in U.S. hospitals] are a leading cause of death" and "at least 44,000, and perhaps as many as 98,000, Americans die in hospitals each year as a result of medical errors." L.T. Kohn, J.M. Corrigan, M. Donaldson, eds., "To Err is Human: Building a Safer Health System" (Institute of Medicine: 1999). However, those conclusions have been disputed. *See* Clement J. McDonald, Michael Weiner, and Siu L. Hui, "Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report," 284 JAMA 1: 93–95 (July 5, 2000), at 93–94 ("Motor vehicle occupants do survive their ride if collisions are avoided. Unlike most people who step into motor vehicles, most patients admitted to hospitals have high disease burdens and high death risks even before they enter the hospital . . . The Harvard Study [upon which the Institute of Medicine's conclusions are based] includes no information about the baseline risk of death in [the patients studied] or information about deaths in any comparison group. Therefore, it cannot be determined whether adverse events are correlated with, let alone whether they cause, death . . . Given these facts, using available data and some reasonable assumptions, we believe that the increment in the published death rate due to adverse events above the baseline death rate could be very small.").

[49] Editorial, "Learning from Our Mistakes: Quality Grand Rounds, a New Case-Based Series of Medical Errors and Patient Safety," 136 *Annals of Internal Medicine* 11 (June 4, 2002) at 850.

[50] *See* Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," 60 *Law and Contemporary Problems* 1: 81–106 (1997), at 105 ("[P]hysicians from states enacting liability reforms that directly reduce malpractice pressure experience lower growth over time in malpractice claims rates and in real malpractice insurance premiums. [Also], physicians from reforming states report significant relative declines in the perceived impact of malpractice pressure on practice patterns.").

[51] *See* Thomasson *et al.*, Patient Safety Implications of Medical Malpractice Claimed Resolution Procedures, in Proceedings of Enhancing Patient Safety and Reducing Errors in Health Care (1998) at 158.

[52] *See* Sara C. Charles, M.D. *et al.*, Sued and Nonsued Physicians' Satisfaction, Dissatisfactions, and Sources of Stress, 28 *Psychosamtics* 462, 466 (1987) ("The finding that sued physicians were more stressed from dealing with high-risk and emergency situations, being on call, and from fear of making an incorrect diagnosis suggests that the experience of litigation

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significantly more of sued physicians than nonsued physicians reported that they were likely to stop seeing patients with whom the risk of litigation seemed greater, to think about retiring early, and to discourage their children from pursuing medicine as a career. Also, research has found that both sued and nonsued physicians order more diagnostic tests that their clinical judgment deems unnecessary and have stopped performing certain high-risk procedures. As the researchers concluded, "The changes in professional behavior among the respondents suggest that malpractice litigation may have an impact on physicians" freedom to exercise their own clinical judgment. As a result, patients may be deprived of the full range of a physician's professional expertise. In addition, almost half of those sued (48.9%) reported that because of fear of potential litigation they will not see certain kinds of patients . . . [A]ccess to health care may be becoming restricted because of factors associated with malpractice litigation. The funding that many physicians may opt for early retirement and discourage others from entering medicine may also eventually have an impact on health care availability . . . [T]he resultant stress on both sued and nonsued physicians may in the long run not serve the public interest or the quality of medicine. It may diminish rather than enhance the integrity and availability of medical care.' [53]

Senator Joe Lieberman has described the current medical care legal crisis as follows: "Mr. President, in my view, you can add the civil justice system to the list of fundamental institutions in our country that are broken and in need of repair . . . In our time, unfortunately, the civil justice system has too often become a game of legalistic sophistry, of bullying, of bluffing, a game which overcompensates lawyers, undercompensates victims, particularly seriously injured victims, and costs all the rest of us an awful lot of money in higher prices for consumer products, for health care, higher premiums for insurance, fewer jobs, and fewer new products to improve and protect our lives . . . Our present system for compensating patients who have been injured by medical malpractice is ineffective, inefficient and, again, in many respects, unfair." [54]

As Senator Lieberman has described, the crisis is national in scope and warrants a Federal response: "Mr. President, I did not always support a national or Federal approach to product liability reform or tort reform generally, and I can understand the hesitancy, particularly of some of the Members, to support Federal involvement in what traditionally has been a province of the States . . . So I listened to [] folks, and I came to understand the necessity of Federal action and, of course, to understand the reality and appreciate the reality that we are one country; that products travel from State to State; that people using them travel from State to State; and that there is a crying need out there in the interest of

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accentuates the stresses of ordinary practice . . . Increased anxiety about these activities, however, may result in avoidant behaviors, which, in the long run, diminish rather tan refine clinical competence.").

[53] Sara C. Charles, M.D. et al., Sued and Nonsued Physicians Self-reported Reactions to Malpractice Litigation, 142:4 Am. J. Psychiatry 437, 440 (1985).

[54] Senator Lieberman, floor statement on the Common Sense Product Liability and Legal Reform Act (April 27, 1995). As Senator Lieberman has summed up his own reform proposals: "Key provisions of the reform include, No. 1, establishing a uniform statute of limitations, 2 years; No. 2, allowing periodic payments for awards . . . No. 3, applying several—not joint and several—liability for noneconomic damages, pain and suffering." These or very similar provisions are in the HEALTH Act.

every State and our country, our economy, the equity of our society, to build a floor of fairness, a common system that will protect the rights of all." [55]

The personal impact of the current crisis is made clear in the following poignant report from the Mississippi *Clarion-Ledger*:

> Dr. Kirk Kooyer arrived in the Mississippi Delta in 1994 to serve the poor. "I came here with a Christian conviction in my heart," said the 39-year-old Michigan native. Now he and his wife, Maria Weller, a Vicksburg pediatrician, are moving their mission to North Dakota, he said, because of increasing litigation. "It's the harassment of dealing with meritless lawsuits," he said. "It makes you feel frustrated and demoralized." . . . When Kooyer leaves Rolling Fork on Thursday, Sharkey and Issaquena counties will lose their only pediatrician, who is also a board-certified internist. Two doctors will remain to handle all emergencies at the already struggling Sharkey-Issaquena Community Hospital, where nearly every patient is below the poverty level. "If one of us is on vacation and the other one's sick, you don't have a doctor," said Dr. Andrew George of Rolling Fork, one of the remaining physicians. "You can't have a hospital without a doctor." Hospital administrator Winfred Wilkinson said the loss of Kooyer "is going to put a terrible strain on us. What's going to be hard is to find someone to replace him because whoever comes will face the same thing. It's the patients who'll suffer." . . . Since Kooyer arrived in 1994, Sharkey County's infant mortality has declined. According to state Department of Health statistics, mortality dropped from an average of 10 deaths per 1,000 live births between 1990 and 1994 to 3.4 deaths between 1996 and 2000. Contributing to that success is the Cary Christian Center, which provides prenatal classes and home visits. Kooyer has assisted in the ministry there. "Every year, we save one or two babies in the emergency room," Kooyer said. "I'm concerned a lot of the progress we've made could be lost when there's no longer a pediatrician in Sharkey County." . . . "It just kills me he's leaving because he's one of the brightest physicians around," said Dr. Chris Glick of Jackson, president-elect of the National Perinatal Association. "He's made an incredible difference in the health of women and children." In fact, if Normal Rockwell painted a doctor, he would probably look like Kooyer, she said. "People say, 'I want my doctor to be a kind-hearted family man who's soft and gentle.' That's what he is. "It's so ironic he's being run off because he's the kind of guy we need in the Delta. He could have had a very well-to-do practice in Michigan but instead he chose to work in the poorest counties in Mississippi as a gift from his heart." . . . When Hazel Norton of Rolling Fork, the patient who filed suit [against Kooyer], read [a] drug [Propulsid, which Kooyer prescribed] might cause harm, she said she stopped taking it. "Actually, I didn't get hurt by Propulsid," Norton, who had the drug prescribed for her heartburn, said. But because she had taken the drug, she said she thought she could join a class-action lawsuit "and I might get a couple of thousand dollars." The last thing she in-

[55] *Id.*

tended, Norton said, was for Kooyer to be sued. "He's really a good doctor, very intelligent," said Norton, who's been Kooyer's patient since 1994. "He makes you feel so comfortable." She said she intended for the drug company to be sued, but that lawyers told her it would be better for her case to sue Kooyer in order to keep the case in Mississippi. After finding out Kooyer had been sued, she said she wrote a letter to her attorneys, objecting. "I'm kind of upset. I do not want him leaving because of all the suits," she said. "If we run off all the doctors, what are the people gonna do?" Kooyer was eventually dropped from the litigation but not before he made up his mind to leave Mississippi. "These are just the symptoms of a state in which key people have lost their ethical integrity," he said . . . Verdicts in lawsuits against pharmaceutical companies are not against doctors, Sweet said. He acknowledged his law firm and others have included physicians in recent lawsuits against drug companies, which he said often put the blame on physicians. "I'm not after the doctors, but the way the law is I have to do this," Sweet said. [56]

SKYROCKETING INSURANCE RATES ARE PREVENTING ACCESS TO HEALTH CARE

The combined national effects of the nation's patchwork of medical care litigation rules have led doctors to face skyrocketing insurance rates and caused untold numbers of doctors to leave the profession or reduce the number of patients they see. [57]

Women are being particularly hard hit. The American College of Obstetricians and Gynecologists ("ACOG"), in a release entitled "How Caps Protect Women's Access to Health Care," states that it "believes that the meteoric rise in liability premiums threatens women's access to [health] care." ACOG continues that "[e]xperience demonstrates that obstetric providers—when confronted with substantially higher costs for liability coverage—will stop delivering babies, reduce the number they do deliver, and further cut back, or eliminate, care for high-risk patients, the uninsured, and the underinsured . . . Also hurt without a cap will be the nation's 39 million uninsured patients—the majority of them women and children—who rely on non-profit licenced community clinics for health care. Unable to shift higher insurance costs to their patients, these clinics will have no alternative but to care for fewer people." ACOG continued that, without a cap on non-economic damages, "women's access to prenatal care will be reduced" and that "[a]s premiums increase, women's access to general health

[56] Jerry Mitchell, "Tort Reform: Just What the Doctor Ordered?" *Clarion-Ledger* (July 29, 2002) at A1.

[57] *See, e.g.,* Joelle Babula, "Crisis Alters Lives, Livelihoods," The *Las Vegas Review-Journal* (April 7, 2002) ("You don't just pick a doctor out of the phone book to perform open heart surgery on your baby daughter," said Emma's father, Steve Walker. "We were supposed to wait as long as we could for the surgery, until she gets bigger and stronger. But now she won't get that chance because the doctors may no longer be here." Emma's heart surgeon, Dr. Robert Wiencek, is one of only four pediatric cardiac surgeons in Las Vegas. The four doctors, who practice together at Cardiovascular Surgery Associates, all are preparing to move out of state because they are having problems finding medical malpractice insurance . . . "My cardiologist friends in California pay between $45,000 and $50,000 a year for malpractice," Wiencek said. "What I pay now is $78,000 and I expect that to at least double." If Wiencek and his group do move and if Emma needs more surgeries or has to postpone her next one, her family will follow Wiencek wherever he ends up. "We'd fly or drive wherever he goes," said Emma's mother, Kelly Walker. "We found out about Emma's heart condition when I was 4 months pregnant, and this team of doctors has been with us since then.".).

care—including regular screenings for reproductive cancers, high blood pressure and cholesterol, diabetes, sexually transmitted diseases, and other serious health risks—will decrease without a cap."[58] As the *Las Vegas Review-Journal* reports, "Most of the doctors are insured by American Physicians Assurance, a company that recently began charging doctors even more for delivering what it considers too many babies, said Dennis Coffin, an insurance agent representing the company . . . Doctors say that if they deliver less than 125 babies a year, they face annual malpractice premiums that jump from about $40,000 to $80,000. Those who deliver between 125 and 175 babies will have to pay more than $100,000 per year in medical malpractice premiums. The prices continue to rise for doctors who deliver more than 175 babies a year."[59]

Skyrocketing medical insurance rates have caused similar crises nationwide.[60] Medical malpractice insurance premiums are increasing at the highest rate since the mid-1980's[61] and con-

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[58] Release, American College of Obstetricians and Gynecologists, "How Caps Protect Women's Access to Health Care" (March 7, 2002).

[59] Joelle Babula, "Medical Malpractice Crisis: Pregnant Women Turned Away" *Las Vegas Review-Journal* (May 7, 2002).

[60] Doctors across America are seeing steep jumps in their medical malpractice premiums from years 2000 to 2001. *See* Steve Friess, "Malpractice Insurance Soars, Doctors Feel Hit" *USA Today* (April 8, 2002) ("St. Paul ended coverage for 42,000 doctors nationwide, citing nearly $1 billion in losses, attributed primarily to high jury awards and settlements in malpractice lawsuits. Now those doctors are shopping for other insurance, but other companies are refusing to write policies for obstetricians, general surgeons and emergency room doctors in states with no or ineffective limits to jury awards."). In Florida, liability insurance coverage for pregnancy-related care is now running as high as $202,000 in some counties. *See USA Today*, "You Might Feel a Bit of a Pinch: Malpractice Insurance Costs Push Doctors to Cut Services or Move" (December 4, 2001). In Texas, liability insurance coverage for pregnancy-related care runs as high as $160,000 for physicians in Dallas, Houston, and Galveston. Id. In Michigan, liability insurance coverage for general surgery in Detroit is running as high as $94,000 annually. Id. The following are some more examples provided in 26 Medical Liability Monitor 10 (October 2001) "Trends in 2001 Rates for Physicians Medical Professional Liability Insurance." Internal Medicine—Florida (Dade and Broward counties) $26,896–$50,774; Florida (Palm Beach county) $30,464–$44,660; Michigan (Wayne and McComb counties, Detroit area) $18,376–$40,233; Illinois (Chicago/Cook County) $15,539–$28,153; Massachusetts $8,428–$9,768; Ohio (Cleveland area) $10,853–$16,270; Texas (Dallas, Houston, Galveston) $14,552–$25,563 and (rest of Texas) $16,779–$28,289; Nevada (Las Vegas area) $11,636–$15,804; New York (N.Y., Nassau, Suffolk counties) $16,751–$21,648; General surgeons—Florida (Dade/Broward counties) $63,189–$159,166; Florida (Palm Beach county) $62,120–$81,998; Massachusetts $27,244–$31,521; Texas (Dallas, Houston, Galveston) $34,306–$133,957 and (rest of Texas) $29,830–$50,293; Michigan (Wayne and McComb counties, Detroit area) $66,611–$94,195; Illinois (Chicago/Cook County) $50,021–$70,178; Ohio (Cleveland area) $33,397–$60,021; Nevada (Las Vegas area) $40,388–$56,892; West Virginia $36,094–$56,371; Obstetricians/gynecologists—Florida (Dade/Broward counties) $143,249–$202,949; Florida (Palm Beach county) $128,584–$169,731; Massachusetts $76,176–$88,288; Texas (Dallas, Houston, Galveston) $69,918–$160,746 and (rest of Texas) $46,607–$78,579; New York (New York, Nassau, Suffolk counties) $89,317–$115,429; Michigan (Wayne and McComb counties, Detroit area) $87,444–$123,890; Illinois (Chicago/Cook County) $88,928–$110,091; Ohio (Cleveland) $58,131–$95,310; Nevada (Las Vegas area) $71,092–$94,820; Ohio (Cleveland) $58,131–$95,310; West Virginia $63,165–$84,551.

In 2002, medical malpractice insurance rates are up by the following amounts in the following states: Internal medicine—Arkansas (32.5%); Colorado (9.4%); D.C. (19%); Georgia (29% to 34%); Illinois (16% to 35%); Indiana (46% to 58.3%); Louisiana (23.4%); Maryland (25%); Montana (58%); Nevada (27.5%); Pennsylvania (46% to 81%); Texas (40% to 57%); Utah (40%); Virginia (25.9%); West Virginia (36%–66.8%); General surgery—Arkansas (32.5%); Colorado (8.7%); D.C. (19%); Georgia (29% to 34); Illinois (16% to 35%); Indiana (39.4% to 52.3%); Louisiana (15%); Maryland (24.9%); Montana (55.7%); Nevada (39.5%); Pennsylvania (46% to 81%); Texas (32.1% to 54%); Utah (40%); Virginia (25.8%); West Virginia (36% to 50.3%); Obstetrics/gynecology—Arkansas (32.5%); Colorado (5.6%); D.C. (19%); Georgia (29% to 34%); Illinois (16% to 35%); Indiana (39.4% to 52.4%); Louisiana (15%); Maryland (25%); Montana (55.5%); Nevada (15% to 38.5%); Pennsylvania (40% to 81%); Texas (31.7% to 48%); Utah (40%); Virginia (25.9%); West Virginia (28.5% to 36%). *See* 27 Medical Liability Monitor 1 (January 21, 2002) at 5.

[61] *See* Joseph B. Treaster, "Doctors Face A Big Jump In Insurance" *The New York Times* (March 22, 2002) ("Higher malpractice insurance rates are likely to add to rising health care costs, although managed care has limited doctors' ability to pass along their higher expenses. Beyond that, rising malpractice rates have caused some doctors to quit practicing or to practice medicine defensively, ordering extra tests or choosing procedures that limit their risks. 'The situation is very ominous,' said Gerry Conway, the director of government affairs for the New York

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sequently doctors are practicing more defensively, ordering unnecessary extra tests and choosing unnecessary procedures that limit their risks. [62]

The medical insurance crisis has already caused St. Paul—an insurer of 42,000 doctors, 750 hospitals, 5,800 health care facilities, and 72,000 health care providers such as nurses—to leave the business entirely. [63] In the words of Thomas A. Bradley, chief financial officer of St. Paul, the medical malpractice insurance crisis was "basically another World Trade Center loss for us this year." [64] Other medical malpractice insurers have also recently left the market, [65] and many others have become insolvent. Licensed carriers'

State Medical Society. 'Increases like this cannot be absorbed by physicians.'"); Tricia Cortez, "Texas Doctors Plan One Day Strike" *Loredo Morning Times* (February 19, 2002) ("One Laredo doctor, who requested anonymity, said malpractice insurance for doctors has doubled or even tripled because of the escalating number of lawsuits and jury awards. 'Last year, I was paying $9,000 in insurance for $1.5 million maximum yearly coverage. This year, I am paying $24,000 a year for $600,000 maximum coverage. So, my insurance premiums nearly tripled, but my coverage was cut in half,' the doctor said. These costs, however, pale in comparison to insurance costs paid by obstetricians/gynecologists and other high-risk specialty doctors. Dr. Santiago Gutierrez, a Laredo ob-gyn, said fellow ob-gyns along the border are paying $60,000 to $250,000 in malpractice insurance a year . . . A January article in American Medical News reported that Texas was one of eight states where physicians saw medical liability rates increase by 30 percent or more.").

[62] *See* Joseph B. Treaster, "Malpractice Rates Are Rising Sharply; Health Costs Follow," *The New York Times* (September 10, 2001) ("Medical malpractice insurance premiums are increasing at the highest rate since the mid-1980's, adding to rising health care costs. Insurers say the increases, typically in the double digits, result mainly from a rise in jury awards, now averaging $3.49 million. Some of the biggest insurers are raising rates in many states by more than 30 percent. Even insurers owned by doctors and hospitals, which work to keep rates low, are increasing prices by 10 percent to 18 percent. Insurers began raising rates last year, after several years of price-cutting competition that left premiums behind inflation. A 4-percent rise in premiums last year was the biggest since 1994, and insurers say the increases are greatly accelerating this year . . . Health care costs are expected to increase about 10 percent this year. Rising malpractice premiums account for about one-tenth of the increase, according to Dr. William F. Jessee, chief executive of the Medical Group Management Association, which represents 188,000 doctors, or nearly half of those who buy the coverage . . . Rising medical malpractice premiums are also adding to medical costs in another way: Doctors are practicing more defensively, ordering extra tests and choosing procedures that limit their risks. Dr. Nigel Spier, an obstetrician-gynecologist in Hollywood, Fla., said doctors were performing more Caesarean deliveries, for example, which are more costly than vaginal deliveries. Insurers put most of the blame for the increases on a jump in big awards by juries and large settlements. While the number of malpractice suits has been holding steady, the average jury award rose to $3.49 million in 1999, up 79 percent from $1.95 million in 1993, according to the latest compilation by Jury Verdict Research of Horsham, Pa. . . . St. Paul, the second-largest malpractice insurer, has raised rates for doctors an average of 24 percent this year in 25 states, with rates jumping 65 percent in Ohio and Mississippi. Scpie Companies is raising rates an average of 30 percent to 50 percent in a dozen states, including Florida and Texas.").

[63] *See* Joseph T. Hallinan, "St. Paul Gradually Will Pull Out Of Malpractice-Insurance Sector," *The Wall Street Journal* (December 13, 2001) at B2 ("Among its biggest money losers is the medical-malpractice business, expected to generate underwriting losses this year of $940 million. St. Paul provides malpractice insurance to 42,000 doctors in the U.S., in addition to 750 hospitals, 5,800 health-care facilities and 72,000 health-care providers such as nurses. St. Paul said it won't cancel these policies but will instead allow them to lapse as they come up for renewal. The company said it will take roughly 2 years to complete the process of not renewing the business. Last year, the malpractice business accounted for about 10% of the company's $5.8 billion of total written premiums. St. Paul insures about 6% of the nation's 797,000 doctors.").

[64] "St. Paul to Exit Medical Malpractice, Pose $900 Million Charge," Best's Insurance News (December 12, 2001) ("While medical malpractice was once 40% of St. Paul's book of business, the company has been backing away from the line, which has now fallen to 10.5% of its net premiums written in 2000, according to A.M. Best Co. data. The company will take in an estimated $530 million in net written premiums for medical malpractice in 2001, and will post an underwriting loss of $940 million, including the $600 million reserve charge, for the year. 'It's basically another World Trade Center loss for us this year,' Thomas A. Bradley, chief financial officer, said in the call. Medical malpractice has become an increasingly difficult business to write, Fishman said, noting that over the years, many low-risk doctors have pulled out of the commercial market to form mutual companies that offered cheaper coverage, which has increased adverse selection in the market. 'The fundamentals of the business has changed. This is not just a cycle,' he said.").

[65] *See* Meg Green, "Med Malcontent: Top medical malpractice writer St. Paul Cos. Abandons the Unprofitable Business. Who Will Fill the Void?" Best's Review (February 1, 2002) at 12 ("St. Paul Cos.' decision to withdraw from the market . . . comes on the heels of two other companies also leaving the market this year. Phico Group Inc., which wrote $182.5 million in direct medical malpractice premiums for 2000, has been taken under control by regulators. Also, Frontier In-

medical professional liability insurance business has, on average, been unprofitable in every year from 1990–2000.[66] It has also been recently reported that "nearly all companies that used to write nursing home liability [insurance] are getting out of the business."[67] Since the costs of nursing home care are mainly paid by Medicaid and Medicare, these increased costs are borne by taxpayers, and consume resources that could otherwise be used to expand health (or other) programs.

According to the Department of Health and Human Services:

> The litigation crisis is affecting patients' ability to get care not only because many doctors find the increased premiums unaffordable but also because liability insurance is increasingly difficult to obtain at any price, particularly in non-reform states. Demonstrating and exacerbating the problem, several major carriers have stopped selling malpractice insurance.
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> - St. Paul Companies, which was the largest malpractice carrier in the United States, covering 9% of doctors, announced in December 2001 that it would no longer offer coverage to any doctor in the country.
> - MIXX pulled out of every state; it will reorganize and sell only in New Jersey.
> - PHICO and Frontier Insurance Group have also left the medical malpractice market.
> - Doctors Insurance Reciprocal stopped writing group specialty coverage at the beginning 2002.
>
> States that had not enacted meaningful reforms (such as Nevada, Georgia, Oregon, Mississippi, Ohio, Pennsylvania, and Washington) were particularly affected. Fifteen insurers have left the Mississippi market in the past 5 years.[68]

Many other insurers are also pulling out of the professional medical liability market, while staying in the insurance market generally as a combination of factors that came together in the past few years caused turmoil in the medical-malpractice market. Frequency of claims has leveled off at a high level, for example, while the severity of claims has grown at an annual rate of 5% to 8%.[69]

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surance Group, which wrote $69.3 million in direct medical malpractice premiums, stopped taking on risk earlier this year . . . 'It used to be someone had to make an error to get sued,' Riley said. 'Now you have failure to do something. These cases are being brought in hindsight.' . . . The medical malpractice market is littered with failed companies. From Frontier and Phico to companies like PIC Insurance Group and PIE Mutual Insurance Co., both of which were taken over by regulators—some insurers are finding medical malpractice too dangerous to their bottom line. Once a profitable product for insurers, medical malpractice has seen losses soar in recent years as combined ratios have skyrocketed. In 2000, the industry lost $1.30 for every $1 in premium it took in, according to A.M. Best Co. data.").

[66] *See* American Medical Association, "Trends Report: Medical Professional Liability Insurance" (April 2002) at 5.

[67] A.M. Best Company, Inc., "As Nursing home liability losses soar, carriers stop writing business," (February 7, 2000).

[68] Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July 24, 2002) at 14.

[69] *See* Best's Insurance News, "Nevada Complaint Blames St. Paul Cos. for Med-Mal Crisis" (May 31, 2002) ("A combination of factors that came together in the past few years caused turmoil in the medical-malpractice market, said Larry Smarr, president of Physicians Insurers Association of America, a trade group representing most of the physician-owned medical liability companies. 'Frequency of claims has leveled off, but at a high level, while the severity of claims has grown at an annual rate of 5% to 8% and there has been nothing to forestall that trend," he said. "We're seeing more and more larger awards driving up costs to the extent that carriers

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The commonly made claim that sharp increases in medical liability insurance rates are due to insurer losses in the stock market is dubious, as less than 15% of the assets of medical liability insurance companies are stocks. [70]

Beyond insurers, rising rates due to an unregulated litigation system are decimating the ranks of doctors and physicians, who are being forced to leave their patients and practices. [71] The problem

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have to take rate increases.' The industry is on an uphill progression on paid-claims severity, Smarr said. When you look at California, which has instituted tort reform, the medical-malpractice costs have risen since 1976—the year the California micro law went into effect—through 2001, just as it has in other states, he said. But according to information compiled by the National Association of Insurance Commissioners, California med-mal costs grew by 196% in that time, compared with the rest of the country, which grew by 505% for the same period, he said.").

[70] *See* Physician Insurers Association of America, "Bordering on Malpractice: Serious Errors Found in Consumer Federation of America Report on Medical Liability Insurance" (May 9, 2002).

[71] *See* Rachel Zimmerman and Christopher Oster, "Assigning Liability: Insurers' Missteps Helped Provoke Malpractice 'Crisis'," *The Wall Street Journal*, (June 24, 2002 edition) at A1 ("[M]alpractice litigation has a big effect on premiums . . . Premiums in Maine are relatively low [because] 'the heavily rural population isn't notably litigious . . . 'Scpie stopped writing coverage in any state other than California.'). Scpie Holdings, a medical professional liability insurer, can survive in California, where health care is particularly accessible, because California enacted reasonable medical litigation management reforms over 25 years ago that include a $250,000 cap on noneconomic damages and limits on the contingency fees lawyers can charge, among other reforms. The HEALTH Act contains the very same litigation management reforms that have kept medical professional liability premiums affordable—and health care accessible—in California. Modeled after California's reforms, the HEALTH Act will do the same for the rest of country. *See also* 'Lack of Surgeons Threatens Network,' Mississippi State Medical Association Legislative Report (March 15, 2002) Dr. Hugh Gamble, MSMA President and Trauma Committee Chairman said hospitals around the state are in danger of losing their trauma level status because surgeons are leaving the state . . . Neurosurgeons in Tupelo, Columbus, Greenwood and Greenville are limiting trauma care because of the liability risk. Dr. Rodney Frothingham, 'People who have children traveling from school in the north half of the state are going to have to pray a little harder that they make it home safely,' said Frothingham."); John Porretto, the Associated Press, "Doctors Looking Elsewhere to Practice," published in the Tupelo Daily Journal (March 21, 2002) ("The Mississippi State Medical Association says it knows of at least 20 frustrated physicians who have decided in the past 3 weeks to quit or move as it's become clear Mississippi lawmakers will not pass tort reform legislation in the 2002 session, which ends April 7. Dr. Hugh Gamble of Greenville, the medical association's president, estimates the state could lose 10 percent of its 4,000 to 4,500 doctors to departure or retirement by year's end . . . Mississippi Insurance Commissioner George Dale said Wednesday the chances of more companies offering malpractice coverage in the near future are not good . . ."); Mel Huff, "Texas Docs Twice as Likely to Get Sued," *The Brownsville Herald* (March 17, 2002) ("A Texas Medical Association survey of area doctors taken in April 2001 showed that of those who responded, 65 percent had been sued; 71 percent said they were afraid to respond to emergency room calls because of lawsuits; and 55 percent said they were inclined to leave the Valley if the liability crisis does not improve . . . Dr. Carlos Chavez, a Brownsville heart surgeon, described the effect of frivolous lawsuits as a chain reaction that increases physicians' malpractice premiums, causes them to practice medicine more defensively, drives up costs and ultimately restricts the availability of health care . . . Dr. Bradley Nordyke, a general practitioner, noted that although he has never been sued, his insurance company told him last year that his coverage was being dropped. He found another carrier at a 400 percent rate increase. Then—although he still has not been sued—that insurer also dropped him . . . Dr. Carol Erwin said that today she can treat only half as many patients as she could 20 years ago because of the increase in paperwork needed to document a defense against potential lawsuits."); Tom Gorman, "Physicians Fold Under Malpractice Fee Burden," The *Los Angeles Times* (March 4, 2002) at A1 ("In Las Vegas, more than 10% of the doctors are expected by summer to quit or relocate, plunging the city toward crisis. Already, specialists are becoming harder to find around the country and trauma centers that treat life-threatening emergencies are closing . . . The turmoil began when the St. Paul Cos. of Minnesota, the nation's second largest malpractice insurer, announced in December it would no longer renew policies for 42,000 doctors nationwide. The insurer said it had lost nearly $1 billion in its malpractice business last year. Other companies are offering coverage, but charging much higher rates to avoid the losses encountered by St. Paul. The situation is particularly acute in Las Vegas, home to two-thirds of the state population, because 60% of its 1,700 doctors were insured by St. Paul. Replacement policies are costing some doctors four or five times as much—$200,000 or higher annually, more than most doctors' take-home pay . . . Dr. Cheryl Edwards, 41, closed her decade-old obstetrics and gynecology practice in suburban Henderson because her insurance jumped from $37,000 to $150,000 a year. She moved her practice to West Los Angeles, leaving behind 30 pregnant patients. 'I was happy in Las Vegas,' she said, 'but I had no choice but to leave.' In California—where juries hearing malpractice lawsuits are limited to maximum awards of $250,000 for pain and suffering—Edwards' insurance premium this year is $17,000. Because of 1975 tort reform, doctors in California are largely unaffected by increasing insurance rates. But the situation is dire in states such as Nevada where

is particularly acute for practitioners in managed care, where prescribed fixed costs prevent them from recouping insurance costs.[72] Hardest hit by the premium increase are doctors in high-risk specialties, such as obstetrics and emergency medicine.[73] Obstetricians and gynecologists are facing increasing numbers of lawsuits nationwide,[74] yet the majority of these costly lawsuits are dropped or settled without any payment on behalf of the practitioner.[75] This situation is depleting the ranks of obstetricians and gynecologists.[76] Further, malpractice premiums are disproportionately high among obstetricians and family practitioners that deliver babies.[77] These high premiums and correspondingly lower incomes discourage medical students from entering into obstetrics or high risk specialties. In addition, physicians approaching retirement will

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there is no monetary cap . . . The Legislature, however, isn't scheduled to meet for a year. Dr. Frank Jordan—a 31-year veteran of vascular surgery, including 13 years in Las Vegas—couldn't wait. He closed his practice and retired. I did the math,' the 56-year-old doctor said. 'If I were to stay in business for 3 years, it would cost me $1.2 million for insurance. I obviously can't afford that. I'd be bankrupt after the first year, and I'd just be working for the insurance company. What's the point?' . . . Last year, St. Paul lost $1.88 in Nevada for every dollar paid by doctors, spokeswoman Andrea Woods said . . . Both trauma centers in Wheeling, W.Va., have closed because their neurosurgeons couldn't pay their new malpractice premiums. The trauma center at Abington Memorial Hospital outside Philadelphia faces closure next month as its doctors scramble to find affordable insurance. Las Vegas' only trauma center has announced it will close for 12 hours March 12 because two of its eight trauma surgeons can't afford insurance premiums. People in southern Nevada needing emergency surgery during that period will be airlifted to hospitals in Southern California, Phoenix, Reno or Salt Lake City.").

[72] *See* Terry E. Tyrpin, "Tort Reform Would Cure Med Mal Crisis," National Underwriter Property & Casualty-Risk & Benefits Management (January 28, 2002) at 25 ("Because most doctors are locked into 1-IMO or PPO plans that prescribe fixed costs for services, there is not much wiggle room for doctors to charge their patients higher medical fees that reflect increased overhead expenses, such as insurance. Doctors are now resorting to dropping risky procedures, fleeing heavily litigious states, practicing without insurance, or deciding they can no longer afford to practice medicine. Insurers also are backed into a corner. Unless they pass on the cost of the exorbitant jury awards, insurers transacting professional liability coverage in the medical field will be looking for more commercially viable business. If the medical malpractice insurance market contracts as insurers look for more lucrative areas in which to allocate capital, it could force some medical professionals to refrain from practicing or to affiliate with large firms with pre-existing insurance coverage. Ultimately, the cost of medical care will go up if malpractice coverage becomes scarce. If the cost of insurance dissuades some from practicing medicine, those communities will have fewer choices among physicians . . . In Texas, insurers pay out $1.65 in losses and expenses per $1 received in malpractice premiums. In Connecticut, that ratio is more than 180 percent. The national average is a 126 combined ratio—not exactly the type of lure that will drive insurers to pick up the 10 percent marketshare St. Paul is leaving behind . . . Increasing rates by an average of 24 percent this year in 27 states couldn't save St. Paul, the nation's largest malpractice underwriter . . . Meanwhile, in August, the Pennsylvania Insurance Department placed PHICO into rehabilitation after its surplus dropped from $127 million to $6 million in just 6 months. Both companies' failed medical malpractice business—which leaves between 50,000 and 100,000 doctors across the country without coverage—are high-profile symptoms of a high-stakes problem.").

[73] *See* Emily Richmond, "Nevada Doctors Face Insurance Crisis; Skyrocketing Premiums Could Force Some Out of Business," The *Las Vegas Sun* (January 28, 2002) ("Nevada has one of highest rates of medical malpractice suit filings, legal experts said. There's no limit in Nevada to what juries can award patients for damages in medical malpractice suits, unlike the $250,000 cap in neighboring California. 'We see lawyers moving here from as far away as Florida to take advantage of the no cap,' said Las Vegas attorney John Cotton, who specializes in defending physicians and health-care providers. 'You can't turn on the television without seeing one of their ads.' . . . Hardest hit by the premium increase are doctors in high-risk specialties, such as obstetrics and emergency medicine.").

[74] *See* 5 ACOG Clinical Review 5 (September/October 2000) at 15 ("The average number of claims filed against all [ob/gyn] 1999 survey respondents during their careers was 2.53. This number represents a significant increase from the 1996 survey (2.31).").

[75] *See id.* at 16 ("Of the 570 closed claims that were reported in the survey, 53.9% were dropped or settled without any payment on behalf of the ob/gyn. These claims include those dropped by the plaintiff, dismissed by the court, and settled without payment by the ob/gyn.").

[76] *See id.* ("Of the survey respondents, 8.9% reported that they no longer practiced obstetrics as a result of the risk of malpractice. Another 17.1% reported that they had decreased the level of high-risk obstetric care. An additional 6.2% reported that they had decreased the number of deliveries . . . Of the ob/gyns who completed the survey, 8.2% reported that they decreased gynecologic services as a result of the risk of malpractice.").

[77] *See* Stephen A. Norton, "The Malpractice Premium Costs of Obstetrics," Inquiry, (Spring 1997) at 62.

have a greater incentive to retire earlier instead of later. Surveys of physicians show that malpractice premiums are affecting decisions on specialty areas that rising malpractice premiums will most significantly impact low-income women who are insured through Medicaid.[78] In sum, rising malpractice premiums will cost lives.[79] High or no caps on non-economic damages in medical malpractice cases decrease access to health care, particularly for low-income people and those seeking physician care in high-risk specialties such as obstetrics and gynecology.

A report prepared on behalf of the American Health Care Association analyzing the cost of general liability and professional liability ("GL/PL") claims to the long term care industry in the United States summarizes the current crisis in that industry:

> National trends in GL/PL losses are increasing at an alarming rate. In the 5-year period between 1990 and 1995 costs more than doubled from $240 per bed to $590 per bed. Since 1995 costs have quadrupled to an estimated $2,360 per bed . . . In many states, the increase in liability costs is largely offsetting annual increases in Medicaid reimbursements . . . The average long term care GL/PL cost per annual occupied skilled nursing bed has increased at an annual rate of 24% a year from $240 in 1990 to $2,360 in 2001. National costs are now ten times higher than they were in the early 1990's . . . Florida and Texas were leaders in driving the increase in GL/PL costs for the long term care industry. With trends during the 1990's in the range of 25% to 35% a year, costs in these two states have risen to close to $11,000 per bed in Florida and $5,500 per bed in Texas. Numerous states across the country are indicating similar annual trends including Georgia (50%), West Virginia (50%), Arkansas (45%), Mississippi (40%), Alabama (31%), and California (29%). With current costs in these states up to $3,300 per bed, it won't take long at these annual trend rates to reach Florida level loss costs . . . GL/PL claim costs have absorbed 20% ($3.78) of the $18.47 increase in the countrywide average Medicaid reimbursement rate from 1995 to 2000. Almost half of the total amount of claim costs paid for

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[78] *See id.* at 68. *See also* Committee to Study Medical Professional Liability and the Delivery of Obstetrical Care, Division of Health Promotion and Disease Prevention, Institute of Medicine, 1 Medical Professional Liability and the Delivery of Obstetrical Care (1989) at 6–7 ("Although this reduction in available obstetrical care [due to the current state of liability law] may affect the entire population, the evidence suggests that it particularly affects low-income women . . . The general reductions in obstetrical practice among obstetricians, family physicians, and nurse-midwives reported in both state and national survey data appear to have a disproportionate affect on the availability of care for low-income women . . . Sixty-seven percent of the respondents to the survey indicated that professional liability concerns reduced their center's ability to furnish obstetrical services of the scope of services they could offer . . . [T]he committee is persuaded that the effects of medical liability concerns in obstetrics are being disproportionately experienced by poor women and women whose obstetrical care is financed by Medicaid or provided by Community and Migrant Health Centers, and that this problem is, in turn, exacerbating the long-standing problems of financing and delivering obstetrical care to poor women.").

[79] *See* Patricia Neighmond, National Public Radio, "All Things Considered" (April 3, 2002) ("NEIGHMOND: But today the University Medical Trauma Center is on fragile footing. The reason? Some doctors have stopped practicing emergency medicine because they can no longer afford malpractice insurance. In certain cases, premiums have increased sixfold in just 1 year. One trauma surgeon's policy rose to $200,000, about the same amount as his income. Nevada state law requires a certain number of emergency physicians and specialists to be on call 24 hours a day 7 days a week. And if the Trauma Center can't comply, it could be shut down. If that happens, Carrison says critically injured patients would have to be sent to trauma centers in nearby states. Dr. CARRISON: Some patients are going to die that wouldn't die, and that extra time, that's what saves lives. Time saves lives. The quicker you're at the trauma center, the better chance you have of survival.").

