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108TH CONGRESS, 1st Session | HOUSE OF REPRESENTATIVES | REPT. 108–32, Part 1

HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2003

MARCH 11, 2003.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. SENSENBRENNER, from the Committee on the Judiciary,

submitted the following

R E P O R T

together with

DISSENTING AND ADDITIONAL DISSENTING VIEWS

[To accompany H.R. 5]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 5) 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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19–006

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 2003".

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;

(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.

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

(1) Upon proof of fraud;

(2) Intentional concealment; or

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

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

SEC. 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. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

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, if awarded, in a health care lawsuit, the trier of fact shall consider only the following:

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

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

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

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

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

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

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

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

(1) IN GENERAL.—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, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes, or who dispenses pursuant to a prescription, 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, or any medical product, affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services, or any medical product, affecting interstate commerce, brought in a State or Federal

court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(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 relate 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 law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this Act, 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.

SEC. 13. SENSE OF CONGRESS.

It is the sense of Congress that a health insurer should be liable for damages for harm caused when it makes a decision as to what care is medically necessary and appropriate.

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 rav-

[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

Continued

aging 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 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]

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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.

[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)).

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 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.
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> 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."
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> 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 . . .
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> 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."
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> 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

[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.'").

> 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." Before the 1960's, only one physician in seven had ever been sued in their entire lifetime,[8] whereas today's rate is about one in seven per year.[9] In addition, 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

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

[8] *See* "Opinion Survey of Medical Professional Liability," JAMA 164:1583–1594 (1957).

[9] *See* R. Bovbjerg, "Medical Malpractice: Problems & Reforms," The Urban Institute, Intergovernmental Health Policy Project (1995).

1999. Defense expenses per paid claim increased by $24,000 over the same period.[10]

As a recent survey conducted for Floridians for Quality Affordable Healthcare concluded, "Our survey shows that most South Florida physicians have been sued at least once. In contrast to the notion that only 'bad' physicians get sued, we found that the odds of being sued are highly correlated with certain specialties . . . [E]ach and every neurosurgeon and vascular surgeon in our sample has been sued at least once. Neurosurgeons have the highest number of lawsuits, with an average of over 5.2 per physician. Over 94% of cardiovascular or thoracic surgeons have been sued; over 90% of general surgeons; almost 89% of radiologists; and over 78% of obstetrician/gynecologists have been sued at least once . . . The 1,460 physicians who answered this survey question have been sued an average of 1.44 times. Over 57% of the physician respondents have been sued at least once in their career."[11] That more claims are brought against some doctors more than others does not mean the former are "bad doctors." Rather, they practice in high-risk specialties, perform high-risk procedures, and are more willing to treat high-risk patients.

H.R. 5 (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.[12] If California's legal reforms were imple-

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[10] 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.

[11] Summary of Results: Physician Professional Liability Survey (conducted by RCH Healthcare Advisers, LLC) (December 2002).

[12] 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:

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

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mented nationwide, we would have to spend 300% less in medical professional liability insurance, and those saved funds (billions of dollars annually) could have gone to patient care. As the Los Angeles Times reported, "According 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%"[13] Cruz Reynoso, Democratic Vice Chairman of the U.S. Civil Rights Commission and a former Justice on the California Supreme Court, wrote in a recent op-ed, "What is obvious about MICRA is that it works and works well . . . Our [California] doctors and hospitals pay significantly less for liability protection today than their counterparts in States without MICRA-type reforms."[14] Democratic Senator Dianne Feinstein has also stated that "I think we can get the California MICRA passed in the Senate and expanded because it stood the test of time. It's workable. It's balanced. It has provided a substantial level of satisfaction."[15]

According to the Congressional Budget Office, "certain tort limitations, primarily caps on awards and rules governing offsets from

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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]."

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

[14] Cruz Reynoso, "California's Medical Liability Cure," The Los Angeles Times (February 4, 2003) at B13.

[15] Transcript, CNN with Wolf Blitzer (January 16, 2003).

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, [the HEALTH Act] would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law . . . CBO estimates that, under [the HEALTH Act], premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."[16] Economists have also concluded that direct medical care litigation reforms—including caps on non-economic 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.[17] 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.[18]

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[16] Congressional Budget Office Cost Estimate of H.R. 4600 (the HEALTH Act) (September 24, 2002).

[17] *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.").

[18] 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

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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 than would be brought in Federal court otherwise. 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.[19] 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.[20] Con-

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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.

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).

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

[20] **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) (six-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) (two-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) (twelve-year product liability statute of repose held unconstitutional under State constitution); *Kenyon* v. *Hammer*, 688 P.2d 961 (Ariz. 1984) (three-year statute of limitations for wrongful death claim held unconstitutional under State constitution); **Colorado**—*Austin* v. *Litvak*, 682 P.2d 41 (Colo. 1984) (three-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 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) (two-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) (five-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) (twelve-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) (ten-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) (two-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

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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 law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether or not such monetary amount 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.[21] Some States place aggregate limits on medical malpractice awards.[22] 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.[23]

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

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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) (ten-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) (two-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 malpractice statute of limitations held unconstitutional under State constitution), *aff'd on other grounds*, 424 N.W.2d 191 (Wis. 1988).

[21] *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).

[22] *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).

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

> 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 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."[24]

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.[25]

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."[26] Another purpose is to "promote settlements by eliminating 'the unknown possiblity of phenomenal

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[24] 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.

[25] *Id.* at 14–15.

[26] *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).

awards for pain and suffering that can make litigation worth the gamble.'"[27] 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."[28]

BACKGROUND AND NEED FOR THE LEGISLATION

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

A recent survey conducted for the bipartisan legal reform organization "Common Goo'—whose Board of Advisors include former Senator George McGovern, former Speaker of the House Newt 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:
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> - Order more tests than they would based only on professional judgment of what is medically needed. (91% have noticed

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

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 noticedother 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.[29]

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

[29] *See* Harris Interactive, "Common Good Fear of Litigation Study: The Impact of Medicine," Final Report (April 11, 2002) ("Executive Summary") at 8–11.

(85%); and suggest invasive procedures more often than they would based solely on their professional judgment (73%).[30] Ninety-four percent of physicians think such extra tests, referrals, or procedures contribute in a significant way to health care costs.[31] 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."[32] 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."[33]

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.[34] 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.[35] 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,[36] and 83% somewhat or strongly disagree with the statement that physicians can trust the current system of justice to achieve a reasonable result.[37] Indeed, median awards for malpractice claims grew 7 times the rate of general inflation between 1994 and 2000, while

[30] *Id.* at 20 (Table 7).
[31] *Id.* at 21 (Table 8).
[32] *Id.* at 30 (Table 17).
[33] 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).
[34] 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).
[35] *See* http://www.thepiaa.org/about—piaa/what—is—piaa.htm.
[36] *See* Harris Interactive, "Common Good Fear of Litigation Study: The Impact of Medicine," Final Report (April 11, 2002) at 16 (Table 3).
[37] *Id.* at 39 (Table 26).

negotiated settlement payouts grew at nearly triple the rate of inflation.[38]

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 particularly 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 ex-

[38] *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.

> cess profits for themselves through self-insurance or the formation of captives.[39]

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."[40] 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 liability risks with any degree of confidence. This appears to have severely exacerbated the problem.[41]

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.[42]
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> . . .
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> 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:
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> - 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,

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[39] 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.

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

[41] *Id.* at 3.

[42] *Id.* at 49.

- Transaction costs are far too high.[43]

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."[44] Indeed, the researchers found that, of the 47 medical malpractice claims they studied that resulted in litigation,[45] "[i]n 14 cases, the physicians 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."[46] 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.[47] Thus, of the 47 claims filed that the researchers analyzed, less than half demonstrated any actual negligence, and many demonstrated no discernable injury.[48] 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.[49]

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,

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[43] *Id.* at 51–52.

[44] *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).

[45] *See id.* at 7–1.

[46] *See id.* at 7–33.

[47] *See id.* at 7–33.

[48] *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.").

[49] *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).

was statistically significant in predicting whether a plaintiff would receive payment.[50] 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."[51] 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."[52] 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.[53]

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."[54]

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"[55] 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

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[50] *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.").

[51] *See id.* at 1963.

[52] *Id.* at 1967.

[53] *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 evidence is growing that there is a poor correlation between injuries caused by negligent medical treatment and malpractice litigation.").

[54] 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.").

[55] 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.

of medical care.[56] Researchers' findings point to the stresses created by the adversarial quality of both litigation and equally adversarial pre-trial maneuvers.[57] 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.[58] Researchers have found that 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."[59]

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

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[56] *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.").

[57] *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.

[58] *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 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.").

[59] 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).

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."[60]

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 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."[61]

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

[60] 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.

[61] *Id.*

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." . . .[62]

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.[63]

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 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

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

[63] *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.'".).

cap."[64] 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."[65]

Skyrocketing medical insurance rates have caused similar crises nationwide.[66] Medical malpractice insurance premiums are increasing at the highest rate since the mid-1980's[67] and consequently

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

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

[66] 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.

[67] *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 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 cov-

doctors are practicing more defensively, ordering unnecessary extra tests and choosing unnecessary procedures that limit their risks.[68]

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.[69] 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."[70] Other medical malpractice insurers have also recently left the market,[71] and many others have become insolvent. Licensed carriers'

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erage 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.").

[68] *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.")*.

[69] *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.").

[70] "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.").

[71] *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 Insurance 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

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medical professional liability insurance business has, on average, been unprofitable in every year from 1990–2000.[72] It has also been recently reported that "nearly all companies that used to write nursing home liability [insurance] are getting out of the business."[73] 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.
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> 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.[74]

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%.[75]

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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.").

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

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

[74] 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.

[75] *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 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.").

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.[76]

In a February 7, 2003, letter responding to questions from Senator Gregg, the President of the National Association of Insurance Commissioners stated the following: "To date, insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation. The preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices."[77] He further stated that "states have strong laws that prohibit price-fixing and anti-competitive practices by insurers."[78]

State insurance commissioners strictly regulate insurance companies to make sure they don't engage in speculative investments that tie their earnings to wildly fluctuating stock market activity, and according to extensive research by Brown Brothers Harriman,[79] over the last 5 years, the amount medical malpractice companies have invested in equities has remained fairly constant. In 2001, the equity allocation was 9.03%. Using information from National Association of Insurance Commissioners filings, medical malpractice companies have less invested in equities than other sectors of the industry. Further, in order for any form of insurance coverage to be viable, the insurance company must receive more in premium dollars and investment income than they pay in losses and expenses. A simple measure of this is the ratio of paid losses to premiums. Over the last 27 years, and especially over the last 16, the paid loss ratio in medical malpractice coverage has steadily increased. Using data derived from Americans for Insurance Reform's "Medical Malpractice Insurance: Stable Losses/Unstable Rates" (October 10, 2002), over the last 27 years, the average paid loss ratio was 47% and the minimum paid loss ratio was 16%. In 2001, the industry paid loss ratio was nearly 75%. In other words, for every dollar that comes in the door, 75 cents is paid out. When combined with other expenses such as general operating expenses, it is clear that it has been extremely difficult—if not impossible—for insurance companies to earn a profit writing medical malpractice insurance.

It appears that the investment gain of medical malpractice companies has not declined. While the amount of gain medical malpractice companies receive from equities has declined, the bond rally caused by the decline in interest rates and realized in the form of capital gains has more than offset this decline. Expenses including losses have grown faster than premiums while invest-

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[76] *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).

[77] Letter from Mike Pickens, President, National Association of Insurance Commissioners, to Senator Judd Gregg (February 7, 2003).

[78] *Id.*

[79] Raghu Ramachandran, Senior Portfolio Strategist, Brown Brothers Harriman, "Did Investments Affect Medical Malpractice Premiums?" (January 21, 2003) (available at http://salsa.bbh.com/news/Articles/MedMal.html).

ment gains remain relatively constant. From this, it is clear that investments did not precipitate the current crisis.[80]

The true cause of skyrocketing medical professional liability premiums is escalating jury verdicts. According to exhaustive research by the firm Tillinghast-Towers Perrin, "Since 1975 (the first year in this study for which medical malpractice costs are separately identified), the increase in medical malpractice costs has outpaced increases in overall U.S. tort costs. Medical malpractice costs have risen an average of 11.6% per year, in contrast to an average annual increase of 9.4% per year in overall tort costs."[81]

An extensive analysis of the previous medical professional liability crisis also concluded that increased litigation costs—not anything else—was the "dominant cause." The authors of the study included a business school professor, a law professor, an actuarial professor, and a doctor—all members of the professional staff of the Academic Task Force for Review of the Insurance and Tort Systems, an agency within the Executive Office of the Governor of the State of Florida tasked with studying the causes of the medical professional liability crisis in the late 1980's. These researchers came to the following conclusions:

> Based upon the data analyzed by the authors, excessive profitability is not a cause of the medical malpractice problem . . . The authors . . . reject the assertion that excess insurance company profits are a cause of the medical malpractice crisis . . .
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> Clearly . . . the underwriting cycle[82] and alleged poor insurance company management and investment practices are not the primary cause of increases in the cost of malpractice insurance . . . [T]he underwriting cycle is not unique to medical malpractice insurance, nor even to third-party liability insurance in general. The underwriting cycle affects other types of insurance such as first-party fire, windstorm, and other property insurance. These lines have not experienced comparable premium increases, however, nor have most other liability lines . . .
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> [B]oth of the factors that determine total claims costs—frequency and severity of claims—have been responsible for the large increase in total paid claims and the resulting increase in malpractice premiums . . . The study demonstrates that increased premiums are not the result of high insurance company profits but rather are primarily driven by increased loss payments . . . When viewed over the course of a decade . . . the dramatic increase in claims payments is the dominant cause of increased malpractice premiums . . . [T]he huge in-

[80] Raghu Ramachandran, Senior Portfolio Strategist, Brown Brothers Harriman, "A Note on Investment Income of Medical Malpractice Companies," (February 4, 2003) (available at http://salsa.bbh.com/news/Articles/medmal2).

[81] Tillinghast-Towers Perrin, U.S. Tort Costs: 2002 Update—Trends and Findings on the U.S. Tort System, at 2.

[82] Insurance premiums represent one of the two main sources of revenue for insurance carriers. The other source is the profits earned by insurance carriers from investing premium dollars between the time premiums are received from the insured and the time these funds are disbursed to pay for losses and expenses attributable to that policy year. When investment rates of return are unusually high, insurers reduce rates to insure as many risks as possible and thereby capture and invest premium dollars. During underwriting cycles, rates are reduced when carriers expect to offset any losses with investment income. If investment income falls, insurers lose that source of income, creating pressure to raise premiums.

crease in the size of claims payments, particularly the increasing frequency of very large payments, largely accounts for the total increase in paid losses.[83]

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.[84] The problem is

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[83] D. Nye, D. Gifford, B. Webb, and M. Dewar, "The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances," 76 Georgetown L.J. 1495, 1515, 1525, 1528–29, 1556, 1560 (1988).