> GL/PL claims in the long term care industry is going directly to attorneys . . . Annual commercial insurance premium levels increased on average 130% between 2000 and 2001, often with reduced coverage . . . On average, a quarter of a million more dollars of premium was charged per insured for almost half a million less coverage per claim. [80]

Due to the significant lag time between the time an insurance policy is issued and the payment of any claims that may arise, it is difficult to measure actual insurance payment trends as of any given moment. That is, data on medical professional liability claims closed with indemnity on behalf of individual defendants for claims reported in 2000 show that the average total payment per claim is $149,449 for the reporting period of 0–12 months, $258,968 for the reporting period of 13–24 months, $292, 825 for the reporting period 25–36 months, $312,981 for the reporting period 37–48 months, and $408,352 thereafter. [81] This means that looking at total payments made this year will fail to account for medical professional liability claims paid out 2 years from now and consequently they will underestimate the depth of the current crisis, especially since smaller claims tend to be paid out first, and larger more controversial claims paid out much later. However, data reported for closed claims demonstrate the following escalation in average loss and allocated loss adjustment expenses for the following years: 1991 ($181,351); 1992 ($206,050); 1993 ($214,293); 1994 ($218,262); 1995 ($210,299); 1996 ($230,223); 1997 ($257,557); 1998 ($266,308); and 1999 ($286,184). [82] The average payments have risen 81.1% between 1991 and 2000. This is a compound annual growth of approximately 6.9%, which is over two and a half times as great as the 2.6% compound annual growth of the Consumer Price Index during this same period. [83]

THE HEALTH ACT INCLUDES REFORMS WITH PROVEN TRACK RECORDS OF MAKING HEALTH CARE MORE ACCESSIBLE

The HEALTH Act is modeled on California's Medical Injury Compensation Reform Act of 1975 ("MICRA"), whose major reforms include a $250,000 cap on the amount of non-economic damages, such as those for pain and suffering, that may be awarded in medical malpractice lawsuits [84]; limits on contingency fees lawyers can charge in such suits [85]; authorization for defendants in such cases to introduce evidence showing the plaintiff received compensation for all or a portion of the plaintiff's losses and a prohibition on subrogation to the rights of the plaintiff by providers of collateral source payments [86]; and authorization for courts to require periodic payments for future damages instead of lump sum awards. [87] The contingency fee limits were upheld by the California Supreme Court in *Roa* v. *Lodi Medical Group*, 37 Cal.3d 920 (1985). The

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[80] Theresa W. Bourdon and Sharon C. Dubin, Aon Risk Consultants, Inc., "Long Term Care General Liability and Professional Liability Actuarial Analysis" (February 28, 2002) at 3–4.
[81] *See* Physician Insurers Association of America, "Analysis of October 13, 2001 Consumer Federation of America Report on Medical Malpractice Industry Performance" (May 1, 2002) at 4.
[82] *See id.* at 5.
[83] *See id.* at 6.
[84] *See* Ca. Civ. § 3333.2.
[85] *See* Ca. Bus. & Prof. § 6146.
[86] *See* Ca. Civ. § 3333.1.
[87] *See* Ca. Civ. Pro. § 667.7.

other provisions were upheld by the California Supreme Court in *Fein* v. *Permanente Medical Group*, 38 Cal.3d 137 (1985), and the United States Supreme Court upheld the same without written opinions.[88] The Congressional Research Service has concluded that current Supreme Court Commerce Clause jurisprudence supports the constitutionality of Congressional regulation of medical malpractice.[89]

As outlined in a report examining the effects of raising California's existing cap on non-economic damages in medical malpractice cases, high or no such caps increase incentives to litigate weak or marginal claims.[90] Further, as the Reagan Administration's Tort Policy Working Group reported in its seminal study of the effects of tort laws on insurance premiums, "Plaintiffs' attorneys also often see high non-economic damage awards as necessary to justify high contingency fees, which may lead them to press for a high non-economic damage award when it may be in their clients' interest to obtain a quick and fair settlement."[91] Further, "Contingency fees also distort the incentives of attorneys. Such fees may lead plaintiffs' attorneys to hold out for high non-economic damages (and, potentially, windfall profits for the attorney requiring only minimal additional work on the attorney's part), while the clients may be best served with obtaining economic damages and more limited non-economic damages as promptly as possible."[92]

When health care providers are forced to pay more for malpractice insurance, payers—including businesses providing employee health insurance and consumers—ultimately pick up the tab. The Government Accounting Office ("GAO"), in its study of medical liability costs, has documented the linkages between malpractice premiums and the cost of health care. The GAO found that "hospitals and physicians incur and pass on to consumers additional expenses that directly or indirectly relate to medical liability. Therefore, estimates of higher malpractice premiums—taken by themselves—understate the full effect of medical liability costs on national health expenditures."[93] Additional evidence shows that an

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[88] *Fein* v. *Permanente Medical Group*, 38 Cal.3d 137 (1985), *appeal dismissed*, 474 U.S. 892 (1985) (Justice White dissenting); *Roa* v. *Lodi Medical Group, Inc.*, 37 Cal.3d 920, (1985), *appeal dismissed*, 474 U.S. 990 (1985).

[89] *See* Henry Cohen, CRS Report for Congress 95–797: *Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes* (updated March 26, 2002) at 3 ("The Court in *[United States* v. *Lopez]* then noted that, if the Gun-Free School Zones Act of 1990 was 'to be sustained, it must be under the third category as a regulation of an activity that substantially affects interstate commerce' [citing 514 U.S. 549, 561 (1995)]. The Act, however, had 'nothing to do with "commerce" or any sort of economic enterprise . . . [and] is not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated" [citing 514 U.S. 549, 561 (1995)]. The same apparently could be said of some torts, such as the assault example suggested above. *But it does not appear that it could be said with respect to torts that substantially affect commerce, such as the manufacture of defective products or medical malpractice.*") (emphasis added). *See also* Henry Cohen, CRS Report for Congress 95–797A: *Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes* (updated May 23, 2002) (Summary) (concluding that "Congress has the authority to enact tort reform 'generally,' [including] reforms that have been widely implemented at the state level, such as caps on damages and limitations on joint and several liability and on the collateral source rule" and that "there would appear to be no due process or federalism (or any other constitutional) impediments to Congress' limiting a state common law right of recovery" and that "there seems little doubt that tort reform legislation, in general, would be within Congress' commerce power.").

[90] *See* Hamm *et al.*, "California's MICRA Reforms: How Would A Higher Cap on Non-Economic Damages Affect the Cost of an Access to Health Care?" LECG, Inc. (July 27, 1998) at 5.

[91] Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability (February 1986) at 67.

[92] *Id.* at 73.

[93] *See* GAO (GAO/AIMD–95–169), "Medical Liability: Impact on hospital and Physician Cost Extends Beyond Insurance," (September 1995) at 1.

increase in malpractice premiums results in an increase in doctor's fees. Researchers who modeled the effects of premium increases on doctors' fees and found that an increase in medical malpractice premiums increased doctors' fees by an average of 16% for physician visits, and 9–17% for hospital visits.[94]

To the extent that physicians are successful in shifting the increased costs resulting from the higher cap to patients, the cost of employer-sponsored health insurance will go up. An increase in the cost of employer-sponsored health insurance programs will affect employees in one of two ways. One, employers that continue to offer health insurance tot heir employees are likely to raise the employees' required contribution toward the cost of health care by requiring larger coinsurance payments, higher deductibles, or increases in the employee's share of premiums. Two, some employers may decide to terminate health insurance coverage for their employees, or firms on the verge of adding health insurance to their benefit package may decide not to so, for reasons of costs. Employers may also decide to reduce the size of their benefit package.

A fundamental tenet of economics is that, for most goods and services, an increase in price will cause a reduction in demand. Consequently, increases in health care insurance premiums lead to an increase in the number of individuals going without coverage. An increase in health insurance costs will decrease participation in health insurance programs, particularly by low-income workers. And just as an increase in price causes consumers to buy less, a reduction in price causes providers to supply less health care. Retirement decisions are influenced by future earnings potential. If a physician nearing retirement sees his or her malpractice costs increase a significant amount, the physician will be more likely to retire sooner rather than later. Further, hospitals currently provide uncompensated care to the uninsured. An increase in expenditures on the direct and indirect costs of medical liability will require hospitals to cut back on other expenditures, including such care. This will reduce the ability of these institutions to provide needed services to those unable to pay for them.[95]

In addition, many rural and inner city areas are medically under-served because these communities do not offer the potential income that other communities offer. To the extent it is more difficult for physicians to pass along the higher cost of malpractice premiums to lower-income families, a higher cap will exacerbate the provider shortage in rural and inner city areas.[96] The higher costs brought about by a higher cap on non-economic damages will increase these hospitals" costs without adding to their revenues, further jeopardizing their survival.[97]

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[94] Danzon, Patricia M., Pauly, Mark V., and Raynard S. Kington, "The Effects of Malpractice Litigation on Physicians' Fees and Incomes," 80 AEA Papers and Proceedings 2: 122–27 (May 1990) at 125.

[95] *See* Hamm *et al.*, "California"s MICRA Reforms: How Would A Higher Cap on Non-Economic Damages Affect the Cost of an Access to Health Care?" LECG, Inc. (July 27, 1998) at 24.

[96] *See id.* at 21.

[97] *See id.* at 22.

Finally, MICRA's limits on attorneys fees allow more money to go directly to injured patients.[98] According to the Department of Health and Human Services:

> The friction generated by operating the [medical litigation] system takes most of the money. When doctors and hospitals buy insurance (sometimes they are required to buy coverage that provides more "protection" than the total amount of their assets), it is intended to compensate victims of malpractice for their loss. However, only 28% of what they pay for insurance coverage actually goes to patients; 72% is spent on legal, administrative, and related costs. Less than half of the money that does go back to injured patients is used to compensate the patient for economic loss that is not compensated from other sources—the purpose of a compensation system. More than half of the amount the plaintiff receives duplicates other sources of compensation the patient may have (such as health insurance) and goes for subjective, non-economic damages (a large part of which, moreover, actually goes to the plaintiff's lawyer). The malpractice system does not accurately identify negligence, deter bad conduct, or provide justice. The results it obtains are unpredictable, even random. The same study that found that only 1.53% of patients who were injured by medical error filed a claim also found, on the flip side, that most events for which claims were filed did not constitute negligence. Other studies show the same random results.[99]

Most other countries, including England and Scotland, prohibit contingent fees in many circumstances.[100] Indeed, other professional associations in the United States, including medicine and accounting, regard the use of contingent fees in those occupations as unethical. Yet unlike their counterparts in other countries and certain other professions, lawyers in the United States have long been permitted to charge contingent fees. With lawyers now representing plaintiffs on a contingent fee basis in the vast majority of the roughly one million tort cases that are filed each year, the practice is more common than ever.[101] Researchers have estimated that "no less than $7.5 to $10 billion in unethical, windfall contingency fees are now charged annually."[102]

As the Reagan Administration's Tort Policy Working Group reported in its seminal study of the effects of tort laws on insurance premiums, "Where plaintiff's award is moderate, such a contingency fee may, in fact, be quite reasonable, since the attorney has significant costs and may face substantial risks that must be reim-

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[98] Defense fees, unlike the fees charged by the complainant's lawyer, are not based on the size of the award nor are they contingent upon winning the case. The defending party has a powerful economic incentive to keep defense costs to a minimum.

[99] Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July 24, 2002) at 11.

[100] *See* Mary A. Glendon, A Nation under Lawyers 54 (1994).

[101] *See* Lester Brickman, Contingency Fee Abuses, Ethical Mandates, and the Disciplinary System: The Case Against Case-by-Case Enforcement, 53 Wash. & Lee L. Rev. 1339, 1349, n.45 (1996). Plaintiffs' lawyers take roughly 95% of all personal injury cases on a contingency. *See* Richard W. Painter, Litigating on a Contingency: A Monopoly of Champions or a Market for Champerty, 71 Chi.-Kent L. Rev. 625, 626 n.3 (1995) (citing sources).

[102] Lester Brickman, ABA Regulation of Contingency Fees: Money Talks, Ethics Walks, 65 Fordham L. Rev. 247, 314 app. A (1996).

bursed." [103] The HEALTH Act's sliding scale under which attorneys fees are allocated allows attorneys to keep more of plaintiff's moderate awards. However, we live in a world of limited resources. Those resources can either fund lawyers and the legal system, or they can fund patients in our health care system, and the HEALTH Act appropriately limits contingency fees attorneys charge for very large plaintiff's awards.

For example, today, in a case in which a victim that is awarded $2,000,000 in economic damages to cover his demonstrable, actual injuries—including the costs of pain relief medication, their lost wages, their future lost wages, rehabilitation costs, and any other quantifiable losses—and $500,000 in unquantifiable noneconomic damages, the victim's lawyer will take his standard one-third cut out of the total $2.5 million award. That would leave the lawyer with $832,500 and the victim would recover $1,667,500. With the protections of the HEALTH Act in place, on the other hand, the same case would yield tens of thousand of dollars more for the victim. Even though the HEALTH Act caps noneconomic damages at $250,000, it reduces the amounts of money a victim's lawyer can take the higher the victim's demonstrable economic damages are. The HEALTH Act limits attorney awards on the following scale: lawyers can only take 40% of the first $50,000 awarded, 33.3% of the next $50,000 awarded, 25% of the next $500,000 awarded, and 15% of any award over $600,000. Under this scale, of a total award of 2,000,000 in economic damages and $250,000 in noneconomic damages, the victim's lawyer would gets $409,150, and the victim would get $1,840,850 in damages. That's $173,350 more than the same victim would get without the protections of the HEALTH Act. Even with the cap on unquantifiable noneconomic damages in the HEALTH Act—which allows doctors to stay in business to provide medical care in the first place by making liability insurance affordable—the larger the demonstrable, real-life economic damages are, the better off victims will be under the HEALTH Act because under its provisions lawyers can take only 15% of awards over $600,000. The more actual losses a victim suffers, the better off they are under the HEALTH Act. The more clearly a victim has suffered harm (that is, the more quantifiable their damages are), the better off that victim will be under the HEALTH Act. And it is only fair that victims with more demonstrable losses be able to keep a greater percentage of their awards. The HEALTH Act provides more money to victims, and less money to lawyers. Indeed, insofar as quantifiable, economic damages may be awarded under the HEALTH Act, [104] the HEALTH Act not only does not limit such awards; it requires that a greater percentage of such awards go to victims, not lawyers. In sum, under the HEALTH Act, the larger a victim's demonstrable, real-life economic damages are, the more they will receive because lawyers will be allowed to take only 15% of awards over $600,000. Standard attorney contingency fee agreements allow lawyers to take one-third—a full 33.3%—of their cli-

[103] Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability (February 1986) at 72.

[104] *See* Marilyn Werber Serafini, "Risky Business" *The National Law Journal* (May 18, 2002) at 1474 ("Trial lawyers don't dispute that court awards have risen. But they argue that the increase has been mostly in awards for economic damages, which are meant to reimburse a patient for lost wages, and to cover tangible expenses, such as medical bills for hospital stays, rehabilitation, and physician visits.").

ent's awards, so victims are left with only 66%. The HEALTH Act would allow victims to keep roughly 75% of awards under $600,000, and 85% of awards over $600,000.

Further, as the Reagan Administration's Tort Policy Working Group reported in its seminal study of the effects of tort laws on insurance premiums, "[T]he prevailing plaintiff is not only liable to his attorney for the agreed to contingency fee, but also for litigation expenses. Such expenses often can amount to an additional five to 8 percent of the underlying award."[105] Allowing victims to keep more of their awards, and lawyers less, will allow them to recoup more of their awards devoted to paying litigation expenses.

THE HEALTH ACT PREVENTS WASTEFUL AND UNNECESSARY "DEFENSIVE MEDICINE"

One of the most harmful effects of limitless non-economic damages is their adverse impact on settlement. When a contingency fee attorney is presented with the possibility of a windfall on non-economic damages, that attorney is much less likely to settle a case. If Congress is to encourage settlement rather than litigation, it must control the arbitrary and unpredictable award of non-economic damages. To avoid situations in which a contingency fee attorney can claim injury occurred because certain tests weren't performed, doctors engage in "defensive medicine" by performing tests and prescribing medicines that are not necessary for health. Research by two Stanford economists demonstrates that direct litigation reforms, including the same caps on non-economic damages and collateral source rule reforms included in the HEALTH Act, would greatly increase health care productivity by reducing the incidence of wasteful "defensive medicine" without increasing harmful health outcomes.[106] The types of reforms these researchers considered "direct" include caps on non-economic damage awards and collateral source rule reforms.[107]

ENACTING THE HEALTH ACT WILL SAVE FEDERAL TAXPAYERS BILLIONS OF DOLLARS A YEAR

Two Stanford University economists have conducted two extensive studies using national data on Medicare populations and concluded that patients from states that adopted direct medical care

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[105] Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability (February 1986) at 72, n.20.

[106] *See* Daniel P. Kessler and Mark B. McClellan, "How Liability law Affects Medical Productivity," National Bureau of Economic Research (NBER) Working Paper 7533 (February 2000) at 31–32 ("[P]revious research suggests that 'direct' reforms—designed to reduce the level of compensation of potential claimants—improve productivity in health care by reducing the prevalence of defensive treatment practices . . . Direct reforms affect treatment intensity primarily through their effect on claims rates . . . Because defending against any claim imposes nonfinancial as well as financial costs on physicians, and because the nonfinancial costs of claim defense are correlated with compensation, direct reforms reduce treatment intensity by reducing both the (insured) financial and the (uninsured) nonfinancial dimensions of malpractice pressure. However, these reform-induced reductions in treatment intensity have negligible effects on health outcomes. This implies that doctors practice defensive medicine, and that reform-induced reductions in the level of liability improve medical productivity . . . For example, our estimates suggest a savings of $4.76 in hospital expenditures on elderly patients with cardiac illness for each $1 reduction in ALAE (e.g., litigation costs incurred by the malpractice insurer in connection with claim defense) per physician per year. In contrast, we found no consistent evidence of any substantial effects on health outcomes of reducing such measures of malpractice pressure.").

[107] *See* Daniel P. Kessler and Mark B. McClellan, "How Liability law Affects Medical Productivity," National Bureau of Economic Research (NBER) Working Paper 7533 (February 2000) at 25 (Table 1).

litigation reforms—such as limits on damage awards—incur significantly lower hospital costs while suffering no increase in adverse health outcomes associated with the illness for which they were treated. In sum, the studies concluded that in states with medical litigation reforms in place, there was an average reduction of 4.3% in hospital costs for patients in managed care programs,[108] and an average reduction of 7.4% in hospital costs for patients in non-managed care programs.[109] They have thereby quantified the cost of "defensive medicine," in which doctors perform tests and prescribe medicines that are not necessary for health in order to avoid patients' future claims that they suffered adverse health effects because the doctor did not do more.

If the same sorts of litigation reforms studied by the Stanford economists were to apply nationwide, those health care cost reductions—which, again, are not associated with any adverse health outcomes—would result in vast savings of Federal taxpayer dollars currently spent through the Medicare and Medicaid programs.[110]

Using recent data, it is estimated that 96.8% of Federal Medicare payments pays for physician and hospital expenses.[111] In 2001, the net Federal outlays for Medicare beneficiaries in managed care group plans was $42.1 billion[112] out of total Federal Medicare benefits of $233 billion.[113] If direct health care litigation reforms had been applied nationwide a few years ago, we could expect $40.8 billion in managed care costs reduced by 4.3%, and $191 billion in non-managed care costs reduced by 7.4%. This amounts to a total of approximately $15.45 billion ($1.75 billion plus $13.7 billion) in Federal taxpayer savings in Federal Medicare hospital costs.

The latest estimates from the Congressional Budget Office are that, in 2002, Federal Medicaid payments to beneficiaries in managed care programs will be $19.6 billion out of total Federal Medicaid payments of $146.1 billion.[114] There is no way to know exactly how much Federal Medicaid payments go to pay certain expenses because there are no requirements under Medicaid for providers to notify states or for states to notify the Federal Government regarding the amounts of Medicaid funds that go to pay certain costs. However, if we assume that roughly the same percentages of Federal dollars go to pay for hospital costs under Medicaid as they do under Medicare, then if direct health care litigation reforms had been applied nationwide a few years ago, we could expect the $19.6 billion in managed care costs to be reduced by 4.3%,

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[108] Daniel P. Kessler and Mark B. McClellan, "Medical Liability, Managed Care, and Defensive Medicine," National Bureau of Economic Research (NBER) Working Paper 7537 (February 2000) at 16. The researchers in this study analyzed populations in managed care programs. Id. at 3.

[109] Daniel P. Kessler and Mark B. McClellan, "Do Doctors Practice Defensive Medicine?" *The Quarterly Journal of Economics* (May 1996) at 386 ("Our analysis indicates that reforms that directly limit liability—caps on damage awards . . . and collateral source rule reforms—reduce hospital expenditures by 5 to 9 percent within 3 to 5 years of adoption . . . ."). The researchers in this study analyzed populations in predominantly non-managed care programs in the mid-1980's, and found that, of the populations studied with two different types of illnesses, direct health care litigation reforms would reduce hospital expenditures by 5.8% and 8.9% several years after their adoption. *Id.* at 367, 382.

[110] Medicaid is a needs-based, health care benefit financed jointly by State and Federal Government, but administered by the State governments, whereas Medicare is a Federal health care program, not based on need, financed by FICA taxes (Part A), and a combination of premiums plus matching Federal funds (Part B).

[111] "Medicare: Payments to Physicians" CRS Report to Congress (November 26, 2001) at 6, 2.

[112] Congressional Budget Office, Medicare and Medicaid/SCHIP "Fact Sheets".

[113] *Id.*

[114] *Id.*

and the $126.5 billion in non-managed care costs to be reduced by 7.4%. Therefore, we could expect a total of approximately $10.2 billion ($843 million plus $9.36 billion) in Federal taxpayer savings in Medicare hospital costs.

Further, we also know that in the years following the enactment of the Medical Injury Compensation Reform Act ("MICRA") in California—which among other things capped noneconomic damages at $250,000—medical malpractice premiums declined by roughly 25%.[115] Federal Medicare payments for physician services are estimated at $41.2 billion in 2001,[116] and the percent of that figure that pays for malpractice premiums is 3.2%,[117] or $1.32 billion. Consequently, if direct health care litigation reforms had been applied nationwide a few years ago, we could expect $33 million in Federal Medicare savings. If roughly the same 3.2% in malpractice premiums came from the in $117.4 billion Federal dollars spent on Medicaid in 2000,[118] we could expect an additional $939 million in Federal Medicaid savings.

In sum, if direct health care litigation reforms had been applied nationwide a few years ago, we could expect a total of approximately $25.65 billion in Federal taxpayer savings in Medicare and Medicaid hospital costs, plus another $972 million in Federal taxpayer savings in Medicare and Medicaid malpractice premium costs, per year. That constitutes a total Federal savings of $27 billion, enough money to provide millions of Americans with annual health care insurance coverage.

These estimated savings are in line with aggregate statistics regarding Federal expenditures on health services and supplies reported by the Health Care Financing Administration ("HCFA"). The HCFA projects that the Federal Government spent $431.8 billion on health services and supplies in 2001.[119] Using an estimated savings rate of 6.5%—weighted to account for greater savings rates in non-managed care and accounting for the fact that more Federal funds pay for health care for beneficiaries in non-managed care than in managed care—one would expect that if direct medical care litigation reforms had been applied nationwide a few years ago, the Federal taxpayer would have saved approximately $28 billion in 2001.

The two Stanford University economists measured the savings from direct health care litigation reforms on hospital expenditures for treating elderly heart disease patients. As they reported, however, "Hospital expenditures on treating elderly heart disease patients are substantial—over $8 billion per year in 1991—but they comprise only a fraction of total expenditures on health care. If our results are generalizable to medical expenditures outside the hospital, to other illnesses, and to younger patients, then direct reforms could lead to expenditure reductions of well over $50 billion

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[115] Office of Health Research, Statistics & Technology, U.S. Department of Health and Human Services (1968) at 203.

[116] "Medicare: Payments to Physicians" CRS Report to Congress (November 26, 2001) at 1.

[117] *Id.* at 6, 2.

[118] "Medicaid: A Fact Sheet" CRS Report to Congress (updated October 25, 2001) at 1.

[119] *See* Table 4: Health Services and Supplies Expenditures Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1980–2011 (Health Care Financing Administration) at http://www.hcfa.gov/stats/NHE-Proj/proj2001/tables/t4.htm.

per year without serious adverse health outcomes." [120] The $50 billion figure has been cited by former Senators George McGovern and Alan Simpson, who co-signed a *Wall Street Journal* op-ed urging health care litigation reform stating "Legal fear drive[] [doctors] to prescribe medicines and order tests, even invasive procedures, that they feel are unnecessary. Reputable studies estimate that this 'defensive medicine' squanders $50 billion a year, enough to provide medical care to millions of uninsured Americans." [121] The savings resulting from direct health care litigation reforms is particularly important given the dire predictions of increased health care costs in the coming decade. For example, a report by the Centers for Medicare and Medicaid Services, an arm of the Department of Health and Human Services, reports that health costs are expected to grow at a rate of 7.3 percent annually between now and 2011. The report, published on March 12, 2002, in the journal *Health Affairs*, says health care spending could reach $2.8 trillion, or 17 percent of the nation's gross domestic product, by 2011, up from 13.2 percent in 2000. Last January, the centers said health care costs rose 6.9 percent, to $1.3 trillion, in 2000, as Americans spent more on prescription drugs and hospital care. Health care spending averaged $4,637 per person, marking what the report's authors called the "end of an era of reasonable health care cost growth throughout most of the 1990's." [122]

Senator Lieberman, in advocating direct health care litigation reforms such as those contained in the HEALTH Act, has also commented on the need to reduce wasteful medical spending. In his floor statement on the Common Sense Product Liability and Legal Reform Act, Senator Lieberman stated that "The system promotes the overuse of medical tests and procedures defensively by doctors who have told me, and I am sure told every other Member of this Chamber, they would not order this test, it is not medically necessary, but they do it to protect themselves from the fear of a possible lawsuit. The Rand Corp. has estimated the ways in which the current *defensive* practice of medicine actually costs the victims of malpractice. Rand has estimated that injured patients receive only 43 percent of the money spent on medical malpractice and medical product liability litigation. That is 43 cents out of every dollar, and victims often receive their awards only after many, many years of delay because of the ornate process, the bullying and bluffing that the current rules of malpractice encourage . . . Let me go back to defensive medicine and try to detail briefly its impact on the current system because it is even greater than the direct cost of liability insurance. The Office of Technology Assessment—our own office

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[120] Daniel P. Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *The Quarterly Journal of Economics* (May 1996) at 387–88. *See also* Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July 24, 2002) at 7 (citing Kessler, D. and McClellan, M., "Do Doctors Practice Defensive Medicine," *Quarterly Journal of Economics*, 111(2): 353–390 (1996)) ("The leading study estimates that limiting unreasonable awards for non-economic damages could reduce health care costs by 5–9% without adversely affecting quality of care. This would save $60–108 billion in health care costs each year. These savings would lower the cost of health insurance and permit an additional 2.4–4.3 million Americans to obtain insurance.").

[121] *See* George McGovern and Alan Simpson, "We're Reaping What We Sue," *The Wall Street Journal* (April 17, 2002) at A20.

[122] *See* press release of the Centers for Medicare & Medicaid Services, "Health Care Costs Expected to Rise to $2.8 Trillion Over Next 10 Years" (March 12, 2002); *see also* "Health Costs May Double by 2011" *The Washington Post* (March 12, 2002) at A4.

here—has found that as high as 8 percent of diagnostic procedures are ordered primarily because of doctors' concerns about being sued. That does not sound like a high percentage, but it amounts to billions of dollars. These defensive practices alone—sometimes difficult to measure—present a hidden but very significant burden on our health care system . . . Taxpayers and health care consumers bear the financial burden of these excessive costs. Liability insurance and defensive medicine insurance premiums also drive up the cost of Medicare and Medicaid and therefore exacerbate an increased Federal budget deficit." [123]

According to the Department of Health and Human Services:

> The Federal Government—and thus every taxpayer who pays Federal income and payroll taxes—also pays for health care, in a number of ways. It provides direct care, for instance, to members of the armed forces, veterans, and patients served by the Indian Health Service. It provides funding for the Medicare and Medicaid programs. It funds Community Health Centers. It also provides assistance, through the tax system, for workers who obtain insurance through their employment. The direct cost of malpractice coverage and the indirect cost of defensive medicine increases the amount the Federal Government must pay through these various channels, it is estimated, by $28.6–47.5 billion per year. This amount includes $23.66–42.59 billion for the cost of defensive medicine; $3.91 billion in liability insurance paid to Medicare, Medicaid, Veteran's Affairs, and other Federal programs; $246 million in liability insurance paid through health benefits for its employees and retired employees; and $778 million in lost tax revenue from self-employed and employer-sponsored health insurance premiums that are excluded from income. If reasonable limits were placed on non-economic damages to reduce defensive medicine, it would reduce the amount of taxpayers' money the Federal Government spends by $25.3–44.3 billion per year. This amount includes $23.66–42.59 billion in savings from elimination of defensive medicine and $1.68 billion in reductions in liability insurance premiums paid by the Federal Government. This is a very significant amount. It would more than fund a prescription drug benefit for Medicare beneficiaries and help uninsured Americans obtain coverage through a refundable health credit. The Administration's proposed Medicare prescription drug plan is estimated to cost $190 billion over 10 years by the CBO. The Administration's proposed Health Insurance Tax Credit is estimated to cost $89 billion over 10 years. [124]

CONGRESS SHOULD ENACT A FAIR SHARE RULE

Respect for the law is fostered when it is fair and just and punishments are proportionate to the wrongs committed. As Thomas Jefferson noted, "if the punishment were only proportional to the

[123] Senator Lieberman, floor statement on the Common Sense Product Liability and Legal Reform Act (April 27, 1995).

[124] Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July 24, 2002) at 6 (citing Maulik, Joshi, Anderson, John *et.al.*, "A Systems Approach to Improving Error Reporting," 16 *Journal of Health Care Information Management* 1)).

injury, men would feel that their inclination as well as their duty to see the laws observed." [125]

The rule of joint liability, commonly called joint and several liability, provides that when two or more persons engage in conduct that might subject them to individual liability and their conduct produces a single injury, each defendant will be liable for the total amount of damages. [126] Joint liability is unfair because it puts full responsibility on those who may have been only marginally at fault. [127]

As Senator Lieberman has observed, "There is a concept—joint and several liability started out in the law as a way of proportioning responsibility when an accident was caused by a number of different parties working together in a way that caused negligence, and often it was not clear which one actually caused it. So they said everybody could be held liable regardless of the percentage of negligence. It now has grown to a point where what it really means is that somebody who is not liable, or liable very little, if they happen to have deep pockets, they can be held fully liable. That is the wrong message to send . . . If you hurt somebody, you have to pay. If you do not, you should not have to pay. What kind of cynicism is developed when somebody who did little or no wrong ends up having to pay the whole bill because somebody else slipped away. Our amendment also adopts the basic proposal of the underlying bill that punitive damages—which have been much discussed here and are an essential part of the continued bullying and bluffing that goes on in our tort system—be limited to $250,000 or three times economic damages." [128]

The Volunteer Protection Act of 1997, Pub. L. No. 105–19, 111 Stat. 218, abolished joint liability for non-economic damages for volunteers of nonprofit organizations. That law was overwhelmingly supported by a bipartisan majority of Congress. [129] Joint liability also brought about a serious public health crisis that critically threatened the availability of implantable medical devices, such as pacemakers, heart valves, artificial blood vessels, and hip and knee joints. Companies had ceased supplying raw materials and component parts to medical implant manufacturers because they found the costs of responding to litigation far exceeded potential sales revenues, even though courts were not finding the suppliers liable. Congress responded to the crisis and enacted legislation, the Biomaterials Access Assurance Act of 1998, P.L. No. 105–230, 21 U.S.C. §§ 1601–1606, that allows medical device suppliers to obtain early dismissal, without extensive discovery or other legal costs, in certain tort suits involving finished medical implants.

As Senator Lieberman has observed, "Consumers are the ones who suffer when valuable innovations do not occur or when needed products, like life-saving medical devices, do not come to market or

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[125] Thomas Jefferson, A Bill for Proportioning Crimes and Punishments in Cases Heretofore Capital, in 2 The Papers of Thomas Jefferson 492, 493 (Julian P. Boyd ed., 1950).

[126] *See Coney* v. *J.L.G. Indus., Inc.*, 454 N.E.2d 197 (Ill. 1983).

[127] For example, in *Walt Disney World Co.* v. *Wood*, 515 So.2d 198 (Fla. 1987), Disney was required to pay 86% of the damages award, even though it was found only 1% at fault for the claimant's harm.

[128] Senator Lieberman, floor statement on the Common Sense Product Liability and Legal Reform Act (April 27, 1995).

[129] *See* Dan Carney, Volunteer Liability Limit Heads to President, *Cong. Q.*, May 24, 1997, at 1199 ("The measure passed the House on May 21 by a vote of 390–35, and the Senate cleared it by voice vote later that day. An earlier Senate version passed May 1 by a vote of 99–1. ") (omitting references to bill numbers).

are not available in our country any longer because no one will supply the necessary raw materials. The inadequacies and excesses of our product liability system are quite literally matters of life and death for some people whose lives depend on medical devices that may no longer be available in the United States." [130]

Joint and several liability, although motivated by a desire to insure that plaintiffs are made whole, leads to a search by plaintiffs' attorneys for "deep pockets" and to a proliferation of lawsuits against those minimally liable or not liable at all. The HEALTH Act, by providing for a "fair share" rule that apportions damages in proportion to a defendant's degree of fault, prevents unjust situations in which hospitals can be forced to pay for all damages resulting from an injury even when the hospital is minimally at fault. For example, say a drug dealer staggers into the emergency room with a gunshot wound after a deal goes bad. The surgeon that works on him does the best he can, but it is not perfect. The drug dealer sues. [131] The jury finds the drug dealer responsible for the vast majority of his own injuries, but it also finds the hospital 1% responsible because the physician was fatigued after working too long. Today the hospital can be made to pay 100% of the damages if no other defendant has the means to pay their share of the damages. That is unfair.

The HEALTH Act's "fair share" rule in which damages must be allocated against a defendant only in direct proportion to that defendant's fault means accountability.

THE HEALTH ACT ALLOWS UNLIMITED ECONOMIC DAMAGES

Nothing in the HEALTH Act denies injured plaintiffs the ability to obtain adequate redress, including compensation for 100% of their economic losses (anything to which a receipt can be attached), including their medical costs, including the costs of pain relief medication, their lost wages, their future lost wages, rehabilitation costs, and any other economic out of pocket loss suffered as the result of a health care injury. Ceilings on non-economic damages limit only the inherently unquantifiable elements of damages, such as those awarded for pain and suffering, loss of enjoyment, and other intangible items.

THE HEALTH ACT IS A NECESSARY CONGRESSIONAL RESPONSE TO A NATIONAL ECONOMIC CRISIS

Modern Federal liability reform efforts have their roots in a project that took place from 1976 to 1980 under Presidents Ford and Carter. During that time, a Federal Interagency Task Force on Product Liability conducted an in-depth research and analysis of state product liability law. The Task Force found that the patchwork of ever-changing product liability laws in 51 jurisdictions—50 states and the District of Columbia—created problems for inter-

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[130] Senator Lieberman, floor statement on the Common Sense Product Liability and Legal Reform Act (April 27, 1995).

[131] This hypothetical is not fanciful. *See* Ray Flanagan, "After Stabbing Son, Mom Sues Doctors" *The Scranton Time Tribune* (May 29, 2002) ("Mrs. Taylor and her husband, Brian, are suing . . . the obstetricians who treated her in the months before she exploded in violence that left her son, Zachary, with two punctured lungs, a severed jugular vein and scalp wounds on July 14, 2000 . . . They accuse the doctors and their employers of not adequately responding as she became more psychotic, delusional and depressed as the end of her pregnancy neared.").

state commerce.[132] The HEALTH Act is based on Congress' authority to regulate interstate commerce under Article I, § 8 of the Constitution.

The HEALTH Act does not preempt existing or future State laws that cap the amount of economic, non-economic, or punitive damages that may be awarded in a health care lawsuit. It does, however, preempt State laws[133] that contain weaker protections and conflict with the HEALTH Act's other provisions.

It takes time, of course, for legal reforms to fully control insurance premiums. As the Reagan Administration's Tort Policy Working Group reported in its seminal study of the effects of tort laws on insurance premiums:

> [M]any insurers are reluctant to write policies which take tort reforms completely into account until those reforms have been found to be constitutionally valid . . . Just as insurers are reluctant to write policies on the basis of statutes that may be declared unconstitutional, they also are reluctant to write policies on the basis of statutes whose meaning is ambiguous and whose effect may be eviscerated through hostile judicial interpretation . . . It also is important to note that tort liability is only one factor—albeit the most important factor—which determines the price of insurance. There are other considerations which also change over time, such as the prevailing interest rates, the return available from investment securities, State regulatory practices (including reserve requirements), and taxes, which affect the price of insurance. If some or all of these considerations exert upward pressure on the price of insurance, tort reform provisions may do no more in the short-term than to reduce the rate of premium increases.[134]

However, as the Reagan Administration's Tort Policy Working Group made clear, there is no question that the HEALTH Act's reforms do work: "The inescapable conclusion is that MICRA has had a very substantial impact on the cost of medical malpractice insurance for California physicians."[135]

THE HEALTH ACT'S PROVISIONS ALLOWING CONSIDERATION OF COLLATERAL SOURCE COMPENSATION PREVENTS UNFAIR DOUBLE RECOVERIES

Many plaintiffs receive compensation for medical bills or lost wages via health insurance, disability insurance or workers' compensation, yet the hospital, physician or other health care provider being sued is not allowed to tell the jury about this other source of compensation. Even after these "collateral source payments" have already been paid to the person bringing the lawsuit, that person is allowed to try to collect a second time in their lawsuit. As a result, plaintiffs often are paid twice for the same damages.

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[132] *See* Interagency Task Force On Product Liability, U.S. Department of Commerce, Final Report V–19 to V–21 (1976).

[133] The term "state law" includes the common law as well as statutes and regulations. *See Cipollone* v. *Liggett Group*, 505 U.S. 504, 522 (1992) ("At least since *Erie R. Co.* v. *Tompkins*, [304 U.S. 64 (1938)], we have recognized the phrase 'state law' to include common law as well as statutes and regulations."); *Norfolk & Western R. Co.* v. *Train Dispatchers*, 499 U.S. 117, 128 (1991) (stating the phrase "all other law, including State and municipal law" "does not admit of [a] distinction . . . between positive enactments and common-law rules of liability.").

[134] Tort Policy Working Group, An Update on the Liability Crisis (March 1987), at 90–91.

[135] *Id.* at 95.

This phenomenon is sometimes referred to as double recovery. However, allowing the plaintiff to collect twice for the same medical bills or other economic losses drives up the cost of health care for all.

The HEALTH Act allows the trier of fact to determine whether to offset damage awards based on evidence of collateral benefits. The tier of fact should be informed of the collateral source as a factor to consider when determining the net amount of compensation necessary to make the claimant whole. The purpose of this provision is to eliminate a double recovery, or recovery substantially greater than the trier of fact determined to be appropriate under a the circumstances.

The HEALTH Act also prohibits "collateral sources" from obtaining reimbursement from medical malpractice defendants or their insurers. This provision is modeled after that in California's MICRA law,[136] and its purpose was described in an opinion signed by former Supreme Court Justice and current Vice Chair of the U.S. Commission on Civil Rights Cruz Reynoso, as follows: "by redistributing the financial impact of malpractice among the different types of insurers involved in the health field, the costs would be spread over a wider base, alleviating the immediate problems posed by a growing cadre of uninsured doctors and a potential shortage of medical care."[137]

THE HEALTH ACT DOES NOT CAP PUNITIVE DAMAGES, BUT DOES INCLUDE REASONABLE GUIDELINES FOR THEIR USE

The United States Supreme Court has observed that punitive damages have "run wild" in the United States, jeopardizing fundamental constitutional rights.[138] The Supreme Court has also emphasized that "the impact of [a punitive damages award] is unpredictable and potentially substantial."[139]

The HEALTH Act does not cap punitive damages. Rather, it includes reasonable guidelines that would govern their award. Under these guidelines, a punitive damages award could not exceed the greater of $250,000, or two times the amount of economic damages that are awarded (and economic damages under the HEALTH Act are not limited at all). Federal legislation should put reasonable parameters on punitive damages to make the punishment fit the offense.[140] Proportionality has been an important part of the United States Supreme Court's consideration of the validity of criminal punishment.[141] Even serious crimes such as larceny, robbery, and arson have sentences defined with a maximum set forth

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[136] Ca.Civ. § 3333.1.

[137] *Barme* v. *Wood*, 689 P.2d 446, 450 (Ca. 1984).

[138] *Pacific Mutual Life Ins. Co.* v. *Haslip*, 499 U.S. 1, 18 (1991). *See also Honda Motor Co., Ltd.* v. *Oberg*, 512 U.S. 415, 432 (1994) (stating that punitive damages "pose an acute danger of arbitrary deprivation of property," raising serious due process concerns).

[139] *International Bhd. of Elec. Workers* v. *Foust*, 442 U.S. 42, 50 (1979).

[140] Congress included a cap on punitive damages for individuals and small businesses in the Year 2000 Readiness and Responsibility Act, Pub. L. 106–37, 113 Stat. 135 (1999). The "Y2K Act" established procedures and legal standards for lawsuits stemming from Year 2000 date-related computer failures.

[141] *See Solem* v. *Helm*, 463 U.S. 277, 284 (1983) ("The principle that a punishment should be proportionate to the crime is deeply rooted and frequently repeated in common-law jurisprudence "); *Weems* v. *United States*, 217 U.S. 349, 366–67 (1910) (it is "a precept of the fundamental law" as well as "a precept of justice that punishment should be graduated and proportioned to the offense ").

in a statute.[142] As former Supreme Court Justice Lewis Powell wrote, "It is long past time to bring the law of punitive damages into conformity with our notions of just punishment."[143] Under the HEALTH Act, the larger the economic losses suffered by the victim, the larger the punishment will be.