[84] *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 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

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particularly acute for practitioners in managed care, where prescribed fixed costs prevent them from recouping insurance costs.[85] Hardest hit by the premium increase are doctors in high-risk specialties, such as obstetrics and emergency medicine.[86] Obstetricians and gynecologists are facing increasing numbers of lawsuits nationwide,[87] yet the majority of these costly lawsuits are dropped or settled without any payment on behalf of the practitioner.[88] This situation is depleting the ranks of obstetricians and gynecologists.[89] Further, malpractice premiums are disproportionately high among obstetricians and family practitioners that deliver babies.[90] These high premiums and correspondingly lower incomes discourage medical students from entering into obstetrics or high risk specialties. In addition, physicians approaching retirement will 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 Med-

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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.").

[85] *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.").

[86] *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.").

[87] *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).").

[88] *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.").

[89] *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.").

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

icaid.[91] In sum, rising malpractice premiums will cost lives.[92] 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 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

[91] *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.").

[92] *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.").

dollars of premium was charged per insured for almost half a million less coverage per claim.[93]

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.[94] 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).[95] 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.[96]

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[97]; limits on contingency fees lawyers can charge in such suits[98]; 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[99]; and authorization for courts to require periodic payments for future damages instead of lump sum awards.[100] The contingency fee limits were upheld by the California Supreme Court in *Roa* v. *Lodi Medical Group*.[101] The other provisions were upheld by the California Supreme Court in *Fein* v. *Permanente Medical Group*,[102] and the United States Supreme Court upheld

[93] 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.
[94] *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.
[95] *See id.* at 5.
[96] *See id.* at 6.
[97] *See* Ca. Civ. § 3333.2.
[98] *See* Ca. Bus. & Prof. § 6146.
[99] *See* Ca. Civ. § 3333.1.
[100] *See* Ca. Civ. Pro. § 667.7.
[101] 37 Cal.3d 920 (1985).
[102] 38 Cal.3d 137 (1985).

the same without written opinions.[103] The Congressional Research Service has concluded that current Supreme Court Commerce Clause jurisprudence supports the constitutionality of Congressional regulation of medical malpractice.[104]

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.[105] 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."[106] 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."[107]

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."[108] Additional evidence shows that an increase in malpractice premiums results in an increase in doctor's fees. Researchers who modeled the effects of premium in-

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[103] *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).

[104] *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.").

[105] *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.

[106] 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.

[107] *Id.* at 73.

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

creases 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.[109]

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 to their 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.[110]

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.[111] 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.[112]

Finally, MICRA's limits on attorneys fees allow more money to go directly to injured patients.[113] According to the Department of Health and Human Services:

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[109] 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.

[110] *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.

[111] *See id.* at 21.

[112] *See id.* at 22.

[113] 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.

> 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.[114]

Most other countries, including England and Scotland, prohibit contingent fees in many circumstances.[115] 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.[116] Researchers have estimated that "no less than $7.5 to $10 billion in unethical, windfall contingency fees are now charged annually."[117]

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 reimbursed."[118] 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—who are "officers of the court" and not simply private actors—and the legal system, or they

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[114] 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.

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

[116] *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).

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

[118] 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.

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 or her demonstrable, quantifiable 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, quantifiable 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,[119] 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 client'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

[119] *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.").

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."[120] 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 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.[121] The types of reforms these researchers considered "direct" include caps on non-economic damage awards and collateral source rule reforms.[122]

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

Economists have conducted two extensive studies using national data on Medicare populations and concluded that patients from States that adopted direct medical care 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 pa-

[120] 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.

[121] *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.").

[122] *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).

tients in managed care programs,[123] and an average reduction of 7.4% in hospital costs for patients in non-managed care programs.[124] 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 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.[125]

Using recent data, it is estimated that 96.8% of Federal Medicare payments pays for physician and hospital expenses.[126] In 2001, the net Federal outlays for Medicare beneficiaries in managed care group plans was $42.1 billion[127] out of total Federal Medicare benefits of $233 billion.[128] 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.[129] 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%, 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.

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[123] 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.

[124] 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 three 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.

[125] 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).

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

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

[128] *Id.*

[129] *Id.*

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%.[130] Federal Medicare payments for physician services are estimated at $41.2 billion in 2001,[131] and the percent of that figure that pays for malpractice premiums is 3.2%,[132] 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,[133] 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.[134] 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 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 per year without serious adverse health outcomes."[135] The $50 billion figure has been

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[130] Office of Health Research, Statistics & Technology, U.S. Department of Health and Human Services (1981) at 203.

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

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

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

[134] *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.

[135] 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

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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."[136] 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."[137]

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 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 con-

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.").

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

[137] *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.

sumers 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." [138]

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.[139]

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 injury, men would feel that their inclination as well as their duty to see the laws observed." [140]

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

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

[139] 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).*

[140] 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).

amount of damages.[141] Joint liability is unfair because it puts full responsibility on those who may have been only marginally at fault.[142]

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."[143]

The Volunteer Protection Act of 1997,[144] abolished joint liability for non-economic damages for volunteers of nonprofit organizations. That law was overwhelmingly supported by a bipartisan majority of Congress.[145] 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,[146] 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 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."[147]

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

[142] 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.

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

[144] P.L. No. 105–19, 111 Stat. 218.

[145] *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).

[146] P.L. No. 105–230, 21 U.S.C. §§ 1601–1606.

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

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.[148] 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

H.R. 5 does not limit in any way an award of "economic damages" from anyone responsible for harm. Economic damages include anything whose value can be quantified, including lost wages or home services (including lost services provided by stay-at-home mothers), medical costs, the costs of pain-reducing drugs, therapy, and lifetime rehabilitation care, and anything else to which a receipt can be attached. Only economic damages—which the Federal legislation does not limit—can be used to pay for drugs and services that actually reduce pain. Nothing in H.R. 5 prevents juries from awarding very large amounts to victims of medical malpractice, including stay-at-home mothers and children. California's legal reforms cap non-economic damages at $250,000, but do not cap quantifiable economic damages. In just the last few years, juries in California have awarded the following in economic damages to medical malpractice victims: an $84,250,000 award to a 5-year-old boy, a $59,317,500 award to a 3-year-old girl, a $50,239,557 award to a 10-year-old boy, a $12,558,852 award to a 30-year-old homemaker, $27,573,922 award to a 25-year-old woman,[149] and $49 million to a minor child.[150] In those very rare cases in which a plaintiff was injured yet can demonstrate absolutely no quantifiable economic losses, under H.R. 5 that plaintiff can still get up to $250,000 in noneconomic damages and up to $250,000 in punitive damages, for a total of $500,000 in damages even when absolutely no quantifiable damages at all result from an alleged injury.

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[148] 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.").

[149] Information provided by Californians Allied for Patient Protection.

[150] *Steven Andrew Olsen, by and through his Guardian Ad Litem, Kathy Olsen* v. *Regents of University of California*, Superior Court of California, County of San Diego, Case No. 666808 (order entered January 24, 1995).

H.R 5 also does not preempt any State law that limits damages at specific amounts, be they higher or lower than the limits provided for in H.R. 5.

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

Reform at the Federal level is necessary to increase workers' access to health care everywhere. We live in an interconnected economy that includes many businesses that operate in many different States. Unlimited liability in some States makes health care costs go up. When health care costs go up in one State, they can affect a company's ability to offer health insurance to employees nationwide. Because of this, CBO concluded that the HEALTH Act would lead to "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." [151]

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 fifty-one jurisdictions—fifty States and the District of Columbia—created problems for interstate commerce.[152] The HEALTH Act would be enacted pursuant to 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 [153] 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 deter-

[151] Congressional Budget Office Cost Estimate of H.R. 4600 (the HEALTH Act) (September 24, 2002).

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

[153] 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.").

> mines 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.[154]

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." [155]

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. 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 trier 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 reduce 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,[156] 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." [157]

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[154] Tort Policy Working Group, An Update on the Liability Crisis (March 1987), at 90–91.
[155] *Id.* at 95.
[156] Ca.Civ. § 3333.1.
[157] *Barme* v. *Wood*, 689 P.2d 446, 450 (Ca. 1984).

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.[158] The Supreme Court has also emphasized that "the impact of [a punitive damages award] is unpredictable and potentially substantial."[159]

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.[160] Proportionality has been an important part of the United States Supreme Court's consideration of the validity of criminal punishment.[161] Even serious crimes such as larceny, robbery, and arson have sentences defined with a maximum set forth in a statute.[162] 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."[163] 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.[164]

At the State level, limits on punitive damages awards exist in a number of States.[165]

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[158] *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).

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

[160] 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.

[161] *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 ").

[162] 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).

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

[164] *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).

[165] *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).

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.[166] In many of these cases, the threat of punitive damages may be abused to force higher settlements.[167] 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."[168] 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 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.[169]

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.[170] 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

[166] *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).

[167] *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.

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

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

[170] *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).

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 [171] 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 Laws.[172] The Supreme Court has also specifically endorsed the "clear and convincing evidence" standard in punitive damages cases.[173] There is also support for the "clear and convincing evidence" standard at the Federal level. The Volunteer Protection Act of 1997,[174] 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

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[171] *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).

[172] *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).

[173] *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'").

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

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.[175] Other States have made changes through court rules or legislation.[176] Bifurcation of punitive damages trials is supported by the American Bar Association, the American College of Trial Lawyers, and the National Conference of Commissioners on Uniform State Laws, among other well-known organizations.[177]

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.[178]

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

Litigation is threatening the viability of the life-saving drug industry.[179] To help encourage new drug development and contain

[175] *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).

[176] *See, e.g.,* Cal. Civ. Code §3295(d); Minn. Stat. Ann. §549.20; Miss. Code Ann. §11–1–65(1)(a).

[177] *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.

[178] *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.").

[179] *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

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the costs of life-saving drugs, the HEALTH Act contains a safe harbor from punitive damages for defendants whose drugs or medical products [180] 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 hearing, to withdraw approval for marketing of a drug.[181] 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." [182]

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").[183] The NDA process requires the pharmaceutical manufacturer to submit proposed labeling for the drug.[184] 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.[185] If the FDA approves

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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.").

[180] The term "medical product" as used in the HEALTH Act is meant to include human blood and its components and derivatives. The Committee recognizes that the statutory definition of "drug" in section 201(g)(1) of the Federal Food, Drug and Cosmetic Act includes these products. *See United States* v. *Calise*, 217 F.Supp. 705, 709 (S.D.N.Y. 1962) (human blood is a drug under section 201(g)(1)).

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

[182] *See* 21 U.S.C. § 355(e).

[183] Under the FDCA, the manufacturer must submit an NDA to the agency and receive premarketing 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).

[184] 21 U.S.C. § 355(b)(1)(F).

[185] 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.

the NDA and licenses the drug for sale, the manufacturer has a continuing obligation to report safety-related information to the agency.[186] 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.[187] 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.[188] 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 information.[189] 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.[190] 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.[191]

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

[187] *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.").

[188] *See* 21 C.F.R. § 314.80.

[189] *See* 21 C.F.R. § 314.80(c)(1).

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

[191] 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.Stat.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. Colorado and North Dakota also have versions of the government standard defense. *See* Co.St. § 13–21–403; N.D.St. § 32–03.2–11.

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

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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. 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.[192] However, in 1976, Congress enacted amendments which require premarket approval for medical devices such as the Dalkon Shield.[193] Both the Senate and House Committee Reports specifically mention the Dalkon Shield as a product which had caused harm that could have been prevented if the new law had been in effect when it was first marketed.[194] 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.

Section 7 of H.R. 5 also contains a provision that protects doctors and pharmacists from being named in products liability lawsuits for forum shopping purposes. Such provision addresses situations in which plaintiffs' attorneys name a local doctor or pharmacist as a defendant in a lawsuit to oust Federal courts of appropriate jurisdiction in products liability cases so they can fix cases in plaintiff-friendly and potentially biased courts. Under the rules governing diversity jurisdiction in Federal cases, complete diversity must exist for a case to be brought in, or removed to, Federal court—that is, all of the plaintiffs must be from different States than all of the

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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.

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

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

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

defendants. Therefore, if a plaintiffs' attorney names a local defendant, however marginal its involvement may be in the case, the attorney can prevent the case from being heard in Federal court. In order to put an end to this abuse of the legal system, H.R. 5 contains a provision that precludes plaintiffs from naming a health care provider who prescribes, or dispenses pursuant to a prescription, a drug or device approved by the FDA as a party to a product liability lawsuit regarding that drug or device. The effect of that section is to preclude plaintiffs' lawyers from naming a local doctor as a defendant in a lawsuit simply to defeat Federal court jurisdiction. This provision prevents health care providers from being subject to lawsuit abuse. When doctors or pharmacies are added to product liability cases when they have only sold a product as it was manufactured, judgments are virtually never entered against them. Rather, the manufacturer pays. Nevertheless, local doctors and pharmacists are subject to huge legal costs and valuable time away from an important job.

Take the following example recounted in the Mississippi Clarion-Ledger describing the problem faced by a Dr. Kirk Kooyer:

> Last fall, Kooyer found himself sued again, this time for prescribing Propulsid. The U.S. Food and Drug Administration has linked the heartburn drug to 80 deaths nationally and has said it should be used only as a last resort for patients given heart tests to ensure they are at a low risk for the side effects. When Hazel Norton of Rolling Fork, the who filed suit, read the drug 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 intended, 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.[195]

Another example is Hilda Bankston, a Mississippi pharmacist, who has testified before both the House and Senate Judiciary Committees that the pharmacy that she and her husband formerly owned has been named as a defendant in "hundreds" of lawsuits against pharmaceutical manufacturers simply to keep the cases in State court. Mrs. Bankston described the "nightmare" that she endured as follows: "In using Bankston Drugstore as a springboard into Jefferson County courts, class action attorneys have caused me to spend countless hours retrieving information for potential plaintiffs. I have been dragged into court on numerous occasions to tes-

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

tify. I have endured the whispers and questions of my customers and neighbors wondering what we did to end up in court so often."[196] Local business owners should not have to endure what Mrs. Bankston has had to endure.

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.[197] The periodic payment 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 im-

[196] Written testimony of Hilda Bankston submitted to the Committee on February 6, 2002.

[197] 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 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.

proper 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—and 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)." [198]

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 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 manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following: (1) upon proof of fraud; (2) intentional concealment; or (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person. Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or

[198] 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.

collusion in the failure to bring an action on behalf of the injured minor. These provisions are based on California's MICRA law.[199]

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 otherwise caps damages, including 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.