Academic groups have recommended limiting punitive damages to prevent excessive punitive damages awards.[144]

At the state level, limits on punitive damages awards exist in a number of states.[145]

Opponents of punitive damages reform argue that changes in the law are not needed because large punitive damages awards are often reduced on appeal. However, the practical reality is that the impact of potentially infinite punitive damages stretches beyond an actual award. The amounts of punitive damages actually awarded are dwarfed by the amounts paid out in settlements because of the mere threat of the imposition of potentially infinite punitive damages causes defendants to settle for large amounts they would not have otherwise. On average, over 90% of product liability cases are settled out of court or otherwise disposed of without trial.[146] In many of these cases, the threat of punitive damages may be abused to force higher settlements.[147] As Yale law professor George Priest has observed: "[T]he availability of unlimited punitive damages affects the 95% to 98% of cases that settle out of court prior to trial. It is obvious and indisputable that a punitive damages claim increases the magnitude of the ultimate settlement and, indeed, affects the entire settlement process, increasing the likelihood of litigation."[148] This observation is supported by the findings of a February 1996 study by the Pacific Research Institute for Public Policy. The Institute's study concluded that the unpredictability of a

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[142] Some examples of Federal criminal fines, even for particularly egregious crimes, do not exceed $250,000 and include the following: tampering with consumer products ($250,000 if death results), U.S. Sentencing Guidelines Manual §§ 2N1.1, 5E1.2 (1998); assault on the President ($30,000), U.S. Sentencing Guidelines Manual §§ 2A6.1, 5E1.2 (1998); bank robbery ($75,000), U.S. Sentencing Guidelines Manual §§ 2B3.1, 5E1.2; and sexual exploitation of children ($100,000), U.S. Sentencing Guidelines Manual §§ 2G2, 5E1.2 (1998). *See* generally Jonathan Kagan, Comment, Toward a Uniform Application of Punishment: Using the Federal Sentencing Guidelines as a Model for Punitive Damages Reform, 40 U.C.L.A. L. Rev. 753 (1993).

[143] Lewis Powell, "The 'Bizarre' Results of Punitive Damages," *Wall Street Journal* (March 8, 1995), at A21.

[144] *See* American Bar Association, Special Committee on Punitive Damages of the American Bar Association, Section on Litigation, Punitive Damages: A Constructive Examination (1986) at 64–66 (recommending that punitive damages awards in excess of three-to-one ratio to compensatory damages be considered presumptively "excessive "); American College of Trial Lawyers, Report on Punitive Damages of the Committee on Special Problems in the Administration of Justice 15–16 (1989), at 15 (proposing that punitive damages be awarded up to two times a plaintiff's compensatory damages or $250,000, whichever is greater); American Law Institute, 2 Enterprise Responsibility for Personal Injury—Reporters' Study (1991), at 258–59 (endorsing concept of ratio coupled with alternative monetary ceiling).

[145] *See* Ala. Code § 6–11–21 (1999); Alaska Admin. Code tit. 58 § 9.17.020(f)-(h) (1999); Colo. Rev. Stat. § 13–21–102(1)(a)(1998); Conn. Gen. Stat. § 52–240b (1999); Fla. Stat. Ann. § 768.73(1)(b) (West Supp. 1998); Ind. Code Ann. § 34–51–3–4 (1999); Kan. Stat. Ann. § 60–3701 (1998); N.J. Stat. Ann. § 2A:15–5.14 (West 1999); N.C. Gen. Stat. § 1D–25 (1999); N.D. Cent. Code § 32.03.2–11(4) (1999); Okla. Stat. tit. 23 § 9.1 (1998); Tex. Civ. Prac. & Rem. Code Ann. § 41.008 (West 1999); Va. Code Ann. § 8.01–38.1 (1999).

[146] *See* Brian J. Ostrom and Neal B. Kauder, State Justice Inst., Examining the Work of State Courts, 1993: A National Perspective from the Court Statistics Project 24 (1993).

[147] *See* Stephen Daniels and Joanne Martin, Myth and Reality in Punitive Damages, 75 Minn.L.Rev. 1, 28 (1990) (noting that "jury verdicts in the minority of matters actually adjudicated play an important role in determining the worth, or settlement value, of civil matters filed but not tried"). Furthermore, in some states, punitive damages are not insurable. Thus, a business that does not self-insure can be subject to unwarranted pressure to settle a case for compensatory damages, which are insurable; a punitive damages award could end the business.

[148] George L. Priest, Punitive Damages Reform: The Case of Alabama, 56 La. L. Rev. 825, 830 (1996).

prospective punitive damage award contributes significantly to the uncertainty, and therefore the risk, of a court trial outcome; and that both the uncertainty posed by the prospect of unlimited punitive damages, combined with the relative probability of a punitive damage award if a case goes to jury trial, provide litigants who demand punitive damages with potent leverage against risk-averse defendants, and tip the balance in settlement bargains in favor of litigants with weak or frivolous cases. [149]

It has also been argued that unlimited punitive damages are needed to police wrongdoing. However, there is no credible evidence that the behavior of profit-making enterprises is less safe in either those states that have set limits on punitive damages or in the six states—Louisiana, Nebraska, Washington, New Hampshire, Massachusetts, and Michigan—that do not permit punitive damages at all. [150] Furthermore, plaintiffs in these six states have no more difficulty obtaining legal representation than in those states where punitive damages are potentially limitless.

THE "CLEAR AND CONVINCING" RULE IS APPROPRIATELY APPLIED TO CLAIMS FOR QUASI-CRIMINAL PUNITIVE DAMAGES

The HEALTH Act provides that punitive damages may be awarded against a person in a health care lawsuit only if it proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. The "clear and convincing evidence" burden of proof standard is appropriate because it reflects the quasi-criminal nature of punitive damages. Such a standard takes a middle ground between the burden of proof standard ordinarily used in civil cases—that is, proof by a "preponderance of the evidence"—and the criminal law standard, that is, proof "beyond a reasonable doubt."

The "clear and convincing evidence" standard is the law in twenty-nine states and the District of Columbia [151] and it has been recommended by the principal academic groups that have analyzed the law of punitive damages over the past 15 years, including the American Bar Association, the American College of Trial Lawyers, and the National Conference of Commissioners on Uniform State

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[149] *See* Steven Hayward, Pacific Research Inst. Public Policy, The Role of Punitive Damages In Civil Litigation: New Evidence 8 (1996).

[150] *See* W. Kip Viscusi, Punitive Damages: The Social Costs of Punitive Damages Against Corporations In Environmental and Safety Torts, 87 Geo. L.J. 285, 294 (1998).

[151] *See* Ala. Code §6–11–20 (1999); Alaska Stat. §09.17.020 (1999); Cal. Civ. Code §3294(a) (1999); Fla. Stat. ch. 768.73 (1998); Ga. Code Ann. §51–12–5.1 (1999); Iowa Code Ann. §668A.1 (1997); Kan. Stat. Ann. §60–3701(c) (1998); Ky. Rev. Stat. Ann. §411.184(2) (Michie/Bobbs-Merrill 1998); Minn. Stat. Ann. §549.20 (West Supp. 1998); Miss. Code Ann. §11–1–65(1)(a) (Supp. 1998); Mont. Code Ann. §27–1–221(5) (1998); N.J. Stat. Ann. §2A:15–5.12 (1999); Nev. Rev. Stat. Ann. §42–005(1) (1998); N.C. Gen. Stat. 10–15(b) (1999); N.D. Cent. Code §32–03.2–11 (Supp. 1999); Ohio Rev. Code Ann. §2307.80(A) (Anderson 1999); Okla. Stat. Ann. tit. 23, §9.1 (West Supp. 1998); Or. Rev. Stat. §18.537 (1997); S.C. Code Ann. §15–33–135 (Law. Co-op. Supp. 1998); S.D. Codified Laws Ann. §21–1–4.1 (1999); Tex. Civ. Prac. & Rem. Code §41.003 (1999); Utah Code Ann. §78–18–1 (1999); *Linthicum* v. *Nationwide Life Ins. Co.*, 723 P.2d 675 (Ariz. 1986); *Jonathan Woodner, Co.* v. *Breeden*, 665 A.2d 929 (D.C. 1995); *Masaki* v. *General Motors Corp.*, 780 P.2d 566 (Haw. 1989); *Travelers Indem. Co.* v. *Armstrong*, 442 N.E.2d 349 (Ind. 1982); *Tuttel* v. *Raymond*, 494 A.2d 1353 (Me. 1985); *Owens-Illinois* v. *Zenobia*, 601 A.2d 633 (Md. 1992); *Rodriguez* v. *Suzuki Motor Corp.*, 936 S.W.2d 104 (Mo. 1996); *Hodges* v. *S.C. Toof & Co.*, 833 S.W.2d 896 (Tenn. 1992); *Wangen* v. *Ford Motor Co.*, 294 N.W.2d 437 (Wis. 1980). One state, Colorado, requires proof "beyond a reasonable doubt" in punitive damages cases. *See* Colo. Rev. Stat. §13–25–127(2) (1987).

Laws.[152] The Supreme Court has also specifically endorsed the "clear and convincing evidence" standard in punitive damages cases.[153] There is also support for the "clear and convincing evidence" standard at the Federal level. The Volunteer Protection Act of 1997,[154] which was enacted with strong bipartisan support, requires "clear and convincing evidence" of punitive damages liability before punitive damages can be imposed against volunteers of nonprofit organizations.

BIFURCATED PROCEDURES FOR CONSIDERING PUNITIVE DAMAGES PREVENTS UNFAIR AND PREJUDICIAL AWARDS

The HEALTH Act also contains a procedural reform called "bifurcation." Under such a procedure, at either party's request, a trial would be divided so that the proceedings on punitive damages would be separate from and subsequent to the proceedings on compensatory damages. This procedure would achieve judicial economy by having the same jury determine both compensatory damages and punitive damages issues.

Bifurcated trials are fair because they prevent evidence that is highly prejudicial and relevant only to the issue of punishment from being heard by jurors and improperly considered when they are determining underlying liability. For example, plaintiffs' lawyers routinely introduce evidence of a company's net worth. Although a jury is often instructed to ignore such evidence unless it decides to punish the defendant, this is very difficult as a practical matter for jurors to do. The net result may be that jurors overlook key issues regarding whether a defendant is liable for compensatory damages and make an award simply because they believe the defendant can afford to pay it. Bifurcation would help prevent that unfair result because evidence of the defendant's net worth would be inadmissible in the first, compensatory damages phase of the case. Bifurcation also helps jurors compartmentalize a trial, allowing them to more easily separate the burden of proof that is required for compensatory damage awards—that is, proof by a preponderance of the evidence—from a higher burden of proof for punitive damages, that is, proof by clear and convincing evidence.

Recognizing the benefit of bifurcation, some courts have adopted the procedure as a matter of common law reform.[155] Other states have made changes through court rules or legislation.[156] Bifurcation of punitive damages trials is supported by the American Bar Association, the American College of Trial Lawyers, and the Na-

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[152] *See* American Bar Association, Special Committee on Punitive Damages of the American Bar Association, Section on Litigation, Punitive Damages: A Constructive Examination 19 (1986); American College of Trial Lawyers, Report on Punitive Damages of the Committee on Special Problems in the Administration of Justice 15–16 (1989); National Conference Of Commissioners On Uniform State Laws, Uniform Law Commissioners' Model Punitive Damages Act § 5 (approved on July18, 1996); *see also* American Law Institute, 2 Enterprise Responsibility for Personal Injury—Reporters' Study 248–49 (1991).

[153] *See Pacific Mutual Life Ins. Co.* v. *Haslip*, 499 U.S. 1, 23 n.11 (1991) (stating that "[t]here is much to be said in favor of a state's requiring, as many do . . . a standard of 'clear and convincing evidence' ").

[154] Pub. L. No. 105–19, 111 Stat. 218.

[155] *See Hodges* v. *S.C. Toof & Co.*, 833 S.W.2d 896 (Tenn. 1992); Transportation Ins. Co. v. Moriel, 879 S.W.2d 10 (Tex. 1994).

[156] *See, e.g.*, Cal. Civ. Code § 3295(d); Minn. Stat. Ann. § 549.20; Miss. Code Ann. § 11–165(1)(a).

tional Conference of Commissioners on Uniform State Laws, among other well-known organizations. [157]

The HEALTH Act provides that a court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. These provisions are also in California's MICRA law. [158]

CONGRESS SHOULD ENACT A SAFE HARBOR FROM PUNITIVE DAMAGES FOR FDA COMPLIANCE

Litigation is threatening the viability of the life-saving drug industry. [159] To help encourage new drug development and contain the costs of life-saving drugs, the HEALTH Act contains a safe harbor from punitive damages for defendants whose drugs or medical products comply with rigorous regulations and do not misrepresent or withhold information from the FDA or make illegal payments to FDA officials. Under the HEALTH Act, the FDA retains its authority to outright ban harmful products.

FDA standards and regulations are rigorous. The regulatory objectives of the Food, Drug, and Cosmetics Act ("FDCA") are to ensure that the manufacturer shares all risk information with the FDA so that the agency may make informed risk-benefit judgments about the utility of a pharmaceutical. These judgments occur throughout the life of the drug. The agency determines which drugs reach the market and the labeling for those that do. The receipt of new safety information can lead the agency, after holding a hear-

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[157] *See* American Bar Association, Special Committee on Punitive Damages of the American Bar Association, Section on Litigation, Punitive Damages: A Constructive Examination (1986) at 19; American College of Trial Lawyers, Report on Punitive Damages of the Committee on Special Problems in the Administration of Justice (1989) at 18–19; National Conference Of Commissioners On Uniform State Laws, Uniform Law Commissioners' Model Punitive Damages Act § 5 (approved on July18, 1996) at § 11; American Law Institute, 2 Enterprise Responsibility for Personal Injury—Reporters' Study 248–49 (1991) at 255 n.41.

[158] *See* Ca.Civ.Pro. § 425.13 ("In any action for damages arising out of the professional negligence of a health care provider, no claim for punitive damages shall be included in a complaint or other pleading unless the court enters an order allowing an amended pleading that includes a claim for punitive damages to be filed. The court may allow the filing of an amended pleading claiming punitive damages on a motion by the party seeking the amended pleading and on the basis of the supporting and opposing affidavits presented that the plaintiff has established that there is a substantial probability that the plaintiff will prevail on the claim pursuant to Section 3294 of the Civil Code.").

[159] *See* Michael Freedman, "The Tort Mess" *Forbes* (May 13, 2002) ("The pharmaceutical industry has always been a ripe target for suits. The difference nowadays is simply that the dollar amounts have gotten bigger. Between 1989 and 2000 the 300,000 claimants alleging damage from the Dalkon Shield contraceptive device got $2.6 billion in settlements. By contrast, the 320,000 claimants in the Wyeth (formerly American Home Products) diet drug litigation will share $13 billion. The litigation sliced Wyeth's net worth from $7 billion in 1996 to $2.8 billion in 2000. If a drug saves 100 lives for every one it loses, someone who faces certain death should not hesitate to use it. But what happens if the tort system says every death must be paid for? The average payout on a wrongful death claim increased from $1 million in 1994 to $5.7 million in 2000 (the most recent data point available), according to Jury Verdict Research. To merely break even, the drug's maker would have to charge $57,000 for every dose. It can't get away with that. So a potential wonder drug may never see the light of day. A study in the Journal of the American Medical Association estimates that 100,000 people die each year in the U.S. from drug-related deaths. If the families of each sued and won that average of $5.7 million, total liability would hit $570 billion. That's twice the combined revenues of the top 12 drug companies . . . Steven Garber, a researcher at the Rand Research Institute for Civil Justice, says drug companies are willing to take on the risk of lawsuits in marketing blockbusters like Viagra and Vioxx. But in other cases the chance of liability is too great. Garber says companies once stopped making new products for use during pregnancy because of the high risk of birth defects. Companies also limit research on orphan drugs—those that cure rare, often fatal illnesses—because the potential tort liability outweighs the profit potential.").

ing, to withdraw approval for marketing of a drug.[160] The Secretary of Health and Human Services also has the authority to order the withdrawal of marketing approval without a hearing where there appears to be an "imminent hazard to public health."[161]

In particular, before permitting the sale of a pharmaceutical product, the manufacturer is required to generate both safety and efficacy information and must present this information to the FDA in a new drug application ("NDA").[162] The NDA process requires the pharmaceutical manufacturer to submit proposed labeling for the drug.[163] The FDA and the manufacturer then generate the drug's initial label based on the manufacturer-supplied information concerning the drug's safety and efficacy.[164] If the FDA approves the NDA and licenses the drug for sale, the manufacturer has a continuing obligation to report safety-related information to the agency.[165] Drug product labeling often changes over time as the FDA receives information from the manufacturer or other sources about a drug's safety in the marketplace.

To obtain FDA approval for marketing a prescription drug, a pharmaceutical applicant must generate substantial pre-marketing safety and efficacy information through human clinical trials. The FDA must ensure that the proposed new drug complies with the FDCA mandate that safety be established and that "substantial evidence" of efficacy be demonstrated for the drug's proposed uses.[166] The FDA review process often takes years of evaluation after the NDA's submission. Ultimately, approval by the FDA reflects a risk-benefit judgment that the product will enhance public health. The entire NDA process is a lengthy one, typically taking between five and 7 years to complete.

The FDCA and its implementing regulations ensure that a manufacturer shares risk information with the FDA.[167] Post-marketing surveillance consists of two primary components—reports of individual adverse experiences and epidemiologic studies. Serious reactions must be reported within fifteen working days of receipt of the

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[160] *See* 21 U.S.C. § 355(e)(1); 21 C.F.R. § 5.82.

[161] *See* 21 U.S.C. § 355(e).

[162] Under the FDCA, the manufacturer must submit an NDA to the agency and receive pre-marketing approval in order to market a "new drug," that is, any drug that is "not generally recognized, among experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, as safe and effective for use under the condition prescribed, recommended, or suggested in the labeling thereof." 21 U.S.C. § 321(p)(1). If the manufacturer of a "new drug" wishes to distribute it lawfully, he can submit an NDA in conformance with 21 U.S.C. § 355(b). Approval for marketing can be obtained only if, among other things, the applicant submits "adequate and well-controlled studies" demonstrating safety and efficacy. *Id.* § 355(d). Alternatively, the manufacturer can claim that the product is not a "new drug" because it is "generally recognized" as being "safe and effective" for its intended uses. Id. § 321(p)(1), (2). Courts have, however, construed such general recognition to be based on the same adequate and well-controlled investigations required for approval of an NDA under 21 U.S.C. § 355(d). *See Weinberger* v. *Bentex Pharmaceuticals, Inc.*, 412 U.S. 645, 653 (1973).

[163] 21 U.S.C. § 355(b)(1)(F).

[164] Although the manufacturer submits proposed initial labeling with the NDA, the actual labeling is often the result of negotiations between the FDA and the manufacturer. The agency's power to disapprove the NDA ensures that it retains practical control over the contents of drug labeling.

[165] The post-marketing requirements are set forth in 21 C.F.R. § 314.80 (1993).

[166] *See* 21 U.S.C. § 355(d) (1988) ("[S]ubstantial evidence" means evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified . . . to evaluate the effectiveness of the drug involved, on the basis of which it could fairly and responsibly be concluded by such experts that the drug will have the effect it purports or is represented to have under the conditions of use prescribed, recommended, or suggested in the labeling or proposed labeling thereof.").

[167] *See* 21 C.F.R. § 314.80.

information.[168] A comprehensive, post-marketing system of reporting and record-keeping requirements ensures that the manufacturer reports adverse drug experiences discovered in clinical, epidemiological, or surveillance studies, through review of the medical literature, or otherwise.[169] Post-marketing reporting obligations include the disclosure of data regarding adverse reactions outside the United States.

The FDCA regulatory scheme in the end confers upon the FDA final regulatory authority for a pharmaceutical product's labeling. Due to the FDA's experience and expertise, initial labeling and post-marketing drug labeling determinations are ultimately made by the FDA, an agency with a high degree of institutional competence.

A few states have specifically focused on pharmaceuticals and punitive damages and statutorily provide an FDA regulatory compliance defense against such damages.[170]

Where the FDA has approved a pharmaceutical for marketing, the agency has made an explicit judgment that the product will aid the public health. This judgment should be respected absent fraud or the provision of false information, the failure to include material safety information in the NDA, or the failure to provide post-marketing information which would have led to withdrawal of the product or changes in the approved uses of the product. The requirements for an NDA are so extensive however that, at the margin, punitive damages will not provide additional societal benefits beyond those achieved by the FDCA's rules and regulations.

Opponents of the HEALTH Act often cite litigation surrounding the Dalkon Shield and Copper-7 IUD's as examples of harmful products the FDA did not find harmful. However, at the time Dalkon Shield and Copper-7 IUD's that were the subject of litigation were sold, the Food, Drug, and Cosmetic Act did not require approval by the FDA before a medical device could be marketed and the FDA could initiate enforcement action against a device only if it could be established that the device was adulterated or misbranded.[171] However, in 1976, Congress enacted amendments which require premarket approval for medical devices such as the Dalkon Shield.[172] Both the Senate and House Committee Reports specifically mention the Dalkon Shield as a product which had

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[168] *See* 21 C.F.R. § 314.80(c)(1).

[169] *See* 21 C.F.R. §§ 310.303(a), 314.80(c).

[170] The five states that have proscribed punitive damages where the manufacturer has complied with the FDCA are Arizona, Az.Rev.State.Ann. § 12–701; New Jersey, N.J.Sata.Ann. § 2A:58C–5(c); Ohio, Ohio.Rev.Code Ann. § 2307.80(c); Oregon, Or.Rev.Stat. § 30.927; and Utah, Utah Code Ann. § 78–18–2.

The award of punitive damages against pharmaceutical companies who have complied with the FDCA is quite rare. *See* Product Liability Government Standards Defense Proposal, 53 F-D-C REP. (The Pink Sheet), Sept. 23, 1991, at 6 (quoting Northeastern University Law Professor Michael Rustad) ("[A]lmost all the [punitive damages] drug cases we studied involved either fraudulent test results, suppression of negative impacts or withholding information from the Food and Drug Administration . . ."). However, the availability of punitive damages undoubtedly has untoward effects on the course of pharmaceutical litigation. According to some commentators: "The mere presence of punitive damage counts has an undesirable effect on the course of drug product liability litigation. As is true for punitive damage claims involving other products, these counts are only rarely dismissed on summary judgment. . . . Punitive damage claims, therefore, have caused substantial increases in settlement and litigation costs for pharmaceutical manufacturers." Bruce N. Kuhlik & Richard F. Kingham, The Adverse Effects of Standardless Punitive Damage Awards on Pharmaceutical Development and Availability, 45 Food Drug Cosm.L.J. 693, 697 (1990). This effect alone warrants preclusion of punitive damages where there has been regulatory compliance.

[171] *See* 21 U.S.C. §§ 331(a)-(c), 351, 352 (1970).

[172] *See* Pub. L. No. 94–295, 90 Stat. 539 (codified at 21 U.S.C. §§ 360–360K (1976)).

caused harm that could have been prevented if the new law had been in effect when it was first marketed.[173] Consequently, the FDA approval process is much more extensive today than it was at the time Dalkon Shield and Copper-7 IUD's that have been the subject of litigation were sold.

The HEALTH Act also provides that, in a health care lawsuit for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug required to have tamper-resistant packaging under Department of Health and Human Services regulations, including labeling regulations related to such packaging, the manufacturer or drug seller may not be held liable for punitive damages unless the packaging or labeling is found by clear and convincing evidence to be substantially out of compliance with such regulations.

PROVIDING FOR PERIODIC PAYMENTS PRESERVES PLAINTIFFS' FUNDS AND MAKES FULL COMPENSATION MORE LIKELY BY MAKING IT EASIER FOR DEFENDANTS TO AFFORD

The HEALTH Act provides that in any health care lawsuit, if an award for future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act ("UPPJA") promulgated by the National Conference of Commissioners on Uniform State Laws.[174] The periodic payment

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[173] *See* S. Rep. No. 33, 94th Cong., 1st Sess. 1 (1975); H.R. Rep. No. 853, 94th Cong., 2d Sess. 8 (1976).

[174] Further, the ability of the defendant to obtain a savings is translated into lower premium costs for casualty insurance. Anything that lowers casualty insurance rates or that retards the inflation of those rates, benefits anyone who has some exposure to liability for personal injury of another person, and buys insurance to cover potential loss if there is such an injury.

Under UPPJA, either party to a tort action involving bodily injury may elect to have the award of future damages for economic loss be in periodic form. The other party may contest such an election by showing that the time period for periodic payment is too short or the amount of damages too small to make periodic payment an advantage over a lump sum award, or by showing that a periodic payment judgment cannot be properly and securely funded. If an election is effective, UPPJA then requires a specific sequence of findings pertaining to damages that lead to a declaration of a periodic payment award. Initially, both past and future damages are stated separately in lump sum form. Deductions are then made in specific order for pro rata shares of such things as prior settlements with joint tortfeasors, and comparative fault determinations, followed by setoffs or credits. After dealing with these issues, the court then allocates attorneys' fees. They must be taken insofar as possible from future, non-economic damages. The remainder of such fees are taken proportionally from the other categories of damages, if future non-economic damages are insufficient. After all of the deductions, the court lastly determines punitive damages, if any, in a lump sum. The periodic payment of future damages is then set out, literally year by year. This is how a periodic payment award is established under UPPJA.

In establishing a periodic payment award, the court may receive evidence of future changes in the purchasing power of the dollar, and the trier of fact may factor such evidence into the allocation of damages or make separate findings upon the annual rates of change that must be applied to the actual damage figure. In this way a judgment can be created that takes inflation into account over the life of the judgement.

Before a periodic payment award is made, the defendant must provide a qualified funding plan. A qualified plan can take several forms, including an annuity from a qualified insurance company. The essential characteristic for each form is adequate security to assure payment of the award over its lifetime to the injured person. Part of that assurance is reliance upon what UPPJA calls a qualified insurer.

UPPJA requires the state insurance commissioner to keep a list of qualified insurers. These are insurers that meet standards of reliability and financial quality as expressed in common industry rating systems. A qualified funding plan cannot be effected without reliance upon a qualified insurer in some fashion either to provide the plan or guarantee the obligation. The list maintained by the insurance commissioner assures that there will be a reliable pool of qualified insurers from which plans can be obtained to fund periodic payment judgments. The UPPJA

Continued

system recommended by the National Conference of Commissioners on Uniform State Laws calls for payment of such damages as they accrue, periodically, rather than for payment of a lump sum all at one time following the award of damages. The Uniform Law Commissioners contributed to this evolution with the Model Periodic Payment of Judgments Act in 1980. In 1990, this earlier act was replaced by an updated Uniform Periodic Payment of Judgments Act. The advantages of this system are, one, a periodic payment system removes the risk that the money will be lost by either improper expenditure or bad investment before it is needed to pay for actual loss. A periodic payment award of damages is usually funded through the purchase of an annuity from an insurance company or other similar system of secured payment. The obligation of payment is secured without burdening the injured person with the responsibility for keeping and investing the damage award. Second, the defendant is able to acquire the annuity or similar system of secured payment at a price less than the aggregate amount of the damages that must be paid to the plaintiff. This is an immediate savings to the defendant—or more properly the defendant's casualty insurer—who is obligated to pay the damages. This savings is obtained without depriving the plaintiff of any damages to which he or she is entitled and without risking insolvency on the part of the defendant, which would result in victims receiving mere pennies on the dollar.

As the Reagan Administration's Tort Policy Working Group reported in its seminal study of the effects of tort laws on insurance premiums, "Periodic payments, as noted, are not unfair to plaintiffs because the payments would be scheduled to be made as the damages are in fact incurred (that is, as earnings are actually lost, or as certain expenses actually occur)."[175]

STATUTE OF LIMITATIONS

The best way to allow every patient her day in court while preventing prejudice to health care providers is to codify a reasonable statute of limitations, along with a statute of repose, which the HEALTH Act does. Statutes of limitation define the time period following an injury in which a suit must be brought. Their purpose is to protect defendants from prejudicially stale claims by requiring trials to be conducted while the best evidence is still available and, at the same time, encouraging patients to have themselves checked for any illnesses that may result from negligent medical care sooner rather than later. Statutes of limitations are particularly important for ob-gyns, because without reasonable statutes of limitation they remain subject to lawsuits even decades after they deliver a child. The HEALTH Act provides that a medical malpractice lawsuit must be filed no later than 1 year after a person discovers an injury, and in any case within 3 years of an injury. The HEALTH Act makes an exception for minors under the age of 6, extending the time within which a suit must be filed to the longer of 3 years

provides assurances to those who suffer bodily injury that funds will be available to pay the damages while reducing the costs of such damage awards. Its adoption uniformly will be of great benefit to both defendants and plaintiffs.

[175] Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability (February 1986) at 70.

or the date on which the minor reaches the age of 8. These provisions are based on California's MICRA law. [176]

SUMMARY

A national insurance crisis is ravaging the nation's health care system. Skyrocketing insurance rates have caused major insurers to drop coverage, decimated the ranks of doctors and other health care providers by forcing them to abandon patients and practices, particularly in high-risk specialties such as obstetrics and emergency medicine. The problem is particularly acute for practitioners in managed care, where prescribed fixed costs prevent them from recouping insurance costs. The HEALTH Act, modeled after California's quarter-century old and highly successful health care litigation reforms, addresses the current crisis and will make health care delivery more accessible and cost-effective in the United States. Its time-tested reforms will make medical malpractice insurance affordable again, encourage health care practitioners to maintain their practices, reduce health care costs for patients, and save billions of dollars a year in Federal taxpayer dollars by significantly reducing the incidence of wasteful "defensive medicine" without increasing the incidence of adverse health outcomes. Its enactment will particularly help traditionally under-served rural and inner city communities, and women seeking obstetrics care. It will create a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault, reasonable guidelines—but not caps—on the award of punitive damages, and a rule preventing unfair and wasteful windfall double-recoveries. Finally, it will accomplish reform without in any way limiting compensation for 100% of plaintiffs' economic losses, their medical costs, their lost wages, their future lost wages, rehabilitation costs, and any other economic out of pocket loss suffered as the result of a health care injury. The HEALTH Act also does not preempt any State law that caps non-economic damages, such as those for pain and suffering.

Many opponents of the legislation make two fundamental errors. First, they think that when friends or loved ones suffer serious injuries requiring immediate medical attention, Americans will think first about lawyers and lawsuits, not doctors and healing. And second, they assume that when friends or loved ones suffer serious injuries, there will be a doctor to sue in the first place. But we know just the opposite is true. Americans want most to see their friends and loved ones receive the best and most accessible health care available, but with greater and greater frequency doctors are not there to deliver it. To be clear, with or without the HEALTH Act, wrongfully injured victims can receive unlimited awards to cover their medical costs—including the costs of pain relief medication—their lost wages, their future lost wages, rehabilitation costs, and any other quantifiable losses. The difference is that without the HEALTH Act, there will be no doctors to potentially sue because there will be no doctors administering care because they will have been priced out of the healing profession by unaffordable professional liability insurance rates.

The American Bar Association estimates there are 1 million lawyers in America. But all of us—all 287 million Americans—are pa-

[176] *See* Cal.C.C.P. § 340.5.

tients. As patients, and for patients, the Committee recommends that the House pass the HEALTH Act.

HEARINGS

On June 12, 2002, the Subcommittee on Commercial and Administrative Law held a hearing on "Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care?" Testimony was received from Donald J. Palmisano, M.D., J.D., Secretary-Treasurer of the American Medical Association; Joanne Doroshow, Executive Director of the Center for Justice & Democracy; Danielle Walters, Executive Vice President of Californians Allied for Patient Protection; and Lawrence E. Smarr, President of the Physician Insurers Association of America, with additional material submitted by other individuals and organizations.

COMMITTEE CONSIDERATION

On September 10, 2002, the Committee met in open session and ordered favorably reported the bill H.R. 4600 with amendment by a voice vote, a quorum being present.

VOTE OF THE COMMITTEE

1. Mr. Nadler offered an amendment that would have adjusted the $250,000 cap on noneconomic damages annually according to adjustments made in the consumer price index. By a rollcall vote of 14 yeas to 14 nays, the amendment was defeated.

ROLLCALL NO. 1

	Ayes	Nays	Present
Mr. Hyde		X	
Mr. Gekas		X	
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte		X	
Mr. Chabot	X		
Mr. Barr		X	
Mr. Jenkins	X		
Mr. Cannon			
Mr. Graham			
Mr. Bachus	X		
Mr. Hostettler		X	
Mr. Green	X		
Mr. Keller		X	
Mr. Issa		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence			
Mr. Forbes		X	
Mr. Conyers	X		
Mr. Frank	X		
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren	X		
Ms. Jackson Lee			
Ms. Waters			
Mr. Meehan			

ROLLCALL NO. 1—Continued

	Ayes	Nays	Present
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner			
Mr. Schiff	X		
Mr. Sensenbrenner, Chairman		X	
Total	14	14	

2. Mr. Nadler offered an amendment that would have allowed courts to make public court records when specified criteria were met. By a rollcall vote of 6 yeas to 16 nays, the amendment was defeated.

ROLLCALL NO. 2

	Ayes	Nays	Present
Mr. Hyde			
Mr. Gekas		X	
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte		X	
Mr. Chabot		X	
Mr. Barr		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Graham			
Mr. Bachus		X	
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Mr. Issa		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence			
Mr. Forbes			
Mr. Conyers			
Mr. Frank			
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt			
Ms. Lofgren			
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan			
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner			
Mr. Schiff			
Mr. Sensenbrenner, Chairman		X	
Total	6	17	

3. Mr. Nadler offered an amendment that would have provided that the provisions of the HEALTH Act would not apply to State laws regarding the liability of health maintenance organizations. By a rollcall vote of 7 yeas to 15 nays, the amendment was defeated.

ROLLCALL NO. 3

	Ayes	Nays	Present
Mr. Hyde			
Mr. Gekas		X	
Mr. Coble	X		
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte		X	
Mr. Chabot		X	
Mr. Barr		X	
Mr. Jenkins		X	
Mr. Cannon			
Mr. Graham			
Mr. Bachus		X	
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Mr. Issa		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence			
Mr. Forbes			
Mr. Conyers			
Mr. Frank			
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt			
Ms. Lofgren			
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan			
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner			
Mr. Schiff			
Mr. Sensenbrenner, Chairman		X	
Total	7	15	

4. Mr. Nadler offered an amendment that would have added a provision to the HEALTH Act providing that nothing in the Act would reduce the liability of a tax haven corporation to any person on any claim. By rollcall vote of 6 yeas to 16 nays, the amendment was defeated.

ROLLCALL NO. 4

	Ayes	Nays	Present
Mr. Hyde			
Mr. Gekas		X	
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte		X	
Mr. Chabot		X	
Mr. Barr		X	
Mr. Jenkins		X	
Mr. Cannon			
Mr. Graham			
Mr. Bachus		X	
Mr. Hostettler			

ROLLCALL NO. 4—Continued

	Ayes	Nays	Present
Mr. Green		X	
Mr. Keller		X	
Mr. Issa		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence			
Mr. Forbes			
Mr. Conyers			
Mr. Frank			
Mr. Berman		X	
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt			
Ms. Lofgren			
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan			
Mr. Delahunt			
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff			
Mr. Sensenbrenner, Chairman		X	
Total	6	16	

5. Ms. Jackson Lee offered an amendment that would have exempted persons who had not attainted the age of 12 years at the time a claim arose from the provisions imposing a cap on non-economic damages. By rollcall vote of 6 yeas to 14 nays, the amendment was defeated.

ROLLCALL NO. 5

	Ayes	Nays	Present
Mr. Hyde			
Mr. Gekas		X	
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte			
Mr. Chabot		X	
Mr. Barr		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Graham			
Mr. Bachus		X	
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Mr. Issa			
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence		X	
Mr. Forbes			
Mr. Conyers			
Mr. Frank			
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		

ROLLCALL NO. 5—Continued

	Ayes	Nays	Present
Mr. Watt			
Ms. Lofgren			
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan			
Mr. Delahunt			
Mr. Wexler			
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff			
Mr. Sensenbrenner, Chairman		X	
Total	6	16	

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee reports that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

PERFORMANCE GOALS AND OBJECTIVES

H.R. 4600 does not authorize funding. Therefore, clause 3(c) of rule XIII of the Rules of the House of Representatives is inapplicable.

NEW BUDGET AUTHORITY AND TAX EXPENDITURES

Clause 3(c)(2) of House rule XIII is inapplicable because this legislation does not provide new budgetary authority or increased tax expenditures.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the Committee sets forth, with respect to the bill, H.R. 4600, the following estimate and comparison prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 24, 2002.

Hon. F. JAMES SENSENBRENNER, Jr., *Chairman,*
Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4600, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2002.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Alexis Ahlstrom (for Federal revenues and spending), who can be reached at 226–9010,

and Stuart Hagen (for private-sector impact) who can be reached at 226–6666.

Sincerely,

DAN L. CRIPPEN, *Director.*

Enclosure

cc: Honorable John Conyers, Jr.
Ranking Member

H.R. 4600—Help Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act of 2002.

SUMMARY

H.R. 4600 would impose limits on medical malpractice litigation in State and Federal courts by capping awards and attorney fees, reducing the statute of limitations, eliminating joint and several liability, and changing the way collateral-source benefits are treated.

Those changes would lower the cost of malpractice insurance for physicians, hospitals, and other health care providers and organizations. That reduction in insurance costs would, in turn, lead to lower charges for health care services and procedures, and ultimately, to a decrease in rates for health insurance premiums.

Because employers would pay less for health insurance for employees, more of their employees' compensation would be in the form of taxable wages and fringe benefits. As a result, CBO estimates that enacting H.R. 4600 would increase Federal revenues by $40 million in 2003 and by $2.4 billion over the 2003–2012 period.

Enacting H.R. 4600 also would reduce Federal direct spending for Medicare, Medicaid, the Government's share of premiums for annuitants under the Federal Employees Health Benefits (FEHB) program, and other Federal health benefits programs. CBO estimates that direct spending would decline by $11.3 billion over the 2004–2012 period. Because the bill would affect revenues and direct spending, pay-as-you-go procedures would apply.

Federal spending for active workers participating in the FEHB program is included in the appropriations for Federal agencies, and therefore is discretionary. CBO estimates that enactment of H.R. 4600 would reduce discretionary spending for the FEHB program by about $400 million over the 2004–2012 period.

The bill would preempt State laws that provide less protection for health care providers and organizations from liability, loss, or damages (other than caps on awards for damages). That preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA). Such a preemption would limit the application of State law, but it would require no action by States that would result in additional spending or a loss of revenue. Thus, the threshold established by UMRA for intergovernmental mandates ($58 million in 2002, adjusted annually for inflation) would not be exceeded.

H.R. 4600 would impose a private-sector mandate on attorneys in malpractice cases by limiting the size of the awards they could receive. CBO estimates that the direct cost of that mandate would exceed the annual threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation) in each of the first 5 years the mandate would be effective.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 4600 is shown in the following table. The effects of this legislation on direct spending fall within budget functions 550 (health) and 570 (Medicare). The effects on spending subject to appropriation fall within multiple budget functions.

	By Fiscal Year, in Millions of Dollars										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003 - 2012
CHANGES IN REVENUES											
Income and HI Payroll Taxes (on-budget)	30	80	130	160	170	180	190	210	240	260	1,650
Social Security Payroll Taxes (off-budget)	10	30	60	70	80	90	90	100	110	110	750
Total	40	110	190	230	250	270	280	310	350	370	2,400
CHANGES IN DIRECT SPENDING											
Estimated Budget Authority	0	-250	-390	-690	-1,220	-1,520	-1,660	-1,770	-1,880	-1,920	-11,300
Estimated Outlays	0	-250	-390	-690	-1,220	-1,520	-1,660	-1,770	-1,880	-1,920	-11,300
CHANGES IN SPENDING SUBJECT TO APPROPRIATION											
Estimated Authorization Level	0	-20	-40	-40	-40	-50	-50	-50	-50	-60	-400
Estimated Outlays	0	-20	-40	-40	-40	-50	-50	-50	-50	-60	-400

NOTE: HI = Medicare Hospital Insurance program.

BASIS OF ESTIMATE

This estimate assumes that H.R. 4600 will be enacted in October 2002. It would apply to lawsuits initiated on or after the date of enactment.

Major Provisions of the Bill

H.R. 4600 would place caps on awards by limiting non-economic damages, such as pain and suffering, to $250,000, and punitive damages to twice the amount of economic damages or $250,000, whichever is greater. Punitive damages would be further constrained by limiting the circumstances under which they may be sought. Economic, or compensatory, damages would not be limited. Attorney fees would be restricted as follows: 40 percent of the first $50,000 of the award, 33.3 percent of the next $50,000 of the award, 25 percent of the next $500,000, and 15 percent of that portion of the award in excess of $600,000. The caps on attorney fees would apply regardless of whether the award was determined in the courts or settled privately, and could be reduced further at the discretion of the court. (The court could not, however, increase attorney fees beyond the caps.) For awards of future damages equal to or exceeding $50,000, any party to the lawsuit could request that future damages be paid by periodic payments.

The bill would impose a statute of limitations requiring that lawsuits begin within 3 years after the injury alleged to have happened as a result of malpractice occurs or 1 year after the claimant discovers, or should have discovered, the injury, whichever occurs

first. Under the joint and several liability provisions of current law, defendants found negligent in a lawsuit are each liable for the full amount of damages, regardless of their proportionate share of responsibility for the injury. H.R. 4600 would limit the liability of each defendant to the share of damages attributable to his or her responsibility.