Regardless of the merits of any given case, there are inherent problems with so-called "pain and suffering" or "noneconomic" dam-

[199] *See* Cal.C.C.P. § 340.5.

ages: they are utterly standardless, unquantifiable, and subject to discriminatory application based of whether or not a particular person happens to be sympathetic or unsympathetic, and even whether or not a particular case has attracted media attention. Tony Dyess injury did not receive media attention. He was in a car accident in Mississippi. There were no longer any neurosurgeons in the area. They had stopped practicing because they couldn't afford medical professional liability insurance. It took 6 hours to airlift Tony Dyess to a hospital that could treat his brain injury. It was too late. The "golden hour" had passed, and Tony Dyess has been left permanently brain damaged. As Tony Dyess' wife Leanne has said, From my perspective, sitting here today, this problem far exceeds any other challenge facing America's health care—even the challenge of the uninsured. My family had insurance when Tony was injured. We had good insurance. What we didn't have was a doctor. And now, no amount of money can relieve our pain and suffering."[200]

Injured victims should be adequately compensated for their injuries. But too often in this debate we lose sight of the larger health care picture. The best evidence about medical injuries comes from two large studies of hospital records, which both concluded that under 1 percent of hospital charts showed negligent medical injury.[201] This country is blessed with the finest health care technology in the world. It is blessed with the finest doctors in the world. People are smuggled into this country for a chance at life and healing—the best chance they have in the world. Just read the report charting health trends recently issued by the Department of Health and Human Services.[202] During the past half century, death rates among children and adults up to age 24 were cut in half. Mortality among adults 25–64 years fell nearly as much, and dropped among those 65 years and over by a third. The infant mortality rate has plummeted 75% since 1950. These amazing statistics did not just happen. They happened because America produces the best health care technology and the best doctors to use it. But today, there are fewer and fewer doctors to use that miraculous technology, or to use that technology where their patients are. For example, we have the best brain scanning and brain operation devices in history, and fewer and fewer neurosurgeons to use them. According to the American Board of Neurological Surgery, in 2001 alone, 327 board-certified neurosurgeons retired, an alarming 10% of the entire neurological workforce in the United States.[203] Only about 150 neurosurgeons graduate from residency training programs each year, and it takes about 5 years of post-residency to become board certified. Yet while fewer and fewer neurosurgeons can be reached by injured people within the "golden hour" that often separates life and death, unlimited lawsuits—driven by the desire

[200] Written testimony of Leanne Dyess, submitted to the Committee March 24, 2003.

[201] D. Mills, J. Boyden, and D. Rubsamen, "Report on the Medical Insurance Feasibility Study," (San Francisco: Sutter Publications 1977, sponsored jointly by the California Medical Association and California Hospital Association); A. Localio, A. Lawthers, T. Brennan, N. Laird, L. Hebert, L. Peterson, J. Newhouse, P. Weiler, and H. Hiatt, "Relation Between Malpractice Claims and Adverse Events Due to Negligence," New Engl. J. Med. 325:245–251 (1991).

[202] *See* "HHS Issues Report Showing Dramatic Improvements in America's Health Over Past 50 Years: Infant Mortality at Record Low, Life Expectancy at Record High" (September 12, 2002) (available at http://www.cdc.gov/nchs/releases/02news/hus02.htm).

[203] Statement of the Alliance of Specialty Medicine, submitted to the Committee on February 28, 2003.

of some personal injury lawyers for their cut of unlimited awards for unquantifiable damages—are driving doctors out of the healing profession. They are setting back the clock. They are making us all less safe. When someone gets sick, or is bringing a child into the world, and we can't call a doctor, who can one call? A lawyer?

As amazing as America's health statistics are, California—where the reforms in H.R. 5, including its cap on noneconomic damages, have been the law for over 25 years—has even healthier people than the nation as a whole. According to California Health Statistics for the year 2000 (the most recent available information) the overall mortality rate in California is 24% below the national average and the infant mortality rate in California is 19% below the national average. Lower noneconomic damage awards in California have led to healthier people.

Under H.R. 5, victims will be fairly compensated and medical errors will be deterred. Without H.R. 5, victims will be left to suffer and die because there will fewer doctors there to treat them. Sound policy does not favor supporting people's abstract ability to sue a doctor for unlimited, unquantifiable damages when doing so means that there is no doctor to treat people in the first place. The American Bar Association estimates there are 1 million lawyers in America. But all of us—all 287 million Americans—are patients. As patients, and for patients, the Committee recommends that the House pass the HEALTH Act.

HEARINGS

On March 4, 2003, the Committee held 1 day of hearings on H.R. 5. Testimony was received from Sherry Keller, Conyers, Georgia; Leanne Dyess, Member, Coalition for Affordable and Reliable Health Care; Donald J. Palmisano, M.D., J.D., President-elect, American Medical Association; Lawrence E. Smarr, President, Physician Insurers Association of America, with additional material submitted by other individuals and organizations.

COMMITTEE CONSIDERATION

On March 5, 2003, the Committee met in open session and ordered favorably reported the bill H.R. 5 with amendment by a rollcall vote of 15 yeas and 13 nays, a quorum being present.

VOTE OF THE COMMITTEE

1. Mr. Delahunt offered an amendment to the amendment in the nature of a substitute to H.R. 5 that would have allowed health care providers (such as obstetricians and gynecologists) to be sued for up to 21 years after they allegedly caused an injury (for example, up to 21 years after they delivered a baby). By a rollcall vote of 15 yeas to 19 nays, the amendment was defeated.

ROLLCALL NO. 1

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte		X	

ROLLCALL NO. 1—Continued

	Ayes	Nays	Present
Mr. Chabot		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Bachus		X	
Mr. Hostettler			
Mr. Green		X	
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence		X	
Mr. Forbes		X	
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Ms. Blackburn		X	
Mr. Conyers	X		
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren	X		
Ms. Jackson Lee	X		
Ms. Waters	X		
Mr. Meehan	X		
Mr. Delahunt	X		
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff	X		
Mr. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	15	19	

2. Mr. Berman offered an amendment that would have delayed the implementation of the amendment in the nature of a substitute to H.R. 5 until after States put in place various health care provider licensing and disciplining procedures. By a rollcall vote of 10 yeas to 16 nays, the amendment was defeated.

ROLLCALL NO. 2

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte		X	
Mr. Chabot		X	
Mr. Jenkins		X	
Mr. Cannon			
Mr. Bachus			
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake			
Mr. Pence		X	
Mr. Forbes		X	
Mr. King		X	
Mr. Carter			

ROLLCALL NO. 2—Continued

	Ayes	Nays	Present
Mr. Feeney		X	
Ms. Blackburn			
Mr. Conyers	X		
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt		X	
Ms. Lofgren	X		
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan			
Mr. Delahunt	X		
Mr. Wexler	X		
Ms. Baldwin	X		
Mr. Weiner			
Mr. Schiff			
Mr. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	10	16	

3. Mr. Nadler offered an amendment to the amendment in the nature of a substitute to H.R. 5 that would have allowed courts to make public court records when specified criteria were met. By a rollcall vote of 13 yeas to 19 nays, the amendment was defeated.

ROLLCALL NO. 3

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte		X	
Mr. Chabot		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Bachus			
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence		X	
Mr. Forbes		X	
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Ms. Blackburn		X	
Mr. Conyers	X		
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren			
Ms. Jackson Lee	X		
Ms. Waters	X		
Mr. Meehan	X		
Mr. Delahunt	X		
Mr. Wexler			
Ms. Baldwin	X		

ROLLCALL NO. 3—Continued

	Ayes	Nays	Present
Mr. Weiner	X		
Mr. Schiff	X		
Mr. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	13	19	

4. Mr. Nadler offered an amendment to the amendment in the nature of a substitute to H.R. 5 that would have indexed its default limits on damages to the consumer price index. By a rollcall vote of 16 yeas to 17 nays, the amendment was defeated.

ROLLCALL NO. 4

	Ayes	Nays	Present
Mr. Hyde		X	
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte		X	
Mr. Chabot	X		
Mr. Jenkins	X		
Mr. Cannon		X	
Mr. Bachus	X		
Mr. Hostettler		X	
Mr. Green			
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence		X	
Mr. Forbes		X	
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Ms. Blackburn		X	
Mr. Conyers	X		
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren	X		
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan	X		
Mr. Delahunt	X		
Mr. Wexler			
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff	X		
Mr. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	16	17	

5. Mr. Watt offered an amendment to the amendment in the nature of a substitute to H.R. 5 that would have prohibited its protections from applying in State courts and in alternative dispute resolution procedures. By a rollcall vote of 12 yeas to 18 nays, the amendment was defeated.

ROLLCALL NO. 5

	Ayes	Nays	Present
Mr. Hyde		X	
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte		X	
Mr. Chabot		X	
Mr. Jenkins		X	
Mr. Cannon		X	
Mr. Bachus			
Mr. Hostettler			
Mr. Green		X	
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence		X	
Mr. Forbes		X	
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Ms. Blackburn			
Mr. Conyers	X		
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren			
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan	X		
Mr. Delahunt	X		
Mr. Wexler			
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff	X		
Mr. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	12	18	

6. Mr. Delahunt offered an amendment to the amendment in the nature of a substitute to H.R. 5 that would have increased its default limits on damages from $250,000 to $1,600,000. By a rollcall vote of 14 yeas to 15 nays, the amendment was defeated.

ROLLCALL NO. 6

	Ayes	Nays	Present
Mr. Hyde		X	
Mr. Coble		X	
Mr. Smith (Texas)		X	
Mr. Gallegly		X	
Mr. Goodlatte			
Mr. Chabot			
Mr. Jenkins	X		
Mr. Cannon		X	
Mr. Bachus			
Mr. Hostettler			
Mr. Green		X	
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence		X	

ROLLCALL NO. 6—Continued

	Ayes	Nays	Present
Mr. Forbes		X	
Mr. King		X	
Mr. Carter			
Mr. Feeney		X	
Ms. Blackburn		X	
Mr. Conyers	X		
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren			
Ms. Jackson Lee	X		
Ms. Waters	X		
Mr. Meehan	X		
Mr. Delahunt	X		
Mr. Wexler			
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff	X		
Mr. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	14	15	

7. Mr. Scott offered an amendment to strike the amendment in the nature of a substitute to H.R. 5's provisions relating to subrogation by providers of collateral source benefits. By a rollcall vote of 11 yeas to 17 nays, the amendment was defeated.

ROLLCALL NO. 7

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

ROLLCALL NO. 7—Continued

	Ayes	Nays	Present
Mr. Delahunt	X		
Mr. Wexler			
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff			
Mr. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	11	17	

8. Mr. Scott offered an amendment to strike subsection 4(d) of the amendment in the nature of a substitute to H.R. 5. By a rollcall vote of 12 yeas to 16 nays, the amendment was defeated.

ROLLCALL NO. 8

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble		X	
Mr. Smith (Texas)			
Mr. Gallegly		X	
Mr. Goodlatte			
Mr. Chabot		X	
Mr. Jenkins		X	
Mr. Cannon			
Mr. Bachus			
Mr. Hostettler		X	
Mr. Green		X	
Mr. Keller		X	
Ms. Hart		X	
Mr. Flake		X	
Mr. Pence		X	
Mr. Forbes		X	
Mr. King		X	
Mr. Carter		X	
Mr. Feeney		X	
Ms. Blackburn		X	
Mr. Conyers	X		
Mr. Berman	X		
Mr. Boucher			
Mr. Nadler	X		
Mr. Scott	X		
Mr. Watt	X		
Ms. Lofgren			
Ms. Jackson Lee	X		
Ms. Waters			
Mr. Meehan	X		
Mr. Delahunt	X		
Mr. Wexler			
Ms. Baldwin	X		
Mr. Weiner	X		
Mr. Schiff	X		
Mr. Sánchez	X		
Mr. Sensenbrenner, Chairman		X	
Total	12	16	

9. Motion to Report H.R. 5 with an amendment in the nature of a substitute was agreed to by a rollcall vote of 15 yeas to 13 nays.

ROLLCALL NO. 9

	Ayes	Nays	Present
Mr. Hyde			
Mr. Coble			
Mr. Smith (Texas)			
Mr. Gallegly	X		
Mr. Goodlatte			
Mr. Chabot	X		
Mr. Jenkins	X		
Mr. Cannon	X		
Mr. Bachus			
Mr. Hostettler	X		
Mr. Green	X		
Mr. Keller	X		
Ms. Hart	X		
Mr. Flake			
Mr. Pence	X		
Mr. Forbes	X		
Mr. King	X		
Mr. Carter	X		
Mr. Feeney	X		
Ms. Blackburn	X		
Mr. Conyers		X	
Mr. Berman		X	
Mr. Boucher			
Mr. Nadler		X	
Mr. Scott		X	
Mr. Watt		X	
Ms. Lofgren		X	
Ms. Jackson Lee		X	
Ms. Waters		X	
Mr. Meehan		X	
Mr. Delahunt		X	
Mr. Wexler			
Ms. Baldwin		X	
Mr. Weiner		X	
Mr. Schiff			
Mr. Sánchez		X	
Mr. Sensenbrenner, Chairman	X		
Total	15	13	

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. 5 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. 5, 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, March 10, 2003.

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. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003.

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, Leo Lex (for the State, local, and tribal impacts), who can be reached at 225–3220, and Stuart Hagen (for the private-sector impact), who can be reached at 226–6666.

Sincerely,

DOUGLAS HOLTZ-EAKIN.

Enclosure

cc: Honorable John Conyers, Jr.
Ranking Member

H.R. 5—Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003.

SUMMARY

H.R. 5 would impose limits on medical malpractice litigation in State and Federal courts by capping awards and attorney fees, modifying 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 other fringe benefits. As a result, CBO estimates that enacting H.R. 5 would increase Federal revenues by $15 million in 2004 and by $3 billion over the 2004–2013 period.

Enacting H.R. 5 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 $14.9 billion over the 2004–2013 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. 5 would reduce discretionary spending for the FEHB program by about $230 million over the 2004–2013 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 ($59 million in 2003, adjusted annually for inflation) would not be exceeded.