Collateral-source benefits are other sources of compensation a claimant may have access to in the event of an injury. A common source of such benefits is the claimant's health insurance, which would likely pay for a portion of the medical costs arising from the injury. Other sources include disability insurance payments, workers' compensation, and life insurance payments. The bill would allow evidence of such benefits to be introduced at trial by either claimants or defendants. In addition, providers of collateral-source benefits would not be allowed to place a lien on the claimant's award or recover any amount from the claimant, whether or not the case goes to trial.

Impact on Medical Malpractice Insurance Premiums

CBO's estimate of the impact of this bill is based on a statistical analysis of historical premiums for medical malpractice insurance coverage in States that have and have not enacted medical malpractice tort limitations. We conducted another analysis using medical malpractice claims data provided by the Physician Insurers Association of America. CBO also considered the impact of factors not directly related to trends in malpractice claim payments that may have contributed to recent increases in medical malpractice premiums. Those factors include reduced investment income of insurers, the need of insurers to replenish depleted reserves, and recent increases in reinsurance costs for all types of insurance.

CBO's analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in States that currently do not have controls on malpractice torts, H.R. 4600 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law. That effect would increase somewhat over the 10-year time horizon of this estimate because caps on awards would not be indexed to increase with inflation. As a result, the caps on awards would become more constraining in later years.

CBO estimates that, under this bill, premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law. However, other factors discussed above may exert upward pressure on future premiums, possibly obscuring at least some of the anticipated effect of the legislation. The effect of H.R. 4600 would vary substantially across States, depending on the extent to which a State already limits malpractice litigation. There would be almost no effect on malpractice premiums in about one-quarter of the States, while reductions in premiums would be substantially larger than the overall average in about one-third of the States.

Impact on Health Insurance Premiums

The percentage effect of H.R. 4600 on overall health insurance premiums would be far smaller than the percentage impact on medical malpractice insurance premiums. Malpractice costs account for a very small fraction of total health care spending; even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums. In addition, some of the savings leading to lower medical malpractice premiums—those savings arising from changes in the treatment of collateral-source benefits—would represent a shift in costs from medical malpractice insurance to health insurance. Because providers of collateral-source benefits would be prevented from recovering their costs arising from the malpractice injury, some of the costs that would be borne by malpractice insurance under current law would instead be borne by the providers of collateral-source benefits. Most such providers are health insurers.

CBO's estimate does not include savings from reductions in the practice of defensive medicine—services and procedures that are provided largely or entirely to avoid potential liability. Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.

A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments that are disproportionately likely to experience malpractice claims. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending. Although the provisions of H.R. 4600 could result in the initiation of fewer lawsuits, the economic incentives for individual physicians or hospitals to practice defensive medicine would appear to be little changed.

Nonetheless, while there is insufficient evidence to justify including a defensive medicine adjustment in the estimate, the promising nature of the studies' results merits further analysis. CBO has obtained a person-based longitudinal database that contains detailed claims information on Medicare spending for covered services used by a random sample of fee-for-service beneficiaries between 1989 and 1997. Using these data, CBO hopes to expand the analysis of earlier researchers to include broader measures of spending (including hospital services, physician care, post-acute care, and ancillary services) and a larger number of conditions, to help determine the extent to which the results of the earlier studies may apply to overall health care spending.

Federal Revenues

CBO estimates that, over a 3-year period, enacting H.R. 4600 would lower the price employers, State and local governments, and

individuals pay for health insurance by about 0.4 percent, before accounting for the responses of health plans, employers, and workers to the lower premiums. Those responses would include an increase in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered, and increases in the scope or generosity of health insurance benefits. CBO assumes that these behavioral responses would offset 60 percent of the potential impact of the bill on the total costs of health plans.

The remaining 40 percent of the potential reduction in premium costs, or about 0.2 percent of group health insurance premiums, would occur in the form of lower spending for health insurance. Those savings would be passed through to workers, increasing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumes that all of that savings would ultimately be passed through to workers. We assume that State, local, and tribal governments would absorb 75 percent of the decrease and would increase their workers' taxable income and other fringe benefits to offset the remaining one-quarter of the decrease. CBO estimates that the resulting increase in taxable income would grow from $126 million in calendar year 2003 to $1.1 billion in 2012.

Those increases in workers' taxable compensation would lead to more Federal tax revenues. The estimate assumes an average marginal rate of about 20 percent for income taxes and the current-law rates for the Hospital Insurance and Social Security payroll taxes (2.9 percent and 12.4 percent, respectively). CBO further assumes that 15 percent of the change in taxable compensation would not be subject to the Social Security payroll tax. As a result, we estimate that Federal tax revenues would increase by $40 million in 2003 and by a total of $2.4 billion over the 2003–2012 period if H.R. 4600 were enacted. Social Security payroll taxes, which are off-budget, account for about 30 percent of those totals.

Federal Spending

CBO estimates that H.R. 4600 would reduce direct spending for Federal health insurance programs by $11.3 billion over the 2004–2012 period. Those totals reflect reductions in spending resulting from the effect of lower premiums for malpractice insurance, partially offset by increases in direct spending because Federal programs could no longer collect collateral-source benefits.

CBO estimates that premiums for the Federal Employees Health Benefits (FEHB) program would decline by the same 0.4 percent as the estimated average change in premiums for private health insurance. (That estimate includes the effects of H.R. 4600 on both premiums for malpractice insurance and the collection of collateral-source benefits.) We assume that participants in the FEHB program would offset 60 percent of that reduction by choosing more expensive plans, so that spending for the FEHB program would decline by about 0.2 percent. The 2003 premiums for FEHB plans have already been announced, so there would be no effect on FEHB spending in 2003.

Federal spending for annuitants in the FEHB program is considered direct spending. CBO estimates that H.R. 4600 would reduce

direct spending for annuitants in FEHB by $270 million over the 2004–2012 period. Federal spending for active workers participating in the FEHB program is included in the appropriations for Federal agencies, and therefore is discretionary. CBO estimates that enactment of H.R. 4600 would reduce discretionary spending for FEHB by about $400 million over the 2004–2012 period. Spending for postal workers and postal annuitants participating in the FEHB program is off-budget. CBO estimates that changes in spending for Postal Service participants would be offset by changes in the prices of postal services, and therefore would net to zero.

Each year, the Centers for Medicare & Medicaid Services sets Medicare payment rates for physician services and hospital services that include explicit adjustments for changes in the cost of malpractice premiums. CBO estimates that H.R. 4600 would have no effect on Medicare spending in 2003, because payment rates have already been set for hospital services and will be set for physician services before the effects of the bill could be incorporated in the rate-setting process. CBO estimates that incorporating lower malpractice premiums in Medicare payment rates would reduce Medicare spending by $10.8 billion over the 2004–2012 period.

CBO assumes that the rates that State Medicaid programs pay for hospital and physician services would change in proportion to the changes in Medicare payments. In addition, lower Medicare payment rates would result in lower payments by beneficiaries for cost sharing and premiums. Therefore, H.R. 4600 would reduce spending by Federal programs that pay premiums and cost sharing for certain Medicare beneficiaries—Medicaid and the Tricare for Life program of the Department of Defense (DoD). CBO estimates that H.R. 4600 would reduce direct spending for Medicaid and DoD by $3.6 billion over the 2004–2012 period.

Under current law, Medicare and Medicaid pay the medical costs arising from medical malpractice injuries. In the event that a patient wins a settlement, the programs require reimbursement for the costs they incurred. H.R. 4600 would prohibit Medicare and Medicaid from making any future collections. CBO estimates that implementing this provision would increase outlays by $3.4 billion over the 2004–2012 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects through 2006 are counted.

	By Fiscal Year, in Millions of Dollars										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Changes in receipts	0	30	80	130	160	170	180	190	210	240	260
Changes in outlays	0	0	-250	-390	-690	-1,220	-1,520	-1,660	-1,770	-1,880	-1,920

INTERGOVERNMENTAL AND PRIVATE SECTOR IMPACTS:

The Unfunded Mandates Reform Act defines a mandate as legislation that "would impose an enforceable duty" upon the private sector or a State, local, or tribal government. CBO believes that UMRA's definition of a mandate does not include legislation that would, for example, impose requirements or limitations on recoveries, address burdens of proof, or modify evidentiary rules because such changes would be methods of enforcing existing duties, rather than new duties themselves as contemplated by UMRA. The provisions of H.R. 4600 would not impose or change the underlying enforceable duties or standards of care applicable to those providing medical items and services under current law. Rather, they would address the enforcement of existing standards of professional behavior through tort litigation procedures.

Clearly, a cap on recoveries of damages from medical malpractice would lower recoveries by future plaintiffs while reducing the costs borne by potential defendants. This cost effect, however, would not itself establish a new mandate. It would be more reasonably viewed as part of the process for enforcing the professional duties of medical providers, rather than an enforceable duty as defined by UMRA.

Intergovernmental Mandates and Other Public-Sector Impacts

Intergovernmental Mandates. The bill would preempt State laws that would prevent the application of any provisions of the bill, but it would not preempt any State law that provides greater protections for health care providers and organizations from liability, loss, or damages. Those that provide a lesser degree of protection would be preempted. (State laws governing damage awards would not be preempted, regardless of whether they were higher or lower than the caps provided for in the bill.) These preemptions would limit the application of State law, but they would require no action by States that would result in additional spending or a loss of revenue. Thus, the threshold established by UMRA for intergovernmental mandates ($58 million in 2002, adjusted annually for inflation) would not be exceeded.

Other Public-Sector Impacts. State, local, and tribal governments would realize net savings as a result of provisions of H.R. 4600. State, local, and tribal governments that assess income taxes also would realize increased tax revenues as a result of increases in workers' taxable income. CBO has not estimated the magnitude of those increased revenues.

State, local, and tribal governments would save money as a result of lower health insurance premiums precipitated by the bill. Based on information from the Bureau of the Census and the Joint Committee on Taxation and on our estimates of the effect of the bill on health care premiums, CBO estimates that State and local governments would save about $5 billion over the 2003–2012 period as a result of lower premiums for health care benefits they provide to their employees. That figure is based on estimates of State and local spending for health care growing from about $95 billion in 2003 to $189 billion in 2012 and an expectation that savings would phase in over a 3-year period. The estimate accounts for some loss in receipts because State health, sickness, income-dis-

ability, accident, and workers' compensation programs would no longer be able to recover a share of malpractice damage awards.

State and local governments also would save Medicaid costs as a result of lower health care spending. CBO estimates that State Medicaid spending would decrease by about $2 billion over the 2003–2012 period.

Private-Sector Mandates and Other Impacts

The bill would impose a private-sector mandate on attorneys in malpractice cases by limiting the size of the awards they could receive. CBO estimates that the direct cost of that mandate to affected attorneys would amount to about $140 million in 2003, rising to about $320 million in 2007. Those costs would exceed the annual threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation) in each of the first 5 years the mandate would be effective.

ESTIMATE PREPARED BY:

Federal Revenues: Alexis Ahlstrom (226–9010)
Federal Outlays: Medicaid—Jeanne De Sa and Eric Rollins; Medicare—Julia Christensen and Alexis Ahlstrom; and FEHB—Alexis Ahlstrom (226–9010).
Impact on State, Local, and Tribal Governments: Leo Lex (225–3320)
Impact on the Private Sector: Stuart Hagen (226–2666)

ESTIMATE APPROVED BY:

Robert A. Sunshine
Assistant Director for Budget Analysis

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds the authority for this legislation in article I, section 8, clause 3 of the Constitution.

SECTION-BY-SECTION ANALYSIS AND DISCUSSION

Section 1. Short Title.

This section provides that the Act may be cited as the "Help Efficient, Accessible, Low-cost, Timely, Healthcare (HEALTH) Act of 2002."

Section 2. Findings and Purpose.

This section sets out Congressional findings and the purposes of the Act.

Section 3. Encouraging Speedy Resolution of Claims.

This section provides for a 3-year statute of limitations with exception for minors. It provides that a health care lawsuit may be commenced no later than 3 years after the date of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no case can a lawsuit be brought after 3 years, expect for those regarding alleged injuries sustained by a minor before the age of 6,

in which case a health care lawsuit may be commenced by or on behalf of the minor until the later of 3 years from the date of injury, or the date on which the minor attains the age of 8.

Section 4. Compensating Patient Injuries.

Subsection (a) of this section provides that any economic damages (that is, any damages to which a receipt can be attached) are unrestricted. It provides that the full amount of a claimant's economic loss, including their medical costs, the costs of pain relief medication, their lost wages, their future lost wages, rehabilitation costs, and any other economic out of pocket loss suffered as the result of a health care injury, may be fully recovered without limitation.

Subsection (b) of this section provides that "pain and suffering" and other noneconomic damages are capped at $250,000. It provides that the amount of noneconomic damages recovered may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

Subsection (c) of this section provides that in any health care lawsuit, an award for future noneconomic damages shall not be discounted to present value. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment.

Subsection (d) of this section provides that defendants should only be liable for the percentage of damages for which they are at fault. It provides that each party shall be liable only for the amount of damages allocated to such party in direct proportion to their percentage of fault.

Section 5. Maximizing Patient Recovery.

Subsection (a) of this section limits on attorneys' fees. It provides that in no event shall the total of all attorneys fees for representing all claimants in a health care lawsuit exceed the following limits: (1) 40% of the first $50,000 recovered by the claimants; (2) 33.3% percent of the next $50,000 recovered by the claimants; (3) 25% of the next $500,000 recovered by the claimants; and (4) 15% of any amount by which the recovery by the claimants is in excess of $600,000.

Subsection (b) of this section provides that in a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

Section 6. Additional Health Benefits.

This section provides that a jury can hear evidence of payments received by plaintiffs from other sources. It provides that any party may introduce evidence of collateral source benefits received or reasonably likely to be received from other sources (and which benefits would cover the same injuries) in order to prevent double recoveries.

Section 7. Punitive Damages.

This section provides guidelines for punitive damages.

Subsection (a) of this section provides that punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer; provides that where no judgment for compensatory damages is rendered against a defendant, no punitive damages may be awarded; provides that for a "bifurcated" punitive damages trial in which a claimant may request punitive damages upon a motion and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages; if a such separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

Subsection (b) of this section sets out the criteria the trier of fact may use to award punitive damages. This subsection also provides that in determining the amount of punitive damages, the amount of punitive damages awarded may be up to as much as two times the amount of economic damages awarded or $250,000, whichever is greater.

Subsection (c) of this section provides a safe harbor from punitive damages for manufacturers of products that are FDA-approved, with an exception for those who give false or incomplete information or who make illegal payments. It provides that no punitive damages may be awarded against the manufacturer or distributor of a medical product based on a claim that such product caused the claimant's harm where (A) such medical product was subject to premarket approval or clearance by the FDA with respect to the safety of the formulation or performance of the aspect of such medical product which caused the claimant's harm or the adequacy of the packaging or labeling of such medical product; and such medical product was so approved or cleared; or (B) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the FDA and applicable FDA regulations, including without limitation those related to packaging and labeling. Also provides that in a lawsuit for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially out of compliance with such regulations. These provisions regarding drugs and medical devices shall not apply in any lawsuit in which (A) a person, before or after premarket approval or clearance of such medical product, knowingly misrepresented to or withheld from the FDA information that is required to be submitted under the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and is

causally related to the harm which the claimant allegedly suffered; or (B) a person made an illegal payment to an FDA official for the purpose of either securing or maintaining approval or clearance of such medical product.

Section 8. Authorization of Payment of Future Damages to Claimants in Health Care Lawsuits.

This section allows periodic payments of future awards over time. It provides that, if an award of future damages equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

Section 9. Definitions.

This sections provides the definitions of terms used in the Act.

Section 10. Effects on Other Laws.

Subsection (a) of this section provides that to the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death, this Act does not affect the application of the rule of law to such an action; and any rule of law prescribed by this Act in conflict with a rule of law of such title XXI shall not apply to such action. This section also provides that if there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this Act or otherwise applicable law (as determined under this Act) will apply to such aspect of such action.

Subsection (b) of this section provides that except as provided in this section, nothing in this Act shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

Section 11. State Flexibility and Protection of States' Rights.

Subsection (a) of this section provides that the provisions governing health care lawsuits set forth in this Act preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this Act. The provisions governing health care lawsuits set forth in this Act supersede chapter 171 of title 28, United States Code, to the extent that such chapter provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this Act; or prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

Subsection (b) of this section provides that any issue that is not governed by any provision of law established by or under this Act (including State standards of negligence) shall be governed by otherwise applicable State or Federal law. This Act does not preempt

or supersede any law that imposes greater protections (such as a shorter statute of limitations) for health care providers and health care organizations from liability, loss, or damages than those provided by this Act.

Subsection (c) of this section provides that no provision of this Act shall be construed to preempt any State statutory limit (whether enacted before, on, or after the date of the enactment of this Act) on the amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, whether or not such State limit permits the recovery of a specific dollar amount of damages that is greater or lesser than is provided for under this Act or any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

Section 12. Applicability; Effective Date.

This section provides that this Act shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

MARKUP TRANSCRIPT

BUSINESS MEETING

TUESDAY, JULY 23, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., in Room 2141, Rayburn House Office Building, Hon. F. James Sensenbrenner, Jr. [Chairman of the Committee] presiding.

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Now, one note on process on where we go from here: It is the intention of the Chair to call up the medical malpractice bill. The Chair will give an opening statement. Mr. Conyers will then be recognized for an opening statement. The Chair will ask unanimous consent that all Members may place opening statements in the record. The Chair will then call if there are any amendments, and then we will immediately adjourn and mark the bill up after we get back following the August recess. So we've had our last vote for the day.

Now, pursuant to notice, I call up the bill H.R. 4600, the "Help Efficient, Accessible, Low Cost, Timely Health Care Act of 2002," for purposes of markup and move its favorable recommendation to the House. Without objection, the bill will be considered as read and open for amendment at any point.

[The bill, H.R. 4600, follows:]

I

107TH CONGRESS
2D SESSION

H. R. 4600

To improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

IN THE HOUSE OF REPRESENTATIVES

APRIL 25, 2002

Mr. GREENWOOD (for himself, Mr. COX, Mr. MURTHA, Mr. TOOMEY, Mr. MORAN of Virginia, Mr. PETERSON of Minnesota, Mr. STENHOLM, Mr. LUCAS of Kentucky, Mr. PICKERING, and Mr. WELDON of Florida) introduced the following bill; which was referred to the Committee on the Judiciary, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

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 ''Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

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

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

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

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

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

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

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

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability in-

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

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

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

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

SEC. 3. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

A health care lawsuit may be commenced no later than 3 years after the date of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years, except that in the case of an alleged injury sustained by a minor before the age of 6, a health care lawsuit may be commenced by or on behalf of the minor until the later of 3 years from the

date of injury, or the date on which the minor attains the age of 8.

SEC. 4. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, the full amount of a claimant's economic loss may be fully recovered without limitation.

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

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

and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 5. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles

of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

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

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

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

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

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

SEC. 6. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to

such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder.

SEC. 7. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a

hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

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

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, the trier of fact shall consider only the following:

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

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

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

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

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

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

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

(c) NO CIVIL MONETARY PENALTIES FOR PRODUCTS THAT COMPLY WITH FDA STANDARDS.—

(1) IN GENERAL.—No punitive damages may be awarded against the manufacturer or distributor of a medical product based on a claim that such product caused the claimant's harm where—

(A)(i) such medical product was subject to premarket approval or clearance by the Food and Drug Administration with respect to the

safety of the formulation or performance of the aspect of such medical product which caused the claimant's harm or the adequacy of the packaging or labeling of such medical product; and

(ii) such medical product was so approved or cleared; or

(B) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes a drug or device (including blood products) approved by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such drug or device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug or device.

(3) PACKAGING.—In a health care lawsuit for harm which is alleged to relate to the adequacy of

the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially out of compliance with such regulations.

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

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

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or main-

taining approval or clearance of such medical product.

SEC. 8. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

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

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

SEC. 9. DEFINITIONS.

In this Act:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a man-

ner other than through a civil action brought in a State or Federal court.

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

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

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

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

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

(D) any other publicly or privately funded program.

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

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

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

(7) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the

claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

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

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment

for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

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

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

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

human disease or impairment, or the assessment of the health of human beings.

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

(14) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans, and the terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

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

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

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

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

SEC. 10. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

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

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

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

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this Act shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 11. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this Act preempt, subject to subsections (b) and (c), State law to the extent

that State law prevents the application of any provisions of law established by or under this Act. The provisions governing health care lawsuits set forth in this Act supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this Act; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS.—Any issue that is not governed by any provision of law established by or under this Act (including State standards of negligence) shall be governed by otherwise applicable State or Federal law. This Act does not preempt or supersede any law that imposes greater protections (such as a shorter statute of limitations) for health care providers and health care organizations from liability, loss, or damages than those provided by this Act.

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

(1) any State statutory limit (whether enacted before, on, or after the date of the enactment of this Act) on the amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, whether or not such State limit permits the recovery of a specific dollar amount of damages that is greater or lesser than is provided for under this Act, notwithstanding section 4(a); or

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

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

This Act shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

○

Chairman SENSENBRENNER. And the Chair recognizes himself for 5 minutes to explain the bill.

A national insurance crisis is ruining the Nation's essential health care system. Medical professional liability rates have soared, causing major insurers to either drop coverage or raise premiums to unaffordable levels.

Doctors and other health care providers are being forced to abandon patients and practices, particularly in high-risk specialties such as emergency medicine and obstetrics and gynecology.

This has hit home to my family. The vascular surgeon who corrected my mother's carotid artery and gave her several more years of good, quality life before she passed away has abandoned his vascular surgery practice to go into something that is less risky and has a lower malpractice premium.

Women are being particularly hard hit, as are low-income neighborhoods and rural areas and medical schools large and small.

When California faced a similar crisis 25 years ago, its Democratic Governor, Jerry Brown, enacted the Medical Injury Compensation Reform Act, the so-called MICRA act. MICRA's reforms included a $250,000 cap on non-economic damages, limits on contingency fees lawyers can charge, and provisions that prevent double recoveries.

According to the L.A. Times, because of 1975 tort reform, doctors in California are largely unaffected by increasing insurance rates. But the situation is dire in other States.

Exhaustive research by two Stanford University economists has confirmed that direct medical care litigation reforms, including caps on non-economic damage awards, generally reduce malpractice claims rates, insurance premiums, and other stresses on doctors that may impair the quality of medical care.

The HEALTH Act includes MICRA's reforms while also creating a fair-share rule by which damages are allocated fairly in direct proportion to fault, and reasonable guidelines but not caps on punitive damages.

The HEALTH Act will accomplish reform without in any way limiting compensation for 100 percent of plaintiffs' economic losses, their medical costs, their lost wages, their future lost wages, rehabilitation costs, and any other economic out-of-pocket loss suffered as a result of a health care injury. The HEALTH Act also does not preempt any State law that otherwise caps damages.

A recent survey conducted for the bipartisan legal reform organization Common Good, whose board of advisers includes former Clinton administration Deputy Attorney General Eric Holder and former Democratic Senator Paul Simon, reveals the dire need for regulating the current medical tort system in America.

According the survey, which was conducted by the reputable Harris Organization, more than three-fourths of the physicians feel their concern about malpractice litigation has hurt their ability to provide quality care in recent years. Seventy-nine percent of the physicians report the fear of malpractice claims causes them to order more tests than they would based only on professional judgment of what is medically needed.

As former Democratic Senator and presidential candidate George McGovern and former Republican Senator Alan Simpson have written, legal fear drives doctors to prescribe medicines and order tests,

even invasive procedures, that they feel are unnecessary. Reputable studies estimate that this defensive medicine squanders $50 billion a year.

The Common Good survey also asked physicians the following question: Generally speaking, how much do you think that fear of liability discourages medical professionals from openly discussing and thinking of ways to reduce medical errors?

An astonishing 59 percent of the respondents replied: A lot.

So it's apparent that doctors themselves, who are the most keenly aware of the litigation threats they face, are not blaming insurance companies for high premiums, because they know the problem lies in an unregulated medical litigation system.

Some of opponents of reforms that reasonably limit the currently unregulated health care litigation system make two fundamental errors.

First, they think that when friends or loved ones suffer serious injuries requiring immediate medical attention, Americans will think first about lawyers and lawsuits, not about doctors and healing.

And second, some opponents of reform assume that when friends or loved ones suffer serious injury, there will be a doctor to sue in the first place. But just the opposite is increasingly true.

Americans want most to see their friends and loved ones receive the best and most accessible health care available, but with greater and greater frequency, doctors aren't there to deliver it, because they have been priced out of the healing profession by unaffordable professional liability insurance rates. Sound policy does not favor supporting people's abstract ability to sue a doctor for unlimited and unquantifiable damages when doing so means that there's no doctor to treat people in the first place.

The gentleman from Michigan, Mr. Conyers.

Mr. CONYERS. Thank you, Mr. Chairman.

I was going to yield our Member from California, Mr. Berman, some time during my opening remarks, but I think he's going to need a lot more time than I could yield him.

This could also be called the "product liability and medical malpractice markup." We have more than a dozen sections that seem to combine many of the issues we've been examining for many years into one bill.

Now, all of us recognize that the medical profession has been experiencing difficulties obtaining malpractice insurance as malpractice insurers are abandoning the market, and the ones that aren't are raising the premiums. This presents, clearly, a problem.

We've seen in the past that the insurance industry goes through boom and bust cycles with premiums ebbing and flowing as companies enter and exit the market and investment incomes rise and fall. We know from past experience that the insurance industry, which, by the way, is largely exempt from antitrust laws, is not itself immune from collusion, price-fixing, and other anticompetitive circumstances.

So we approach this legislation—and I'm happy that we're taking it up early. But it's just occurred to perhaps more than one Member of the Committee that possibly the premiums for some reasons have increased because more members of the medical profession

have been forced to work longer hours, some have grown careless, and are working under terrible working conditions.

Fact: Nearly 100,000 people die in this country every year from medical malpractice. It is the third leading cause of preventable deaths. Overworked resident physicians, inadequate nursing support staff are all contributing causes for these deaths.

Now, it's also clear to me that a legislative solution that is largely focused on limiting the victims, the patients who have suffered, limiting their rights available under State tort law, may not do much to change this situation other than to increase the incidents of medical malpractice in the country.

As a matter of fact today, this measure before us presents us with solutions that make the malpractice provisions that were within the Contract with America pale by comparison.

So I think that giving us time, Mr. Chairman, to examine this bill more carefully will be very important, and I ask unanimous consent to include the rest of my statement in the record.

Chairman SENSENBRENNER. Without objection, so ordered.

[The prepared statement of Mr. Conyers follows:]

PREPARED STATEMENT OF THE HONORABLE JOHN CONYERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CHIGAN

It is clear to me that the medical profession has been experiencing difficulties obtaining medical malpractice insurance as malpractice insurers are abandoning the market and raising premiums.

We have seen in the past that the insurance industry goes through boom and bust cycles, with premiums ebbing and flowing as companies enter and exit the market and investment income rises and falls. We also know from past experience that the insurance industry—which is largely exempt from the antitrust laws—is not immune from collusion, price fixing and other anticompetitive problems.

It is also clear to me that a legislative solution largely focused on limiting victims rights available under our state tort system will do little other than increase the incidence of medical malpractice in our nation. As a matter of fact, the bill before us today is the most far reaching and dangerous malpractice bill before Congress and is far worse than previous malpractice provisions passed during the "Contract with America."

Under this proposal, Congress would be saying to the American people that we don't care if you lose your ability to bear children, we don't care if you are forced to bear excruciating pain for the remainder of your life, and we don't care if you are permanently disfigured or crippled.

The proposed new statute of limitations takes absolutely no account of the fact that many injuries caused by malpractice or faulty drugs take years or even decades to manifest themselves. Under the proposal, a patient who is negligently inflicted with HIV-infected blood and develops AIDs six years later would be forever barred from filing a liability claim.

The so-called periodic payment provisions are nothing less than a federal installment plan for HMO's. The bill would allow insurance companies teetering on the verge of bankruptcy to delay and then completely avoid future financial obligations. And they would have no obligation to pay interest on amounts they owe their victims.

And guess who else gets a sweetheart deal under this legislation? The drug companies. The producers of killer devices like the Dalkon Shield, the Cooper-7 IUD, high absorbency tampons linked to toxic shock syndrome, and silicone gel implants all would have completely avoided billions of dollars in damages had this bill been law.

Nearly 100,000 people die in this country each and every year from medical malpractice. It's the third leading cause of preventable deaths in America. The last thing we need to do is exacerbate this problem, while ignoring the true causes of the medical malpractice crisis in America. I urge my colleagues to reject this anti-patient, anti-victim legislation.

Chairman SENSENBRENNER. Without objection, all Members may insert opening statements in the record.

[The prepared statement of Ms. Jackson Lee follows:]

SHEILA JACKSON LEE
18TH DISTRICT, TEXAS

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JUDICIARY
SUBCOMMITTEES:
CRIME
RANKING MEMBER
IMMIGRATION AND CLAIMS

SCIENCE
SUBCOMMITTEES:
SPACE AND AERONAUTICS
ENERGY

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OPENING STATEMENT

OF

CONGRESSWOMAN SHEILA JACKSON LEE

ON

H. R. 4600, HELP EFFICIENT, ACCESSIBLE, LOW COST,

TIMELY HEALTH CARE (HEALTH) ACT OF 2002

Tuesday

July 23, 2002

Thank you, Mr. Chairman. A two-car crash on a busy street leading to the Las Vegas airport came just one day after the nearest trauma clinic, at the University Medical Center, closed down. There was one fatality, but no one can be sure that the death, which was confirmed at an emergency room an hour away,

could have been avoided. However, the incident prompted a quick 3 reopening of the university medical center. Some 10 to 15 of the doctors agreed to become temporary employees of the county hospital, limiting their liability to $50,000.

The rising cost of medical malpractice insurance is a national problem that doctors say are obliging many of them to flee certain states or give up certain specialties, because of skyrocketing insurance premiums linked to soaring jury awards. The numbers of communities are suffering similar problems. Texas is one of 12 states where rising premiums, tied to awards by state juries in malpractice cases, are creating a crisis, according to the American Medical Association. The others are New York, Nevada, Florida, Ohio, Mississippi, Georgia, Pennsylvania, New Jersey, Washington, Oregon and West Virginia. Because of risks associated with certain medical conditions and forms of treatment, some specialties pay especially high rates, and those rates are compounded by being charged in states where laws place fewer limits on jury awards. For example, while premium increases this

year average about 15 percent nationwide for all practices, rates for obstetricians and gynecologists in Pennsylvania are set to balloon by anywhere from 40 percent to even 81 percent, according to Medical Liability Monitor, a trade publication.

Concerns about rising medical malpractice insurance rates are shared by all groups primarily affected by medical malpractice. Since the 1970s each "crisis" in medical malpractice has resulted in limitations on the very persons who the most vulnerable in this process – the injured patient. Reformers have repeatedly focused efforts against the civil justice system as opposed to the insurance industry or the health care system. The most effective ways in which to lower medical malpractice rates is to 1) lower the incidence and egregiousness of medical malpractice; and 2) reform the insurance industry to prevent its gouging of doctors to compensate for poor market performance, bad business decisions and/or national economic downturns.

In the 1970's, there was a medical malpractice crisis in California, which was trigger when the Pacific Indemnity and Star

Insurance companies notified 2,000 Southern California physicians that their malpractice insurance coverage would not be renewed. California responded to the crisis with legislation. The Medical Injury Compensation Reform Act of 1975 (MICRA) was supposedly designed to ensure realistic rates for doctors to obtain medical malpractice coverage, which would enable the public to receive affordable health care services.

One of MICRA's key provisions significantly revised the process under which malpractice cases were handled in California courts. First, MICRA imposed a $250,000 limit on "non-economic" damages. Second, periodic payments for future damages over $50,000 were permitted as opposed to lump sum payments. Third, a statute of limitations shortened the period of time in which a malpractice suit could be brought to within three years of the date of injury (for an adult) or one year after discovery of the injury. MICRA also altered the traditional "collateral source rule" by allowing malpractice defendants to present to the jury proof of other payments to which an injured

plaintiff was entitled as a result of the defendant's negligence. Limits on plaintiff's attorney's contingent fee awards sought to ensure that the plaintiff receive the bulk of any jury award.

MICRA have not reduced California's health liability insurance costs. MICRA laws have failed to resolve California's health care problems. H. R. 4600 is modeled after MICRA. Unlike the limited reform of MICRA, however, H.R. 4600 would impose restrictions throughout the United States on litigation to compensate patients injured by negligent practices or products. Under this bill, manufacturers and sellers are given total immunity from punitive damages, even if their conduct is deliberate or malicious, in any action involving a FDA approved drug or device. Additionally, Congress has never before proposed total elimination of joint liability for all damages. H.R. 4600 would impose several liability for product liability actions involving drugs and devices in all fifty states regardless of existing state law. Unlike previous malpractice bills, H.R. 4600 would limit HMO and

insurance company liability. It would also supercede state laws to limit severely recoveries by harmed patients.

In the 1980s, the insurance industry maintained affordable premiums assessing only minimal increases. The companies were able to keep increases low due to investments at high interest rates that produced significant yields. When interest rates dropped in 1984, however, insurance providers responded with considerable increases in medical malpractice insurance premiums. States also responded again by implementing changes to the legal process designed to recover damages for sub-standard conduct.

Today, we are experiencing perhaps the third cycle of the crisis in "medical malpractice." Unlike the state reforms of the 1970's that focused on both the affordability and accessibility of medical malpractice insurance, or those of the 1980's that focused on the affordability of premiums, today there are persistent demands for a federal fix.

Factors that may affect insurance rates include: changes in state law and regulatory requirements; competitiveness within the insurance market; the types of policies issued within the industry; interest rates; and national economic trends. State socio-economic factors, such as urbanization, may also be relevant to rate-setting by insurance companies. Still, the tendency throughout each "crisis" cycle for medical malpractice has been to target unfairly the legal system designed to compensate, deter, and punish the injured and the wrongdoers, respectively.

H.R. 4600 represents one of the most far-reaching and dangerous malpractice bills introduced in Congress, and is even more draconian to plaintiffs and their attorneys than those previously passed during the "Contract with America." Congress has never before proposed to cap non-economic damages in the *aggregate*. Likewise, Congress has never before proposed to bar entirely the award of punitive damages in product liability actions - even for the most reckless misconduct - unless it can be proved by clear and convincing evidence that a manufacturer or seller

maliciously *intended* to injure a specific plaintiff. Under this bill, manufacturers and sellers are given total immunity from punitive damages, even if their conduct is deliberate or malicious, in any action involving an FDA approved drug or device. Additionally, Congress has never before proposed total elimination of joint liability for *all* damages. H.R. 4600 would impose several liability for product liability actions involving drugs and devices in all fifty states regardless of existing state law. Unlike previous malpractice bills, H.R. 4600 would limit HMO and insurance company liability. It would also supercede state laws to limit severely recoveries by harmed patients. This bill would encourage irresponsibility since there would be little to no liability. I request my colleagues adopt the two amendments I will propose to strengthen this bill. I yield back the balance of my time.

Chairman SENSENBRENNER. Let me say, the gentleman from Michigan had a very good suggestion, and the Chair is prepared to adjourn this markup until after we get back from the August recess, which will give people plenty of time to look at this legislation as well as perhaps relax a bit.

Let me just say, are there amendments?

And we've now gotten to the point of amending the bill, and the Committee is adjourned.

[Whereupon, at 11:36 a.m., the Committee was adjourned.]

* * * * * * *

The Committee met, pursuant to notice, at 10:00 a.m., in Room 2141, Rayburn House Office Building, Hon. F. James Sensenbrenner, Jr. [Chairman of the Committee] presiding.

Chairman SENSENBRENNER. The Committee will be in order, and a working quorum is present.

[Intervening business.]

Chairman SENSENBRENNER. The next bill will be H.R. 4600. When we last met, the Chair moved the favorable recommendation of H.R. 4600, the "Help Efficient, Accessible, Low-cost, Timely Health Care Act of 2002," to the full House. Pursuant to the order of the Committee, the bill has been considered as read and open for amendment at any point.

Chairman SENSENBRENNER. Are there amendments?

The gentleman from Virginia.

Mr. SCOTT. I have an amendment at the desk, number 1.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 4600, offered by Mr. Scott. On page 4, strike all of section 3.

[The amendment follows:]

AMENDMENT TO H.R. 4600
OFFERED BY MR. SCOTT
#1

On page 4, strike all of Section 3

Chairman SENSENBRENNER. The gentleman from Virginia is recognized for 5 minutes.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. Chairman, the bill preempts State statute of limitations on health care lawsuits and sets a national standard statute of limitations of 1 year from the time the person knows or should have known of the injury, with a maximum period in any case of 3 years from the date of injury. This would not only limit most cases to a 1-year statute of limitations for filing suit but it would also invoke litigation over whether or not someone not filing within a year should have know that they had injuries.

Consider the case of a foreign object left in a person from an operation where the impact was not manifested until 2 or 3 years later, or the case of a hemophiliac who contracted AIDS with tainted blood who didn't learn they had the disease until much later.

In none of these cases was the victim able to detect the problem within the period of time, if it goes more than 3 years, but the bill provides a basis for arguing the person should have known.

The bill also sets a national standard statute of limitations on how minors are to file suits for injuries with severe limitations.

This amendment would strike the section.

Mr. Chairman, most people who practice law practice in State courts. And when you have a Federal statute of limitations preempting State law, all you've done is transfer the medical malpractice to legal malpractice, because a lot of lawyers will think they have a 2-year statute of limitations on a personal injury suit and wait for a year and a half, file suit, and then find out there's a Federal preemption. I think the States have worked on this for years, and I don't see any reason for the Federal Government to preempt what is essentially State law.

And I yield back the balance of my time.

Chairman SENSENBRENNER. The Chair recognizes himself for 5 minutes.

This amendment should be opposed because it weakens the statute of limitations provisions in the bill. Statutes of limitations define the time period following an injury in which a suit must be brought in order to protect the defendants from the prejudice of stale claims by requiring trials while the best evidence is still available while at the same time encouraging the patients to have themselves checked for any injuries that may have resulted from negligent medical care sooner rather than later.

The best way to allow every patient her or his day in court while preventing prejudice to health care providers is to codify a reasonable statute of limitation, which the bill does.

The HEALTH Act provides that a medical malpractice lawsuit must be filed no later than a year after the person discovers an injury or within 3 years at the latest. The HEALTH Act makes an exception for minors under the age of 6, extending the time within which a suit must be filed to the longer of 3 years or the date when the minor reaches the age of 8. These provisions are based upon California's MICRA law.

The HEALTH Act statutes of limitations are designed to protect, for example, OB/GYNs, who are particularly hard hit by high medical malpractice insurance rates because they currently have to worry about being sued a decade or more after they have delivered a baby.

I would urge opposition to the amendment and yield back the balance of my time.

The question is on the amendment offered by the gentleman from Virginia, Mr. Scott.

Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it, and the amendment is not agreed to.

Are there further amendments?

Mr. FRANK. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from Massachusetts.

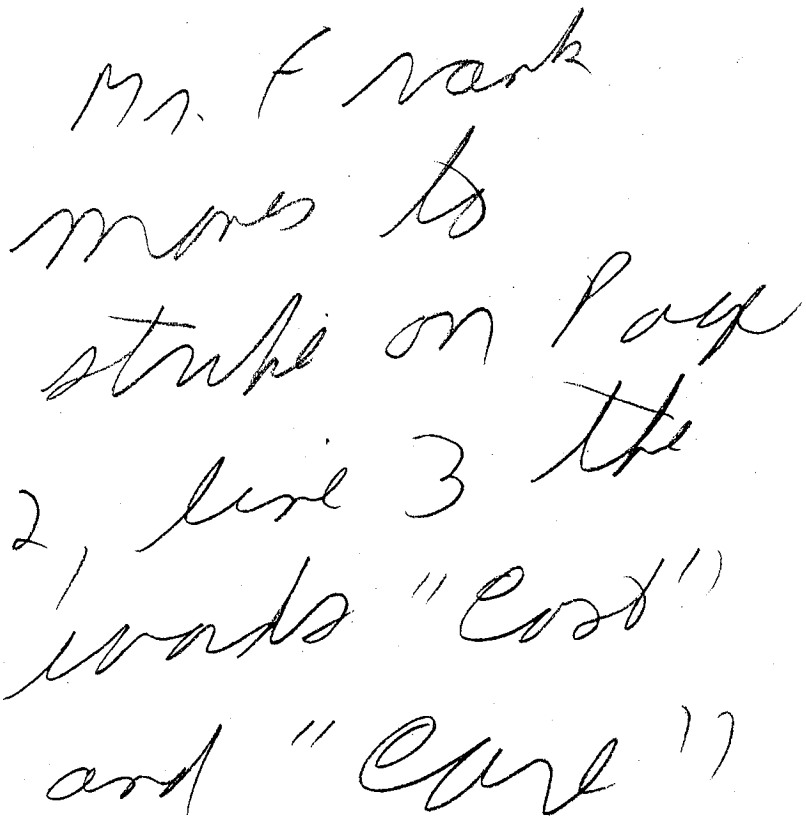
Mr. FRANK. Mr. Chairman, I have an amendment that's just being delivered to the desk.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 4600, offered by Mr. Frank. Mr. Frank moves to strike on page 2, line 3, the words "cost" and "care."

[The amendment follows:]

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC



Chairman SENSENBRENNER. The gentleman from Massachusetts is recognized for 5 minutes.

Mr. FRANK. Mr. Chairman, this is a grammatical amendment. I have become increasingly unhappy with the acronym fever that has broken out here. I think we are doing the language a great disservice by our list of acronyms. It kind of peaked with the "USA PATRIOT Act," but we're keeping it going.

But if we are going to have acronyms, it seems to me we ought to at least spell them correctly. So since none of these words really make any sense anyway, we might as well go for correct spelling. We can at least be autographic role models to the young people of America.

So on line 3, I move to strike the words "cost" and "care," because otherwise it would be the HEALCTHC Act—— [Laughter.]

Mr. FRANK.—which sounds like something we should have been saying on Rosh Hashanah. [Laughter.]

Chairman SENSENBRENNER. Will the gentleman yield?

Mr. FRANK. Yes.

Chairman SENSENBRENNER. Maybe the doctor ought to check your throat out, if—— [Laughter.]

Mr. FRANK. No, Mr. Chairman, the "kh" sound is a long-standing sound of great religious significance. [Laughter.]

Chairman SENSENBRENNER. So noted.

Mr. FRANK. But "cost" and "care"—and I think it would spell better and make no less sense. So I offer that amendment.

Chairman SENSENBRENNER. The question is on agreeing to the amendment of the gentleman from Massachusetts.

All those in favor will say aye.

Opposed, no.

The aye appears to have it. [Laughter.]

Chairman SENSENBRENNER. The aye has it, and the amendment is agreed to.

Are there further amendments?

The gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Mr. Chairman, I have an amendment at the desk, number 3.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 4600, offered by Mr. Scott. On page 5, strike all of section 4.

[The amendment follows:]

AMENDMENT TO H.R. 4600
OFFERED BY MR. SCOTT
#2

On page 5, strike all of Section 4.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCOTT. Mr. Chairman, this bill eliminates section 4 of the bill. This would have the effect of trusting States to be able to continue to strike the balance between appropriate compensation systems for negligently injured victims and any impact such a system has on tort-feasors. Section 4 of the bill limits noneconomic damages to a total of $450,000, no matter the number of counts or causes, no matter how severe the injury, no matter how much the pain and suffering, no matter how much the loss of reproductive capacity, and so forth.

This would exact a grossly discriminatory impact on poor people and children. With such a limitation on noneconomic damages, ironically, for poor people, the bulk of whom will be women and children, the more egregious the negligence, the bigger break for the tort-feasor.

This section also eliminates the possibility of having awards reflect the impact of inflation. To match the buying power of a 1975 award of $250,000 today, one would need $1.5 million. Then $40,000 would buy what $250,000 buys today. So inflation is important to a victim being made whole.

This section also, Mr. Chairman, gives tort reform advocates one of the crown jewels of tort reform; it eliminates joint and several liability. This would have the effect of first invoking excess litigation over which of several tort-feasors is liable for what amount of the award, and then affect the shifting of burden of collecting each portion from each guilty tort-feasor.

Joint and several liability means that guilty parties will work out contributions amongst themselves and generally means that they will insure themselves, based on those contributions. That is, one insurance company will take the burden, or they'll insure themselves such that they all have insurance with one policy. This ensures that an innocent victim, after establishing the amount of compensation owed for injuries, will be made whole by one person, and then that person can go chase after everybody else.

The lack of joint and several liability, Mr. Chairman, also guarantees that some health professionals that are not generally roped in to malpractice cases will be, like nurses. If they are 2 percent liable, they're going to be part of the lawsuit, and you have establish what all they did. So the doctor, instead of paying the damage, might be able to shift 2 percent, 5 percent, 10 percent onto a nurse. That will increase litigation, increase malpractice costs for people who are not paying very much right now, because they're not on the barrel end of malpractice suits.

Mr. Chairman, I would hope that we would adopt the amendment and not federalize what is essentially State law.

I yield back.

Chairman SENSENBRENNER. The Chair recognizes himself.

This amendment strikes at two very important parts of the bill, the cap on noneconomic damages and the change on joint and several liability.

I just want to have a couple of quotes.

Cruz Reynoso, the Democratic vice chairman of the U.S. Commission on Civil Rights and a former justice of the California Supreme Court, said this about caps, quote, "Medical insurance has been going up. I think there's no question that what the Legislature did and continues to do has had an influence on keeping those expenses down, and that's a very important public policy. Publicly funded medical centers were very supportive of continued protection of MICRA because if their own insurance rates would go up, they would be less able to serve the poor."

"I personally have favored having as much access to the courts as possible, but at the same time, you have to be careful that it doesn't do so in a way that is destructive; for example, in the medical field, destructive of the ability of society to respond to the medical needs of the people," unquote.

Nancy Sasaki, president and CEO of Planned Parenthood of Los Angeles, said, quote, "If the caps on noneconomic damages in MICRA were to be increased, you actually would begin to see a kind of domino effect. If insurance costs for physicians go up, they typically will then, as any business would, look at what services are their highest risks, which services are costing them the most, then they'd no longer provide that. That's what has happened in the past, where physicians have stopped providing obstetric care because of the costs."

That's on noneconomic damages. On the fair share rule, or the joint and several liability, although it's motivated by a desire to ensure that plaintiffs are made whole, it leads to a search by plaintiffs' attorneys for deep pockets and a proliferation of lawsuits against those minimally liable or not liable at all. The HEALTH Act, by providing a fair share rule, it apportions damages in proportion to a defendant's degree of fault and prevents unjust situations in which hospitals can be forced to pay for all damages for an injury, even when the hospital is minimally at fault.

For example, a drug dealer staggers into the emergency room with a gunshot wound after a deal goes bad. The surgeon that works on him does the best he can, but it's not perfect. The drug dealer sues. The jury finds that the drug dealer is 99 percent responsible for his own injury, but also finds the hospital 1 percent responsible because the physician was fatigued after working too long. Today the hospital can be made to pay 100 percent of the damages, and that's unfair.

As Senator Lieberman has observed, the joint and several liability rule now has grown to a point where it really means that somebody who is not liable or liable very little, if they happen to have deep pockets, they can be held fully liable. That is the wrong message to send.

If you hurt somebody, you have to pay. If you do not, you should not have to pay. And this was said by Senator Lieberman on the Senate floor.

I yield back the balance of my time.

Mr. GEKAS. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from California, Mr. Berman.

Mr. BERMAN. Mr. Chairman, I believe the gentleman from Virginia indicated he's eliminating the cap of $450,000. But as I read it in here, it's $250,000.

Mr. SCOTT. I was reading "$250." I thought I said "$250," so if I said "$450," that was a mistake.

Mr. BERMAN. Mr. Chairman, I'm quite sure I am the only Member of this Committee that was a member of the California Legislature when MICRA passed. I had the wonderful pleasure of being the chairman of the Select Committee on Medical Malpractice during that time, supported the legislation when it went through the Assembly, did not like the final product that came out of the conference committee but supported the—filed briefs in support of upholding the provisions of MICRA, which were upheld in the California Supreme Court.

A couple of points. This amendment addresses the heart of my concern about this bill.

First of all, the $250,000 cap on economic damages was a cap put in 1975. If you allowed and measured any kind of cost-of-living factor from that time, that cap would be much closer to $1 million at this time than it would be to $250,000. This bill, an effort to copy the provisions of MICRA, simply takes that $250,000, makes no allowance for the fact that it was a figure deemed to be a reasonable cap in 1975, and now imposes it in 2002, and, at least as I understand it, has no provision for future cost-of-living increases on that cap. So that's one reason why I think going with a bill that has a cap like this is much too low, even if you accept the premise that we should cap noneconomic damages and pain and suffering recoveries in medical malpractice cases.

Secondly, it raises the larger issue. There's no doubt MICRA has helped substantially in keeping down medical malpractice premiums in California. There's also no doubt that California is plagued with serious, severe medical cost problems that threaten its entire public health care delivery system, leave physicians feeling adequately undercompensated in the context of both insurance and Medicare reimbursements, and has the highest penetration of HMO participation because of the high cost of medical care in California.

In other words, my point is, dealing with this one part of the problem does not in any sense deal with the more substantial issue of health care costs and the cost of delivering health care in California.

Moreover, if ever there were a situation where you would think the battle, the fight over how to deal with medical malpractice premiums, and the balance between patient rights and maintaining reasonable malpractice premiums should be left to a State-by-State basis, it's in this particular area, where you don't have—this is not product liability, a manufacturer in one area is delivering a product to 50 different States and faced with 50 different laws and trying to figure out 50 different standards. This is uniquely—you're licensed to practice in a particular State, and it should be a matter of State law.

And finally, on the issue of the pain and suffering, over and over again, the majority party, since 1995, has always sought to eliminate joint and several liability and, as a result, has never achieved its goal in a variety of different areas, when the more reasonable approach is to say, since one way or another somebody loses, if you eliminate the recoveries of the people who can't afford to pay, then the plaintiff is not going to be made whole. If you leave the people who are partially liable but not fully liable to pay the whole thing, then you're putting an unfair burden on them.

It seems to me an appropriate balance here is for the smaller tort-feasors, the people who are liable for, say, less than 15 or 20 percent, to restrict their liability to that percentage of a liability that they have found to have been guilty of and then to allow the joint and several principle to apply for the larger tort-feasors, to make sure the plaintiff isn't totally left out of any meaningful portion of his recovery.

So once again, an approach that seems to copy a law that was made in 1975, that while it's had a beneficial effect on the size of medical malpractice premiums, has not addressed the fundamental

problem of health care costs in California. Copying that without the flexibility——

Chairman SENSENBRENNER. The gentleman's time has expired.

Mr. BERMAN.—I think is a mistake. I think, while there's an area between this amendment and the present bill, on balance, I think this amendment makes sense, and I would urge support for it.

Chairman SENSENBRENNER. The gentleman from Pennsylvania.

Mr. GEKAS. I thank the Chair. I rise to move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. GEKAS. This Committee has received testimony on this subject in which the California experience of course was the basis for the movement in which we find ourselves today.

We were struck, many of us, by the fact that even with the restrictions on damages that appear in the California experience, the costs of health care kept on rising even within medical malpractice on the economic damages. In other words, the costs that were recoverable always showed an upward trend, except for noneconomic losses, which were capped at $250,000. The point is that even with the restrictions of the California experience, costs still go up.

To now tinker with the noneconomic damage cap would render the whole exercise futile on our part and make it not worthwhile for us to pursue it. We ought to stick to the premise that is found in the basis of the bill, to allow—of course, we have to allow the economic losses to appear as they might, but to preserve the cap on noneconomic damages.

Mr. BERMAN. Will the gentleman yield?

Mr. GEKAS. Yes.

Mr. BERMAN. I understand the gentleman's point, but the economic damages are about wages lost, about health care costs expended and incurred. Of course they're going to rise. Wages have risen since 1975; health care costs have risen since 1975. Why the notion—when you maintain a $250,000 cap that was appropriate in 1975, in 2002, you are decreasing the recovery for pain and suffering every single year by the percentage of the cost-of-living. By any measurement, it is a decrease. To simply graft that figure onto here without making any compensation for 27 years of time, and without including some kind of cost-of-living factor for the future, is not maintaining the equilibrium of the California law at the time it passed. It's imposing a serious cut.

Mr. GEKAS. Seizing back the remainder of my time, the only real discipline we have in this bill, if we're seeking discipline to try to help in the area of medical malpractice, is the cap on noneconomic damages. We must stay with it.

I yield back the balance of my time.

Chairman SENSENBRENNER. The gentleman from New York, Mr. Nadler.

Mr. NADLER. Mr. Chairman, I'm opposed to the notion of this cap, as I'm sure you know.

I think the point the gentleman from California makes about an inflation factor is undeniable.

I had a college scholarship when I went to college. It was established by the will of Joseph Pulitzer in, I think, 1902 or something. It provided the recipients of this scholarship $250 a year to any col-

lege in the country, which was a lot of money when they did this. By the time I went to college, it wasn't a lot of money, and today it's a pittance, in light of tuition costs.

It also adds that if the recipient of the scholarship goes to Columbia, he's exempt from tuition.

When that scholarship was first established by the will of Joseph Pulitzer, the $250 to any college in the country would have paid all the costs. The exemption from tuition if you went to Columbia was a minor little add-on. Today, of course, the exemption from tuition is the only thing that matters, because that $250 is a minor pittance.

This $250,000, which may have been an appropriate amount, perhaps, in 1975 is certainly an inadequate amount now and certainly will be a much more inadequate amount 20 years from now.

I fail to see how you can put any limit on real damages. They're not economic damages. Pain and suffering are real damages, though hard to quantity. But how you can put an absolute limit without providing any inflation factor—we take for granted that we put COLAs, cost-of-living adjustments, in Social Security. We put them in pensions. We put them in congressional salaries. We put them in Federal salaries. How can you not have at least an inflation factor, cost-of-living adjustment, whatever you want to call it? Unless you want to say that what you really want to do is say no noneconomic damages eventually, because that's what this does. It reduces it to insignificance, ultimately.

It seems to me that any hard-dollar amount in legislation has to have an inflation factor in it. And if you don't put that in what you're really saying, and maybe that's the will of the Republicans, that we don't want people to get compensation for noneconomic damages. We don't dare say it, but that's what we want. So we set up an amount that was appropriate in 1975 and by 2000, it's inadequate, and by 2025, no one will even care about it anymore, because it's a pittance.

It's unfair. It's unjust. And frankly, it's totally indefensible not to have an inflation factor in a limit like this.

Mr. COBLE. Mr. Chairman?

Mr. NADLER. I yield back.

Chairman SENSENBRENNER. The gentleman from the North Carolina, Mr. Coble.

Mr. COBLE. I move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. COBLE. Mr. Chairman, this is an issue, it seems to me, that involves compelling arguments on either side. I have consistently, with rare exceptions, voted against the imposition of caps. I believe when State Legislatures and the Congress insert their oars into the juries' waters, we're invading the province of the jury. I feel very strongly about that.

Having said that, I think this issue does, however, deserve full House floor attention. I have at least implied to the sponsor of the bill that I would not stand in the way of this bill going to the floor and would hopefully get it to the floor in its present form. But I do—if this bill is reported out from this Committee, Mr. Chairman, and does go to the House floor, at that point, I'm going to have more flexibility in expressing my views about this because, I reit-

erate, I just believe that damages is an issue that ought to be exclusively reserved for juries.

Mr. NADLER. Will the gentleman yield for a question?

Mr. COBLE. Let me continue just a minute, and then I'll yield to the gentleman from New York.

I just believe that that province is sacred. Again, with rare exceptions—there are always exceptions to every rule. But compelling arguments have been presented on both sides.

And that's my posture for the moment, and we'll see how this plays out as we go along. But I thank the Chairman for having recognized me. And I yield to the gentleman from New York.

Mr. NADLER. Thank you. I just wish to ask the gentleman if he really believes that there are any odds at all that the Rules Committee will allow and amendment on the floor to change the $250,000 question. It seems to me now is the only chance we have to do it.

Mr. COBLE. Let me reclaim my time, and I say to the distinguished gentleman from New York, I am not blessed with a prophetic crystal ball, so I can't speak for the Rules Committee.

And I'll be glad to yield—I'm going to reluctantly yield to the gentleman from Massachusetts, because I can't match wits with him.

Mr. FRANK. I just want to say, I was interested to hear my friend describe his posture. And he's been my friend, and we've collaborated. But I just want to express some concern for his posture. I think bent over that way, it's not good for your posture. And I hope the gentleman will get a little more upright, less he suffer some permanent curvature. [Laughter.]

Mr. COBLE. I thank the gentleman.

Chairman SENSENBRENNER. Without objection, Committee contingency funds will be appropriated to buy a new chair for the gentleman from North Carolina. [Laughter.]

Mr. COBLE. I thank the gentleman. I yield back my time.

Chairman SENSENBRENNER. The gentleman from Alabama, Mr. Bachus.

Mr. BACHUS. Thank you. Mr. Chairman, Mr. Berman has, I think, offered a good point, and that's that this cap was established some 25 years ago. So I think we do want to look at it in today's terms.

But Mr. Nadler has said it's mainly Republicans who want to keep this cap on and Democrats who want to raise it. In that regard, I want to read a statement from someone that I don't think is—I don't know if they're Republican. I don't think they're typical Republican, if they are. But they certainly made that settlement just recently.

And it's Donna Stidham, who is the director of managed care and patient services for the AIDS Healthcare Foundation. And here's what she said: "An increase in the noneconomic cap would increase our premiums phenomenally. In a single clinic setting, it would probably increase premiums maybe $20,000 or $30,000. For multiple physicians, I'd hate to even guess, but it would be in the hundreds of thousands, which would take away from direct patient care, so it would directly take away from care for the patients. You'd see us perhaps not being able to admit all types of patients.

Right now, we can take any kind of patient, whether they have the ability to pay or not."

So this director of the AIDS Healthcare Foundation, at least her statement seems to indicate that——

Mr. BERMAN. Where?

Mr. BACHUS. I'll find out where. But, I mean, it's in—you've also got Senator Lieberman, who is very much for these caps. And I don't think—unless he's switched parties recently, he's still a Democratic. In fact, I think he was the vice presidential nominee.

I'll also offer a third reason. I think the fair share rule, without the fair share rule, you have a situation—one of the hypotheticals that we heard earlier was somebody challenged it as being—that things like that really never happen. They were just offering hypotheticals, because if a drug dealer gets shot in a drug deal gone bad and he walks in a hospital, he receives treatment from a doctor who is somewhat fatigued, and the jury finds that the drug dealer is 99 percent at fault for his injuries, but the hospital is 1 percent at fault for his injuries, yet the hospital could be required to pay 100 percent of the damages for his injuries.

Mr. SCOTT. Would the gentleman yield?

Mr. BACHUS. Yes.

Mr. SCOTT. On those States that have comparative negligence, Virginia doesn't, if the person is 1 percent at fault, and somebody else is 99 percent at fault, they lose altogether. But even with comparative negligence, you only have to pay for that 1 percent.

Mr. BACHUS. All right, let me say that that's what was said earlier, and I was hoping that I'd get the response that you gave, that, no, that's not true. That's what was said a few weeks ago. When someone else on the Committee offered this analogy, they were told, no, it doesn't apply to 1 percent.

However, at least the staff of this Committee has offered us the fact that, yes, and I'll give the decision, *Walt Disney World* v. *Wood*, a 1987 Florida case, unless the law has been changed. Disney was required to pay an entire damages award even though it was found only 1 percent at fault for the claimant's harm.

Mr. SCOTT. Would the gentleman yield?

Mr. BACHUS. So unless that case has been reversed——

Mr. SCOTT. Will the gentleman yield?

Mr. BACHUS. Yes.

Mr. SCOTT. In that case, the other 99 percent wasn't the plaintiff. That was other people.

Mr. BACHUS. But what you just said is if you're 1 percent at fault, and what was said a few weeks ago—and it wasn't as a result of something I said—if you're only 1 percent at fault, you can't be required to pay 100 percent of the damages; in fact, you can.

Mr. SCOTT. And in this case, if the gentleman would be kind enough to yield, in this case, when you buy insurance, if the nurse was 50 percent at fault, if the hospital was 25 percent at fault, if everybody else in the health care industry was at fault, when they buy their insurance, they know that they're going to be on the hook for the whole 100 percent. And if you find one that's at fault, you don't have to show that he is 1, the nurse is 25, that this was that, that that was the other.

Mr. BACHUS. My point, and I——

Mr. SCOTT. It's not up to——

Mr. BACHUS.—is that if somebody is 1 percent at fault, there's nothing fair about making them pay 100 percent of the damages. And, yes, in fact, those cases exist. I just——

Mr. SCOTT. If the gentleman would yield one more time——

Chairman SENSENBRENNER. The gentleman's time has expired.

Mr. FRANK. Mr. Chairman?

Mr. SCOTT. Would the gentleman——

Mr. FRANK. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from Massachusetts.

Mr. FRANK. Mr. Chairman, I yield first to the gentleman from Virginia.

Mr. SCOTT. Thank you.

The question is, if you go to the hospital and you know that malpractice has been committed upon you, and you find one that has 1 percent fault, then that person, right, will have to pay the whole thing. And then they will go back and find out all of whatever else happened.

The alternative is that the plaintiff—all you know is that they left something after the surgery in your stomach. That's all you know. And then the surgeon says, "Well, it was probably my fault. Okay. But only 1 percent. But it's somebody else's fault." The plaintiff then has to go chasing after everybody in the hospital.

Now, which is more fair? For the hospital to decide to apportion all of that amongst itself, which is all insured anyway? Or have the plaintiff have that possibility and lose 1 percent there because they couldn't find that one, or 2 percent there, and they collect all from this one and a little bit—this one goes bankrupt? Which is more fair? You've got somebody with a $100,000 judgment and 50 people, possibly, at fault.

Mr. FRANK. Let me——

Mr. BACHUS. But I think, if you——

Mr. FRANK. Excuse me, it's my time, I would say to the gentleman from Alabama. And I will do something that he has told me he would never do for me: I'll yield to him.

Mr. BACHUS. Well, I think we both arrived at what you said; who would pay is whoever had insurance. So if one party who is 1 percent liable, if they were responsible enough to take out insurance, those that there were the other collection of 99 percent—say somebody was 40 percent liable, somebody else 40 percent liable, someone 15 percent liable, some 4 percent liable. But the person that had high coverage or multimillion dollar coverage, they end up paying—they could end up paying——

Mr. FRANK. I'll take back my time, Mr. Chairman, to stress the major point I wanted to make, which was that the gentleman's example, the gentleman from Alabama, was totally misleading, and he's trying to, I think, obscure the point, which was he came forward with an example, and that's when the gentleman from Virginia talked about the comparative negligence, where the plaintiff was himself mostly responsible for the injury. He dropped that and, in fact, in his response to the gentleman from Virginia, left out that crucial point.

That's what the gentleman from Virginia was talking about. He was talking about the situation, the hypothetical, where the plaintiff himself was responsible for almost all the injury.

Mr. BACHUS. No, I said——

Mr. FRANK. Excuse me, I didn't yield.

Mr. BACHUS. I said——

Mr. FRANK. Mr. Chairman, please, get a copy of the rules, the gentleman from——

Chairman SENSENBRENNER. The time belongs to the gentleman from Massachusetts.

Mr. FRANK. And I stress this because there ought to be some kind of outer limit on exactly how bizarre examples can be. I know that there is apparently a lack of faith in the jury system, but the notion that a jury would tell a criminal that he was 99 percent responsible for the problem but that he was going to get 100 percent recovery, it seems to me highly unlikely, sufficiently unlikely that with all of the diligent searching that the majority staff has done, apparently there is no such example.

So what the gentleman gave us was a very hypothetical hypothetical. He gave us the situation of Disney, but we weren't talking about a drug dealer who was suing Disney because the needle jumped on Space Mountain. What we are talking about is a qualitatively different issue. And that invalidates entirely the example.

So I would be interested, if anyone had an example——

Mr. SCOTT. Will the gentleman yield?

Mr. FRANK. Yes, I would yield to the gentleman from Virginia.

Mr. SCOTT. When we had the example of 40 percent here, 40 percent there, 15 percent here, 4 percent there, and 1 percent there, the question is, where do you get those numbers? You get those numbers because you have to go chasing after everybody, trying to——

Mr. FRANK. I would——

Mr. SCOTT.—and you can never get to the end of litigation.

Mr. FRANK. I would tell the gentleman, I think he said 40 percent here and 40 percent there and——

Mr. SCOTT. If you have a situation where you go in the hospital and the doctor is 40 percent, the hospital is 40 percent——

Mr. FRANK. They're two separate issues, and I appreciate that. But I did want to make clear that the effort to kind of appeal to, well, the outrageousness of a criminal being 99 percent responsible and getting a recovery, that was the example given. I don't think that——

Mr. BACHUS. I did not say that.

Mr. FRANK.—kind of example——

Mr. BACHUS. I did not say it was——

Mr. FRANK. Does the gentleman not understand the rules of the House?

Chairman SENSENBRENNER. The Committee will be in order. The time is controlled by the gentleman from Massachusetts, Mr. Frank.

Mr. FRANK. That was the example given, a drug dealer who was shot and was 99 percent responsible and recovered. And that is the sort of example that makes no constructive contribution to the debate.

I would yield back.

Chairman SENSENBRENNER. The gentleman from Illinois, Mr. Hyde.

Mr. HYDE. I ask leave to strike the last word——

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. HYDE.—and yield to the gentleman from Alabama.

Mr. BACHUS. I did not say that the drug dealer was 99 percent responsible. What I said, and I'll say it again, I said that he was shot in a drug deal gone bad. Now, you can assume two different things. You can assume that he shot himself in a drug deal gone bad, or you can assume that another person shot him. And I don't know how many people in drug deals that get shot are shot by themselves, in a self-inflicted wound. I would assume that someone else shot him and that he was shot in a drug deal gone bad. People get shot all the time.

In fact, in my experience, I don't think I've ever seen a drug dealer shoot himself in a drug deal gone bad. I would think somebody else probably shot him, and he was taken to the hospital. And in fact, the hospital could be required to pay 100 percent of the damages.

And it's been said on more than one occasion in this Committee that if a party is only 1 percent responsible, they can't—they don't have to pay, and that's just not true. I've cited one recent Federal case where they were 1 percent responsible; they paid 100 percent of the damages.

Yes, in a case where a drug dealer shot himself and then was brought to the hospital, then Mr. Frank and the gentleman from Virginia would be correct. But if someone else shot him, which is much more likely, and what I thought when I said he was shot in a drug deal gone bad——

Mr. SCOTT. Would the gentleman——

Mr. BACHUS. I certainly didn't mean to imply that he shot himself.

Mr. SCOTT. Would the gentleman yield?

Mr. BACHUS. Yes.

Mr. SCOTT. I think in your case, the jury concluded that the drug dealing had contributed 99 percent of the problem.

But in any case, the medical malpractice wouldn't have anything to do with the bullet wound, the damage done by the bullet wound. If the medical malpractice came after the fact, he would be liable for the damage done by the medical malpractice.

The problem is that all of the litigation—without joint and several liability, all of the litigation is going to be on which member of the hospital did what. All the patient knows is, he's lying up there unconscious and was inflicted with malpractice and had $100,000 worth of damage.

Now, if it was a doctor, he doesn't know; he was unconscious. They bought insurance to cover whatever the damage was. That's an easy transaction. But the doctor is going to be cross-claiming the hospital, make them pay 40 percent. The anesthesiologist, we'll make him pay. And they're going to be arguing it's not 15 percent; it ought to be 20 percent.

And this is the extent—if you're trying to reduce the aggravation of litigation, this doesn't do anything except the possibility of the plaintiff having a more complicated case and somebody not paying their little share.

When you go to the hospital, the hospital has already worked out how the deal is going to be. If anybody is liable, the hospital mal-

practice coverage will cover. And then they don't worry about anything else. They don't worry whether it's 40 percent or 35 percent or 20 percent.

How do you settle with anybody?

Mr. BACHUS. Well, reclaiming my time, I would just simply say——

Chairman SENSENBRENNER. The time belongs to the gentleman from Illinois.

Mr. BACHUS. Is that—but he yielded to me.

Anyway, I would just close by saying, we keep saying—we're getting around to this—is, that's what you have insurance for. And I would say you really don't have insurance to pay claims for injuries or for percentage of injuries that you didn't cause. If you're 1 percent at fault, I don't think you anticipated having to pay 100 percent of the cost. And I think that's why Senator Lieberman is right on this, and why this bill is right. I just don't think that we ought to be getting insurance to pay for what we've done and also pay for those who have failed to get insurance or have no insurance.

Chairman SENSENBRENNER. Does the gentleman from Illinois yield back?

Mr. HYDE. I yield back.

Chairman SENSENBRENNER. The question is on the amendment offered by the gentleman from Virginia, Mr. Scott.

Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it. The amendment is not agreed to.

[Intervening business.]

We will now resume consideration of H.R. 4600, the HEALTH Act, which is open for amendment at any point.

Are there further amendments?

The gentleman from New York, Mr. Nadler.

Mr. NADLER. Mr. Chairman, I have three amendments at the desk. I ask that number 3 be called up.

Chairman SENSENBRENNER. The clerk will report amendment 3.

The CLERK. Amendment to H.R. 4600, offered by Mr. Nadler. On page 5, on line 10, 19, and page 6, line 1, after "$250,000," add "adjusted annually, according to the adjustments in the consumer price index."

[The amendment follows:]

Amendment to H.R. 4600
Offered by Mr. Nadler

On page 5, on lines 10, 19, and page 6, line 1, after "$250,000," add ", adjusted annually according to the adjustments in the consumer price index,"

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. NADLER. Thank you, Mr. Chairman. This will not take 5 minutes.

This amendment actually came out of a discussion we were having a little while ago. Accepting the figure of $250,000 as a limit on noneconomic damages, even though it's worth much less than when it was first enacted in California in 1975, I think Mr. Ber-

man said. But accepting that now, we certainly ought to put in an inflation adjustment for the future. If noneconomic damages are to be held to $250,000, there ought to be a real $250,000 5 years from now, 10 years from now, and so forth, and shouldn't be reduced in amount every year by inflation.

Failure to adopt this amendment would say that what we really want to do is, for all practical purposes, to eliminate noneconomic damages gradually altogether. Or, I should say, to eliminate noneconomic damages altogether, gradually.

We put in inflation adjustments for almost everything else we do, as I said, for salaries, for pensions, for Social Security, and so forth. And if we're going to have an absolute limit on noneconomic damages—unless we want to eliminate noneconomic damages, which would be grossly unfair, because I think everybody concedes that noneconomic damages are real damages. I mean, if you're crippled for life, that's real damage even though—in addition to your lost of wages and so forth.

So I hope that, in the spirit of reasonableness, people will support this amendment to add an inflation adjustment in the future, not in the past, but in the future, to the $250,000 limit.

I yield back.

Chairman SENSENBRENNER. The Chair recognizes himself for 5 minutes.

Much has been stated about the lack of an inflation adjustment. The California Legislature has got the power and has had the power since they passed the MICRA law to increase the $250,000 cap in that State. They have failed to do so.

And I believe one of the reasons they have failed to do so is that an increase in the cap is going to be directly reflected in increased medical malpractice insurance rates, which have to be passed on to consumers—meaning their health insurance premiums, or in the case of Medi-Cal or title XIX, to the taxpayers. Or alternatively, the consequence is that the provider will simply stop providing services to high-risk patients.

Now, the cap has worked in California since MICRA was passed. According to data of the National Association of Insurance Commissioners, the rate of increase in medical professional liability premiums in California since the enactment of MICRA in 1976 has been 167 percent, whereas the rest of the United States has experienced a 505 percent rate of increase, which is 300 percent larger than that which was experienced in California.

Perhaps at some time the future an adjustment should be made. But I think that should be determined in the future by Congress, based upon economic conditions and an assessment how this law, if it is enacted, works, rather than an automatic increase based upon some type of index.

I would urge opposition to the amendment. I yield back the balance of my time.

Mr. BERMAN. Mr. Chairman? Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from California, Mr. Berman.

Mr. BERMAN. I am actually moved by the deference, the respect given to the California Legislature. It's well-deserved.

The California Legislature has passed legislation giving the farm workers the right to organize and join unions. The U.S. Congress hasn't.

The California Legislature has passed minimum wage laws significantly more protective of low-income workers than the U.S. Government.

The California Legislature has legislated higher air quality standards, stronger coastal protection, and a variety of consumer rights legislation that goes far beyond anything that we've done at the Federal level.

The California Legislature has done more to ensure the privacy of its individuals, both constitutionally and statutorily, than anything that has come out of this Committee.

I just wish that this respect for the Legislature, as shown by its close tracking of its work on this issue, was reflected in other actions by the Congress. I think the real thing here is, where we like what the Legislature has done—and by the way, I've noticed that, by and large, this majority doesn't like most of that Legislature has done. But in those rare instances where we do like it, we will praise it, respect it, and honor it with high praise. Otherwise, we'll ignore it.

Mr. FRANK. Would the gentleman yield?

Mr. BERMAN. I'd be happy to.

Mr. FRANK. Well, I would ask the gentleman to be a little more optimistic, because as he noted, we are here being asked to emulate what the California Legislature did 27 years ago. So maybe 27 years from now, in the areas the gentleman mentioned—the rights of farm workers, domestic partnerships, clean air—maybe 27 years from now there will be similar progress. It will be outdated, but given what we're working with, it's probably better than nothing.

Mr. BACHUS. Mr. Chairman?

Chairman SENSENBRENNER. Does the gentleman from California wish to use the remainder of his time?

Mr. BACHUS. Mr. Chairman?

Chairman SENSENBRENNER. For what purpose does the gentleman from Alabama, Mr. Bachus, seek recognition?

Mr. BACHUS. Mr. Chairman, I'd like to really pose some questions to the author of the amendment.

Mr. Chairman, Mr. Coble earlier mentioned that what we are doing here is we are putting limitations on the jury's right to make an award. And that does give me some concern. But we are limiting it, and I feel that limitations are appropriate.

Secondly, I'm mindful—but I think we should be cautious in doing so. We should be mindful of inflation and that inflation does eat away at these caps.

Third, I think we're all mindful that once we set a cap, that it's easier to resistance to ever changing it, even if inflation erodes it.

So I will say that, at some point, whether it's on the floor or whatever, I, for one—a carefully constructed adjustment using the consumer price index, it's something I would certainly consider.

I would say this, I would ask the gentleman at some point to consider something that adjusts to the nearest $10,000, say every 5 years or something of that nature, because here you're going to have something that would be $250,000, and then it would adjust every year. You know, so it may $251,814.08 the next year. And

as we do other things, I think it would be prudent to limit the adjustments to at least maybe every 5 years and at that time to round them to at least to the nearest $1,000, if not $5,000.

Mr. NADLER. Will the gentleman yield?

Mr. BACHUS. I'd yield.

Mr. NADLER. Well, I appreciate the gentleman's comments. I don't know why we would want to limit it to every 5 years. It's easy enough to do.

And I certainly—especially if it'll get the gentleman's vote—but I certainly would have no objection to amending the amendment by adding the phrase "to the nearest $1,000." I mean, in the word of $253,234.85 is not—I don't care, frankly. It doesn't make a difference. It's easy to do it either way.

But I would ask unanimous consent to add the phrase to the amendment "to the nearest $1,000."

Chairman SENSENBRENNER. Without objection. Without objection, the amendment is modified.

Mr. NADLER. Thank you.

Let me just go further. I think we have to do this, in fairness. I don't like the limitation at all. I'll be frank; I won't vote for a limitation. But if we're going to have a limitation, unless we really want to eliminate noneconomic damages altogether, gradually, we have to have an inflation clause.

We decided—I heard the distinguished Chairman say, well, maybe Congress every few years can adjust this. Well, we used to do that for Social Security, and we found out that the exigencies of budgets and politics and other things made it grossly unfair. And so we put in an annual inflation adjustor. We have annual inflation adjustors in for a host of things. And frankly, we ought to have it in for anyplace where you write a figure into the law, I think.

But certainly here, where someone is injured and is getting a recovery to make them whole, and we're putting a limitation on how much the jury can say, we have to put an inflation adjustment in that.

And frankly, yes, I understand, it may mean the malpractice insurance will cost more, and the whole purpose of the bill is to make it cost less. But the purpose of the bill should not be to make it cost less by doing things that are manifestly unfair and cause grievous injury to someone who is injured, which is what a limitation without an inflation adjustment would do.

So I certainly hope the gentleman will consider voting for this amendment.

And let me add one other thing on the gentleman's time, if I may, very briefly. We all know—I mean, Mr. Coble says you can't predict the Rules Committee, but we all know that the odds of the Rules Committee allowing substantive amendments of this nature on the floor are very small. So if we think it is right to do something like this, we really ought to do it here. And then, if other powers that be don't like it, they can deal with it in conference. But if we want to put our opinion in, we should do it here and not wait for the floor, because we won't get a chance to. The odds are, heavily, we will not get a chance to consider these kinds of amendments on the floor.

I yield back, and I thank the gentleman.

Chairman SENSENBRENNER. The time of the gentleman from Alabama has expired.
The question is on the Nadler amendment.
Those in favor will say aye.
Opposed, no.
The noes appear to have it.
Mr. NADLER. Mr. Chairman, I ask for a rollcall.
Chairman SENSENBRENNER. rollcall is ordered.
The question is on the amendment offered by the gentleman from New York, Mr. Nadler, as modified.
Those in favor will, as your names are called, answer aye. Those opposed, no. And the clerk will call the role.
The CLERK. Mr. Hyde?
Mr. HYDE. No.
The CLERK. Mr. Hyde, no. Mr. Gekas?
Mr. GEKAS. No.
The CLERK. Mr. Gekas, no. Mr. Coble?
Mr. COBLE. No.
The CLERK. Mr. Coble, no. Mr. Smith?
Mr. SMITH. No.
The CLERK. Mr. Smith, no. Mr. Gallegly?
[No response.]
The CLERK. Mr. Goodlatte?
Mr. GOODLATTE. No.
The CLERK. Mr. Goodlatte, no. Mr. Chabot?
Mr. CHABOT. Aye.
The CLERK. Mr. Chabot, aye. Mr. Barr?
Mr. BARR. No.
The CLERK. Mr. Barr, no. Mr. Jenkins?
Mr. JENKINS. Aye.
The CLERK. Mr. Jenkins, aye. Mr. Cannon?
[No response.]
The CLERK. Mr. Graham?
[No response.]
The CLERK. Mr. Bachus?
Mr. BACHUS. Aye.
The CLERK. Mr. Bachus, aye. Mr. Hostettler?
Mr. HOSTETTLER. No.
The CLERK. Mr. Hostettler, no. Mr. Green?
Mr. GREEN. Pass.
The CLERK. Mr. Green, pass. Mr. Keller?
Mr. KELLER. No.
The CLERK. Mr. Keller, no. Mr. Issa?
[No response.]
The CLERK. Ms. Hart?
Ms. HART. No.
The CLERK. Ms. Hart, no. Mr. Flake?
Mr. FLAKE. No.
The CLERK. Mr. Flake, no. Mr. Pence?
[No response.]
The CLERK. Mr. Forbes?
Mr. FORBES. No.
The CLERK. Mr. Forbes, no. Mr. Conyers?
Mr. CONYERS. Aye.
The CLERK. Mr. Conyers, aye. Mr. Frank?

Mr. FRANK. Aye.
The CLERK. Mr. Frank, aye. Mr. Berman?
Mr. BERMAN. Aye.
The CLERK. Mr. Berman, aye. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
Mr. WATT. Aye.
The CLERK. Mr. Watt, aye. Ms. Lofgren?
Ms. LOFGREN. Aye.
The CLERK. Ms. Lofgren, aye. Ms. Jackson Lee?
[No response.]
The CLERK. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
[No response.]
The CLERK. Mr. Schiff?
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff, aye. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.
Chairman SENSENBRENNER. Are there additional Members who wish to cast or change their votes?
The gentleman from California, Mr. Issa.
Mr. ISSA. No.
The CLERK. Mr. Issa, no.
Chairman SENSENBRENNER. The gentleman from California, Mr. Gallegly.
Mr. GALLEGLY. No.
The CLERK. Mr. Gallegly, no.
Chairman SENSENBRENNER. The gentleman from Wisconsin, Mr. Green.
Mr. GREEN. Aye.
The CLERK. Mr. Green, aye.
Chairman SENSENBRENNER. Further Members who wish to cast or change their votes?
If not, the clerk will report.
The CLERK. Mr. Chairman, there are 14 ayes and 14 nays.
Chairman SENSENBRENNER. And the amendment is not agreed to.
Before getting to the next amendment, the Chair will say we will come back after these votes. There are three votes. Would it be okay—the Chair is trying to get a consensus. Would it be okay if

we came back at 12:30 p.m. promptly and started again? We do have to finish this entire schedule today.

Mr. WATT. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from North Carolina.

Mr. WATT. I understand—there are some of us who have primaries in our States and are trying to get out of here this afternoon to go and do that.

Chairman SENSENBRENNER. The last vote is scheduled between 3 and 4 this afternoon. And if we come back at 12:30, I hope it would be possible that we would finish this bill and then do the other three bills, which are nowhere near as controversial.

Mr. NADLER. Mr. Chairman?

Chairman SENSENBRENNER. Yes, the gentleman from New York.

Mr. NADLER. The Democratic whip windup I think said the last bill is scheduled for, the last vote, 1 to 2 p.m. today.

Chairman SENSENBRENNER. Well, let's come back at 12:30. That gives everybody an hour for lunch and everything else. And we will complete the business today.

The Committee is recessed until 12:30, and please be prompt.

[Recess.]