H.R. 5 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 ($117 million in 2003, adjusted annually for inflation) in all but the first year the mandate would be effective.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 5 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										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004 - 2013
CHANGES IN REVENUES											
Income and HI Payroll Taxes (on-budget)	10	70	170	210	220	230	250	270	290	330	2,050
Social Security Payroll Taxes (off-budget)	5	20	60	90	100	110	120	130	140	150	925
Total	15	90	230	300	320	340	370	400	430	480	2,975
CHANGES IN DIRECT SPENDING											
Estimated Budget Authority	-170	-480	-910	-1,250	-1,570	-1,820	-1,990	-2,130	-2,220	-2,350	-14,900
Estimated Outlays	-170	-480	-910	-1,250	-1,570	-1,820	-1,990	-2,130	-2,220	-2,350	-14,900
CHANGES IN SPENDING SUBJECT TO APPROPRIATION											
Estimated Authorization Level	-2	-10	-20	-20	-20	-30	-30	-30	-30	-30	-230
Estimated Outlays	-2	-10	-20	-20	-20	-30	-30	-30	-30	-30	-230

NOTE: HI = Medicare Hospital Insurance program.

BASIS OF ESTIMATE

This estimate assumes that H.R. 5 will be enacted in July 2003. It would apply to lawsuits initiated on or after the date of enactment.

Major Provisions of the Bill

H.R. 5 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. 5 would limit the liability of each defendant to the share of damages attributable to his or her responsibility.

The bill would allow evidence of collateral-source benefits to be introduced at trial by either claimants or defendants. 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. 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 and claims data for medical malpractice insurance coverage in States that have and have not enacted laws that limit awards for medical malpractice torts. The data include information on malpractice awards and insurance premiums, the characteristics of State insurance markets, State laws regarding malpractice torts, and socioeconomic measures. Data were provided by several organizations including Medical Liability Monitor; Insurance Services Office, Inc.; Physician Insurers Asso-

ciation of America; National Association of State Insurance Commissioners; and the U.S. Census Bureau. 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 for unpaid claims, changes in market structure in certain States, and increases in the price of reinsurance.

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. 5 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 also took into consideration the likelihood that, in the future, some additional States would enact laws limiting malpractice torts in the absence of Federal legislation.

CBO estimates that, under this bill, premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent lower than what they would be under current law. However, other factors noted above may affect future premiums, possibly obscuring the anticipated effect of the legislation. The effect of H.R. 5 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-fifth 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. 5 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. A substantial portion of collateral source benefits are provided by 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 few 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 spending for a small number of ailments. One study analyzed the impact of tort limits on Medicare hospital spending for patients suffering acute myocardial infarction or ischemic heart disease, and observed a significant reduction in spending in States with such laws. Other research examined the effect of tort limits on the proportion of births by Caesarean section. It also found savings in States with tort limits, albeit of a much smaller magnitude. Using a longitudinal database of Medicare spending for fee-for-service beneficiaries between 1989 and 1999, CBO found no effect of tort controls on medical spending in an analysis that considered a broader set of ailments. Moreover, using a different data set, CBO could find no statistically significant difference in per capita health care spending between States with and without malpractice tort limits. These findings are preliminary, however, and CBO continues to explore this issue.

Federal Revenues

CBO estimates that, over a 3-year period, enacting H.R. 5 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. In the short term, some of the savings would be retained by employers as higher profits, and would result in higher collections of income taxes from employers. Ultimately, however, 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 $65 million in calendar year 2004 to $1.4 billion in 2013.

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 $15 million in 2004 and by a total of $3 billion over the 2004–2013 period if H.R. 5 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. 5 would reduce direct spending for Federal health insurance programs by $14.9 billion over the 2004–2013 period.

CBO estimates that premiums for the 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. 5 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.

Federal spending for annuitants in the FEHB program is considered direct spending. CBO estimates that H.R. 5 would reduce direct spending for annuitants in FEHB by $230 million over the 2004–2013 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. 5 would reduce discretionary spending for FEHB by about $230 million over the 2004–2013 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. 5 would have no effect on Medicare spending in 2003, because payment rates have already been set for hospital and physician services. CBO estimates that incorporating lower malpractice premiums in Medicare payment rates would reduce Medicare spending by $11.2 billion over the 2004–2013 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. 5 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. 5 would reduce direct spending for Medicaid and DoD by $3.5 billion over the 2004–2013 period.

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 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. 5 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 ($59 million in 2003, 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 the bill. 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 $6 billion over the 2004–2013 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 2004 to $185 billion in 2013 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 spending for Medicaid would decrease by $2.5 billion over the 2004–2013 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 be less than $100 million in 2003, and about $340 million per year in 2004 through 2007. Those costs would exceed the annual threshold specified in UMRA ($117 million in 2003, adjusted annually for inflation) in all but the first year the mandate would be effective.

PREVIOUS COST ESTIMATE

On September 24, 2002, CBO provided a cost estimate for H.R. 4600 as ordered reported by the Committee on the Judiciary. The current estimate differs from the earlier estimate in three ways. It:

- Reflects the exclusion of the Medicare and Medicaid programs from the collateral-source benefits provision in the bill, thus allowing them to continue to be secondary payers in medical malpractice cases. This change increases the estimated savings to the Medicare and Medicaid programs.
- Corrects the previous estimate, which overstated on-budget savings in the FEHB program because it included off-budget effects related to the Postal Service.
- Reflects changes in projections under current law of tax-sheltered health expenditures, as well as changes in projections of spending under current law for the Medicare, Medicaid, and FEHB programs.

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 2003."

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 that a health care lawsuit may be commenced no later than 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following: (1) upon proof of fraud; (2) intentional concealment; or (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person. Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

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 recovered.

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 law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this Act, notwithstanding section 4(a), 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

WEDNESDAY, MARCH 5, 2003

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

The Committee notice, pursuant to call, at 10 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. A working quorum is present. Pursuant to notice, I now call up the bill H.R. 5, the Health Proficient Accessible Low Cost Timely Health Care Act of 2003 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. 5, follows:]

I

108TH CONGRESS
1ST SESSION

H. R. 5

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

FEBRUARY 5, 2003

Mr. GREENWOOD (for himself, Mr. MURTHA, Mr. COX, Mr. SENSENBRENNER, Mr. TAUZIN, Mr. THOMAS, Mr. GOODE, Mr. FERGUSON, Mr. GERLACH, Mrs. CAPITO, Mr. FEENEY, Mr. KIRK, Mrs. BIGGERT, Mr. PLATTS, Mr. SHAYS, Mr. FRELINGHUYSEN, Mr. MURPHY, Mr. PETERSON of Minnesota, Mr. LUCAS of Kentucky, Mr. STENHOLM, Mr. TAYLOR of Mississippi, Mr. HOBSON, Ms. GRANGER, Mrs. JOHNSON of Connecticut, Ms. DUNN, Mr. ROGERS of Michigan, Ms. GINNY BROWN-WAITE of Florida, Mr. HAYES, Mr. LEACH, Mr. OTTER, Mr. GRAVES, Mr. LATOURETTE, Mr. FLETCHER, Mr. WELDON of Florida, Mr. TIBERI, Mr. HAYWORTH, Mr. CRANE, Mr. PORTMAN, Mr. SULLIVAN, Mr. SOUDER, Mr. CANNON, Mr. SHAW, Mr. MCHUGH, Mr. MCKEON, Mr. LEWIS of Kentucky, Mrs. NORTHUP, Mr. SESSIONS, Mr. HULSHOF, Mr. PUTNAM, Mr. GILCHREST, Mr. KNOLLENBERG, Mr. HOUGHTON, Mr. REGULA, Mr. TOM DAVIS of Virginia, Mr. FORBES, Mr. PETERSON of Pennsylvania, Mr. LOBIONDO, Mr. BOEHLERT, Mr. NUSSLE, Mr. SHUSTER, Mr. TIAHRT, Mr. STEARNS, Mr. GILLMOR, Ms. HART, Mr. WALSH, Mr. CRENSHAW, Mr. BARTON of Texas, Mr. KELLER, and Mr. COLLINS) 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 Healthcare (HEALTH) Act of 2003''.

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;

(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.

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

after the date of manifestation of injury unless tolled for any of the following:

(1) Upon proof of fraud;

(2) Intentional concealment; or

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

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

SEC. 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 sec-

tion, 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. This section shall not apply to section 1862(b) (42

U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

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, if awarded, in a health care lawsuit, the trier of fact shall consider only the following:

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

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

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

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

causing the harm complained of by the claimant;

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

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

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

(c) NO CIVIL MONETARY PENALTIES FOR PRODUCTS IN COMPLIANCE WITH FDA STANDARDS.—

(1) PUNITIVE DAMAGES.—

(A) IN GENERAL.—In addition to the requirements of subsection (a), punitive damages may not be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product, on the basis that the harm to the claimant was caused by the lack of safety or effectiveness of the particular medical prod-

uct involved, unless the claimant demonstrates by clear and convincing evidence that—

(i) the manufacturer or distributor of the particular medical product, or supplier of any component or raw material of such medical product, failed to comply with a specific requirement of the Federal Food, Drug, and Cosmetic Act or the regulations promulgated thereunder; and

(ii) the harm attributed to the particular medical product resulted from such failure to comply with such specific statutory requirement or regulation.

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

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes a medical product approved or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and

shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product.

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

SEC. 13. SENSE OF CONGRESS.

It is the sense of Congress that a health insurer should be liable for damages for harm caused when it

1 makes a decision as to what care is medically necessary
2 and appropriate.

○

Chairman SENSENBRENNER. Without objection, the amendment in the nature of a substitute which all Members have before them will be considered as read—considered as original text for purpose of amendment and will be open for amendment at any point.

[The amendment follows:]

AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 5 OFFERED BY MR. SENSENBRENNER

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 2003''.

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;

(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.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the

injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following:

(1) Upon proof of fraud;

(2) Intentional concealment; or

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

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

SEC. 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 judg-

ment 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. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

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, if awarded, in a health care lawsuit, the trier of fact shall consider only the following:

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

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

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

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

causing the harm complained of by the claimant;

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

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

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

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

(1) IN GENERAL.—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, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes, or who dispenses pursuant to a prescription, 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, or any medical product, affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services, or any medical product, affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system,

against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(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, mar-

1 keter, promoter, or seller of a medical product, in-
2 cluding, but not limited to, third-party claims, cross-
3 claims, counter-claims, or contribution claims, which
4 are based upon the provision of, use of, or payment
5 for (or the failure to provide, use, or pay for) health
6 care services or medical products, regardless of the
7 theory of liability on which the claim is based, or the
8 number of plaintiffs, defendants, or other parties, or
9 the number of causes of action.
10 (10) HEALTH CARE ORGANIZATION.—The term
11 ''health care organization'' means any person or en-
12 tity which is obligated to provide or pay for health
13 benefits under any health plan, including any person
14 or entity acting under a contract or arrangement
15 with a health care organization to provide or admin-
16 ister any health benefit.
17 (11) HEALTH CARE PROVIDER.—The term
18 ''health care provider'' means any person or entity
19 required by State or Federal laws or regulations to
20 be licensed, registered, or certified to provide health
21 care services, and being either so licensed, reg-
22 istered, or certified, or exempted from such require-
23 ment by other statute or regulation.
24 (12) HEALTH CARE GOODS OR SERVICES.—The
25 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 relate 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 do-

mestic 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 law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this Act, 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.

SEC. 13. SENSE OF CONGRESS.

It is the sense of Congress that a health insurer should be liable for damages for harm caused when it makes a decision as to what care is medically necessary and appropriate.

Chairman SENSENBRENNER. The Chair now recognizes himself for 5 minutes to explain the bill and the substitute amendment.

A national medical insurance crisis driven by uncontrolled litigation is devastating our Nation's health care system. Medical professional liability insurance rates have soared, causing major insurers to either drop coverage or raise premiums to unaffordable levels. Doctors are being forced to abandon patients and practices particularly in high risk specialties such as emergency medicine, brain surgery and OB-GYN.

H.R. 5 is modeled after the California quarter-century-old and highly successful health care litigation reforms known as MICRA. MICRA's reforms which are included in the HEALTH Act include a $250,000 cap on noneconomic damages, limits on the contingency fees lawyers can charge, and authorization for defendants to introduce evidence to prevent double recoveries. The bill also includes provisions creating a fair share rule by which damages are allocated fairly in direct proportion to fault, reasonable guidelines on the award of punitive damages, and a safe harbor from punitive damages for products that meet applicable FDA safety requirements.

It is important to note that nothing in the bill limits in any way economic damage awards from anyone responsible for harm. Economic damages include anything whose value can be quantified such as lost wages, lost services, provided medical costs, the cost of pain-reducing drugs and lifetime rehabilitation care, and anything else to which a receipt can be attached. Because of this, the reforms in the HEALTH Act still allow for very large multimillion-dollar awards to deserving victims, including homemakers and children.

The amendment in the nature of a substitute I am offering makes a few changes to the bill. As introduced, the bill includes a safe harbor from punitive damages for manufacturers of FDA-approved products, but does not contain exceptions for which or cases in which information required to be given to the FDA was withheld in cases in which illegal payments were made to the FDA.

My amendment in the nature of the substitute restores the language that passed the House last year which includes these exceptions. Not only are they sound policy, but they will further encourage manufacturers to fully share information with the FDA, because if they don't, they will lose the protection of the provision.

The amendment in the nature of substitute also makes clear that the protections in the bill apply to manufacturers of medical products, and it protects pharmacists as well as doctors from being named in product liability suits against drug manufacturers simply because a personal injury lawyer wants to keep the case in a favorite jurisdiction.

We all recognize that injured victims should be adequately compensated, but too often in this debate we lose sight of the broader health care picture. The USA has the finest health care technology in the world. It is blessed with the finest doctors in the world. People are smuggled into this country for a chance at life and healing. The Department of Health and Human Services issued a report recently that includes some amazing statistics. During the past half century, death rates among children and adults up to age 24 were cut in half and infant mortality has plummeted 75 percent. Mor-

tality among adults between ages 25 and 64 fell nearly as much, and dropped among those 65 or older by a third. In 2000, Americans enjoyed the longest life expectancy in history, almost 77 years.

These just didn't happen; they happened because America produces the best health care technology and the best doctors to use them. But now there are fewer and fewer doctors that use miraculous technology, or to use the technology where their patients are. We have the best brain scanning and brain operation devices in history and fewer and fewer neurosurgeons to use them. Unlimited lawsuits are driving doctors out of the healing profession. They are reversing the clock. They are making us all less safe, all in the name of unlimited lawsuits and personal injury lawyers' loss for their cut of unlimited awards for unquantifiable damages; that when somebody gets sick or is bringing a child into the world, if we can't call a doctor, who will we call, the plaintiff's bar?

We as a Nation have to choose. Do we want the abstract ability to sue a doctor for jackpot damage awards when doing so means there will be no doctors to treat ourselves and our loved ones in the first place? On behalf of all 287 million Americans, all of whom are patients, I urge the Committee to favorably report this bill, and yield 5 minutes to the gentleman from Michigan.

Mr. CONYERS. Thank you and good morning, Mr. Chairman and Members of the Committee. The question before us today is should we supersede the law in all 50 States to cap noneconomic damages, to cap and limit punitive damages, to cap attorneys' fees for poor victims, to shorten the statute of limitations, to eliminate joint and several liability, and eliminate any benefits that—from third party payments? If you answer no to those questions, then it will be difficult for you to support the measure that is presented for markup today.

Let's go through this. There are serious problems in health care, but H.R. 5 does not solve those problems. Now, we have studies which are available to Members and others that show that the caps on damages do not reduce insurance premiums. Caps on damages do not reduce insurance premiums. Now, if we can agree on that, then this measure before us has yet another problem.

Now, in a comparison of States that enacted severe tort restrictions in the mid-1980's and those that resisted enacting any tort reform, guess what? No correlation was found between tort reform and insurance rates. If that is true, then the rationale behind this measure is in deep trouble.

An example are two States I will pick at random, Florida and Michigan. The data from the 2002 Medical Liability Monitor shows that Florida and Michigan, two States with caps, had the highest average premiums in the country, while Minnesota and Oklahoma, two States without caps, had two of the three lowest average rates in the country.

Ladies and gentlemen of the Committee, these are the facts that have been presented to me. If there is something wrong with them, I hope that it will be brought out during the course of our discussion and markup. Data from the 2001 Medical Liability Monitor showed that for internal medicine, States with caps on damages had higher premiums than States without caps. For general surgeons, insurance premiums were 2.3 percent higher in States with caps on damages. Higher. Now, if these facts, scrupulously gath-

ered by the very efficient legal staff on Judiciary, are in any way erroneous or misleading or inaccurate or inapplicable, please, please, let us discuss this before you cast your vote before we leave here today.

So why are medical malpractice premiums rising? Well, if you understand or study the economics underlying insurance investment, then you would soon realize that insurers make their money from investment income, which is plummeting at this point. During years of high stock market returns and interest rates, malpractice premiums go down. They always do. When investment income decreases—and we are going through that part of a 4-year bear market right now—the industry responds by increasing premiums and reducing coverage, which creates the liability insurance crisis which is what supposedly brings us here now.

Chairman SENSENBRENNER. The gentleman's time has expired.

Mr. CONYERS. May I get a minute?

Chairman SENSENBRENNER. Without objection.

Mr. CONYERS. Thank you, sir. This boom-and-bust cycle has happened before, in the seventies and the eighties and the present—and presently. The reality is that somewhere between 98,000 and 100,000 people die in this country in hospitals, clinics, medical facilities every year from medical malpractice. So what we don't need to do is make the problem worse and then ignore the true causes for what causes the present crisis that we are in. And that is what I am afraid is the direction we are moving in with this measure.

Now, 5 percent of all the health care professionals are responsible for 54 percent of all malpractice claims paid. And the measure before us doesn't do much or maybe not anything about patient safety with that fact in mind. And on top of it, the industry of which I complain is exempt from antitrust laws. And we don't do anything to increase competition here.

Chairman SENSENBRENNER. The gentleman's time has once again expired.

Mr. CONYERS. I will submit the rest of my statement and I thank the Chairman for his indulgence.

Chairman SENSENBRENNER. Without objection, all Members' opening statements will appear in the record at this point.

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

PREPARED STATEMENT OF THE HONORABLE SHEILA JACKSON LEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. Chairman, thank you for allowing me the opportunity to speak on H.R. 5. This medical malpractice reform bill comes at a very difficult time in our nation. We are facing a crisis in our health care system.

I believe that our time would be better utilized not debating medical malpractice reform, but discussing legislation that promotes safety.

We are all aware of a recent disturbing report that an organ transplant at Duke University went awry, because of a botched heart transplant performed on a Mexican immigrant, Jesica Santillan, who was 17. This tragedy has shocked our nation and is a reminder of the enormous number of fatal medical errors—from 44,000 to 98,000 per year, according to a study from the Institute of Medicine. It also indicates a crisis in our nation's organ donor system.

H.R. 5 would shift costs onto injured individuals and their families. The provisions in the bill are unfair to victims: nursing home operators, medical device manufacturers, pharmaceutical companies, hospitals, and HMOs are covered by the bill's definition of "health care liability claim" and would be equally insulated from liability.

As we know, punitive damages are rarely awarded in medical malpractice cases; however, just the threat of punitive damages is important to deterring reckless dis-

regard for patient safety by HMOs, nursing homes, and drug and medical device manufacturers.

The awards for non-economic loss (pain and suffering resulting from injuries such as lost child-bearing ability, disfigurement, and paralysis) compensate for human suffering.

The $250,000 cap on non-economic damages is simply not sufficient in the face of the injustices to patients who are victims of medical error. Experience has shown that damage cap provisions would do little or nothing to reduce medical malpractice insurance premiums paid by doctors while hurting severely injured patients.

A federal cap of $250,000 on non-economic damages is not likely to reduce malpractice premiums because it does not address the causes of the malpractice insurance crisis.

According to the National Association of Insurance Commissioners, the three major causes of sharp underwriting cycles are large "loss shocks," changes in interest rates, and under-pricing. Lower interest rates and under-pricing have been in place for a while. This is important because insurance companies invest premiums in bonds and stocks before paying them out in claims. The investment "float" on medical malpractice insurance is particularly long—about six years. When interest rates decline or the market is down, insurance companies make up for the loss in income by raising rates. As interest rates have dropped sharply in the last few years, insurers have had to cover a lot of lost income.

More importantly, non-economic damages disproportionately affect children, seniors, low-income workers, and stay at home mothers.

H.R. 5 by placing a cap on attorneys' fees would prevent many victims from obtaining legal counsel. And, the doctrine of joint and several liability says that when two defendants, such as a doctor and a hospital, are both found liable for negligence, a plaintiff may collect the entire award from either of them if necessary. H.R. 5 changes this rule and would leave patients no recovery for the share of damages assigned to an uninsured, underinsured, or bankrupt defendant.

The law in most states starts the limitation period running from the discovery of the malpractice, not the discovery of the injury. This bill would shorten the statute of limitations to one year after discovery of the injury.

The study by the Institute of Medicine proposed a non-punitive method of reporting fatal errors. At Duke University officials have announced they will have three people verbally confirm matching blood type. However, the devastation has already occurred and affected the life of Jesica and her family.

Unfortunately, as we debate medical malpractice reform this botched organ transplant reminds us how the Republican proposed bill that would set a $250,000 cap on compensation for disfigurement, mutilation, blindness and other "non-economic" injuries caused by medical errors hurts patients who have undergone botched surgeries.

H.R. 5 would devastate the rights of patients like Jesica Santillan and their families. This legislation ignores people like Jesica and her family—who have suffered real injuries. These limits on damages deny justice for life-altering losses.

Jesica suffered from a congenital heart defect called restrictive cardiomyopathy. This heart deformity also affected her lungs; she was on the wait list for three years to receive a heart and lung transplant.

The value of Jesica's life as proposed by H.R. 5 would be measured only by the loss of her, "past and future earnings . . . and [the] loss of [her] business and employment opportunities."

It is not the cap on noneconomic damages alone that makes H.R. 5 unfair to the family of Jesica Santillan. Nor is the cap the sole provision in the bill that would act as a disincentive to bringing malpractice cases. Damages under this legislation are awarded only if a plaintiff proves that proves that a defendant specifically intended to injure a patent.

Across the country, efforts have been made to pass laws limiting the rights of medical malpractice victims. These laws typically include the following restrictions: caps on damages; limits on attorney fees; elimination of the collateral source rule; establishment of structured settlement or periodic payment system; mandatory submission of claims to panels or arbitration; and repose statutes.

Courts across the country have recognized the unconstitutionality of such sweeping restrictions on medical malpractice victims' rights. The vast majority of states—31—have ruled that such restrictions on the rights of medical malpractice victims are unconstitutional.

It would be another tragedy if Congress uses its Constitutional authority to eliminate the legal rights of hard-working American families.

My state of Texas has held that such statutes violate fundamental constitutional rights. Texas is one state along with 19 others where the courts have ruled that caps or limitations on medical malpractice damages are unconstitutional. States'

medical malpractice caps on damages have been struck down as unconstitutional violations of equal protection, jury trial, open courts, or due process guarantees.

There is no evidence that malpractice costs have contributed to overall rising medical costs. In fact, deterring malpractice among physicians is the best way to bring down costs and protect our families.

In my state of Texas approximately three to seven thousand preventable deaths in Texas each year are due to medical errors. The costs resulting from preventable medical errors to Texas residents, families and communities are estimated at $1.3 billion to $2.2 billion each year, but the cost of medical malpractice insurance to Texas doctors is only $421.2 million per year. And, in Texas, the total number of Texas malpractice claims has dropped for two consecutive years. Between 1997 and 2002, the number of physicians and osteopaths practicing in Texas increased from 31,459 to 37,188—an increase of 18.2 percent. However to my knowledge, no definitive decreases have made for Texan doctors for their medical malpractice premium rates.

Let us remember as we debate this critical issue that Jesica, a poor 17-year-old whose family was smuggled into the United States from Mexico in the hopes of getting medical care for her, died as a result of physician error. The physicians at Duke University Medical Center mistakenly replaced Jesica's deformed heart and poorly functioning lungs with organs from a donor with the wrong blood type. Only after much publicity did a second transplant come—two weeks later, but Jesica, unfortunately, died.

Our nation's tort reform system is not broken. It is the lives of patients who have undergone procedures that have cost them their lives who are the victims. The system of health services in our country needs reform and not the Constitutional rights of victims seeking rightful redress in our nation's court system.

Chairman SENSENBRENENER. Are there amendments?

Mr. GOODLATTE. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from Virginia.

Mr. GOODLATTE. Mr. Chairman, I have an amendment at the desk.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 5 offered by Mr. Goodlatte. Add at the end the following——

Mr. GOODLATTE. Mr. Chairman I ask unanimous consent that the amendment be considered as read.

Chairman SENSENBRENNER. Well, we will—will the gentleman from Virginia allow the amendment to be distributed first?

Mr. SCOTT. Mr. Chairman, parliamentary inquiry.

Chairman SENSENBRENNER. The clerk will continue reporting the amendment.

The CLERK. Section _____. Award of Reasonable Costs and Attorneys' Fees After an Offer of Settlement.

(a) In General. In any health care lawsuit, any party may at any time——

Chairman SENSENBRENNER. Without objection, the amendment will be considered as read.

[The amendment follows:]

AMENDMENT TO H.R. 5
OFFERED BY MR. GOODLATTE

Add at the end the following new section:

SEC. ___. AWARD OF REASONABLE COSTS AND ATTORNEY'S FEES AFTER AN OFFER OF SETTLEMENT.

(a) IN GENERAL.—In any health care lawsuit, any party may, at any time not less than 10 days before trial, serve upon any adverse party a written offer to settle a claim or claims for money or property, including a motion to dismiss all claims, and to enter into a stipulation dismissing the claim or claims or allowing judgment to be entered according to the terms of the offer. Any such offer, together with proof of service thereof, shall be filed with the clerk of the court.

(b) ACCEPTANCE.—If the party receiving an offer under subsection (a) serves written notice on the offeror that the offer is accepted, either party may then file with the clerk of the court the notice of acceptance, together with proof of service thereof.

(c) TREATMENT OF OFFER.—The fact that an offer under subsection (a) is made but not accepted does not preclude a subsequent offer under subsection (a). Evidence of an offer is not admissible for any purpose except

in proceedings to enforce a settlement, or to determine costs and expenses under this section.

(d) EXEMPTION.—At any time before judgment is entered, the court, upon its own motion or upon the motion of any party, may exempt from this section any claim that the court finds presents a question of law or fact that is novel and important and that substantially affects nonparties. If a claim is exempted from this section, all offers made by any party under subsection (a) with respect to that claim shall be void and have no effect.

(e) PETITION BY OFFEROR.—If all offers made by a party under subsection (a) with respect to a claim or claims, including any motion to dismiss all claims, are not accepted and the dollar amount of the judgment, verdict, or order that is finally issued (exclusive of costs, expenses, and attorneys' fees incurred after judgment or trial) in the health care lawsuit is not more favorable to the offeree with respect to the claim or claims than the last such offer, the offeror may file with the court, within 10 days after the final judgment, verdict, or order is issued, a petition for payment of costs and expenses, including attorneys' fees, incurred with respect to the claim or claims from the date the last such offer was made or, if the offeree made an offer under this subsection, from the date the last such offer by the offeree was made.

(f) RESPONSIBILITY OF OFFEREE.—If the court finds, pursuant to a petition filed under subsection (e) with respect to a claim or claims, that the dollar amount of the judgment, verdict, or order that is finally issued is not more favorable to the offeree with respect to the claim or claims than the last such offer, the court shall order the offeree to pay the offeror's costs and expenses, including attorneys' fees, incurred with respect to the claim or claims from the date the last offer was made or, if the offeree made an offer under this section, from the date the last such offer by the offeree was made, unless the court finds that requiring the payment of such costs and expenses would be manifestly unjust.

(g) CALCULATION OF FEES.—Attorney's fees under subsection (f) shall be a reasonable attorney's fee attributable to the claim or claims involved, calculated on the basis of an hourly rate which may not exceed that which the court considers acceptable in the community in which the attorney practices law, taking into account the attorney's qualifications and experience and the complexity of the case, except that the attorney's fees under subsection (f) may not exceed—

(1) the actual cost incurred by the offeree for an attorney's fee payable to an attorney for services in connection with the claim or claims; or

(2) if no such cost was incurred by the offeree due to a contingency fee agreement, a reasonable cost that would have been incurred by the offeree for an attorney's noncontingent fee payable to an attorney for services in connection with the claim or claims.

(h) APPLICABILITY.—This section does not apply to any claim seeking an equitable remedy.

Mr. SCOTT. Parliamentary inquiry.

Chairman SENSENBRENNER. The gentleman will state his inquiry.

Mr. SCOTT. What is the base bill?

Chairman SENSENBRENNER. There is a base bill and an amendment in the nature of a substitute which I have offered that are both pending and both are amendable.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman SENSENBRENNER. Without objection, the Goodlatte amendment is considered as read. And the gentleman from Virginia is recognized for 5 minutes.

Mr. GOODLATTE. Thank you, Mr. Chairman. Mr. Chairman, this is a good bill, and while I like some provisions in the bill better than others, the core of it, the caps on noneconomic and punitive damages are badly needed, and I think as a result we should support this legislation. And it is particularly supportable because it allows the States to alter those caps if they deem that to be appropriate to do so, based upon their particular circumstances.