Chairman SENSENBRENNER. The Committee will be in order. A working quorum is present. When the Committee recessed, pending was a motion to report the bill H.R. 4600 favorably to the full House. The bill was considered as read and open for amendment at any point.

Are there amendments?

Mr. NADLER. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from New York.

Mr. NADLER. 4600 is the medical mal bill?

Chairman SENSENBRENNER. Yes.

Mr. NADLER. Yes, we have amendments.

Chairman SENSENBRENNER. Does the gentleman from New York have an amendment at the desk?

Mr. NADLER. Yes, I have——

Chairman SENSENBRENNER. The clerk will report the amendment.

Mr. NADLER. Well, wait a minute. Report amendment number 2, please.

The CLERK. Amendment to H.R. 4600, offered by Mr. Nadler. On page 4, strike line 20 and line 21 through the word "in." Substitute "whichever of these events occurs last."

[The amendment follows:]

Amendment to H.R. 4600
Offered by Mr. Nadler #2

On page 4, strike line 20 and line 21 through the word "in." Substitute "whichever of these events occurs last. In"

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. NADLER. Thank you. I won't take 5 minutes. It's a very simple amendment, Mr. Chairman. This bill says that a health care lawsuit may be commenced no later than 3 years after the date of injury—reasonable—or 1 year after the claimant discovers, or,

through the use of reasonable diligence, should have discovered the injury, whichever occurs first. The problem is the "whichever occurs first."

Now, let's say that someone negligently gave someone blood which hadn't been tested properly, and there was HIV virus in the blood, and, thus, the person contracted AIDS. And let's say that this is a normally healthy person. There'd be no way of knowing, no way through diligence of knowing, that he had HIV until symptoms began showing up 8, 9 years later.

Now, most times where we have a statute of limitations, you say something like 3 years, or 4 years or whatever it is, or within a year after he knew or should have known of the injury, whichever occurs last. And that's all this amendment does. It makes a read: "A health care lawsuit may be commenced no later than 3 years after the date of injury or 1 year after the claimant discovers, or, through the use of reasonable diligence, should have discovered the injury, whichever of these events occurs last."

So that if there are injuries, malpractice, no matter how flagrant, which you cannot possibly discover until after 3 years, under the bill as written, there would be no way of suing for that. And that's just wrong.

If someone was terribly damaged by someone's negligence, he should, assuming he shows due diligence in filing the lawsuit within a reasonable time of when he knew or could have known of it, he should not be deprived of his day in court. The bill as written, without this amendment, is, frankly, against our entire legal system by saying that, through no fault of the plaintiff's, through no fault of the victim's, he can't sue at all.

So this simply makes what I assume is a technical—I can't believe they mean "whichever is first," because, as I said, most statutes are written the other way, and this would conform it to most statutes, so people could sue, if they knew about it right away, they've got 3 years, and if not, within a year of when they learned of it, or should have learned of it with proper diligence.

I yield back.

Chairman SENSENBRENNER. The Chair recognizes himself in opposition to the amendment.

This amendment makes the statute of limitations completely open-ended. For example, it exposes OB/GYNs to lawsuit decades after they delivered a baby. And this specialty is particularly hard hit by the current medical professional liability insurance crisis.

Let me say that looking at it from the insurance carrier's perspective, one of the things that an insurance carrier must do is to set aside reserves to pay claims that they are obligated to pay. If you reduce the certainty in when a lawsuit can be filed, then the insurance company prudently is going to have increase its reserves to a higher level. And that is funded by higher premiums.

So by having an open-ended statute of limitations, we are guaranteeing an increase in medical malpractice insurance premiums, simply so that the insurance companies can protect themselves from bankruptcy by having adequate and maybe even more than adequate reserves, since they never know when the claim will be filed.

For the same reasons we voted down the Scott amendment, I would hope we would vote down this amendment. And I yield back the balance of my time.

Mr. SCOTT. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from Virginia.

Mr. SCOTT. Mr. Chairman, I would hope that we would adopt the amendment. It's not as—it doesn't go as far as the amendment that it had introduced. But if you'll notice on line 19 on page 4, it says "through the use of reasonable diligence should have discovered." You're dealing with people—if it's after 3 years, you can't sue at all, or if you should have discovered, it's even less than that.

This is a—you don't even get the 3 years.

I would hope that we would adopt this amendment. It's fair. It doesn't have people losing their cases on technicalities, and also, it doesn't get people roped up in the difference between State and Federal in this Federal preemption. A lot of people will be losing their cases because the lawyers who do most of this in State court will miss this 1-year statute of limitations.

And I yield to the gentleman from New York.

Mr. NADLER. Thank you.

Mr. Chairman, the distinguished Chairman says that an open-ended statute reduces certainty, and the malpractice premiums, therefore, would not be as low as they otherwise might be.

First of all, it's not open-ended. It's not totally open-ended. If it's more than 3 years, you have to show that you only discovered it now and that you could not have discovered it earlier. And that's a burden you have to bear, to show that you could not have discovered it earlier. And secondly—so it's not totally open.

But secondly, I will concede or admit or agree that premiums will be somewhat higher than under the draconian statute in the bill, but that's only fair because we have to balance—the aim of our tort system cannot be only to reduce insurance premiums. It also has to be give some elementary justice to victims. If someone was really injured, he should not be barred from recovering for his injury, for his lost wages, for his medical expenses, because it was impossible to discover the torts, the injury, within the 1 year or within the 3 years. You have to have some modicum of fairness.

And that may cost some money. Fine. There are other provisions in the bill designed to reduce the cost of money—the cost of malpractice premiums.

But if your only goal is reducing malpractice premiums no matter what that does to our justice system, no matter what it does to fairness, then I suppose there's nothing wrong with this provision as written.

But if there's any conception of fairness to someone who may have been severely injured, and any attitude other than "tough luck, go jump in a lake" because you didn't discover it in a year because it was undiscoverable, then you have to provide some provisions such as what I wrote, which is in the law in many States, in order to enable a victim to bring a lawsuit when or shortly after the injury is first discovered or discoverable.

It's a question of elementary fairness, Mr. Chairman. I yield back.

Mr. BACHUS. Mr. Chairman?

Chairman SENSENBRENNER. Does the gentleman from Virginia yield back?

Mr. SCOTT. I yield back.

Chairman SENSENBRENNER. The gentleman from Alabama, Mr. Bachus.

Mr. BACHUS. Mr. Chairman, Mr. Nadler offering this amendment sort of points out something to me that I really wasn't aware of. I'm not sure that, the way it's presently drafted, won't mislead some people into waiting, thinking they've got 3 years. You know, if I were just to read it, at first blush, I'd think this was a 3-year statute of limitations.

But it does appear, when it says 3 years after the date of injury or 1 year after the claimant discovers the injury, whichever occurs first, in most cases you're going to discover that injury a week after it happens or a day or 2 after it happens you probably should have known if they took off—and so that's a 1-year statute of limitations, or, it would be a 1-year, 5-day statute of limitations.

And I know in Alabama, we went from 1 year to 2 years statute of limitations to try to help avoid lawsuits.

So this is sort of—I think the way it's drafted is going to mislead some people into thinking there's a 3-year statute of limitations, and they're going to come walking in after they can't work it out over a year and a half.

My question would be, what does California—is this identical to the California statute? But I think there's a serious problem here.

Mr. ISSA. Would the gentleman yield?

Mr. BACHUS. Yes.

Mr. ISSA. I can't speak to it being exactly the same as California. What I will say is that ordinary tort in California is 1 year. And it is pretty common, although I know Alabama is a special case—and to be honest, Alabama has been a special case of a great deal of concern at times.

Mr. BACHUS. Well, you know, we like Alabama. I haven't moved to California.

Mr. ISSA. No, no. And I was stationed in Alabama, and it's a wonderful place. Although your supreme court justices did need a little reworking to make it a perfect place. [Laughter.]

Mr. BACHUS. It's been reworked now.

Mr. ISSA. It is reworked now. It's a much better perfect place.

But the fact is that it's routine, when you know that somebody has done you wrong, to have 1 year to bring that.

Mr. BACHUS. I think 2 years is much more routine in lawsuits.

Mr. NADLER. Will the gentleman yield?

Mr. BACHUS. I would yield. I don't know—what I'm saying is I almost think that if you had a solid 1 year, it's better than this 3 years after you're injured or 1 year after you should have discovered it. That's going to normally be a 1-year-and-5-day—you know, if you have an operation and you start having trouble 3 days later, then is that a 1-year-and-3-days?

I mean, this is just a little unclear, is what I'm saying.

Mr. ISSA. I thought it was clearly giving, if the gentleman would continue yielding, it's clearly giving 3 years from the date, presuming you didn't know, which does increase the period of time to make a discovery.

The one thing about medical that I think makes that 3 years very reasonable, to extend what would otherwise be normally 1 year, is the fact that in medicine, you often don't discover it.

The gentleman on the other side of the aisle specifically mentioned tainted blood. I mean, there is a good example of something that does take a little while sometimes to discover. On the other hand, you can't leave it ad infinitum. I mean, you have to set a date, and 3 years seems to be quite a generous extension, three times what would be an ordinary tort period of time in most States and under the normal Federal rule.

Mr. BACHUS. I would just use a personal analogy, and I don't mean to take any more time. About a year and a half ago, I was hit by a tractor-trailer truck, which went out of control. And I did not—we're still trying to figure out—the doctors haven't told me whether I'm going to need another operation. So I have not filed a lawsuit. The insurance company and I both want to settle it, but I would have had to file a lawsuit if we had a year statute of limitations.

Chairman SENSENBRENNER. Does the gentleman yield back?

Mr. BACHUS. I yield back.

Chairman SENSENBRENNER. The question is on the amendment offered by the gentleman from New York, M. Nadler.

Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it, and the amendment in not agreed to.

Are there further amendments?

Mr. NADLER. Mr. Chairman?

Chairman SENSENBRENNER. The gentleman from New York.

Mr. NADLER. Mr. Chairman, I have an amendment, the first one, at the desk.

Chairman SENSENBRENNER. The clerk will report the unnumbered "first one" amendment.

The CLERK. Amendment to H.R. 4600, offered by Mr. Nadler. After section 11, insert the following new section and redesignate the succeeding section——

Mr. NADLER. Mr. Chairman, I move to waive the reading.

Chairman SENSENBRENNER. Without objection, the amendment is considered as read.

[The amendment follows:]

AMENDMENT TO H.R. 4600
OFFERED BY Mr. Nadler

After section 11, insert the following new section and redesignate the succeeding section accordingly:

SEC. 12. AVAILABILITY OF COURT RECORDS.

(a) GENERAL RULE.—No order or opinion of the court in the adjudication of a health care lawsuit may be sealed, except as provided in this section.

(b) EXCEPTION.—Any court record in a health care lawsuit, including a record obtained through discovery, whether or not formally filed with the court, may be sealed or subjected to a protective order, and access to such record may otherwise be restricted, only if the court makes a finding of fact in writing that—

(1) the order that would restrict access to a court record would not restrict the disclosure of information which is relevant to public health or safety; or

(2)(A) the public interest in disclosing potential health or safety hazards is clearly outweighed by a specific and substantial interest in maintaining the confidentiality of the information or records in question; and

(B) the order that would restrict access to a court record is no broader than necessary to protect the privacy interest asserted.

Chairman SENSENBRENNER. And the gentleman is recognized for 5 minutes.

Mr. NADLER. Thank you, Mr. Chairman.

Mr. Chairman, this amendment is designed to prevent the sealing of information from medical malpractice lawsuits that could be used and have been used to protect the health and safety of others.

I've been concerned for a number of years about records from lawsuits that affect public health and safety being sealed by court order. I see little justification for this practice. Too often, a doctor who may have been guilty of malpractice settles a lawsuit with a plaintiff and places a restriction in the settlement that all details of the case must remain secret. This ensures that no one else will ever know of the harm he or she has inflicted upon the victim.

Take the case of Judy Fernandez. She went into the hospital for plastic surgery and never came out, having bled to death. Had she known that her doctor had settled a malpractice suit 3 years earlier and been sued since then four times, she might have seen a different doctor. His license has since been revoked, 22 incidents and $1.5 million in malpractice payments later. But that's little comfort to Judy's husband.

In some cases, secrecy costs lives. If we really want to reduce malpractice lawsuits, the place to begin would be to reduce the incidents of malpractice. Without full disclosure of these cases, medical boards will not know who to monitor and patients will not know who to avoid.

Furthermore and more dangerously, we run the risk of doctors and insurance companies regarding lawsuits as merely the cost of doing business. Given the strict caps on liability that would be in place if this bill were to pass, what would stop a doctor with poor practices from budgeting for one or two lawsuits a year rather than changing the dangerous practices that lead to these suits. This should, obviously, be unacceptable.

It's important for people to be aware of the health and safety hazards that may exist in the medical profession so that other people can make informed choices about their lives and, I might add, so that public agencies and professional organizations can crack down on such dangers. Too often, critical information is sealed from the public, and other people may be harmed as a result.

Just last week, South Carolina's Federal judges recognized the dangers inherent in sealed settlements and moved to end this practice except in extraordinary circumstances in the Federal courts in South Carolina.

I ask unanimous consent to enter into the record an editorial from the *New York Times* praising this decision.

Chairman SENSENBRENNER. Without objection.

[The information follows:]

The New York Times

September 5, 2002

Ending Legal Secrecy

Ending Legal Secrecy

One of the most troubling, and least scrutinized, aspects of the child sexual abuse scandal now roiling the Roman Catholic Church is the enabling role played by the court system. In case after case, judges have signed off on secret settlements of child-molestation suits, freeing the offending priests to molest again. In one Boston case, brought on behalf of a boy who was raped by a priest, the judge sealed all the records and the priest moved to New Hampshire, where he later pleaded guilty to abusing two more children.

South Carolina's 10 active federal judges recently struck an important blow against this kind of secrecy when they voted unanimously to ban secret settlements in all kinds of cases. If South Carolina's federal courts formally adopt the rule after a public comment period ends later this month, it will be the nation's strictest ban on secret settlements. Michigan, the only state with such a rule, requires that secret settlements be revealed after two years.

It is not hard to see why secret settlements are popular; they often advance the interests of everyone in the courtroom. Defendants, usually a corporation or a large institution, can dispense with an embarrassing lawsuit without exposing its wrongdoing to public scrutiny. Plaintiffs, by agreeing to remove an obstacle to settlement, can generally get a resolution, and damages, more quickly. For judges, secret settlements make it easier to resolve cases, reducing often overcrowded dockets.

The main loser in secret settlements is the public. Consumers are deprived of information they need to protect themselves from unsafe products. Workers are kept in the dark about unsafe working conditions. And, as we now know, parishioners have been prevented from learning that their priests have been successfully sued for abuse. In 1933 the Johns Manville company settled a lawsuit by 11 employees who had been made sick by asbestos. If that settlement had not been kept secret for 45 years, thousands of other workers might not have contracted respiratory diseases.

The move by the South Carolina judges is still just a start. It would prohibit judges from sealing court files, but it does not prevent the parties themselves from contracting to keep a settlement secret — which could be in their narrow self-interest but is clearly not in the broader public interest. Some experts, including Stephen Gillers of New York University Law School, have put forward the provocative notion that private secrecy agreements constitute illegal obstruction of justice. And they have urged that state legal ethics rules be rewritten, or in some cases simply applied in their current form, to prohibit lawyers from participating in such settlements.

One Boston judge who sealed court records in a priest molestation case told The Boston Globe earlier this year that she might not have done so "if I had been aware of how widespread this issue was." It was, of course, rulings like hers across the country that helped hide just how big a problem sex abuse was in the church. The American public is entitled to know when lawsuits are settled. Judges around the country should follow South Carolina's lead and ban court-approved secret settlements. Obstruction of justice laws and legal ethics rules should be used to prohibit the rest.

Mr. NADLER. Thank you.

I hope that this will signal a beginning of a trend to an openness in courts across the country. But we should take this step today to protect the public health and safety by passing this amendment.

Let me add that this amendment is reasonably drafted to protect for gag orders, to allow for gag orders, when a judge finds that it's appropriate. The amendment is written in such a way that the judge must make a finding of fact where a gag order is requested. If the judge finds that the privacy interests in the case is broader than the public interest, the judge must issue the gag order. If the judge finds the public interest in the health and safety outweighs the privacy interest asserted, the judge may not issue the gag order. The judge also has to make sure the gag order is drafted as tightly as possible, in order to prevent the unnecessary disclosure of confidential information, but will not allow the sealing of information that may harm the public.

I would also note that during floor debate on the Class Action Fairness Act, which capped liability in class action lawsuits in a similar manner as the bill before us, an almost identical amendment was accepted by the majority of the House, and I would hope that the same would occur in this Committee today.

When it comes to health and safety, public access to malpractice lawsuit information is absolutely essential. I hope my colleagues will support this amendment. I thank you, and I yield back the balance of my time.

Chairman SENSENBRENNER. The Chair recognizes himself for 5 minutes in opposition to the amendment.

First, this amendment should be opposed because it governs a vaguely defined but no doubt very large category of documents, namely court records, which could mean just about anything, including, according to the amendment, any record obtained through discovery whether or not formally filed with the court.

The amendment then makes these documents subject to public exposure by stating that public access to such documents can only be restricted under a dramatically lower threshold than they're currently protected by. The amendment would eviscerate the protection of documents from public disclosure simply because the documents could be arguably be described as simply relevant to public health and safety. These provisions threaten to eviscerate the attorney-client privilege.

The amendment also eviscerates protective orders that are now routinely and appropriately applied to documents to the benefit of both sides in a health care lawsuit. Because protective orders offer defendants protections when they disclose documents that they are not legally bound to disclose, plaintiffs get access to a much broader range of information and documents that will help resolve claims without wasteful, costly, and time-consuming discovery disputes. In fact, most protective orders are mutually agreed upon when submitted for approval by the court.

Likewise, because the court is not restricted as to when it can approve such protective orders, they are often granted without delay, giving the patient and his attorney access to the important information.

The amendment, if adopted, would result in an additional layer of costly and time-consuming litigation simply to establish protec-

tive orders and afford the plaintiff access to information important to their own case. It would mire the courts in a blizzard of documents that would have to be considered by the court individually and delay the resolution of the plaintiff's initial claim and increase legal costs for everyone.

The amendment also should be opposed because it takes the unprecedented step of federalizing the rules of State court regarding the confidentiality of documents and eliminating the many and varied protections State court procedures now afford both plaintiffs and defendants.

Finally, a recent survey conducted by the bipartisan legal reform organization Common Good, whose board of advisers includes former Senator George McGovern, former Deputy Attorney General Eric Holder, who served during the Clinton administration, and former Senator Paul Simon, found that more than three-quarters of the physicians feel a concern about malpractice litigation has hurt their ability to provide quality care in recent years.

When physicians were asked, "Generally speaking, how much do you think fear of liability discourages medical professionals from openly discussing and thinking of ways to reduce medical errors?" an astonishing 59 percent of physicians replied "a lot."

The HEALTH Act would dispel the fear and allow doctors to freely suggest improvements in medical care. Just this summer the medical journal Annals of Medicine is beginning to detail reports on medical errors over the next year. In an editorial about the new series, the author of the study and his colleagues write that "the medical profession, for reasons that include liability issues, is not discussing mistakes and harnessing the full power of errors to teach and, thereby, reduce errors," unquote.

I would hope that, for these reasons, that this amendment would be opposed and that the State courts would continue to have the discretion to enter protective orders that the original bill allows them to.

I yield back the balance of my time.

The question is on the Nadler amendment.

Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it, and the amendment is not agreed to.

The gentleman from New York.

Mr. NADLER. Mr. Chairman, I ask for a recorded vote.

Chairman SENSENBRENNER. A recorded vote is requested.

The question is on agreeing to the amendment offered by the gentleman from New York. Those in favor will, as your names are called, answer aye. Those opposed, no. And the clerk will call the role.

The CLERK. Mr. Hyde?

[No response.].

The CLERK. Mr. Gekas?

[No response.]

The CLERK. Mr. Coble?

Mr. COBLE. No.

The CLERK. Mr. Coble, no. Mr. Smith?

[No response.]

The CLERK. Mr. Gallegly?

Mr. GALLEGLY. No.
The CLERK. Mr. Gallegly, no. Mr. Goodlatte?
Mr. GOODLATTE. No.
The CLERK. Mr. Goodlatte, no. Mr. Chabot?
Mr. CHABOT. No.
The CLERK. Mr. Chabot, no. Mr. Barr?
Mr. BARR. No.
The CLERK. Mr. Barr, no. Mr. Jenkins?
[No response.]
The CLERK. Mr. Cannon?
Mr. CANNON. No.
The CLERK. Mr. Cannon, no. Mr. Graham?
[No response.]
The CLERK. Mr. Bachus?
Mr. BACHUS. No.
The CLERK. Mr. Bachus, no. Mr. Hostettler?
Mr. HOSTETTLER. No.
The CLERK. Mr. Hostettler, no. Mr. Green?
Mr. GREEN. No.
The CLERK. Mr. Green, no. Mr. Keller?
Mr. KELLER. No.
The CLERK. Mr. Keller, no. Mr. Issa?
Mr. ISSA. No.
The CLERK. Mr. Issa, no. Ms. Hart?
Ms. HART. No.
The CLERK. Ms. Hart, no. Mr. Flake?
Mr. FLAKE. No.
The CLERK. Mr. Flake, no. Mr. Pence?
[No response.]
The CLERK. Mr. Forbes?
[No response.]
The CLERK. Mr. Conyers?
[No response.]
The CLERK. Mr. Frank?
[No response.]
The CLERK. Mr. Berman?
Mr. BERMAN. Aye.
The CLERK. Mr. Berman, aye. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
[No response.]
The CLERK. Ms. Lofgren?
[No response.]
The CLERK. Ms. Jackson Lee?
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee, aye. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]

The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
[No response.]
The CLERK. Ms. Lofgren?
[No response.]
The CLERK. Ms. Jackson Lee?
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee, aye. Ms. Waters.
[No response.]
The CLERK. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
[No response.]
The CLERK. Mr. Schiff?
[No response.]
The CLERK. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.
Chairman SENSENBRENNER. Are there Members in the chamber who wish to cast or change their vote? The gentleman from Texas, Mr. Smith.
Mr. SMITH. Mr. Chairman, I vote no.
The CLERK. Mr. Smith, no.
Chairman SENSENBRENNER. The gentleman from Tennessee, Mr.Jenkins?
Mr. JENKINS. Mr. Chairman, I vote no.
The CLERK. Mr. Smith, no.
Chairman SENSENBRENNER. The gentlemen from Tennessee, Mr. Jenkins.
Mr. JENKINS. No.
The CLERK. Mr. Jenkins, no.
Chairman SENSENBRENNER. The gentleman from Pennsylvania, Mr. Gekas.
Mr. GEKAS. No.
The CLERK. Mr. Gekas, no.
Chairman SENSENBRENNER. Are there further Members in the chamber who wish to cast or change their votes? If not, the clerk will report.
The CLERK. Mr. Chairman, there are six ayes and seventeen noes.

Chairman SENSENBRENNER. The amendment is not agreed to.

Are there further amendments? The gentleman from New York, Mr. Nadler.

Mr. NADLER. Mr. Chairman, I have an amendment. I have an amendment which I am offering, originally drafted for Mr. Conyers. It is Conyers 120, I think you have it there.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R.4600 offered by Mr. Nadler. Page 22, Line 1, strike subsection——

Mr. NADLER. Mr. Chairman, I move to waive the reading.

Chairman SENSENBRENNER. Without objection, it is so ordered. The gentleman is recognized for 5 minutes.

[The amendment follows:]

H.L.C.

AMENDMENT TO H.R. 4600

OFFERED BY MR. CONYERS

Page 22, line 1, strike "subsections (b) and (c)" and insert "subsections (b), (c), and (d)".

Page 23, after line 14, insert the following new subsection:

(d) PATIENTS' BILL OF RIGHTS.—Notwithstanding any other provision of this Act, if a State has in effect a law that provides for the liability of health maintenance organizations (as defined in section 2791(b)(3) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(3))) with respect to patients, or sets forth circumstances under which actions may be brought with respect to such liability, this Act does not preempt or supersede such law or in any way affect such liability, circumstances, or actions.

Mr. NADLER. Thank you. Mr. Chairman, as currently drafted, this bill, perhaps intentionally, perhaps not, guts HMO reform laws that many States have passed in the last eight or 9 years.

On Pages 17 and 18 of the bill, the bill defines the health care liability claim as "based upon the provision of, use of, or payment for or the failure to provide user pay for health care services or medical products."

The rest of the bill sets caps on non-economic damages and punitive damages for health care liability claims among other things. Those limits are far less friendly to consumers and patients injured by HMOs than the patient protection laws enacted in recent years by the various States.

I offer this amendment because we have reached a national consensus that for too long the law has been on the side of HMOs and big insurance companies and it is time we gave power back to patients and families and doctors.

Both parties in this house and in the other body, Mr. Chairman, would share in that consensus. There are rival HMO reform bills, but they all have the same basic goal. Now, many of the States have passed such bills, but this bill would gut them.

It can be life-threatening when an HMO refuses to authorize a visit to a specialist or the nearest emergency room or denies treatment that is desperately needed by a patient or refuses to be held accountable for any of the decisions that it makes.

These decisions which are medical decisions, really, should not be made by HMOs and insurance companies concerned only about the bottom line. That is why at least eight States have enacted laws specifying that when the HMO steps in and inserts itself into the process of exercising medical judgment, their case goes to State court just as a medical negligence case would go to State court.

Those States have reached consensus on what limits should apply in those cases, if any. I believe the HMO law enacted in Texas, for example, when George W. Bush was Governor, the bill he bragged about during the debate with Vice President Gore, should be respected and not superceded.

That law has a higher cap on punitive damages than this bill, $750,000 and no caps on non-economic damages for suits against HMOs.

The Arizona law has no limits on damages for HMO lawsuits. This bill caps punitive damages at $250,000 and non-economic damages at $250 and would gut the Arizona law.

The California law has no HMO caps. The California law has been repeatedly referred to, but with respect to HMO there are no caps. This bill would undo that provision of the California law. The Georgia law does not allow any punitive damages, but does allow all non-economic damages against HMOs. This bill undoes that State legislative determination.

The list goes on and on. My amendment, Mr. Chairman, would protect these laws and the other HMO laws that have been passed by the States. I hope that this bill is not intended to gut the protections that various States have enacted, given the failure of Congress to act in this area.

States have stepped into the breach and enacted various laws and we should not interfere with those laws and undo what they have done recently to protect patients against HMOs.

So, I urge my colleagues to vote yes on this amendment. I yield back.

Chairman SENSENBRENNER. The chair recognizes himself for 5 minutes in opposition to the amendment. There is a simple reason why this amendment should be opposed. That is that courts have declared HMOs to be practicing medical when they make decisions about what is and is not covered by their plans.

If HMOs are practicing medical, then it is only fair that they receive the same protections and have the same obligations that physicians who are not in an HMO receive under the bill.

Also, if this amendment is adopted, the cost of joining an HMO will go up. That, too, decreases access to health care for everyone.

Now, I would hope that we would have some kind of HMO reform passed by the Congress, but it seems to me that in the context of this bill the medical malpractice laws that apply to physicians ought to apply to HMOs since the courts have determined them to be practicing medicine and the Nadler amendment undoes that. That's why it should be voted down.

I yield back the balance of my time.

Mr. BERMAN. Mr. Chairman.

Chairman SENSENBRENNER. The gentlemen from California, Mr. Berman.

Mr. BERMAN. Thank you, Mr. Chairman. I yield to the gentleman from New York.

Mr. NADLER. Thank you, Mr. Berman.

Mr. Chairman, I could not disagree with your reasoning more. Yes, the courts have held in some cases that the HMOs, when they make these decisions on what treatment you can have, et cetera, are practicing medical.

I do not draw the conclusion, therefore that there liability should be limited to the liability of doctors. Their liability should be 1,000 times it because they have no business practicing medicine. They are insurance companies. Doctors should practice medicine. Maybe nurses should practice medicine. Health care professionals should practice medicine.

Insurance companies should be squashed when they try to practice medicine. That is the purpose of what the States have done and that is the purpose of the HMO legislation pending in the House and the Senate, that HMOs have no business practicing medicine and when they do, they ought to get their hand slapped and hard.

I thank the gentleman and I yield back

Chairman SENSENBRENNER. The question is on the Nadler amendment. Those in favor will say "aye."

Opposed, no.

The noes appear to have it.

Mr. NADLER. Mr. Chairman, I ask for the ayes and nays.

Chairman SENSENBRENNER. A rollcall will be ordered. The question is on the amendment offered by the gentleman from New York, Mr. Nadler.

Those in favor will, when your name is called, answer aye. Those opposed, no. The Clerk will call the role.

The CLERK. Mr. Hyde?

[No response.]

The CLERK. Mr. Gekas?

[No response.]
The CLERK. Mr. Coble.
Mr. COBLE. Aye.
The CLERK. Mr. Coble, aye. Mr. Smith?
[No response.]
The CLERK. Mr. Gallegly?
Mr. GALLEGLY. No.
The CLERK. Mr. Gallegly, no. Mr. Goodlatte?
[No response.]
The CLERK. Mr. Chabot?
Mr. CHABOT. No.
The CLERK. Mr. Chabot, no. Mr. Barr?
Mr. BARR. No.
The CLERK. Mr. Barr, no. Mr. Jenkins?
[No response.]
The CLERK. Mr. Cannon?
[No response.]
The CLERK. Mr. Graham?
[No response.]
The CLERK. Mr. Bachus?
Mr. BACHUS. No.
The CLERK. Mr. Bachus, no. Mr. Hostettler?
[No response.]
The CLERK. Mr. Green?
Mr. GREEN. No.
The CLERK. Mr. Green, no. Mr. Keller?
Mr. KELLER. No.
The CLERK. Mr. Keller, no. Mr. Issa?
Mr. ISSA. Absolutely, positively no.
The CLERK. Mr. Issa, no. Ms. Hart?
Ms. HART. No.
The CLERK. Ms. Hart, no. Mr. Flake?
[No response.]
The CLERK. Mr. Pence?
[No response.]
The CLERK. Mr. Forbes?
[No response.]
The CLERK. Mr. Conyers?
[No response.]
The CLERK. Mr. Frank?
[No response.]
The CLERK. Mr. Berman?
Mr. BERMAN. Aye.
The CLERK. Mr. Berman, aye. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler.
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott.
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
[No response.]
The CLERK. Ms. Lofgren?
[No response.]
The CLERK. Ms. Jackson Lee?
Ms. JACKSON LEE. Aye.

The CLERK. Ms. Jackson Lee, aye. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
[No response.]
The CLERK. Mr. Schiff?
[No response.]
The CLERK. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.
Chairman SENSENBRENNER. Are there Members who wish to cast or change their votes?
The gentleman from Virginia, Mr. Goodlatte?
Mr. GOODLATTE. No.
The CLERK. Mr. Goodlatte, no.
Chairman SENSENBRENNER. The gentleman from Tennessee, Mr. Jenkins.
Mr. JENKINS. No.
The CLERK. Mr. Jenkins, no.
Chairman SENSENBRENNER. The gentleman from Pennsylvania, Mr. Gekas.
Mr. GEKAS. No.
The CLERK. Mr. Gekas, no.
Chairman SENSENBRENNER. The gentleman from Indiana, Mr. Hostettler?
Mr. HOSTETTLER. No.
The CLERK. Mr. Hostettler, no.
Chairman SENSENBRENNER. Are there further Members who wish to change? The gentleman from Arizona, Mr. Flake.
Mr. FLAKE. No.
The CLERK. Mr. Flake, no.
Chairman SENSENBRENNER. The gentleman from Texas, Mr. Smith.
Mr. SMITH. Mr. Chairman, I vote no.
The CLERK. Mr. Smith, no.
Chairman SENSENBRENNER. Are there further Members who wish to cast or change their votes? If not, the clerk will report.
The CLERK. Mr. Chairman, there are seven ayes and fifteen nays.
Chairman SENSENBRENNER. And the amendment is not agreed to.
Are there further amendments? The gentleman from New York.
Mr. NADLER. Thank you, Mr. Chairman. I have——
Chairman SENSENBRENNER. Do you have an amendment at the desk?
Mr. NADLER. Yes. I was about to say that. Actually, I have an amendment labeled Conyers 111 at the desk.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R.4600 offered by Mr. Nadler. Add at the end the following new section: Section 13, Liability.

Mr. NADLER. Mr. Chairman, waive the reading?

[The amendment follows:]

H.L.C.

AMENDMENT TO H.R. 4600

OFFERED BY MR. CONYERS

Add at the end the following new section:

SEC. 13. LIABILITY OF TAX HAVEN CORPORATIONS.

(a) IN GENERAL.—Notwithstanding any other provision of this Act, this Act shall not reduce in any manner the liability of a tax haven corporation to any person on any claim.

(b) DEFINITION.—In this section, the term "tax haven corporation" means a corporation incorporated in Barbados, Bermuda, the British Virgin Islands, the Cayman Islands, the Commonwealth of the Bahamas, Cyprus, Gibraltar, the Isle of Man, the Principality of Monaco, or the Republic of the Seychelles, if the principal market for the trading of stock in that corporation is the United States.

Mr. COBLE. Point of order.

Chairman SENSENBRENNER. The gentleman from North Carolina reserves a point of order. Without objection the amendment is considered as read and the gentleman from New York is recognized for 5 minutes.

Mr. NADLER. Thank you, Mr. Chairman. Mr. Chairman, this is a common sense amendment which will send a message that the U.S. Congress will not condone the practice of U.S. corporations re-incorporating abroad in order to avoid tax and other liabilities.

It does this by providing that U.S. firms which re-incorporate in tax havens abroad cannot benefit from the legal liability protections in this bill. The amendment uses the very same definition of foreign tax traitor that was included in the motion to recommit to the Homeland Security Bill, a motion that passed by a vote of 318 to 110.

With increasing frequency, companies are setting up shell companies in places such as Bermuda while the company continues to be owned by U.S. shareholders and continues to do business in American locations, the new foreign-located company escapes substantial that is liability.

These companies are eager to put "Made in the U.S." on their products while they avoid U.S. taxes and minimize legal liability after shuffling some corporate documents. The actions of these companies, besides increasing taxes for everybody else, obviously, are slaps in the face of every citizen who works hard and pays his or her taxes to this country.

This amendment responds to this egregious behavior by telling these companies that they cannot receive any liability benefits under this bill. This is not a hypothetical concern, Mr. Chairman. The bill before us is so broad that it would benefit not just doctors and hospitals; it would also insulate the manufacturers of medical and drug devices from liability.

And guess what, one of the very largest manufacturers of medical devices is the U.S. Surgical Corporation, a wholly owned subsidiary of the notorious Tyco Corporation. Tyco has its headquarters in New Hampshire, but is treated as a Bermuda corporation for tax purposes.

Under this legislation, U.S. Surgical would be largely insulated from punitive damages, even though essentially it evades all U.S. taxes. That strikes me as wrong. This is an opportunity to let corporations know that it is wrong to claim U.S. citizenship when you are incorporated in Bermuda. It is wrong to seek the benefits of corporate citizenship without the responsibility and it is wrong to engage in sham off-shore transactions which leave hard-working U.S. citizens hanging out to dry.

So, this amendment would say that if you are going to do all those things you don't get the benefits of the legal liability provisions in this bill. It is a simple amendment, Mr. Chairman, I should hope an obvious one. I urge my colleagues to support it. I yield back.

Chairman SENSENBRENNER. Does the gentleman from North Carolina insist on his point of order?

Mr. COBLE. I do, indeed, Mr. Chairman.

Chairman SENSENBRENNER. The gentleman will state his point of order.

Mr. COBLE. Rule 10, Mr. Chairman, places tax matters in the jurisdiction of the House Committee on Ways and Means.

Mr. NADLER. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from New York.

Mr. NADLER. This amendment does not affect tax matters. It does not increase or decrease the tax on anybody. All it says is if you do certain things the legal liability provisions of this bill, the legal liability limitations of this bill don't apply.

The corporation will continue to pay exactly the same tax. This does not affect the tax in any way. Therefore, the point of order is not well taken. This amendment only deals with the legal liability limitations in the bill. It does not change the tax law in any way, does not change the tax liability of any corporation in any way.

It simply says if you do certain things, then the legal liability provisions of this bill, which are within the jurisdiction of this Committee and within the purview of this bill, do not apply.

Chairman SENSENBRENNER. The chair is prepared to rule on the point of order. For the reasons stated by the gentleman from New York that that amendment deals with the legal liability of the corporations rather than the taxes that the corporations either pay or don't pay, the chair believes that the amendment is germane and thus the point of order made by the gentleman from North Carolina is not well taken.

The question is on the amendment offered by the gentleman from New York. Those in favor will say aye.

Opposed no.

The Chair is in doubt. Those in favor will say aye.

Opposed, no.

The Chair is in doubt. Those in favor will raise your hand and be counted. The Chair will order a division. One, two, three four. The ayes will put their hands down and those opposed will raise their hands. One, two, three, four, five, six, seven, eight, nine, ten, eleven.

The noes will put their hands down. There were four ayes and eleven noes. The amendment is not agreed to.

Mr. NADLER. Mr. Chairman, I ask for a rollcall vote.

Chairman SENSENBRENNER. The question is on the amendment offered by the gentleman from New York, Mr. Nadler. Those in favor will, as your names are called answer aye. Those opposed, no. The clerk will call the role.

The CLERK. Mr. Hyde?

[No response.]

The CLERK. Mr. Gekas?

Mr. GEKAS. No.

The CLERK. Mr. Gekas, no. Mr. Coble.

Mr. COBLE. No.

The CLERK. Mr. Coble, no. Mr. Smith?

Mr. SMITH. No.

The CLERK. Mr. Smith, no. Mr. Gallegly?

Mr. GALLEGLY. No.

The CLERK. Mr. Gallegly, no. Mr. Goodlatte?

Mr. GOODLATTE. No.

The CLERK. Mr. Goodlatte, no. Mr. Chabot?

Mr. CHABOT. No.

The CLERK. Mr. Chabot, no. Mr. Barr?

Mr. BARR. No.

The CLERK. Mr. Barr, no. Mr. Jenkins?

[No response.]

The CLERK. Mr. Cannon?

[No response.]
The CLERK. Mr. Graham?
[No response.]
The CLERK. Mr. Bachus?
Mr. BACHUS. Aye.
The CLERK. Mr. Bachus, aye. Mr. Hostettler?
[No response.]
The CLERK. Mr. Green?
Mr. GREEN. No.
The CLERK. Mr. Green, no. Mr. Keller?
Mr. KELLER. No.
The CLERK. Mr. Keller, no. Mr. Issa?
Mr. ISSA. No.
The CLERK. Mr. Issa, no. Ms. Hart?
Ms. HART. No.
The CLERK. Ms. Hart, no. Mr. Flake?
Mr. FLAKE. No.
The CLERK. Mr. Flake, no. Mr. Pence?
[No response.]
The CLERK. Mr. Forbes?
[No response.]
The CLERK. Mr. Conyers?
[No response.]
The CLERK. Mr. Frank?
[No response.]
The CLERK. Mr. Berman?
Mr. BERMAN. No.
The CLERK. Mr. Berman, no. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler.
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
[No response.]
The CLERK. Ms. Lofgren?
[No response.]
The CLERK. Ms. Jackson Lee?
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee, aye. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler, aye. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
Mr. WEINER. Aye.
The CLERK. Mr. Weiner, aye. Mr. Schiff?
[No response.]
The CLERK. Mr. Chairman?
Chairman SENSENBRENNER. No.

The CLERK. Mr. Chairman, no.

Chairman SENSENBRENNER. Are there Members in the room who wish to cast or change their votes? The gentleman from Tennessee, Mr. Jenkins.

Mr. JENKINS. No.

The CLERK. Mr. Jenkins, no.

Chairman SENSENBRENNER. The gentleman from Alabama, Mr. Bachus.

Mr. BACHUS. No.

The CLERK. Mr. Bachus, no.

Chairman SENSENBRENNER. Are there further Members who wish to cast or change their votes? If not, the clerk will report.

The CLERK. Mr. Chairman, there are six ayes and sixteen noes.

Chairman SENSENBRENNER. And the amendment is not agreed to. Are there further amendments? From Virginia, Mr. Scott.

Mr. SCOTT. Mr. Chairman, I have an amendment at the desk, number three.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R.4600 offered by Mr. Scott. On Page 6, strike all of Section 5.

[The amendment follows:]

AMENDMENT TO H.R. 4600
OFFERED BY MR. SCOTT
#3

On page 6, strike all of Section 5.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCOTT. Mr. Chairman, this strikes the limitation on attorney's fees. If we are talking about malpractice costs, I would like to note that the plaintiff pays his attorneys fees out of the award. The amount is not paid for by the defendant.

If you want to reduce malpractice costs, you should limit defense attorney's fees which are paid out of the malpractice premiums. The plaintiff pays the awards, not the defendant. If there is a $100,000 award, the malpractice insurance company or the defendant will pay $100,000. If the attorney fee is 50 percent, the malpractice insurance company or the defendant will pay the same $100,000. If it is 25 percent attorney's fees, they will pay $100,000. If there is no fee at all, they will pay $100,000.