One complaint I have about the bill, however, is that it does very little to discourage frivolous and fraudulent lawsuits. And that is because there are few sanctions in Federal or State court imposed upon those who bring such actions, and this amendment would cure that. This is not a traditional amendment—English, loser-pays amendment—it is more in the nature of an offer of settlement. And what it does is it encourages the parties in a valid lawsuit to move toward settlement of the case and avoid bringing cases to trial unnecessarily. But it also assures the parties in the case that if a case is of a very weak nature, if it is frivolous or if it indeed is fraudulent, that more than just the usual court costs can be recovered in the case. And what it does is it provides a situation in which the prevailing party can, under certain circumstances, but not under all circumstances, recover some attorneys' fees from the other party. And basically, that is based upon an offer in settlement, which if refused—and either party can make such an offer in settlement, and I suspect the way this will work, both parties will negotiate. If at the end of those negotiations the parties nonetheless go to court, if the prevailing party is the plaintiff and he obtains more in the court case than his last offer of settlement, he will recover some attorneys' fees from the defendant. If the defendant in the case prevails and the—or if the plaintiff recovers less than the defendant's last offer in settlement, the defendant will recover some attorneys' fees from the plaintiff.

Now, this will only apply to attorneys' fees incurred by the parties less than 10 days before the trial and the trial itself. So those who are concerned that a very long and protracted discovery period might result in excessive attorneys' fees generated by, for example, a defendant who puts a lot of time and money into the case, they will not be able to recover all of that. Nor if they go to trial with six attorneys will they be able to recover all of the fees for the six attorneys, because they cannot recover more than the cost paid by the plaintiff for his attorneys' fees.

Now you say, well, the plaintiff may have paid nothing because he had a contingent fee. And the amendment also takes that into account by requiring the court to impute a value based upon the

time expended by the plaintiff's attorney for the value of the attorneys' fees incurred by the plaintiff.

This is a good amendment that will encourage settlement of cases but it will also, more importantly, provide a bulwark against those who look in the phone book and see the hundreds of ads in any Yellow Pages in any phone book in America that say "no fee if no recovery"; the suggestion being that there is no risk for the plaintiff to go to trial in these cases because they don't have to worry about having to pay any fees whether they have a meritorious case or not. This will cure that problem by saying oh, yes, if you take a nonmeritorious case to trial and you are unreasonable in the settlement process of the case, you will risk having to pay some attorneys' fees. I urge my colleagues to——

Mr. DELAHUNT. Would the gentleman yield for a question?

Mr. GOODLATTE. I would.

Mr. DELAHUNT. I just want to be clear about your amendment. When it comes to the recoupment of legal fees by the plaintiff, if the plaintiff should prevail in the case in terms—as the case goes to trial, and a verdict is returned for the plaintiff, what is the—is the entire fee, the contingent fee, assessed on the defendant, on the defendant's carrier? Is that my understanding?

Mr. GOODLATTE. No. It is a fee based upon the value of the time expended from 10 days before trial through the trial. If you have a contingent fee, the court will impute an hourly basis for the value.

Mr. DELAHUNT. Just for those 10 days.

Mr. GOODLATTE. Ten days plus the trial of the case. That is right. So if it is a very protracted discovery period, you are not going to be faced with all those attorneys' fees, only the attorneys' fees related to actually preparing for trial and going to trial as an incentive (a) to settle cases and (b) to not bring it.

Chairman SENSENBRENNER. The gentleman's time has expired.

Mr. BERMAN. Will the gentleman yield?

Chairman SENSENBRENNER. For what purpose does the gentleman from California seek recognition?

Mr. BERMAN. To strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. BERMAN. I would like to pursue with the author of the amendment a question. He frames his amendment as an amendment to deal with frivolous or fraudulent lawsuits and then creates a dynamic where offers that are rejected and then not achieved risk liability for attorneys' fees. What is a reasonable offer of a fraudulent and frivolous claim?

Mr. GOODLATTE. Well, it doesn't—it would apply to any claim, but frivolous and fraudulent claims will be the ones most vulnerable.

Mr. BERMAN. Your purpose of that amendment was to weed out frivolous and fraudulent lawsuits?

Mr. GOODLATTE. And to promote settlement of the case.

Mr. BERMAN. And what is a reasonable offer of a frivolous and fraudulent lawsuit?

Mr. GOODLATTE. If the gentleman will yield.

Mr. BERMAN. Yes.

Mr. DELAHUNT. Perhaps I can best explain this by giving an example. If the gentleman were to file suit against me for malpractice, and I were to—for $100,000 and I were to offer him $50,000 to settle the case and he turned that—you turned that down and we went to trial. If the case came back between what I offered and what you demanded, there would be no attorneys' fees paid by either party for the other party. They would pay their own attorneys' fees. If it came back less than $50,000, in other words you left the settlement on the table and got less in court, you would be required to pay a portion of our attorneys' fees. On the other hand, if you got more than the $100,000 you sought originally——

Mr. BERMAN. No, I understand.

Mr. GOODLATTE. That is how, it is an offer in settlement.

Mr. BERMAN. I understand. I just—I think the record should show this is an amendment designed to put the plaintiff in a contingency fee case, the whole purpose of which is to allow moderate- and lower-income people who cannot afford to retain an attorney on an hourly basis or to provide an advance payment of legal fees, this is an amendment that puts them at serious personal risk and has nothing to do with false or frivolous lawsuits. This isn't about the court assessing sanctions against a plaintiff or an attorney who brought such a case. This is a—this is a proposal to deal with trying to promote settlements of reasonable cases, because my assumption is, I don't—you don't offer to pay me $50,000 to settle my false or frivolous lawsuits.

Mr. GOODLATTE. Would the gentleman yield?

Mr. BERMAN. Sure.

Mr. GOODLATTE. As I stated at the outset, it is designed to both promote settlement of valid cases and to weed out frivolous and fraudulent cases.

Mr. BERMAN. Who does anything—only to the extent that putting the plaintiff at risk of paying vast amounts of sums as he decides whether or not to bring a lawsuit, formal practice, presuming there are some false and fraudulent lawsuits included therein, but there is nothing about this amendment that is designed to separate the false and frivolous lawsuits from the reasonable lawsuits.

And I understand what the gentleman is doing, but I don't think you should put the cloak of this is just to get at frivolous and false lawsuits. This has nothing to do with frivolous and false lawsuits. This has to do with undermining the fundamental rationale of the contingency fee for moderate- and lower-income people.

I yield back Mr. Chairman.

Mr. BACHUS. Mr. Chairman.

Chairman SENSENBRENNER. For what purpose does the gentleman from Alabama seek recognition?

Mr. BACHUS. I have a question.

Chairman SENSENBRENNER. Does the gentleman strike the last word?

Mr. BACHUS. I would like to ask the proponent of the amendment——

Chairman SENSENBRENNER. Will the gentleman strike the last word?

Mr. BACHUS. Move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. BACHUS. Mr. Goodlatte, you base the fee on an hourly basis? What about depositions, expert witnesses' fees?

Mr. GOODLATTE. They would not apply because it only applies to the time expended from 10 days before trial through the trial of the case. Extended lengthy discovery, which is one of the complaints that we heard from the other—this, by the way, this amendment has passed this Committee in two other litigation reform bills and has passed the full House in that. But the purpose is to limit the exposure in fairness to those who complain, as the gentleman from California did, that somehow this is targeted at lower-income people. It will only have a limited amount of attorneys' fees.

Mr. BACHUS. Well I am actually more confused now than ever. You are saying this amendment only applies to attorneys' fees and expenses incurred in 10 days before trial.

Mr. SCOTT. Will the gentleman yield?

Mr. GOODLATTE. Let him ask his question first.

Chairman SENSENBRENNER. The time belongs to the gentleman from Alabama.

Mr. BACHUS. So when the judge makes a finding on attorney fees, he is just setting attorneys' fees for those last 10 days?

Mr. GOODLATTE. That is right. That is to limit the exposure. He also is limited to not granting an award of attorneys' fees more than the equivalent in terms of a computed hourly rate to the contingent fee of the plaintiff , so that neither party is going to be able to load up on attorneys' fees because they have six attorneys representing the defendant.

Mr. BACHUS. So there wouldn't be any compensation for attorneys' fees or expenses from the date the suit was filed to 10 days before.

Mr. GOODLATTE. There are no attorneys' fees in any cases like that today. This is a way to do that but to do it in a controlled and limited manner.

Mr. BACHUS. So the attorney, the plaintiff's attorney can still collect his contingency fee.

Mr. GOODLATTE. Oh, yeah, absolutely.

Mr. BACHUS. So he would get a contingency fee plus he would get this award?

Mr. GOODLATTE. No. The plaintiff would recover the attorneys' fees and then they could use a portion of that to pay a portion of the contingent fee. That would depend upon the arrangement that the plaintiff had with their attorney.

Mr. SCOTT. Will the gentleman yield?

Mr. BACHUS. I am still not sure I——

Chairman SENSENBRENNER. Does the gentleman from Alabama yield to the gentleman from Virginia?

Mr. BACHUS. I yield to the gentleman from Virginia.

Mr. SCOTT. Well, I am a little confused as you are because on page 3, line 7—line 6—it says the court shall order the offereee to pay the offerer's costs and expenses including attorneys' fees, which would suggest that there is something going on in addition to attorneys' fees.

Mr. GOODLATTE. No. No.

Mr. SCOTT. No? Well, let me—and one other thing, to the gentleman from Alabama, when you talk about the plaintiff paying this contingent fee, that is true. But if you come in under the offer,

if they have offered 300,00 and you come in at 280, a result less favorable, the plaintiff has to pay his own attorneys' fees and some of the defendant's attorneys' fees too?

Mr. GOODLATTE. That is correct.

Mr. BACHUS. Well, taking back my time, Mr. Goodlatte, that would mean a case when, if you got $280,000, which would mean that it was actually—that was quite a lot of damage—that you couldn't recover for your cost of depositions, for your filing fee, for your expert witnesses. I would almost say that we ought to have a provision, if we wanted to get rid of these, that put an impetus on the parties to come forward in, say, the first 30 days or the first 90 days after the suit was filed before all these expenses were incurred. What if you had a defendant that knew that they had committed malpractice, but for 2 years they didn't reveal that, and it took a bunch of depositions and hearings and—to smoke that out? I would almost say you need to add to this provision for some sort of sanctions or penalty when the defendant is guilty of fraudulent nondisclosure.

Mr. GOODLATTE. If the gentleman would yield, very quickly. This does not preempt the usual standard provisions in either State or Federal law that allows a judge under rule 11 in Federal court to award some of those expenses to pay for expert witnesses that are paid for, things like that, if the court deems it appropriate. What this does, it adds an element of attorneys' fees, because in most cases today very little if anything is awarded, as a hindrance to those who bring suits and do not either act reasonably in settlement of the case, or bring a suit that is frivolous or fraudulent in its outset.

Chairman SENSENBRENNER. The gentleman's time has expired. Gentleman from Michigan.

Mr. CONYERS. Mr. Chairman, we have got a vote pending. Could I ask my good friend from Virginia if he would kindly consider withdrawing the amendment, which was not considered when we brought this bill back up again since we didn't even have Subcommittee hearings. And perhaps we can work together—there seems to be a lot of confusion about it.

Mr. GOODLATTE. Well, I need to have this bill passed by the Committee before it goes to the floor. So if the gentleman is suggesting that we bring it up again later in this process after I have some discussions, that would be fine.

Mr. CONYERS. Absolutely.

Mr. GOODLATTE. What is the Chairman's position on that?

Chairman SENSENBRENNER. Without objection, the amendment is withdrawn without prejudice to it being reintroduced prior to the Committee reporting the bill.

Mr. GOODLATTE. Thank you, Mr. Chair.

Chairman SENSENBRENNER. So ordered. The Committee stands recessed for the vote. Members will please return promptly.

[Recess.]

Chairman SENSENBRENNER. The Committee will be in order. When the Committee recessed, pending was a motion to favorably report the bill H.R. 5. Unanimous consent had been granted to have both the bill and the amendment in the nature of a substitute considered as read and open for amendment at any point. There—

with the withdrawal of the Goodlatte amendment there is no amendment pending.

Are there amendments?

Mr. DELAHUNT. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from Massachusetts.

Mr. DELAHUNT. Mr. Chairman I have an amendment at the desk.

Chairman SENSENBRENNER. The clerk will report the amendment.

The CLERK. Amendment to H.R. 5 offered by Mr. Delahunt. Section 3, amend the text to read as follows:

(a) Statute of Limitations. In any State or Federal court a health care lawsuit——

Chairman SENSENBRENNER. Without objection, the amendment is considered as read and the gentleman from Massachusetts is recognized for 5 minutes.

[The amendment follows:]

AMENDMENT TO H.R. 5
OFFERED BY MR. DELAHUNT

Section 3, amend the text to read as follows:

(a) STATUTE OF LIMITATIONS.—In any State or Federal court, a health care lawsuit shall be barred unless the complaint is filed not later than 3 years after the right of action accrues.

(b) ACCRUAL.—A right of action referred to in subsection (a) accrues upon the latest to occur of the following dates:

(1) The date of the injury.

(2) The date on which the claimant discovers, or through the use of reasonable diligence should have discovered, the injury.

(3) The date on which the claimant becomes 18 years of age.

Mr. DELAHUNT. Mr. Chairman, this amendment would bar health care lawsuits in all cases unless the complaint is filed within a 3-year period after the date the injury occurs or should have been discovered or is discovered. And it would follow the law in most States, or many States rather, by ensuring that the statute does not begin to run while the claimant is still a minor.

Without this particular amendment that we are considering now, it would bar recovery for people like Justin Mathers, a remarkable young man from Englewood Cliffs, New Jersey. I met him at a malpractice forum that was held last month in this very room. His testimony was the most powerful and poignant I have heard since I arrived here in Congress, and I truly wish all of my colleagues had an opportunity to hear what he had to say. He was born through a breach delivery because the obstetrician failed to perform a C-section before Justin's mother went into labor. His umbilical cord prolapsed, cutting off his blood and oxygen supply. Eventually he was resuscitated but immediately developed seizures and other symptoms of cerebral palsy. The condition has deprived him of the ability to perform many essential life activities. He has great difficulty speaking. It was difficult to understand him. But his clear mind and keen intellect came through. He spoke movingly of the daily challenges he faces. And he told us that he was determined to spare his family the financial burden of caring for him as he grew older.

For whatever reason, his parents chose not to sue the doctor for her negligence. But when Justin turned 20, he filed suit on his own behalf. Eventually they reached a settlement that will enable Justin to live a relatively independent live. He could do this because in new Jersey, like many other States, the statute of limitation for minors is tolled until they come of age. Had H.R. 5 been the law, it would have preempted the New Jersey statute and Justin would have forfeited his opportunity to seek recovery.