The amount paid for in the award by the defendant is not affected by attorney's fees. If there is a contingent fee, if it is a frivolous or losing case, the attorney will get nothing, in addition to subject to rule 11 for filing the frivolous case.

The plaintiff can always choose, if he wants, to not do a contingent or percentage fee, but on an hourly rate, $100 an hour, win or lose, or one-third or forty percent of the total if you win.

When I was practicing law, I don't know anybody that wanted to pay the hourly rate. Lawyers would rather get the hourly rate.

That is how defenses lawyers are paid. Win or lose you get paid. That's a much easier thing than only getting paid when you win.

But unfortunately most plaintiffs can't afford the upfront costs and can't afford to pay the lawyer unless they win. Therefore, that is why the percentage fees are so popular with plaintiffs.

This provision is particular egregious, Mr. Chairman, because we, in the same bill, are eliminating joint and several liability which means that the plaintiff's attorney not only has to prove negligence generally, but then has to go and find each and every person in the hospital that committed some negligence, the nurse, the doctor, the assistant physician, the anesthesiologist, the hospital itself and then go and try to assign what percentage went to who and try to guess to make sure they don't under-estimate and settle for the wrong amount.

There is a lot more work that has to be done, so the limitation on attorney's fees is even more egregious because of the other provisions in the bill.

I would hope, Mr. Chairman, that we would defeat this provision. It does nothing to reduce malpractice costs.

Chairman SENSENBRENNER. The chair recognizes himself for 5 minutes in opposition to the amendment.

This amendment on attorney's fees is the same as the California MICRA law. The way the contingency fee system works is that it gives a lawyer an incentive to ask for an outrageous judgment because the higher the judgment, the more the lawyer gets.

Now, the provisions in this bill provide for limitations on attorney's fees to give more money to injured plaintiffs and less to the plaintiff's bar. The large the victim's demonstrable, real life, quantifiable economic damages, the more they will receive under the bill because the lawyers will only be allowed to take 15 percent of awards over $600,000.

Should the amendment be defeated and the provisions of the bill passed, victims would get 75 percent, approximately, of awards under $600,000 and about 85 percent, approximately, of awards over $600,000. So, if we really want to compensate injured plaintiffs, we ought to vote this amendment down.

I yield back the balance of my time.

Mr. BERMAN. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from California.

Mr. BERMAN. Once again the argument is used that this is in the California law. So, I think it pays to take a moment to talk about what is in H.R.4600 that is not in the California law. The $250,000 cap on non-economic damages in California applies to medical malpractice cases only.

In H.R.4600, the $250,000 cap on uneconomic damages not only applies to all medical malpractice cases in all 50 States, as well as at the Federal level, but also to product liability cases against drug and medical device manufacturers and civil actions against nursing homes, HMOs and insurance companies, way beyond the California law.

This is not about dealing with a medical malpractice insurance crisis. This is far more than that. Non-economic damages compensate injured patients for real injuries. MICRA, California law, eliminates joint liability for non-economic damages, for pain and suffering.

H.R.4600, this bill, eliminates joint liability for non-economic and economic injury so that if a party responsible 50 percent of the injury is the only party which can provide the compensation for the loss of wages and the costs of the medical care as a result of the negligence, the plaintiff doesn't become whole as a result of this amendment.

It goes far beyond the California law, not just in the pain and suffering, but on the economic damages as well. In cloaking this with a notion of trying to do here what we are doing in California we are going far beyond it with H.R.4600.

My only final point specifically related to this amendment is that there is no greater equalizer in terms of wealth and income than the plaintiff-attorney contingency fee.

In the effort to bash the plaintiff's bar, those who seek to do the bashing make a mockery of the system of equal justice because there is no other way in which many of the cases involving negligence and which provide recoveries to people without regard to their wealth or ability for staying power.

The only way they can come into court is through the contingency fee. When you start putting on price controls on that in a way to dissuade plaintiff's attorneys from taking the case, who you are hurting are lower-income plaintiffs and only lower-income plaintiffs.

I think it is a good amendment. I think this bill goes far beyond the California law in its effort to sweep in caps and other limitations on liability.

Chairman SENSENBRENNER. The question is on the amendment offered by the gentlemen from Virginia, Mr.Scott. Those in favor will say aye.

Opposed no.

The noes appear to have it. The noes have it and the amendment is not agreed to.

Are there further amendments? The gentleman from Virginia, Mr. Scott.

Mr. SCOTT. The amendment at the desk, number four.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R.4600 offered by Mr. Scott. On page 7, strike all of Section 6.

[The amendment follows:]

AMENDMENT TO H.R. 4600
OFFERED BY MR. SCOTT
#4

On page 7, strike all of Section 6.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCOTT. Thank you, Mr. Chairman. This amendment would remove Section 6 which eliminates the collateral source rule. The collateral source rule guarantees that injured victims who are prudently invested in insurance receive the benefits of their thrift.

Section 6 would guarantee that the wrong-doer would benefit from the victim's thrift. Mr. Chairman, when you have collateral sources you have three parties at interest. For example, if you have Blue Cross Blue Shield paying the hospital bill, you have the injured party who has insurance who ought to be better off because of the insurance than someone without insurance and you have the wrong-doer.

Now, you can make an argument that the person who has insurance ought to benefit from their insurance. And if there happens to be a double payment, well, that's what they paid for in their insurance.

You can make a logical argument for that. You can also make a logical argument that if the plaintiff can't get the benefit of his health insurance coverage, then maybe Blue Cross Blue Shield ought to get their money back and then presumably premiums would be lower. You can make an argument for that.

It seems to me the worst argument you could make is that the person to benefit from the plaintiff's health insurance ought to be the wrong-doer who cause all the problems. That is what the underlying bill provides. The wrong-doer will benefit from the plaintiff's thrift and the fact that he has insurance, not the plaintiff, not the innocent victim and not the health insurance that can get their money back.

But of the three, the last person that we ought to be giving some benefits to is the wrong-doer. What this would do would be to restore the present law. If Blue Cross Blue Shield wants their money back, they can provide subrogation in the contract. That is health insurance law.

But in liability law, helping the wrong-doer is the last thing that we ought to be doing. That is what this amendment does. It puts the priorities back in favor of the one that paid for the insurance or Blue Cross Blue Shield getting their money back, but not the wrong-doer that caused all the problems.

I yield back.

Chairman SENSENBRENNER. The chair recognizes himself for 5 minutes in opposition to the amendment. This amendment weakens the collateral source provisions in the bill that prevent unfair double recoveries. Many plaintiffs receive compensation for medical bills or lost wages by health insurance, disability insurance or workers comp. Yet, the hospital physician or other health care provider being sued is not allowed to tell the jury about this other source of compensation.

Even after these collateral source payments have already been paid to the person bring the law suit, that person is allowed to try to collect a second time in their lawsuit. As a result, plaintiffs are often paid twice for the same damages. This phenomenon is sometimes referred to as double recovery.

However, allowing the plaintiff to collect twice for the same medical bills and other economic losses drives up the cost of health care for all. The Health Act allows the tryer of fact to determine whether to offset damage awards based upon evidence of collateral benefits.

The trier of facts should be informed of the collateral source as a factor to consider when determining the net amount of compensation necessary to make the claimant whole. The purpose of the pro-

vision that the amendment intends to strike is to eliminate double recovery or recovery substantially greater than the trier of fact determined to be appropriate under the circumstances.

I would urge a no vote on the amendment and yield back the balance of my time.

The gentleman from California.

Mr. BERMAN. Mr. Chairman, I apologize for speaking again, but I want to support the Chairman on this one issue involving this bill because I do think that the collateral, what the bill does here makes some sense and I disagree with the gentleman.

I thought a lot about our conversation on the Floor earlier about this issue. In the end, though, the gentleman from Virginia's arguments in favoring this focuses on the wrong-doer. We are not talking about punitive damages here. We are not talking about punishing a wrong-doer.

We are talking about a system to try and make the plaintiff whole. If the plaintiff has already recovered, his health care, his medical expenses as a result of the negligence of the defendant from his own insurance policy, the notion that he should recover again from the malpractice insurance, that creates a system where the plaintiff's recovery is being made more than whole by virtue of this.

By the same reasons that I don't like the caps on pain and suffering and some of the other provisions in this bill, I think the theory of making the plaintiff whole if the right theory. The gentleman's amendment doesn't provide for any subrogation mechanisms. When we decide which insurance company should get the money back and putting it in the context of the wrong-doer, economic damages aren't to penalize the wrong-doer. They are to make the plaintiff whole.

So, I oppose this amendment.

Mr. SCOTT. Would the gentleman yield?

Mr. BERMAN. Sure.

Mr. SCOTT. I would just say if you have two plaintiffs, one has insurance and the other one does not, under the underlying bill they will end up exactly the same. It seems to me that someone with insurance really ought to be better off. But if you are going to deny the plaintiff the right to recover and benefit from his health insurance, it seems to me that the most of the other two left, give the money back to the health insurance or give it to the defendant, it seems to me you ought to give it back to Blue Cross Blue Shield.

If life insurance worked this way and you killed somebody, you would say you don't get no benefit from your life insurance. I would like to make one other comment. I don't know what the law is in Wisconsin, but in Virginia workers comp has subrogation.

You can never get—there is no collateral source issue on workers comp, but in Virginia, certainly, workers comp has subrogation and I thought it was the same everywhere, so in that case there would be no issue of collateral sources.

Mr. BERMAN. If I may reclaim my time, the gentleman's point on workers comp, I think, makes my point. If his amendment were to provide a method of subrogation so that to say that we have decided as a matter of public policy the plaintiff shouldn't recover twice for the medical expenses that he has incurred, but that we

favor the primary health care carrier over the malpractice carrier as a matter of public policy, that would be one thing.

But the effect of his amendment is to maintain the notion that the plaintiff should recover twice.

Mr. SCOTT. Would the gentleman yield?

Mr. BERMAN. I just think that applies a punitive damages standard to an economic damages problem.

Mr. SCOTT. Would the gentleman yield?

Mr. BERMAN. Sure.

Mr. SCOTT. The question of whether Blue Cross Blue Shield gets its money back really is a matter of contract between the plaintiff and Blue Cross Blue Shield. Many provisions under health insurance policies provide subrogation. If you collect, you give your money back.

Mr. BERMAN. You just said that in Virginia, as in California, the workers comp law specifically provides for subrogation for comp carriers against third party carriers by statute.

Mr. SCOTT. And, if the gentleman would yield, your health policy, if they wanted to provide for that provision, you can put that in the contract. But given the bit of requiring by law the benefit go to the wrong-doer, seems to me the last person in line for any benefit of the fact that the plaintiff paid for insurance.

Mr. BERMAN. If I buy earthquake insurance every single year and then sell my home and never had an earthquake, you know, I ought to get my premium back because there was no earthquake. You pay different kinds of premiums to deal with certain contingencies.

Well, I don't think we are going to change each other's mind on this issue.

Chairman SENSENBRENNER. The gentleman's time has just about expired.

The question is on the Scott amendment. Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it. The amendment is not agreed to.

Are there further amendments? The gentleman from Virginia.

Mr. SCOTT. I have an amendment at the desk, number five.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R.4600 offered by Mr. Scott: On Page 8, strike all of Section 7.

[The amendment follows:]

AMENDMENT TO H.R. 4600
OFFERED BY MR. SCOTT
#5

On page 8, strike all of Section 7.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCOTT. Mr. Chairman, the bill limits punitive damages to two times the amount of economic damages or $250,000, whichever is greater. That is without any regard to the cost savings somebody may have had by their outrageous activity that killed or injured somewhat.

It seems to me, Mr. Chairman, if you are going to have punitive damages deterring conduct that the only way to effectively do it is not to limit damages. This also has the FDA immunization that provides for the fact that if you have FDA approval that you can't be hit for punitive damages.

Government safety standards at their best establish only a minimum level of protection for the public. They may be outdated. They may be under-protective. They may be under-enforced. They also give an incentive to companies not to do ongoing research because once they are approved they have their immunity and all the research can do—they are much better off, rather than doing research for safety, they are much better off just sticking their head in the sand and making money.

Mr. Chairman, we have seen cases where companies calculate the amount of profits from a defective product and conclude that the cost of fixing it is more than they want to spend and they will just pay the damages. The fact that you limit $250,000 in punitive damages means that many companies will not be deterred from conduct that will kill or injure certain people.

I would hope that we would not limit the punitive damages as they are in the bill and pass the amendment. I yield back.

Chairman SENSENBRENNER. The chair recognizes himself in opposition to the amendment.

What the bill does is it limits punitive damages to two times economic damages. It doesn't abolish punitive damages at all, but puts reasonable limits on it. The Supreme Court has observed that punitive damages have run wild, jeopardizing fundamental constitutional rights.

This is an attempt to respond to the concern that the Supreme Court has expressed on this where we can put some legislatively imposed reasonableness in punitive damages rather than having the courts do it.

I think it is important to preserve legislative prerogatives in this. There is no evidence that the behavior of profit-making enterprises is less safe than the States that have set limits on punitive damages, Louisiana, Nebraska, Washington, New Hampshire, Massachusetts and Michigan, against those that don't limit punitive damages anymore.

I think that we have done the responsible thing here. There have been academic groups that have recommended limiting punitive damages and also people who have expressed opposition to excessive punitive damages awards, which include the American Bar Association, the American College of Trial Lawyers, and the American Law Institute.

I would urge the Members to vote down this is amendment and to keep the responsible limits that are contained in the bill.

I yield back the balance of my time.

The question is on the Scott amendment. Those in favor will say aye.

Opposed, no.

The noes appear to have it. The amendment is not agreed to.

Are there further amendments?

Mr. SCOTT. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from Virginia is not out yet.

Mr. SCOTT. This is the last one, Mr. Chairman.

Chairman SENSENBRENNER. The clerk will report the last one.

[The amendment follows:]

AMENDMENT TO H.R. 4600
OFFERED BY MR. WATT

On page 23, lines 17 and 18 strike "Federal or State court, or subject to an alternative dispute resolution system"and insert "Federal court".

Mr. SCOTT. It is the one offered by Mr. Watt.

The CLERK. Amendment to H.R.4600 offered by Mr. Scott. On Page 23, lines 17 and 18, strike "federal or State court or subject to an alternative."

Chairman SENSENBRENNER. Without objection, the amendment is considered as read and the gentleman is recognized for 5 minutes.

Mr. SCOTT. Thank you, Mr. Chairman. Mr. Chairman, this is fairly self explanatory. This was just limit all of what we are doing to cases brought in Federal court and would not afflict well-established State law. I yield back the balance of my time.

Chairman SENSENBRENNER. The chair recognizes itself. This guts the entire bill because it doesn't apply to any action brought in the State court. We need to do something about this national problem. We have to have a national law.

I yield back the balance of my time.

The question is on the last Scott amendment. Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it. The amendment is not agreed to.

Are there further amendments? The gentlewoman from Texas.

Ms. JACKSON LEE. I have an amendment at the desk, amendment number 7.

Chairman SENSENBRENNER. The clerk will report amendment number 7.

The CLERK. Amendment to H.R.4600 offered by Ms. Jackson Lee. Page 5, line 13, after the period insert "This limitation does not apply with respect to recovery by a person who has not attained the age of 12 years at the time the claim arose."

[The amendment follows:]

AMENDMENT TO H.R. 4600
OFFERED BY MS. JACKSON LEE

Page 5, line 13, after the period insert ''This limitation does not apply with respect to recovery by a person who has not attained the age of 12 years at the time the claim arose.''

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. JACKSON LEE. Thank you very much, Mr. Chairman. I came to this markup with great expectation, first of all with the Fairness in Sentencing legislation which I thought, before having had the chance to be briefed, that it dealt with eliminating the inequities between crack and cocaine sentencing.

I found to my dismay that that was not the case. Having spent some time this recess with medical doctors, members of the National Medical Association, Mr. Chairman, and listening to the crisis, particularly in the minority community, of doctors' offices being closed one by one; but more importantly of doctors' offices being turned down by insurers precipitously with no concern for the patients that they serve, charging horrific fees for their insurance premiums, some of them saying "no room at the inn."

I was again delighted that we had legislation that was entitled, "The Help Efficient, Accessible, Low Cost, Timely Health Care Act of 2002." I find to my dismay again that this is a misrepresentation. Frankly, the legislative thought behind this bill, the name is good; the actions are poor.

This legislation will not help my physician friends at all. It is expansive. It deals with medical devices. It does not stop the gaping hole. It does not stop the bleeding of seeing minority doctors close in every part of America, along with their fellow counterparts of the American Medical Association.

The reason is because this is the same kind of crisis we saw in the insurance industry in the 1980's, in the 1970's. Really, their problem is on the basement, on the—excuse me, on the basis—it is in the basement—on the basis of the investment practices of insurance companies and a self-created crisis. That is to make every buck they possibly can without being responsive to those who are serving those in need.

I offer this amendment dealing with the age group because it is the most vulnerable population, one of the most vulnerable populations of children. When you begin to limit the non-economic damages, you are talking about ignoring the punitive nature of an ac-

tion that may involve an injury to a child of the perpetrator of that particular act.

For example, if you have a circumstance of a injury that we cannot determine the long-range on a child because they are a child, the injury may be hard to discover long-range. So, limiting the non-economic damages therefore limits the child's ability to recover.

But more importantly, it does not emphasize the greater impact that you have on the child than you might have on someone else who might be able to recoup and find alternative work. That is in response to the changed health condition that they may have.

Frankly, I think as well that H.R.4600, as consumer groups have said, really does not answer the actuarial analysis of medical malpractice insurance suggesting that tort questions or tort cases is not really the basis on which these costs have gone up. So, in fact this legislation is hurting the most vulnerable population and it does not correct the problem.

Our doctors need insurers who are willing, if you will, to risk on good health care and to provide these doctors with premiums they can afford. The tort cases, we will find in totality, do not have the impact that cause these insurance companies to raise their premiums.

I wish we would not have these false representatives behind good legislative thought because I think this legislation could be good because there are important issues that we must address. But certainly to limit punitive damages or non-economic damages is not the way to go and particularly for the most vulnerable and that is children ages 12 and under. I yield back my time.

I ask my colleagues to support this amendment.

Chairman SENSENBRENNER. The chair recognizes himself for 5 minutes in opposition to the amendment.

The policy behind the cap on inherently unquantifiable non-economic damages benefits patients of all ages. Such caps increase access to health care equally for children as well as for adults. In fact, it is the OB-GYNs, those who bring children into the world and providers of emergency medicine who are among those suffering the most without reasonable caps on unquantifiable non-economic damages because the mere threat of potentially limitless liability sends their malpractice insurance rates skyrocketing and consequently drives them out of business.

Children more so than adults tend to get themselves injured. Therefore children have a very pressing need to specialists in Emergency Medicine. Without a reasonable cap on non-economic damages, there will be no one there to provide that emergency medicine and the children will suffer immensely.

I urge a no vote on this amendment and yield back the balance of my time.

The question is on the Jackson Lee amendment. Those in favor will say aye.

Opposed, no.

The noes appear to have it.

Ms. JACKSON LEE. I would like a rollcall.

Chairman SENSENBRENNER. The rollcall is demanded. The question is on the amendment offered by the gentlewoman from Texas, Ms. Jackson Lee. Those in favor will say aye. Those opposed will say no. The clerk will call the role.

The CLERK. The clerk will call the role.
The CLERK. Mr. Hyde?
[No response.]
The CLERK. Mr. Gekas?
Mr. GEKAS. No.
The CLERK. Mr. Gekas, no. Mr. Coble.
Mr. COBLE. No.
The CLERK. Mr. Coble, no. Mr. Smith?
Mr. SMITH. No.
The CLERK. Mr. Smith, no. Mr. Gallegly.
Mr. GALLEGLY. No.
The CLERK. Mr. Gallegly, no. Mr. Goodlatte?
[No response.]
The CLERK. Mr. Chabot?
[No response.]
The CLERK. Mr. Barr?
[No response.]
The CLERK. Mr. Jenkins?
Mr. JENKINS. No.
The CLERK. Mr. Jenkins, no. Mr. Cannon?
Mr. CANNON. No.
The CLERK. Mr. Cannon, no. Mr. Graham?
[No response.]
The CLERK. Mr. Bachus?
Mr. BACHUS. No.
The CLERK. Mr. Bachus, no. Mr. Hostettler?
Mr. HOSTETTLER. No.
The CLERK. Mr. Hostettler, no. Mr. Green?
Mr. GREEN. No.
The CLERK. Mr. Green, no. Mr. Keller?
Mr. KELLER. No.
The CLERK. Mr. Keller, no. Mr. Issa?
[No response.]
The CLERK. Ms. Hart?
Ms. HART. No.
The CLERK. Ms. Hart, no. Mr. Flake?
Mr. FLAKE. No.
The CLERK. Mr. Flake, no. Mr. Pence?
[No response.]
The CLERK. Mr. Forbes?
[No response.]
The CLERK. Mr. Conyers?
[No response.]
The CLERK. Mr. Frank?
[No response.]
The CLERK. Mr. Berman?
Mr. BERMAN. Aye.
The CLERK. Mr. Berman, aye. Mr. Boucher?
[No response.]
The CLERK. Mr. Nadler?
Mr. NADLER. Aye.
The CLERK. Mr. Nadler, aye. Mr. Scott?
Mr. SCOTT. Aye.
The CLERK. Mr. Scott, aye. Mr. Watt?
[No response.]

The CLERK. Ms. Lofgren?
[No response.]
The CLERK. Ms. Jackson Lee?
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee, aye. Ms. Waters?
[No response.]
The CLERK. Mr. Meehan?
[No response.]
The CLERK. Mr. Delahunt?
[No response.]
The CLERK. Mr. Wexler?
[No response.]
The CLERK. Ms. Baldwin?
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin, aye. Mr. Weiner?
Mr. WEINER. Aye.
The CLERK. Mr. Weiner, aye. Mr. Schiff?
[No response.]
The CLERK. Mr. Chairman?
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.
Chairman SENSENBRENNER. Are there Members who wish to cast or change their vote?
The gentleman from Georgia, Mr. Barr.
Mr. BARR.
The CLERK. Mr. Barr, no.
Chairman SENSENBRENNER. The gentleman from Ohio, Mr. Chabot.
Mr. CHABOT. No.
The CLERK. Mr. Chabot, no.
Chairman SENSENBRENNER. Are there further Members who wish to cast or change their vote? If not, the clerk will report.
The gentleman from Indiana, Mr. Pence?
Mr. PENCE. No.
The CLERK. Mr. Pence, no. Mr. Chairman, there are six ayes and sixteen noes.
Chairman SENSENBRENNER. And the amendment is not agreed to. Are there further amendments? The gentlewoman from Texas.
Ms. JACKSON LEE. Mr. Chairman, amendment number 10. It may be listed as amendment number 2, but amendment number 10.
Chairman SENSENBRENNER. The clerk will report the amendment.
The CLERK. Amendment to H.R.4600, offered by Ms. Jackson Lee. Add at the end the following new section: Section 13, Applicability to Individuals 65 and over. Notwithstanding any other provision of this act, this act shall not reduce.
Chairman SENSENBRENNER. Without objection, the amendment is considered as read.
[The amendment follows:]

AMENDMENT TO H.R. 4600
OFFERED BY MS. JACKSON LEE

Add at the end the following new section:

SEC. 13. APPLICABILITY TO INDIVIDUALS 65 AND OVER.

Notwithstanding any other provision of this Act, this Act shall not reduce the noneconomic damages recoverable on a claim for harm caused to an individual if the claim arises after the date on which that individual became 65 years of age.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. JACKSON LEE. Thank you very much, Mr. Chairman. This amendment exempts senior citizens, defined for the purposes of this bill as those over the age of 65, from the reductions in noneconomic damages.

Now, the arguments track the concerns we have regarding children, but are even more enhanced because of the vulnerability of seniors, the devastating impact of the particular injury and the fact that seniors would be left particularly vulnerable in the later years of their life.

The question is: What is the basis of capping those punitive damages in light of the devastating impact that could be faced?

Let me share with my colleagues something that I think is very important and why I think this argument regarding this particular legislation or the argument opposing the legislation strikes at the core of those of us who continuously fight so that doctors can do their business and as well so that we can have the right kind of patient-physician relationship.

I wish we had passed a real patient bill of rights because we might have had the doctors in the position that they want to be. But Robert Hunter, Director of Insurance for the Consumer Federation of America, conducted an actuarial analysis of medical malpractice insurance using the most recent insurance data available from the National Association of Insurance Commissioners and A.M. Best and Company.

His data shows that the cost of medical malpractice at the national health care expenditure level is quite low. Medical malpractice is a fraction of the cost of health care in the United States. For every $100 of national health care costs, medical malpractice

costs 66 cents. In the year 2000, the cost was 56 cents, the second lowest rate of the decade.

But for the life of me, I can't understand why doctors are being told by insurers, "We cannot provide you with insurance without charging you exorbitant crisis-type premiums," $200,000, $150,000, $300,000, literally putting doctors out of business.

All this legislation attempts to do, rather than being able to do this in a bipartisan way, and I note that there are those who are supporting this, it pits one group against another when the real culprit are insurance companies who are only trying to make major profit over vulnerable doctors who simply can do nothing else but follow the Hippocratic Oath, which is to save the people other than close their doors.

We are doing a disservice to them and their patients by passing this kind of legislation. I would hope that we would give some hope, some help to senior citizens, minimally speaking, on this issue.

You know, we really need to get in a room and talk face-to-face about reality. Insurance companies are pitting us and we are both losing because when you have people who cannot recover in the right manner with these non-economic damages, this is a backdoor tort reform. It is not bringing down health care costs and it is not helping my friends who are physicians, though you may think it is.

I ask my colleagues to support this amendment and I yield back my time.

Chairman SENSENBRENNER. The chair recognizes himself for 5 minutes in opposition to the amendment.

Many of the same arguments I made in opposition to the previous amendment by the gentlewoman from Texas prevail here, except we strike out OB-GYNs and put oncologists or geriatric psychiatrists or other types of specialties that treat primarily older people rather than those who treat younger people and children.

Now, how this amendment will actually reduce the cost of health care to senior citizens is beyond me because by saying that senior citizens can recover more money and thus the doctors who treat senior citizens are going to have to pay more in malpractice insurance premiums, you know, simply does not add up.

Fuzzy math was used in the last Presidential campaign. I would hope that we would have a uniform law that applied to everybody. This amendment actually pits doctors against each other and I think will force doctors into not treating senior citizens because the malpractice insurance costs will be much lower if they cut out their treatment of people who are over the age of 65.

I yield back the balance of my time.

The question is on the Jackson Lee amendment. Those in favor will say aye.

Opposed, no.

The noes appear to have it. The noes have it and the amendment is not agreed to.

Are there further amendments? If not, the question occurs on the motion to report the bill, H.R.4600 favorably as amended. The chair notes the presence of a reporting quorum. All in favor will signify by saying aye.

Opposed, no.

The aye appear to have it. The ayes have it and the motion to report favorably is adopted. Without objection the bill will be reported favorably to the House in the form of a single amendment in the nature of a substitute, incorporating the one amendment adopted here today.

Without objection, the Chairman is authorized to move to go to conference pursuant to House rules. Without objection, the staff is directed to make any technical and conforming changes and all Members will be given 2 days, as provided by the rules, in which to submit additional supplemental or minority views.

DISSENTING VIEWS

INTRODUCTION

The undersigned reject the legislation on medical malpractice adopted by the Committee. Not only has the majority gone beyond their purported goal of reducing medical malpractice premiums, they have done so in a manner that jeopardizes and penalizes the health and safety of consumers, particularly women, children, seniors, and the underprivileged.

We oppose this legislation for several reasons. First, medical malpractice is a serious problem in this country—causing an estimated one hundred thousand preventable deaths per year—and the legislation's severe restrictions will no doubt exacerbate this problem. There is also scant evidence that restricting victims' access to damages will have any appreciable impact on medical malpractice premiums, defensive medicine, or physicians' departure from the field. By unilaterally preempting State laws, this bill also raises serious constitutional issues, including Commerce Clause, due process and right to trial-by-jury issues.

We further oppose the legislation because the scope goes well beyond medical malpractice and goes so far as to limit the liability of HMOs for failure to provide coverage and to insulate drug and medical product manufactures from liability. Beyond this we have a number of specific concerns regarding the legislation's impact on victims, including draconian caps on non-economic and punitive damages that discriminate against women, seniors and children; a shortened statute of limitations; elimination of joint and several liability and the collateral source rule; the provision of periodic damages that will shift risk from wrongdoers to victims; and restrictions on contingency fees that will make it more difficult for the poorest members of society to obtain access to justice.

The following is a brief description of the bill and a more detailed itemization of our concerns.

Description of Legislation

H.R. 4600 limits the amount of non-economic damages—damages for pain and suffering—to $250,000.

In addition, H.R. 4600 eliminates joint and several liability, a longstanding common law doctrine that ensures that victims will be made whole. Similarly, the bill eliminates the collateral source doctrine, the effect of which is to shift the costs of malpractice from negligent defendants to innocent victims.

The bill dramatically limits a victim's ability to recover punitive damages in two distinct ways. First, the bill imposes a heightened standard for the recovery of punitive damages, requiring clear and convincing evidence that the defendant acted with malicious intent to injure the plaintiff, or the defendant understood the plaintiff was

substantially certain to suffer unnecessary injury yet deliberately failed to avoid such injury. It also limits punitive damages to two times the amount of economic damages or $250,000, whichever is greater. The second category of punitive damages affected by the bill is with respect to manufacturers and distributors of drugs and medical devices. Specifically, the bill bans punitive damage liability for manufacturers of drugs and devices that are approved by the FDA. It also extends this immunity to the manufacturers of drugs and devices that are not FDA-approved but are "generally recognized as safe and effective," and to manufacturers or sellers of drugs from punitive damages for packaging or labeling defects. These restrictions are simply discriminatory and unjust.

H.R. 4600 also restricts the payment of a claimant's damage recovery to his or her attorney, and sets unprecedented limits on the amount an attorney may receive in contingency fee payments. Specifically, the total amount of all contingent fees for representing all claimants in a health care lawsuit may not exceed: (1) 40% of the first $50,000 recovered by the claimant(s); (2) 33 1/3% of the next $50,000 recovered by the claimant(s); (3) 25% of the next $500,000 recovered by the claimant(s); and (4) 15% of any amount by which the recovery by the claimant(s) is in excess of $600,000.

H.R. 4600 also provides an extremely restrictive statute of limitations for medical malpractice actions. It states that a "health care lawsuit may be commenced no later than 3 years after the date of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, *whichever occurs first*." (Emphasis added). This means that no lawsuit may be commenced after 3 years from the date of injury, regardless of the victim's knowledge of the injury.[1]

The bill also provides for periodic payment rather than a lump sum payments to victims. And finally, H.R. 4600 is not limited to medical malpractice actions but covers lawsuits for failure to cover against HMOs and other insurers as well.

I. Background

Medical malpractice is a tort-based legal claim for damages arising out of an injury caused by a health care provider. Tort claims are part of the "common law," or judge-made law, of the United States' civil justice system. Typically, tort claims have been reserved to the States.[2]

The tort system provides a number of benefits to society. First, it compensates victims who have been injured by the negligent conduct of others. Second, it deters future misconduct and carelessness that may cause injury and punishes wrongdoers who inflict injury. Third, it prevents future injury by removing dangerous products and practices from the marketplace. Fourth, it informs an otherwise unknowing public of such harmful products or practices, thereby expanding public health and safety.[3]

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[1] The only exception is for minors who have sustained injury before the age of 6. These victims may bring a lawsuit until the later of 3 years from the date of injury, or the date on which the minor attains the age 8.

[2] "Tort law at present is almost exclusively State law rather than Federal law. . . ." *Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes* (CRS Report 95–797 A), at 1.

[3] Joan Claybrook, *Consumers and Tort Law*, 34 Fed. B. News & J. 127 (1987).

Most medical malpractice claims are based on the tort of "negligence," defined as conduct "which falls below the standard established by law for the protection of others against unreasonable risk of harm."[4] In medical malpractice cases, this legal standard is based on the practices of the medical profession,[5] and is usually determined based on the testimony of expert witnesses.

As with other torts, remedies for medical malpractice may consist of compensatory damage awards for economic losses such as medical expenses or lost wages; non-economic losses such as pain and suffering, reduced life expectancy and diminished quality of life; and punitive damages to punish and deter willful and wanton conduct.

II. General Concerns

A review of the empirical evidence gathered over the last decade supports a number of conclusions: first, medical malpractice is a serious problem in the United States; second, H.R. 4600 does not respond to the problem of rampant medical malpractice and ignores the true reason for the "crisis" it purports to solve—the insurance industry's cycles and practices; and third, tort reforms have not reduced premiums for medical malpractice to any significant extent.

A. Medical malpractice is a serious problem.

Medical malpractice in the United States is a very real problem with devastating consequences. According to a study conducted in 1999 by the National Academy of Sciences Institute of Medicine ("IOM"), between 44,000 and 98,000 deaths occur each year in U.S. hospitals due to medical errors.[6] This does not even include malpractice committed at outpatient centers, physician offices and clinics. These numbers are greater than the number of people who die due to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).[7]

Study after study has shown that the prevalence of medical malpractice extolls an enormous burden on its victims. A 1990 Harvard Medical Practice study found that medical negligence in New York hospitals results in 27,000 injuries and 7,000 deaths each year. The study found that eight times as many patients are injured by malpractice as ever file a claim; 16 times as many suffer injuries as receive any compensation.[8] At a 1992 meeting of the American Association for the Advancement of Science, it was reported that more than 1.3 million hospitalized Americans, or nearly 1 in 25, are injured annually by medical treatment; about 100,000 such patients, or 1 in 400, die each year as a direct result of such injuries.[9] In contrast to the low number of lawsuits that are filed on behalf of

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[4] Restatement (Second) of Torts § 282 (1965).

[5] David M. Harney, MEDICAL MALPRACTICE § 21.2, at 413 (2d ed 1987).

[6] Kohn, Corrigan, Donaldson, Eds., *To Err is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999). Using the lower estimate, medical malpractice in hospitals is the 8th leading cause of death in this country; using the higher estimate, it is the 5th leading cause of death. *Id.*

[7] *Id.*

[8] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990).

[9] Christine Russell, *Human Error: Avoidable Mistakes Kill 100,000 Patients a Year*, Wash. Post Health Mag., Feb. 18, 1992; *see also* Harvey Wachsman, LETHAL MEDICINE, The Epidemic of Medical Malpractice in America (1993).

malpractice's victims, the total national cost of malpractice is quite high. The 1999 IOM study found that total national cost of medical malpractice (lost income, lost household production, disability and health care costs) is between $17 billion and $29 billion each year.[10]

B. H.R. 4600 does not respond to the problem of rampant medical malpractice and ignores the true cause of the "crisis"—the cyclical nature of the insurance industry and the investment practices of insurance companies.

Supporters of H.R. 4600 claim that insurance companies have become insolvent or have left certain markets because of excessive litigation and unrestrained jury awards. This so-called "crisis," however, mirrors the last insurance "crisis" that hit the United States in the mid-1980's and an earlier one in the mid-1970's. Similar to its predecessors, today's insurance "crisis" has less to do with the legal system, tort laws, lawyers or juries and more with the insurance underwriting cycle and insurance companies' own investment practices.

Insurance industry experts have articulated the cyclical nature of the industry, showing a boom and bust cycle of so-called "crises," beginning in the 1970's. During this first cycle, medical malpractice insurance premiums increased by large margins and certain specialties were denied coverage.[11] As a result, all States but one initiated reforms designed to provide alternative sources of insurance and to reduce the number and costs of claims. Physician and hospital-owned insurance companies emerged as an alternative to traditional policy providers,[12] and, for at least a decade, insurance was accessible and affordable in a market dominated by these companies.

The mid-1980's saw another such "crisis." Prior to that, the insurance industry maintained affordable premiums and only minimal increases because of investments at high interest rates that produced significant yields. When interest rates dropped in 1984, driving down insurers' investment income, however, insurance providers responded with considerable increases in medical malpractice insurance premiums.[13] The mid-1980's saw insurance rate increases of 300% or more for manufacturers, municipalities, doctors, nurse-midwives, day-care centers, non-profit groups and many other commercial customers of liability insurance.[14]

As Joanne Doroshow testified at the hearing before the Subcommittee on Commercial and Administrative Law, what precipitates these crises is always the same. "Insurers make their money from investment income. During years of high interest rates and/or insurer profits, insurance companies engage in fierce competition for premiums dollars to invest for maximum return. More specifically, insurers engage in severe underpricing to insure very poor

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[10] *See* Kohn *et al., supra* note 6.

[11] U.S. Congress, Office of Technology Assessment, Pub. No. OTA–BP–H–119, Impact of Legal Reforms on Medical Malpractice Costs 13 (1993) [hereinafter OTA Report on Legal Reforms].

[12] Medical insurance providers consist of both stock and mutual insurance companies. The physician and hospital owned companies are among the mutual insurance companies created to provide the lowest possible premiums.

[13] *See* OTA Report on Legal Reforms at 15.

[14] Statement of Joanne Doroshow, before the House Subcommittee on Commercial and Administrative Law, June 1, 2002 [hereinafter Doroshow statement].

risks just to get premium dollars to invest. But when investment income decreases because interest rates drop, the stock market plummets and/or cumulative price cuts make profits become unbearably low, the industry responds by sharply increasing premiums and reducing coverage, creating a 'liability insurance crisis.'" [15]

One insurance expert recently described today's situation:

> What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990's. Throughout the 1990's and reaching a peak around 1997 and 1998, *insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses*. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income. Driven in large part by lobbyist for the insurance industry and doctors' groups, H.R. 4600 is the latest attempt to "fix" the system. Unfortunately, H.R. 4600 does not address the real problems, which include the quantity of malpractice being committed by the medical profession and the inability of many victims to obtain reasonable compensation.
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> In a perfect world, investment income would cover any deficiencies that might exist in underwriting results and the insurers' aggressive marketing and pricing strategy would prove to be successful. Alas, we do not live in a perfect insurance world and, as competition intensified, underwriting results deteriorated. Regardless of the level of risk management intervention, proactive claims management, or tort reform, the fact remains that if insurance policies are consistently underpriced, the insurer will lose money.[16]

Thus, there are many factors, completely unrelated to jury verdicts and the civil justice system, that affect insurance rates, including the following: changes in State law and regulatory requirements; competitiveness within the insurance market; the types of policies issued within the industry; interest rates; State socio-economic factors, such as urbanization; national economic trends; and huge portfolio losses due to the falling stock market.[17] According to the National Association of Insurance Commissioners, these factors fall into three categories: (a) changes in interest rates, (b)

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[15] *Id.* at 7. Another factor that may adversely affect insurance rates is the fact that since 1945 insurance companies have been exempt from the antitrust laws. *See* 15 U.S.C. §§ 1011–1015 (1945) (McCarran-Ferguson Act). Under the McCarran-Ferguson Act, courts have held that State regulation need not be meaningful or active in a particular instance to trigger the antitrust exemption. The result over the years has been uneven oversight of the insurance industry by the States, coupled with no possibility of Federal antitrust enforcement, creating an environment that has fostered a wide range of anticompetitive practices.

[16] Charles Klodkin, Gallagher Healthcare Insurance Services, *Medical Malpractice Insurance Trends? Chaos!*, Sept. 2001 (emphasis added).

[17] Numerous GAO studies and testimony over the past two decades have repeatedly demonstrated that the nexus between litigation, insurance rates, and health care costs is neither linear nor coextensive. *See, e.g.,* "Medical Malpractice: A Continuing Problem With Far-Reaching Implications," Statement of Charles A. Bowsher, Comptroller General of the United States Before the Subcommittee on Health House Committee on Ways and Means (GAO/T–HRD–90–24), Apr. 26, 1990.

underpricing in soft markets, and (c) adverse loss shocks that lead to supra-competitive cycles.[18]

The current crisis has also been affected by two additional factors. First, September 11 accelerated the price increases that had already started to set in by providing the adverse shock loss component of the equation.[19] Second, St. Paul Insurance Company withdrew from the medical malpractice market, creating major supply and demand problems. Although St. Paul cited liability risks as the reason for its withdrawal, it is also noteworthy that St. Paul lost a significant amount of investment money in the Enron scandal.[20] In addition, St. Paul engaged in a premium price war in the 1990's, using the go-go stock market to cover the spread. Invested reserves grew so large that some of the funds were released to the bottom line as profit. When the stock market crashed, however, St. Paul was left with the option of exiting the market or increasing premiums.[21]

Astonishingly, given this history, H.R. 4600 addresses none of these problems. It does nothing about insurance companies' bad investment practices or the insurance companies' boom and busy cycles. Rather, as in every other cyclical insurance industry "crisis," the target and focus have been the legal system and restrictions on victims' rights to recover, respectively.

C. Empirical evidence shows tort reforms have not had a significant impact in reducing insurance premiums.

Supporters of H.R. 4600 argue that jury awards have skyrocketed, which in turn has caused malpractice premiums to increase, doctors to practice defensive medicine, and doctors to leave their practices in certain States with high premiums. They argue that restrictions on victims' abilities to pursue and collect on claims for malpractice will reduce these problems. A review of the empirical data indicates that the proponents' arguments are not correct and legal restrictions such as H.R. 4600 will not increase consumer welfare.

First, the empirical data shows that jury awards, particularly punitive damages, are not increasing at a rate far beyond the rate of inflation. According to the actuarial analysis of medical malpractice insurance conducted by J. Robert Hunter, Director of Insurance for the Consumer Federation of America,[22] the average malpractice payout has not changed much over the decade, hovering at approximately $30,000, not even taking into account inflation.[23] For the

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[18] CYCLES AND CRISES IN PROPERTY/CASUALTY INSURANCE: CAUSES AND IMPLICATIONS, edited by Cummings, Harrington and Klein, NAIC, 1991 at 339; *see also Risk Managers Blame Insurers for Renewal Woes*, National Underwriter, Jan. 14, 2002.

[19] Well before September 11, the Federal Reserve had cut interest rates several times, providing the first element, and insurers had been underpricing in the soft market, providing the second element. *See also Year in Review*, Business Insurance, Dec. 24, 2001 ("To be sure, the market began firming in 2000. But the Sept. 11 terrorist attacks sent insurance prices skyrocketing far beyond the estimates of increases that earlier were being attributed to a normal hard cycle.").

[20] Statement of Joanne Doroshow at 11–12.

[21] Todd Sloane, *Back on the tort reform merry-go-round*, 32 Modern Healthcare 28, July 15, 2002.

[22] *See* Letter from J. Robert Hunter to Joanne Doroshow, Oct. 13, 2001 and attached spreadsheet [hereinafter Hunter analysis]. To conduct this analysis, Mr. Hunter used the most recent insurance data available from the National Association of Insurance Commissioners and A.M. Best and Company. *Id.*

[23] *Id.*

decade ending in December 2000, each closed claim for medical malpractice, including million dollar verdicts, averaged only $27,824.[24]

Supporters of H.R. 4600 cite anecdotal evidence that jury awards are increasing. One such study, conducted by Jury Verdict Research and released in March 2002, showed that jury awards in medical malpractice cases jumped 43% from 1999 to 2000. Studies such as this, however, are too narrowly focused to provide the complete picture. The JVR study cites data that is skewed toward the high-end and doesn't include defense verdicts (verdicts in which no money was awarded), verdicts in non-jury trials, verdict reductions by remittitur, or verdicts overturned on appeal. The JVR and similar studies are not adjusted for inflation and have no relation to what insurance companies actually pay out to claimants (an average of $30,000 per claim).[25]

As for punitive damages—damages that are designed to deter willful and wanton misconduct—the evidence shows that they are infrequent. According to the Bureau of Justice Statistics, in 1996 only 1.1 percent of medical malpractice plaintiffs who prevailed at trial were awarded punitive damages and only 1.2 percent of those awards were awarded by juries.[26]

Second, medical malpractice premiums have not increased beyond the rate of inflation. The evidence compiled by Mr. Hunter shows that inflation-adjusted medical malpractice premiums have actually declined in the last decade. Average premiums per doctor barely climbed from $7,701 in 1991 to $7,843 in 2000, an increase of 1.9 percent. Adjusted for inflation, these figures show that premiums have actually decreased by 32.5 percent.[27] Equally importantly, the statistics show that medical malpractice legal costs constitute a small fraction of the of the cost of health care in the United States. Mr. Hunter's analysis supports the conclusion that the cost of medical malpractice at the national health care expenditure level is quite low: for every $100 of national heath care costs, medical malpractice insurance costs 66 cents. In the year 2000, the cost was 56 cents, the second lowest rate of the decade.[28]

Third, proponents' claims that doctors, fearing litigation, engage in the practice of defensive medicine simply do not bear out. In fact, the evidence shows that less than 8 percent of all diagnostic procedures are performed because of liability fears; most doctors who use aggressive diagnostic procedures do so because they be-

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[24] *Id.*

[25] Press Release, *Flawed Jury Data Masks Trends*, Center for Justice and Democracy, Mar. 23, 2002; *see also* Todd Sloane, *Back on the tort reform merry-go-round*, 32 Modern Healthcare 28, July 15, 2002 (JVR admitted that its 2,951-case malpractice database has large gaps in it—it collects award information sporadically and unsystematically, does not know how many it misses, cannot calculate the percentage change in the median for childbirth negligence cases, and excludes trial victories by doctors and hospitals that are worth zero dollars); Rachel Zimmerman and Christopher Oster, *Assigning Liability: Insurers' Missteps Helped Provoke Malpractice "Crisis"—Lawsuits Alone Didn't Cause Premiums to Skyrocket; Earlier Price War a Factor—Delivering Ms. Kline's Baby*, The Wall Street Journal, A1, June 24, 2002 (discussing JVR's incomplete study).

[26] *Tort Trials and Verdicts in Large Counties, 1996*, U.S. Department of Justice, Bureau of Justice Statistics, NCJ 179769 (August 2000), p. 7.

[27] Hunter analysis, *supra.*

[28] *Id.*

lieve the tests are medically indicated.[29] A study conducted by the non-partisan Office of Technology Assessment (OTA) found that "in the majority of clinical scenarios used in OTA's and other surveys, respondents did not report substantial levels of defensive medicine, even though the scenarios were specifically designed to elicit a defensive response."[30] The OTA further found that "[c]onventional tort reforms that tinker with the existing process for resolving malpractice claims while retaining the personal liability of the physician are [unlikely to] alter physician behavior."[31] Thus, the effects of H.R. 4600's limitations on defensive medicine are likely to be small. If anything, we are more likely to see the result of too little services.

Fourth, studies show that, despite claims by doctors' groups and the insurance industry,[32] doctors are not leaving certain fields because they cannot afford the insurance premiums. Data from the American Medical Association actually shows that there are 4.4% more physicians in patient care per 100,000 population in States without damage caps.[33] There are 5.8% more ob/gyn physicians per 100,000 women in States without caps.[34] And in States without malpractice limitations, there are 233 physicians per 100,000 residents, while in States with malpractice limitations, there are 223 physicians per 100,000 residents.[35]

Studies done on particular States bear out this evidence. For example, Charleston Gazette reporters Lawrence Messina and Martha Leonard's series "The Price of Practice"[36] found that, contrary to claims by the West Virginia Medical Association that doctors had left the State because of its lack of tort reform, the number of doctors in West Virginia had actually increased. In fact, between 1990 and 2000 the number of doctors had increased by 14.3 percent, a rate twenty times greater than the population.

The same is true in Pennsylvania. A census conducted by the Pennsylvania Medical Professional Liability Catastrophe Loss Fund found that between 1990 and 2000, the number of doctors increased by 13.5 percent, while the population increased by only 3.4 percent.[37] Not only is Pennsylvania not losing doctors, it had more doctors in 2001 than it did in the preceding five to 10 years.[38] Furthermore, the *Philadelphia Inquirer* notes that in 2000, "Pennsylvania ranked ninth-highest nationally for physician concentration, a top-10 position it has held since 1992. There were 318 doctors for

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[29] U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice, OTA–H–602* (Washington, D.C.: U.S. Government Printing Office, July 1994) at 74.
[30] *Id.*
[31] *Id.* at 92.
[32] *See* Statement of the American Medical Association to the House Committee on Energy and Commerce, July 17, 2002, at 2–7; Statement of the National Medical Liability Reform Coalition, before the House Committee on Energy and Commerce, July 17, 2002, at 2.
[33] American Medical Association, *Physician Characteristics and Distribution in the US* (2001 ed).
[34] *Health Care State Rankings* (Morgan Quitno Press 2001).
[35] Senate Congressional Record, July 30, 2002, S7534.
[36] Martha Leonard, State has seen sharp increase in number of doctors, Sunday Gazette Mail, Feb. 25, 2001.
[37] Ann Wlazelek, *Doctors' ad campaign baseless; They're not fleeing Pa., but malpractice straits create "hostile" climate*, Morning Call, Mar. 24, 2002; Josh Goldstein, *Recent census of doctors shows no flight from Pa.*, Philadelphia Inquirer, Oct. 2, 2001.
[38] Goldstein, *supra.*

every 100,000 residents in 2000, according to the American Medical Association."[39]

Fifth, there is no evidence to support the claim that restrictions on malpractice litigation will bring about appreciable health care savings. To date there is scant quantitative evidence that previous attempts at the State level have accomplished this purported goal.[40] In a comparison of States that enacted severe tort restrictions during the mid-1980's and those that resisted enacting any tort reform, no correlation was found between tort reform and insurance rates.[41] Indeed, some of the resisting States experienced low increases in insurance rates or loss costs relative to the national trends, while some States that enacted tort reforms experienced high rate or loss cost increases relative to the national trends. For example, data provided by Medical Liability Monitor in 2001 showed that in the practice of internal medicine, States with caps on damages had higher premiums than States without caps. For general surgeons, insurance premiums were 2.3% higher in States with caps on damages. And for ob/gyn's, premiums were only 3.3% lower in States with caps on damages.[42] On average, malpractice premiums were no higher in the 27 States that have no limitations on malpractice damages, than in the 23 States that do have such limits.[43] The vast majority of the evidence shows that tort reform does little if anything to reduce medical malpractice premiums.[44]

The California experience is perhaps the most telling of this fact. In 1975, California enacted into law the "Medical Injury Compensation Reform Act" (MICRA), after which many provisions of H.R. 4600 are modeled, including caps on non-economic damages,

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[39] Wlazelek, *supra*. Studies done on the ob/gyn market in New York yield similar conclusions. *See* New York Public Interest Research Group study, http://www.nypirg.org/health/malpractice—facts.html (N.Y. ranked 3rd in the nation in number of ob/gyn's per capita; the number of physicians in N.Y. has skyrocketed and increasing at a rate faster than the national average; N.Y. ranked 2nd in number of doctors per capita).

[40] It is hardly a foregone conclusion that such restrictions will "fix" the problem. In fact, both Republican and Democratic Members of the Judiciary Committee requested the General Accounting Office to conduct an inquiry into the effect of State tort laws on medical professional liability premium increases nationwide.

[41] Robert J. Hunter and Joanne Doroshow, *Premium Deceit—the Failure of "Tort Reform" to Cut Insurance Prices*, Center for Justice & Democracy (1999).

[42] *Medical Liability Monitor* (Vol 26, #10—Oct 2001).

[43] Senate Congressional Record, July 30, 2002, S7534. Moreover, studies show that rising insurance rates have been a trend in the entire commercial industry, not just in the medical malpractice industry. Insurance prices have risen by 21% for small commercial accounts, by 32% for mid-size commercial accounts, and by 36% for large commercial accounts. Insurance for the construction industry, the commercial automobile industry, the property industry, the workers' compensation industry, and more, have all increased between 24% and 56%. See Council of Insurance Agents and Brokers, 4th Quarter 2001 Survey, released January 2002.

[44] Insurance industry spokespersons practically admit this. As Sherman Joyce, president of the American Tort Reform Association (ATRA), stated, "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." *Study Finds No Link Between Tort Reforms and Insurance Rates*, Liability Week, July 19, 1999. ATRA's General Counsel, Victor Schwartz, told *Business Insurance* that "many tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'" Michael Prince, *Tort Reforms Don't Cut Liability Rates, Study Says*, Business Insurance, July 19, 1999. And Debra Ballen, the executive vice president of the American Insurance Association, stated that "insurers never promised that tort reform would achieve specific PREMIUM savings." Press Release, *AIA Cites Fatal Flaws in Critic's Reports on Tort Reform*, Mar. 13, 2002. Moreover, studies conducted by the National Association of Attorneys General and State commissions in New Mexico, Michigan and Pennsylvania confirmed that the crisis was caused not by the legal system but rather by the insurance cycle and mismanaged underwriting by the insurance industry. Francis X. Bellotti, Attorney General of Massachusetts, et al., *Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance* (Boston, MA: Ad Hoc Insurance Committee of the National Association of Attorneys General, May 1986).

collateral source offsets, and limitations on attorneys' fees. Despite these "reforms," premiums for medical malpractice in California grew more quickly between 1991 and 2000 than in the nation (3.5% vs. 1.9%, respectively).[45] And between 1975 and 1993, California's health care costs rose 343%, almost double the rate of inflation.[46]

A comprehensive study of MICRA's impact conducted in 1995 found the following: per capita health care expenditures in California have exceeded the national average every year between 1975 and 1993 by an average of 9% per year; California's medical malpractice liability premiums actually increased by 190% in the twelve years following enactment of MICRA; hospital patient costs are higher in California than in other major States; and California's health care costs have continued to increase at a rate faster than inflation since the passage of MICRA.[47]

Not only does the evidence show that California's tort reform has failed to lower premiums for doctors, it also shows that California's insurance companies are reaping excessive profits in the aftermath of tort reform. In 1997, California's insurers earned more than $763 million, yet paid out less than $300 million to claimants.[48] The National Association of Insurance Commissioners reported the following: malpractice insurance profits are ten times greater than the profits of other lines of insurance in California; the average profit for malpractice insurance in California was 25.40% of the collected premium; and less than half of medical malpractice premiums are paid to claimants—only 38.4% of medical malpractice premiums collected in California since 1988.[49]

III. H.R. 4600 Goes Beyond Medical Malpractice And Applies To Insulate HMO's Insurers, Drug Companies, And Manufacturers And Distributors Of Medical Devices.

Although H.R. 4600's proponents frequently tout it as a medical malpractice bill, its scope is far broader. In fact, the bill applies to (1) lawsuits against HMOs and other insurers, and (2) products liability claims against drug companies and manufacturers and distributors of medical devices.

A. H.R. 4600 completely preempts States' patients' bills of rights that have allowed HMOs to be sued for wrongful actions.

As currently drafted, this bill guts HMO reform laws the States have already passed. On pages 17 and 18, the bill defines a health care liability claim as "based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products."

We find it extremely problematic that legislation purporting to be a medical malpractice bill would be broad enough to cover lawsuits against HMO's and other insurers, particularly because such legis-

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[45] Hunter analysis, *supra.*

[46] Data provided by Consumers Union.

[47] *See* Proposition 103 Enforcement Project, *MICRA: The Impact on Health Care Costs of California's Experiment With Restrictions on Medical Malpractice Lawsuits*, 1995. Inflation rose 186% between 1975 and 1993. California's health care costs grew by 343% during the same period, and generally have grown at almost twice the rate of inflation since 1985.

[48] California Department of Insurance.

[49] National Association of Insurance Commissioners, Profitability By Line By State in 1997 (Dec. 1998).

lation serves to preempt the patients' bills of rights passed by some States. For example, the HMO law enacted in Texas under George W. Bush was Governor has a higher cap on punitive damages ($75,000) than H.R. 4600, and no caps on non-economic damages for suits against HMOs.[50] The Arizona law has no limits on damages for HMO lawsuits.[51] California, on which much of H.R. 4600 is based, has no HMO caps.[52] Georgia's law does not allow any punitive damages but allows all non-economic damages against HMOs.[53] Maine's law does not allow punitive damages but has a higher cap on non-economic damages at $400,000.[54] And Oklahoma, Washington and West Virginia have no limitations on damages.[55] In one piece of legislation, H.R. 4600 completely eviscerates these protections specifically enacted by these States.

B. This "medical malpractice" bill also covers products liability lawsuits against manufacturers and distributors of medical devices and drugs.

The bill also exempts from liability for punitive damages manufacturers and distributors of medical devices, as well as pharmaceutical companies, who happen to obtain FDA approval. This provision provides a complete defense to liability for any drug or medical device that received pre-market approval from the FDA. In other words, if the FDA mistakenly allows a defective product on the market, the victims would not be able to sue at all. Even if both the manufacturer and the FDA have evidence of the dangers of a product, but permit it to be marketed anyway, the innocent, injured victim would be left without any opportunity for compensation whatsoever. We have seen no evidence that placing such faith in underfunded Federal regulators is warranted.

Moreover, these Federal regulators approve the design of the product before it enters the manufacturing process only; they does not approve the manufacturing of each batch of a product. Nevertheless, the manufacturer of a defective product is exempt from punitive damages under this bill. And the examples of products such as the Dalkon Shield, the Cooper-7 IUD device, high absorbency tampons linked to toxic shock syndrome, and silicone gel breast implants provide further reasons for our concerns. For each of these products, the manufacturer had information indicating the dangers posed by the product, and in each of those cases the sometimes lax approval process of the FDA allowed those deadly products to go to market.

IV. H.R. 4600 Raises Constitutional And Federalism Concerns

Among the many problems with H.R. 4600, we are also concerned that the bill may be unconstitutional under the Commerce Clause, the Fifth Amendment, and the Seventh Amendment.

First, the bill as drafted invites legal challenges to Congressional authority to legislate in this area, given the Supreme Court's re-

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[50] TX. Civ. Prac. & Rem. Code, Title 4, sec. 88.001 et seq. (1997).
[51] AZ Rev. Stat. 20–3153 et seq. (2000).
[52] CA Civil Code 3428 (1999).
[53] GA Code ann. 51–1–48 et seq. (1999).
[54] 24–A M.R.S.A. sec. 4313 (1999).
[55] OK. Stat. Title 36 sec. 6593 et seq. (2000); 48.43.545 Rev. Code WA (2000); 33–25C7 Code of W Va (2001).

cent Commerce Clause jurisprudence. There is a genuine issue as to whether H.R. 4600 constitutes a permissible exercise of Congress' power to regulate interstate commerce,[56] particularly to the extent the Act is applied to purely intrastate medical services. The Act itself contains no interstate commerce jurisdictional requirement, but merely makes a flat and unsubstantiated assertion that all of the activities it regulates affect interstate commerce.[57] Furthermore, the Supreme Court repeatedly has frowned upon Federal intervention into areas like medical malpractice law that have been traditionally reserved to the States.[58]

The bill also invites challenges that it violates the Fifth Amendment, which provides that no person shall be "deprived of life, liberty, or property without due process of law,"[59] a proscription which has been held to include an equal protection component.[60] Plaintiffs will no doubt argue that the law does not provide a legislative *quid pro quo* and, as such, violates the Fifth Amendment. In exchange for depriving plaintiffs of their common law rights, the bill does not provide any offsetting legal benefits, at least to the parties directly harmed by the loss of their common law rights.

Finally, the bill may violate the Seventh Amendment, which provides, "[i]n suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law."[61] Because the bill eliminates the right of a jury to determine the appropriate amount of punitive and non-economic damages, this bill arguably deprives a plaintiff of the right to jury trial with respect to those elements of the case. These problems are highlighted by the fact that courts in some States that have enacted similar tort reforms, such as caps on non-economic damages and collateral source offsets, have ruled such reforms unconstitutional as violative of equal protection, due process, and the right to a trial by jury and access to courts.[62]

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[56] Article I, Section 8 of the Constitution provides, *inter alia*, "Congress shall have Power . . . to regulate Commerce with foreign Nations and among the several States. . . ." U.S. Const. art I, § 8, cl. 3.

[57] Section 2 of the bill states that "Congress find that the health care and insurance industries are industries affecting interstate commerce and the health care liability and litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high cost of health care and premiums for health care liability insurance purchased by health care system providers." According to the *Lopez Court*, one of the problems with the school gun ban was that it contained "no express jurisdictional element which might limit its reach to a discrete set of firearms possessions that additionally have an explicit connection with or effect on interstate commerce."

[58] The Court in *Lopez* observed that there were certain traditional areas of State law, such as criminal law and education, which should be off limits to Federal intervention. The concurrence by Justices Kennedy and O'Connor also reasoned that the Federal Government should avoid involving itself in areas which fall within the "traditional concern of the States," noting that over 40 States had adopted laws outlawing the possession of firearms on or near school grounds.

[59] U.S. Const. amend. V.

[60] *See Bolling* v. *Sharpe*, 347 U.S. 497 (1954) (Fifth Amendment due process found to incorporate equal protection guarantees in case involving public school desegregation by the Federal Government in the District of Columbia).

[61] U.S. Const. amend. VII.

[62] Specifically, thirty-one States (AL, AZ, CA, CO, FL, GA, DE, IL, IN, KS, KY, LA, MO, NE, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, UT, WA, WI, WY) have ruled that such sweeping restrictions on the rights of medical malpractice victims are unconstitutional. Courts in twenty States (AL, CO, FL, GA, ID, IL, KS, NE, NH, ND, OH, PA, OK, OR, SC, SC, TX, UT, WA, WI) have ruled caps or limitations on medical malpractice damages to be unconstitutional. Courts in NH and PA have ruled that statutory limitations on attorneys fees in medical malpractice cases are unconstitutional, unfairly burdening medical malpractice victims and their

V. Specific Concerns

In addition to the general problems raised above concerning the overall purpose and effect of H.R. 4600, we have a number of specific concerns relating to particular provisions of the legislation. Most importantly, we are concerned that H.R. 4600 does not solve the alleged insurance and litigation crises but rather unjustly restricts a patient's right to recover for injuries inflicted by a negligent and careless health care provider. The following is an itemization of some of the most pressing problems adopted by the majority in passing H.R. 4600.

A. $250,000 aggregate cap on non-economic damages

We particularly object to the $250,000 cap on non-economic damages. Non-economic damages compensate victims for the human suffering they experience as the result of negligent conduct. Although intangible, these injuries are real and include infertility, permanent disability, disfigurement, pain and suffering, loss of a limb or other physical impairment. These damages are not accounted for in damages for lost wages, which are unrestricted under H.R. 4600.

We object to this cap for three reasons: it is manifestly unfair, it discriminates against women and children and those in low-economic brackets, and it does not take into account inflation.

First, the cap is unfair because it puts a price tag on the most horrendous of injuries and applies a "one-size-fits-all" philosophy that objectifies and erases the person and uniqueness of their suffering. An incident recited by Jamie Court during his testimony before the House Committee on Energy and Commerce,[63] illustrates H.R. 4600's manifest unfairness. Mr. Court told the story of Steve Olsen, a twelve year old from San Diego who is blind and brain damaged because of medical negligence. When he was 2 years old he fell on a stick in the woods. Steve's doctor gave Steve steroids and sent him home. Although his parents asked for a CAT scan, the doctor refused. The following day, Steve returned to the hospital in a coma because of the growing brain abscess he had developed, which would have been detected had the CAT scan been performed. At trial, the jury concluded that the doctor had committed medical malpractice and awarded $7.1 million in "non-economic" damages. One of the jurors later explained that they saw Steve as a boy doomed to a life of darkness, loneliness and pain. He would never play sports, work or enjoy normal relationships with his peers. He would have to endure a lifetime of treatment, therapy,

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lawyer, or resulting in an unconstitutional infringement on the right to jury trial. Courts in KS, NH, ND, OH, PA, and RI have ruled that medical malpractice statutes eliminating the common law "collateral source" rule are unconstitutional violations of due process and equal protection. Eighteen States (AZ, CA, CO, GA, IN, KY, LA, MO, NH, NM, NC, OH, OK, SD, TX, UT, WA, and WI) have held that their States' medical malpractice ultimate statutes of limitations are unconstitutional. Courts in four States (AZ, KS, NH, and OH) have ruled that structured settlement provisions of their States' medical malpractice statutes are unconstitutional violations of the right to jury trial, equal protection and due process. And courts in eighteen States (AZ, CA, CO, GA, IN, KY, LA, MO, NH, NM, NC, OH, OK, SD, TX, UT, WA, and WI) have ruled similar restrictions unconstitutional for failing to include adequate discovery provisions, for imposing restrictions which are too short in time, and for discriminating against minors or incompetent adults, in violation of equal protection, open courts, or due process guarantees, or the privileges and immunities clauses of State constitutions.

[63] Testimony of Jamie Court, before the House Committee on Energy and Commerce, July 17, 2002, at 4–6.

prosthesis fitting and around-the-clock supervision. The judge, however, was forced the reduce that damage award to $250,000 because of the State's cap.

Mr. Court testified that he often visits Steve and his family when he is in San Diego. In 2001 he had 74 doctor visits, 164 physical and speech therapy appointments, and three trips to the emergency room. Steve's mother had to leave her job because caring for him is a full time job. He requires special education classes, for which Steve's mother must constantly fight. His pain and suffering is intangible but unrecognized by the misguided "reforms" that placed an arbitrary, one-size-fits-all cap on the amount he could recover.

Second, the $250,000 cap discriminates against women, children, seniors, and the poor. These categories of victims do not have high economic damages and are more likely to receive a greater percentage of their compensation in the form of non-economic damages. The result is that homemakers and children will be limited to $250,000 in non-economic damages, but CEO's could recover millions of dollars.[64]

Finally, the $250,000 cap is based on MICRA's cap, which was set in 1975 and has not been adjusted for inflation. A close look at California's numbers adjusted for inflation shows exactly what $250,000 is worth today. Using the consumer price index, the medical care value of $250,000 has dropped to just $40,389 over the 27 years since MICRA was enacted. One would need $1,547,461 in 2002 for the equivalent medical purchasing power of $250,000 in 1975.

This problem was acknowledged at the Judiciary's Committee's recent hearing by Rep. Berman, who was a member of the California Legislature when MICRA passed. In response to Mr. Gekas' concern that the recoverable costs of health care in California were still rising, Mr. Berman stated:

> I understand the gentleman's point, but the economic damages are about wages lost, about health care costs expended and incurred. Of course they're going to rise. Wages have risen since 1975; health care costs have risen since 1975. Why the notion—when you maintain a $250,000 cap that was appropriate in 1975, in 2002, you are decreasing the recovery for pain and suffering every single year by the cost-of-living. By any measurement, it is a decrease. To simply graft that figure onto here without making any compensation for 27 years of time, and without including some kind of cost-of-living factor for the fu-

[64] In their 1995 article, Thomas Koenig and Michael Rustad studied the effects of tort reforms on the different genders, finding that women are disproportionately affected by such reforms. Thomas Koenig and Michael Rustad, *His and Her Tort Reform: Gender Injustice in Disguise*, 70 Wash. L. Rev. 1 (1995). Specifically, the study found that women receive smaller economic verdicts for equivalent injuries because of lower overall wages. *Id.* at 78. And medical malpractice awards to women were almost three times more likely to include a pain and suffering component as those given to men. *Id.* at 84. This is true because women are most likely to suffer severe non-economic loss (loss of fertility, disfigurement, etc.) and be the victims of the types of medical malpractice that lead to punitive damages (sexual assault, fraud, false imprisonment, and extreme violation of medical standards, etc.).

> ture, is not maintaining the equilibrium of the California law at the time it passed. It's imposing a serious cut.[65]

Mr. Nadler elaborated on the problem. Pointing out the fact that we put cost-of-living adjustments in Social Security, pensions, congressional salaries, and Federal salaries, he asks why this bill cannot have a cost-of-living, or inflation, adjustment. He states:

> Unless you want to say that what you really want to do is say no economic damages eventually, because that's what this does. It reduces it to insignificance, ultimately.
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> It seems to me that any hard-dollar amount in legislation has to have an inflation factor in it. And if you don't put that in what you're really saying, and maybe that's the will of the Republicans, that we don't want people to get compensation for noneconomic damages. We don't dare say it, but that's what we want. So we set up an amount that was appropriate in 1975 and by 2000, it's inadequate, and by 2025, no one will even care about it anymore, because it's a pittance.[66]

As Mr. Nadler accurately summarized, the $250,000 cap is "unfair. It's unjust. And frankly, it's totally indefensible not to have an inflation factor in a limit like this." [67]

B. Abolition of joint and several liability

In addition, we oppose H.R. 4600's total elimination of joint and several liability from medical malpractice cases because the result is to shift responsibility from the wrongdoer to the innocent victims of medical malpractice. Joint and several liability has been a part of the American common law for centuries. The doctrine provides that all tortfeasors who are responsible for an injury are "jointly and severally" liable for the claimant's damages. This means the victim can sue all responsible defendants and recover from each one in proportion to that defendant's degree of fault, or sue any one defendant and recover the total amount of damages. A defendant who pays more than its share is then entitled, under the doctrine of contribution, to seek compensation from other responsible parties based on their degree of fault.[68] The doctrine is designed to help ensure that victims of wrongful conduct are able to fully recover damages for their injuries, especially when one or more of the defendants is judgment-proof.[69]

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[65] The Help Efficient, Accessible, Low-Cost, Timely Health Care Act: Hearings before the House Comm. On the Judiciary, 107th Cong. 2d Sess (Sept. 10, 2002) [hereinafter "2002 Medical Malpractice Hearing"], Transcript at 21–22.

[66] *Id.* at 23–24.

[67] *Id.* at 24. (The amendment prompting this debate proposed that Section 4, providing for caps on non-economic damages, be struck. The amendment almost passed, receiving a 14–14 vote.)

[68] Restatement (Third) of Torts § 23 (1999).

[69] At the hearing, Mr. Chairman stated the crux of the issue when, after acknowledging that the rule is "motivated by a desire to ensure that plaintiffs are made whole," he said: "The HEALTH Act, by providing a fair share rule, it apportions damages in proportion to a defendant's degree of fault and prevents unjust situations in which hospitals can be forced to pay for all damages for an injury, even when the hospital is minimally at fault." 2002 Medical Malpractice Hearing, Transcript at 16. As we see it, if one has to choose between protecting victims of malpractice or protecting hospitals who every so often may not receive contribution from the other wrongdoers, the choice is obvious. As Mr. Scott put it, "which is more fair? For the hospital to decide to apportion all of that amonst itself, which is all insured anyway? Or have the

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The majority's reasons for eliminating the doctrine in medical malpractice cases is nothing but an extreme reaction to mostly unsubstantiated anecdotal stories, rather than a moderate response to the facts. Mr. Bachus's hypothetical of a drug dealer who gets shot during a drug deal gone bad, who then goes to the hospital and receives treatment from a doctor who is fatigued, is a perfect example. Mr. Bachus raises the possibility that the drug dealer will be found to be 99 percent at fault and the hospital 1 percent at fault, but the drug dealer recovers 100 percent because of joint and several liability.[70] As Mr. Frank correctly points out, "a drug dealer who was shot and was 99 percent responsible and recovered . . . is the sort of example that makes no constructive contribution to the debate."[71]

These preposterous hypotheticals are the basis for the majority's extreme response—the elimination of the doctrine altogether—even though far more moderate responses previously have been propounded. For example, in 1999 the Congress passed the Y2K bill, which had several limitations on the total abolition of joint and several liability. First, it had a complete carve-out where the defendant acted with specific intent to injure the plaintiff or knowingly committed fraud.[72] In addition, the Y2K Act provides that if portions of the plaintiff's damage claim ultimately prove to be uncollectible, and the plaintiff is an individual with a net worth of less than $200,000 and damages are greater than 10 percent of a plaintiff's net worth, a solvent defendant is responsible for paying an additional 100 percent share of the liability, or an additional 150 percent of this amount if it acted with "reckless disregard for the likelihood that its acts would cause injury."[73]

C. Limits on punitive damages in medical malpractice cases

The limitations on punitive damages are also of major concern to us for two reasons: the heightened standard is practically impossible for plaintiffs to prove, and the $250,000 cap is inadequate in extreme cases of abuse, such as those involving rape or drugs.

First, the heightened standard for recovery—the requirement of clear and convincing evidence that the defendant acted with malicious intent to injure (or he was substantially certain the plaintiff would suffer injury but failed to avoid such injury)—is so extreme it is practically criminal. This standard makes it almost impossible for plaintiffs who have been egregiously wronged to recover punitive damages.

Second, even plaintiffs who could meet this standard are still limited by the cap at $250,000 or two times the amount of economic damages. This cap completely eviscerates the deterrent effect punitive damages have on egregious misconduct of defendants because the threat of having to pay a maximum of $250,000 would not affect many large companies or wealthy individuals. Moreover, the

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plaintiff have that possibility and lose 1 percent there because they couldn't find that one, or 2 percent there, and they collect all from this one and a little bit—this one goes bankrupt? Which is more fair? You've got somebody with a $100,00 judgment and 50 people, possibly, at fault." *Id.* at 31.

[70] *Id.* at 28.

[71] *Id.* at 34.

[72] 15 U.S.C. § 6605(c).

[73] *Id.* § 6605(d).

cap applies no matter what the conduct, even in situations where a medical professional harmed a patient because he was under the influence of alcohol or drugs, or where a doctor sexually assaults his patient.[74]

D. Elimination of punitive damages for products approved by the FDA.

In addition to the caps on punitive damages, we are especially troubled by the bill's abolition of punitive damages for products that have been approved by the FDA. Simply because a product has been approved by the FDA does not mean the company should be immunized from punitive liability when the product, despite such approval, causes severe harm to an individual. This is especially compelling given that studies have shown that medical devices cause approximately 53 deaths and over 1,000 serious injuries annually, costing approximately $26 billion annually.[75] Government safety standards, at their best, establish only a minimum level of protection for the public. At their worst, they can be outdated, under-protective, or under-enforced.

Moreover, the bill completely insulates manufacturers and distributors of products and drugs from defects arising during the manufacturing process, which occurs after the FDA has given its approval of the device.

And finally, banning punitive damages for FDA-approved products will have a disproportionate impact on women and seniors, who make up the largest class of victims of medical products. There are many examples of FDA-approved products that are dangerous and have caused harm to scores of women, including DES, the Dalkon Shield and Copper-7 IUDs, super-absorbent tampons, high-estrogen oral contraceptives, and the weight loss drug phen-fen. For each of these products, the manufacturer had information indicating the dangers posed by the product.[76]

E. Repeal of the collateral source rule

We dissent from the bill's repeal of the collateral source rule because the effect is also to shift the costs of malpractice from negligent defendants to innocent victims. The collateral source rule

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[74] In fact, a report by Public Citizen found that "47.7% of doctors [found to have been disciplined for sexual abuse or misconduct by a disciplinary board] were allowed to continue practicing, their behavior probably unknown to most if not all of their patients." Sidney Wolfe et al., *20,125 Questionable Doctors*, Public Citizen Health Research Group, Washington, D.C. (2000).

[75] A recent article by Robert Cohen and J. Scott Orr sets out startling statistics with respect to the medical implant industry. A few are as follows:

- During the past 10 years, 573 recall notices covering more than 2 million implants were issued for lapses such as mislabeling, structural failure, or manufacturing error. All but one of these errors were noticed by manufacturers, not the FDA.
- Of the 3500 proposed medical devices reviewed by the FDA last year, 98% were approved under an expedited process that requires no clinical testing.
- Federal law requires the FDA to inspect medical device manufacturers every 2 years, but due to budget constraints, it actually visits U.S. plants on average every 5 years and overseas plants ever 13 years.

See Robert Cohen and J. Scott Orr, *Faulty Medical Implants Enter Market Through Flawed System*, Newhouse News Service, 2002.

[76] *See also* Koenig and Rustad, *supra*, at 38–46 ("There are far too many examples of instances where the FDA could not by itself adequately protect the public from dangerous, defective medical devices") (citing Lack of Life Saving Medical Devices, Hearing on S. 687 Before the Subcomm. on Reg. and Gov't Info. Comm. of the Senate Comm. on Gov't Affairs, 103d Cong., 2d Sess. (testimony of Kristin Rand, counsel on behalf of Consumer's Union)).

prevents a wrongdoer from reducing the amount of damages it must pay a victim by the amount the victim receives from outside sources. Payments from outside sources often include health or disability insurance, for which the victim already paid premiums and taxes. The rule is fair because the doctrine of subrogation, which provides that the collateral source has the right to reimbursement from the victim out of the damage award, ensures that no source pays more than its share of the liability.[77]

In addition to shifting costs to the plaintiff, eliminating the collateral source rule would discourage prudent insurance planning by penalizing consumers for acting responsibly[78]; would undermine the deterrent effect of the malpractice system by enabling negligent physicians to avoid liability for damages they inflict[79]; and could result in a double reduction of the victim's damages, by the defendant and by subrogation.

F. Contingency fee limitations

In addition, we disagree with the provision in the bill limiting contingency fees for attorneys. Contingency fee arrangements can serve a useful and essential function in the legal system. They allow injured customers who could not otherwise afford legal representation access to the courts because the attorney agrees to take the case on behalf of an injured patient without obtaining any money up front from the client. The attorney thus incurs a risk in taking on the case because if the client loses, the attorney never gets paid. Not only does this help ensure that poor victims have access to the civil justice system, it also serves as a screening mechanism for unmeritorious cases on which attorneys will not take a risk.

H.R. 4600's restrictions make it more difficult for poor victims of medical malpractice with legitimate claims to find legal representation. Moreover, it is unfair to restrict plaintiffs' attorneys fees but not defendants, especially when defense attorneys are usually paid by the hour and thus have incentive to engage in meaningless litigation to drive up the costs.[80]

G. Periodic payments

As with the other provisions of the bill, the provision regarding periodic payments harms victims and protects wrongdoers. First, it allows the negligent party or insurance company to invest and earn interest on the victim's compensation. Second, it puts the onus on the victim, not the wrongdoer, to pursue the compensation in the event that the wrongdoer files for bankruptcy or refuses to pay. And if the wrongdoer files for bankruptcy, the chances of the victim ever receiving compensation for his or her loss is close to nothing. Finally, it leaves the victim without adequate resources in the event of an unanticipated medical emergency, if costs of the

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[77] *See* Kenneth Abraham, DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY, 1330–172 (1986); Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 Cal. L. Rev. 1478, 1481–85 (1966).

[78] *See* James L. Branton, *The Collateral Source Rule*, 18 St. Mary's L.J. 883 (1987).

[79] See Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 Law & Contemp. Probs. 57, 72 (Spring 1986).

[80] We also find it interesting that the majority would support a bill that is so anti-capitalistic. Restrictions on contingency fees are restrictions on compensation to attorneys who have worked hard and performed in the maketplace. This provision could not be more "anti-Republican."

victims's medical care increase beyond his or her means, or a special medical technology is made available which the victim requires. In these circumstances, the injured patient would have to retain a lawyer to have the schedule modified.

H. Reduced statute of limitations

Finally, we oppose this statute of limitations for several reasons. The most important is that it cuts off all meritorious claims involving diseases with long incubation periods. For example, HIV often goes undetected for eight to 10 years. Under H.R. 4600 a patient who contracted HIV through a negligent blood transfusion, but did not learn of the disease until after 3 years from the date of the transfusion, would be barred from filing a claim. Other examples include cases in which doctors have left foreign objects inside patients' bodies during surgery. Or cases where a patient takes a newly developed drug prescribed by his or her dermatologist, only to learn 4 years later that the drug caused heart damage. Or cases where a patient's pacemaker, implanted with a defect 5 years earlier, fails. In each of these cases, the injury would not be discovered until the statute of limitations under H.R. 4600 had come and gone.

Real life examples are abundant. One involves a young girl named Collazo, who was 8 years old when she sought treatment at the hospital for an ankle injury. She was examined but not treated and told to return 2 days later. When she returned, her ankle was severely flexed downward. The hospital placed a splint on her ankle and sent her home, advising her to see a private physician. By the time a private physician diagnosed her (with three severed tendons), her only treatment option was tendon grafting. She suffered significant lost range of motion on her foot, she cannot extend her toes upward, she has a limp, cannot engage in athletics, and can only wear sneakers. Under the State's 10 year statute of limitations, Collazo filed a lawsuit and received $1.2 million from the jury, mostly for noneconomic loss.[81] Under H.R. 4600, however, Collazo would have been prohibited from even filing the lawsuit—she was 8 years old when the injury occurred, placing her outside the minority exemption, and requiring her to file the lawsuit by the time she was nine to preserve her rights.[82]

CONCLUSION

Collectively, the supposed "reform" included in H.R. 4600 would severely limit victims' ability to recover compensation for damages caused by medical negligence, defective products, and irresponsible

[81] *See Collazo* v. *New York City Health & Hosps. Corp.*, N.Y. Bronx County Sup. Ct., No. 8606/94 (1999).

[82] It is useful to note that H.R. 4600's statute of limitations is more restrictive than statutes of limitations provided for by most States. Most States allow plaintiffs 2 years from the date of injury to sue for medical malpractice. And many States afford plaintiffs a discovery rule, which tolls the statute of limitations until the plaintiff knew or should have discovered the injury. For example, Arizona allows plaintiffs to file a lawsuit up to 2 years from "reasonable discovery." *See* Az. Rev. Stat. Ann. §12–542(1). D.C. provides that the time for filing runs from the date the plaintiff should have known of the injury. *See Stager* v. *Schneider*, 494 A.2d 1307 (1985). Indiana allows 2 years from the date of reasonable discovery. *See* In. Code §34–18–7–1(b). There are many more examples of States that do not arbitrarily limit a victims' ability to bring a lawsuit for injuries he or she has sustained as a result of medical negligence but could not reasonably discover for more than 3 years. By contrast, while H.R. 4600 allows plaintiffs 3 years to discover the injury, any reasonable discovery after 3 years is simply too late.

insurance providers. In addition to raising core issues of fairness, the legislation would intrude into an area which has traditionally been the sole province of the States, many of which have enacted their own medical malpractice legislation in recent years. H.R. 4600, which is designed to limit medical malpractice premiums and jury awards, presents a "fix" that is not supported by the empirical evidence; indeed it is being propounded at a time when the great wealth of data suggests that there is no medical malpractice "crisis" in our society. For these and other reasons set forth above, we strongly believe H.R. 4600 should be rejected.

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