Similarly, the bill as is currently written, would override State laws that toll the statute where the medical injury has not been discovered, allowing claimants whose conditions are discovered at a later stage only 1 year to file a claim. This unfairly penalizes victims of medical error whose consequences are not immediately apparent or who discover years later that the condition from which they suffer was in fact caused by a medical error.

Just reflect for a moment on the thousands of young people with hemophilia who acquired AIDS through a contaminated blood infusion. In my district we have a number of families who lost their sons in this way, due to the negligence of the blood products industry to institute proper screening. Under the bill as written, such victims would only have 1 year, once they become aware of the condition, to file suit; hardly a reasonable opportunity to consider their legal options and to find a lawyer that are willing to take the case on.

The amendment would correct this injustice, affording all claimants the same opportunity to take legal action once they become aware of their injury, provided the failure to discover the condition sooner was not due to their failure to exercise reasonable diligence.

We take a look in this—we talk a lot in this Committee about respecting States rights. Well, I believe if a State has made a determination not to bar recovery in cases like these, that decision is

entitled to our respect and those victims are entitled to their day in court, and I urge support for this amendment.

Chairman SENSENBRENNER. The gentleman's time has expired.

The Chair rises in opposition to the amendment and recognizes himself for 5 minutes. This amendment should be opposed, because effectively what it does is it has a statute of limitations of up to 21 years for minors. This will drive practically every OB-GYN in the country out of business, because any insurance company, whether it is in the medical liability area or any other type of casualty area, has to predict its losses, set aside reserves, and then base its premiums accordingly. With an OB-GYN, if negligence occurs at the delivery of a child, that exposure would last for 18 years plus the 3 that is given in the amendment by the gentleman from Massachusetts, and that would mean that the liability premiums for OB-GYNs would become confiscatory—and try finding an OB-GYN when the time comes to bring a life into the world.

Now, I think the statue of limitations in the underlying bill and the amendment in the nature of a substitute are reasonable. It makes—the statute makes an exception for minors under the age of 6, extending the time within which a suit must be filed or the longer of 3 years from the manifestation of the injury or the date when the minor reaches age 8. These provisions are based upon the California MICRA law. And that means that whether there is negligence that has resulted in injury to a newborn, there is a reasonable amount of time to file the lawsuit, which can be up to 8 years.

What the gentleman from Massachusetts is attempting to do is to extend it so that it is an unreasonable time, and those that have to buy insurance will pay and pay and pay till they are out of business. I urge the defeat of the amendment, yield back the balance of my time.

For what purpose the gentleman from Florida seek recognition?

Mr. WEXLER. Speak in support of the amendment, Mr. Chairman.

Chairman SENSENBRENNER. Gentleman is recognized for 5 minutes.

Mr. WEXLER. Thank you, Mr. Chairman. The proponents of this bill would argue as the Chairman so eloquently did, that the generous statute of limitations that exists in certain States contributes greatly to the so-called medical malpractice crisis that is being experienced throughout the country.

Mr. Delahunt's amendment would effectively, as I understand it, take the statute of limitations that is in the bill which is a 1-year-from-date-of-injury statute of limitations, the date that the injury was discovered, but no later than 3 years after the date of injury, with the exception of those instances in which the Chairman right fully pointed out with children under 6.

I rise in support of the amendment because the whole argument of the statute of limitations contributing greatly this so-called generous statute of limitations contributing to our crisis is misplaced. And I would like to talk a moment about the situation in Florida, because I think it highlights why this amendment should be passed and why the basic premise of the objection and many of the basic premises of the bill are faulty.

In Florida, which is a State of roughly 16 million people, we would be told that there are an extraordinary amount of medical

malpractice cases and an extraordinary amount of awards in excess of $250,000. And that is why we are here. That is why the Congress is going to usurp the State's ability to regulate medical malpractice. There is a Federal crisis.

Well, the truth of the matter is in the most-reported year in Florida, which I believe is 2001, a State of 16 million people, there were roughly 230 medical malpractice awards in excess of $250,000. Not 20,000 awards, not 30,000 awards, not even a thousand awards; 230 awards in a State of 16 million people. But because these 230 awards were provided by juries of our peers, we are now going to limit the statute of limitations even further to make certain that there are less.

Now what is the real reason, contributory reason for the malpractice situation in Florida, which I believe is comparable to many States? What we now know from the group Public Citizen in Florida, based on a recent study from data from the Institute of Medicine, 6 percent of physicians are responsible for 50 percent of the malpractice cases in Florida. Six percent are responsible for half the malpractice cases in Florida. That is not a statute of limitations problem. That is a peer review problem. That is a failure of the medical profession to peer-review properly and take the few bad apples out. That is a failure of the insurance industry. That is a failure of the hospitals that employ or otherwise associate themselves with the physicians that are causing the problem.

Let's go further in Florida, if I may. Florida's chief financial officer, a statewide elected Republican, very appropriately admitted that the huge losses by the reinsurance market and the undercharging by insurance companies in a competitive market in previous years have contributed significantly to the rapidly rising increases in medical malpractice rates. The chief financial officer in Florida, an elected Republican, didn't tell the State legislature we have a statute of limitations problem. What he told the State legislature is that we have insurance companies that are messing around with the market. They are not dealing fairly with the people of Florida, and that is the aspect that needs to be changed. It is an issue of insurance reform. It is an issue of peer review. It is an issue of many contributory factors, but it is not an issue of a statute of limitation, and and that is why I support Mr. Delahunt's amendment.

Thank you very much.

Chairman SENSENBRENNER. The gentleman's time has expired. For what purpose does the gentleman from Florida, Mr. Feeney, seek recognition?

Mr. FEENEY. Mr. Chairman, to oppose the amendment.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. FEENEY. With all due respect to my friend and colleague from Florida, I have a little different perspective on the situation that we have in Florida. Indeed, I will tell you that the Governor's task force made up and chaired by my hometown university president, Dr. John Hitt, concluded the other day after a very nonpartisan review of the situation in Florida, that indeed we are in a deep crisis, that we do need to have caps and that the statute of limitations issues are part the problem.

I will tell you in my hometown the Sanford emergency room had to shut down for 4 days back in August. Orlando Regional Medical Center, I just recently toured about four or 5 months ago and their helicopter their trauma unit is now talking about closing down because their neurosurgeons will not practice. Orlando Regional Medical Center serves about 33 counties, including the home county that I represent, throughout my district, and I don't know what we are going to do if and when that trauma unit closes down. I will tell you that my family's OB-GYN, Dr. Diaz, who delivered both my 10-year-old Tommy and my 4-year-old Sean, unfortunately is no longer delivering babies after thousands of successful deliveries, including one very difficult one of my 4-year-old Sean, where he sat with us for about 4 or 5 hours to make sure that everything turned out okay—and it did, although Sean misbehaves on a periodic basis. It wasn't due to the delivery.

The fact of the matter is that it is not just Dr. Diaz, but there are thousands of OB-GYNs practicing in Florida that are either cutting back on the services they offer or they are going out of business completely. We have got young residents that typically of an 80 percent ratio would stay in Florida that are now fleeing the State because of our medical malpractice crisis.

Dr. Joseph Boyd, an Orlando neurosurgeon, had his rates increased by 65 percent last year. I will tell you that we are in a deep crisis. Governor Bush yesterday introduced a doctor from south Florida who treated a young woman 4 months pregnant. That woman was unable to find an OB-GYN to deal with her and to treat her for the first 4 months of her pregnancy. Unfortunately, by the time this doctor was able to see her, because nobody else would, thanks to the medical malpractice crisis, her baby had died of a very easily treatable situation.

Mr. Chairman, I would suggest that the problem we have in Florida is that, just like any other State, there is going to be a certain amount of accidents. There are going to be a certain amount of malpractice that we need to deal with and reimburse the victims of that malpractice. But the problem we have is not that insurance companies are charging too little or too much. Ten years ago we had over 26 insurers writing medical malpractice premiums. If they are making obscene profits, I want to know why we are down to two or three or four insurance companies and why doctors can't get the coverage that they need. We have doctors fleeing the emergency rooms, the delivery rooms. We have patients that now can't find a doctor. And Mr. Chairman, I respectfully would ask everybody to support—to oppose the amendment and support this good bill for Florida's future.

Chairman SENSENBRENNER. The gentleman's time has expired. For what purpose does the gentleman from New York seek recognition?

Mr. WEINER. To support the amendment.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. WEINER. And ask Mr. Delahunt—and I will yield to him to answer the question. It seems that so much of the arguments of the opponents to your amendment seem to be looking past the notion that we are preempting State law wantonly in terms of finding ways to help people become whole, like the case that you outlined.

Can you take the balance of my time to discuss that issue a little bit? Because it seems that for many people who describe themselves as States-righters and limited government people, this seems to be an enormous abridgment on the States rights to come up with laws on their own. And of course, this whole effort shows utter contempt for the notion that juries are capable of dealing with these cases and coming up with fair compensation.

I yield the balance of my time.

Mr. DELAHUNT. Well, I thank the gentleman for yielding. And the Chair made a statement that if we do not adopt, if we do adopt the amendment that I have before the Committee, it would drive OB-GYNs out of their States. And with all due respect to the Chair, I have to take issue because there is absolutely no data, empirical evidence, that supports that premise. It just doesn't exist.

We had a hearing here yesterday. At no time—and there were three witnesses that were put forth by the majority—at no time did they submit testimony to that effect. The reality is that there are many States that toll for minors according—that would comply with the amendment that I have put forth.

Many, most of these States, by the way, are States where the American Medical Association agrees that there is not a crisis, that there is not a crisis. Let me read them to you. Arizona, Illinois, Indiana, Kansas, Kentucky, Maine, Minnesota, Missouri, New Jersey—well, New Jersey does. North Carolina, Pennsylvania, Oregon, Rhode Island, South Dakota, Tennessee, Utah, Vermont.

If the underlying bill passes not amended by what I have put forward, these—all of these States will have their—the provisions which toll the statutes for minors preempted. I don't think we want to go down that route, particularly when it does not appear, according to the AMA, a crisis in those particular States.

Now, the gentleman from—the gentleman from Florida speaks to the issue of malpractice driving out OB-GYN is in the State of Florida. I would suggest that the forces that are escalating malpractice premiums in some States are complex and they require a systematic set of solutions, not just a simple—a single remedy, a panacea that is not going to do the job. There was a story today in USA today and I am quoting from an analyst with Tillinghast-Towers Perrin by the name of James Hurley. Hurley says our efforts to improve patient safety, tougher review and discipline procedures for doctors and hospitals, and a closer look at how the past decade's efforts to cut costs in health care may affect the quality of medical care.

Let me suggest that the level of reimbursements through Medicare and Medicaid to health care providers all over this country are deteriorating the quality of health care that the American people are receiving there, and are as much responsible for the malpractice claims given the stress level that is obviously being imposed on physicians and other health care providers.

So it—to say that it is frivolous lawsuits, to say that it is, you know, greedy trial lawyers that are causing this particular crisis—and by the way, we have had crises before. We had them in the seventies and we had them in the eighties, and we are having this one now. But it's my understanding that in the last 9 months, in fact, the amount of jury verdicts that have been reported are down

substantially. What our problem is, we have a lousy economy, okay. The investment income that——

Chairman SENSENBRENNER. The gentleman's time has expired. The question is on the amendment.

Mr. CONYERS. Mr. Chairman. I am sorry. I need to make a comment on this, please.

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

Mr. CONYERS. Thank you very much. I wanted to commend Mr. Wexler of Florida for his proposal to attempt to repair the limitations that are—or Mr. Delahunt's attempt to repair the limitations here. But my friend from Florida, Mr. Feeney, raises a good question. He said why does—why, if the insurance companies are making so much money, why are they—so many of them going out of business?

And I just wanted to make a suggestion to him that when you make bad investments, your income goes down if you are an insurer, and if your income goes down, the malpractice premiums go up. And sometimes their choices and problems in the stock market are so bad that they can't raise it high enough and they go out of business. And that is why you may be seeing so many of them going under. They made bad choices, some of them which are not correctable by just raising the premiums on the doctors.

But to the amendment, can someone just give me, make me feel a little bit better about this? What if a hemophiliac contracted HIV from tainted blood but didn't learn about it, through no fault of her own obviously, about the disease, until 4 years later? Where would she end up under this bill? I presume out in the streets without a remedy.

Or what about a person who took a newly developed drug prescribed by her dermatologist, to learn 4 years later that the drug caused heart damage, damage to her own heart? What about that for limitations? Anybody?

Okay. What about the case of a man who had a defective pacemaker implanted that failed as a result of a product defect 5 years later? What is his remedy under limitations? Anybody?

So we have got to protect these people, Members of the Committee. Is there somebody that doesn't want to? Well, if you really want to, we have got to take into consideration the Delahunt provision that is before us. Now, you can't be silent on all these questions and then vote against Delahunt. I mean, that is not going to work here. There has got to be some reasons. We are not here to look at each other and just vote like automatons. You have got to have some reasons for what you are doing, and I would like somebody to make me feel better if this is—if we don't make the changes that the Delahunt amendment includes, well, what are we doing here this afternoon?

I return my time.

Mr. KELLER. Mr. Chairman.

Chairman SENSENBRENNER. For what purpose the gentleman from Florida, Mr. Keller, seek recognition?

Mr. KELLER. Move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. KELLER. I want to argue against the amendment but specifically limit my comments really to the other side of what is going on in Florida as first introduced by Mr. Wexler and later commented by Mr. Feeney. I can tell you from firsthand experience, there absolutely is a crisis in Florida.

I represent Orlando and it is home to Orlando Regional Medical Centers's level one trauma unit. A level one trauma unit treats people with serious head injuries. We have the only one within several hours. It was announced this past week that that unit is closing down at the end of the month because neurosurgeons are paying in excess of $200,000 a year in medical malpractice premiums and they can't do it anymore. So it is shutting down.

What effect does that have? Well, we don't have to guess, because yesterday we had a lady, Ms. Dyess, who testified that her husband was critically injured because he was taken to a similar unit in her home State and the neurosurgeons weren't there. They couldn't afford to be there.

Now, I met recently with a group of emergency room physicians from this hospital, the main group of private physicians there. They told me that they haven't had a single claim at all this past year. Yet their medical malpractice premiums went from $24,000 to $80,000. It is a genuine problem.

Mr. Wexler says that a Republican, Gallagher, said that he doesn't think these caps are such a good idea. And I don't know what, frankly, Mr. Gallagher was thinking. But I do know that there was a commission put together by the Governor, made up of university presidents, including a Democrat named Donna Shalala, former Secretary of HHS under President Clinton, and that commission said that we need precisely what we are trying to do today: a $250,000 cap on damages.

We have heard different excuses that why this isn't a good idea. First, insurance companies won't give the reductions to MDs. Well, we heard yesterday from testimony that they will reduce premiums. Second, we have heard that there is really not a crisis; that they have lost all the money in the stock market. We heard from the largest group of physician insurers yesterday they invest less than 10 percent of their money in the stock market. It has nothing whatsoever to do with it. Third, something—that in California the MICRA law didn't have anything to do with it; it was Prop 103. We learned yesterday that really mostly deals with auto insurance.

We have a real crisis and it is genuine. It is in Florida. Mr. Wexler says that maybe we can do a better job of getting rid of bad doctors, and I think that is probably true everywhere. There have been several recent highly publicized cases in my hometown where licenses were revoked, where we had awful malpractice cases, and I think there is some merit to that argument. But there is a genuine crisis.

Mr. CONYERS. Would the gentleman yield, please?

Mr. KELLER. I yield back my time.

Mr. WATT. Would the gentleman yield to me?

Chairman SENSENBRENNER. The gentleman from Florida has yielded back his time. For what purpose does the gentleman from North Carolina seek recognigtion?

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

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. WATT. Thank you, Mr. Chairman. I have a subsequent amendment where I will be trying to frame this whole States rights issue, so I will try not to take the whole 5 minutes here. I just want to rise in support of Mr. Delahunt's amendment briefly, and to say to Mr. Feeney and the gentleman who just spoke, that I really don't have any doubt that Florida is having a crisis.

We just got word in North Carolina that North Carolina is having a—is on the verge of having a crisis. But it seems to me to be sheer arrogance on our part and contrary substantially to most of everything that my Republican colleagues say they believe in, block granting things to the States, getting them back to the local level, allowing States to make decisions about Medicaid through block grants, block granting the housing programs back to the States, and all of a sudden we have this level of arrogance that somehow we have the ability, better ability, better intellect, to solve Florida's problems or North Carolina's problems than the legislators in North Carolina and Florida.

A lot of us came out of the State legislature, not because we thought we were brighter than the people in the State legislature, but because we thought we could serve a different role at the Federal level. And so this is not about whether Florida has a crisis or North Carolina has a crisis. This is about the—how the Federal form of government that we operate under fits together. And I, for the life of me, have never seen anybody malpractice across State lines. I don't know of any hospitals that are sitting on State lines where the malpractice takes place in this way. I just—tort law, malpractice litigation, has always been a matter of State law.

And I just for the life of me, I can't understand how we think in our arrogant minds, sitting here, that we somehow have a better solution to fix Florida's problems than the legislators in Florida have to fix Florida's problems. If they have got a crisis in Florida, let them fix it. If we have got a crisis in North Carolina, let us fix it. I thought that was consistent with the philosophy that most of you all espouse all the time and is certainly consistent with the Federal framework that our Founding Fathers and our constitutional frameworkers set up for us.

And so this seems to me to be an argument of expedience. We are not getting the result that we want at the State level, so let's federalize it. Well, a lot of things get done at the State level that I don't like, but that doesn't mean that I have some better ability to deal with that problem than the folks in the State legislature do.

So, I will come back to this issue at a later time, but I just think we are deluding ourselves and we are making the wrong argument here when we talk about these crises at State levels. Sure, we have got crisies at the State level. Let them solve them.

I yield back.

[11:30 a.m.]

Chairman SENSENBRENNER. The question is on the amendment——

Ms. BALDWIN. Mr. Speaker, I move to strike the last word.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. BALDWIN. I yield my time to Mr. Wexler.

Mr. WEXLER. Thank you. I will be brief, Mr. Chairman. If I could just inquire of my friends and colleagues from Florida, Mr. Keller and Mr. Feeney, following the gentleman from North Carolina's line of argument, is there something in Federal law that we are not aware of that is preventing the Florida legislature from acting? Because certainly it is not politics; it is a legislature totally controlled by the Republican Party, with a Republican Governor, and it has been that way not just this term, but for the past 4 years.

So what is it that we in this Congress are doing that is preventing the Florida legislature from adopting whatever tort reform it sees fit to do? As I see it, the only thing they could not do is maybe the one thing we should do, which is remove the antitrust exemption which the insurance companies currently enjoy, but certainly you are not arguing for that.

So what is it, what remedy do you think should be available to the State of Florida that is not available because of something we are preventing them from doing?

I yield my time to Mr. Feeney, if I could, Mr. Chairman.

Mr. FEENEY. Actually, Congress isn't doing anything to prevent the Republican or formerly Democratic legislature from doing the sorts of things that we need to do here. It is the six Democrats on the Florida Supreme Court. I would refer the gentleman to *Smith* v. *the Department of Insurance*, April 23, 1987, when the Supreme Court basically said that under our right of access provisions, under the Florida Constitution, that a $450,000 cap would be unconstitutional.

So the point of the matter is that judges with certain partisan attitudes actually have prevented the people's legislature from enacting the very thing that we are trying to do here, and that is to preserve access to our doctors for the patients that I represent throughout the district.

Mr. WATT. Will the gentleman yield?

Mr. WEXLER. Yes, of course.

Mr. WATT. I am just wondering whether we ought to impeach the State judges now. Do we have the authority to do that at the Federal level, too, just because of expedience, or do you understand that there is some constitutional framework that we are obligated as a matter of our constitutional oath to try to maintain here?

Mr. CONYERS. Would the gentleman yield?

Chairman SENSENBRENNER. Let me point out that the time belongs to the gentlewoman from Wisconsin.

Mr. CONYERS. Will the gentlewoman yield?

Ms. BALDWIN. I will be delighted to yield to Mr. Conyers.

Mr. CONYERS. I just want my friend from North Carolina to know that impeachment only runs through Federal judges and other officers of the Federal Government.

Mr. WATT. Will the gentlewoman yield?

Ms. BALDWIN. Yes.

Mr. WATT. I think that is only when it is expedient to run to Federal judges. I mean if we are going to talk about expedience, where do we get off this slippery slope once we get on it?

Mr. CONYERS. We could try to impeach a few State judges if you really insist. I mean file your petition. Let's go for it.

Ms. WATERS. Mr. Chairman.

Chairman SENSENBRENNER. The gentlewoman from Wisconsin still has 1 minute and 40 seconds left. Does she want to talk for that period of time?

Ms. BALDWIN. I would be delighted to yield back my remaining time.

Chairman SENSENBRENNER. Okay. The time has been yielded back.

The question is on the Delahunt amendment.

Ms. WATERS. Mr. Chairman, I would like to get on record on this, and I move to strike the last word.

Chairman SENSENBRENNER. Okay. The gentlewoman is recognized for 5 minutes.

Ms. WATERS. Thank you very much.

Mr. Chairman, I think that certainly very, very strong arguments have been made in support of Mr. Delahunt's amendment and I, too, join in supporting this amendment. I think that the information, the evidence, and the documentation on behalf of injured people certainly has been made here in this Committee today in so many ways, and I am very appreciative for our Ranking Member's identification of the kind of cases that must always be kept in mind, so that we understand what it is we do here today.

I think the central debate on not only this amendment, but on this bill, really does have to do with this business about whether or not there is a lawsuit explosion and whether or not there is a crisis in this country.

Let me just say that I suppose that doctors in any State or jurisdiction at any time could all decide to walk off, out of their offices, off the job, out of the hospital, and I suppose if they do it next year and they want to reduce the cap some more and the year after that they want to reduce the cap, we could be put in the position of saying we have no alternatives, we have to do that. But I certainly think we do have alternatives, and I think some of them have been pointed out.

But I would like to just speak to this lawsuit explosion idea. We have been told that there is a lawsuit explosion and that runaway juries are giving skyrocketing awards and injured patients are winning a so-called "litigation lottery." yet, according to the Harvard Medical Practice Study, only one in eight malpractice victims ever file a claim for compensation. According to the National Practitioner Database, which is composed of jury verdicts and settlements, the average payout for 2001 in a medical malpractice case was only $125,000. This amount is hardly comparable to lottery winnings. In fact, studying payouts in constant dollars, we can see that the amount has been stable.

So my question is, where is the explosion? Where is the insurance industry getting their numbers? The Wall Street Journal answered that question on January 24 in an article, and the excerpt from that article basically said that the litigation statistics most insurers trumpet are incomplete. The statistics come from Jury Verdict Research, a Horsham, Pennsylvania information service, but Jury Verdict Research says its malpractice database has large gaps. It collects wide information unsystematically, and it cannot say how many cases it misses. More important, the database excludes trial victories by doctors and hospitals, verdicts that are worth zero dollars. That is a lot to ignore.

I simply want to get that into the record.

Mr. WATT. Will the gentlewoman yield?

Ms. WATERS. Yes, I yield.

Mr. WATT. I just wanted to add one other statistic to the statistic that the gentlewoman has just mentioned. The total, if you added all of the medical negligence recoveries in this country together for last year or the year before last, it would be about $7 billion, I am told, out of a health care system that has approximately $1.2, $1.3 trillion worth of transactions. That would work out to less than one-half of 1 percent of the cost of the health care.

So all of this stuff that we are hearing about how this is going to make some dramatic savings in the health care industry is just not the case.

Mr. DELAHUNT. Would the gentlewoman yield for a question?

Ms. WATERS. Yes, I would yield for a question.

Mr. DELAHUNT. I would ask Mr. Watt if he has had an opportunity in his review of that $7 billion figure, if that $7 billion was broken down into economic and noneconomic costs, could he inform us what was the amount of that $7 billion aggregate that was allocated to noneconomic costs?

Mr. WATT. If the gentlewoman will yield.

Ms. WATERS. I will yield to the gentleman.

Mr. WATT. I don't know the break-out, but I would tell you that if you took your caps to zero, if you eliminated medical malpractice, you would be having less than one-half of 1 percent.

Chairman SENSENBRENNER. The gentlewoman's time has expired.

The gentleman from California, Mr. Schiff.

Mr. SCHIFF. Mr. Chairman, I move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCHIFF. I recognize the concern that the medical community has about rising liability costs, and I think physicians are in a very difficult place right now where they are getting squeezed by the HMOs that are highly regulating their practices and interfering with the patient-physician relationship on the one hand, and they are facing increases in liability insurance on the other, some of which are precluding them from practicing, and certainly precluding many from enjoying the practice of medicine. I happen to think that the vast, vast majority of people that go into medicine do so for the right reasons.

I am not sure that this is really going to address the problem that physicians are facing. It is a very massive preemption of 50 different States' approaches to dealing with this, this crisis in many States and this problem in all of the States.

In California, we passed something very similar called MICRA. We passed this over 25 years ago. It had no adjustment for inflation, and the cap was set at $250,000. Now, $250,000 in 1978 in California is a lot different than $250,000 in 2003.

Why doesn't this bill have a COLA? That is one of the most modest positive changes that could be made. Why is even a COLA being opposed in this bill?

It has to be because the expectation is that you have the same inertia, the same inability to later change this, and 25 years from now the limit would still be $250,000. Why are we preempting a

whole host of other things that States are doing? We are preempting statutes of limitations, fair share rules, contingent fee rules, collateral source rules, and we are also preempting even the standard for punitive damages.

So in California where we have struck quite a complex balance where we have certain caps, we have all the protections that Mr. Berman outlined in the hearing yesterday of greater physician accountability, protections for facilities to report other bad physicians' practices. We have several things that crack down on physicians who are committing malpractice that are a substitute or a proxy, in some respects, for the lack of higher deterrent damage awards.

This bill does not have that intricate balance and it would upset that balance in many States like California that have gone through the laborious process of resolving that problem for their constituents and for their medical practitioners.

When I asked the insurance company representative at the hearing yesterday, would you support a sunset in this bill that says that if rates don't go down as a result of this bill, that it would be sunsetted out of existence, the answer was, well, I can't give you an answer. I won't give you an answer. And why won't we get an answer on that? Because there is a very real prospect that the doctors will get no relief, the patients will get no relief, and the additional revenues that are saved as a result of this will be retained by the insurers, which is great if you are in the insurance business. It just doesn't do much to address the problem. That is the broader question: will this bill really address the problem, or will it simply preempt the 50 laboratories around the country in their efforts to deal with the problem?

I am kind of fascinated and a little bit shocked to hear my colleague suggest that well, we need to do this because in some States our State Constitution is so protective of patients that we can't deal with it, so we want the Federal Government not only to preempt State statutory law, we would like them to come preempt our State constitutions as well. That seems to be an odd defense of the doctrine of local control to say you are not preempting enough if you just preempt our statutory law; you need to preempt our State Constitution. Most States have a mechanism, I don't know what the situation is in Florida, for amending the Constitution if that is necessary, and I think it just goes to the scope and the scale of the preemption that is contemplated here.

Ms. WATERS. Will the gentleman yield for a moment?

Mr. SCHIFF. I think I only have a couple of seconds left. I just want to say very quickly, and then I will yield whatever remaining time I have, we do have a problem here. I am not convinced, given the severity of this bill, that we are going to address the problem in a way that will not really impede the quality of care and recourse for patients.

I yield the balance of my time to the gentlewoman from California.

Ms. WATERS. I would like to ask the gentleman from California if, in fact, and I think we should make it clear that we do have MICRA, but aside from the fact that you just pointed out we don't have cost of living increases in MICRA, that we generally do not support MICRA, and I think that is your position. Could you elaborate on that?

Chairman SENSENBRENNER. The gentleman's time has expired.

Ms. WATERS. I want it on the record that MICRA is a problem in California.

Chairman SENSENBRENNER. Without objection, the gentleman will have an additional minute.

Mr. SCHIFF. I thank the Chair for yielding.

I think the failure of MICRA to keep pace with inflation has been a problem. I think there are some salutary aspects of MICRA, but this bill goes way beyond MICRA, both in capping noneconomic damages—or capping noncompensatory damages at a level they were 25 years ago, capping punitive damages in a way that California doesn't cap them at all, in changing the standard of punitive damages, and a whole host of other things.

So this is not MICRA, this is a much more restrictive measure than MICRA even was 25 years ago, and it does not contain, as Mr. Berman outlined yesterday, any of the safeguards that MICRA has.

Chairman SENSENBRENNER. The gentleman's time has once again expired.

The question is on the Delahunt amendment. Those in favor will say aye; opposed, no. The noes appear to have it.

Mr. DELAHUNT. Mr. Chairman, I request a recorded vote.

Chairman SENSENBRENNER. A recorded vote is demanded. All those in favor of the Delahunt amendment will as your name is called answer aye. Those opposed will say no.

The Clerk will call the roll.

The CLERK. Mr. Hyde.

[No response.]

The CLERK. Mr. Coble.

Mr. COBLE. No.

The CLERK. Mr. Coble votes no.

Mr. Smith.

Mr. SMITH. No.

The CLERK. Mr. Smith votes no.

Mr. Gallegly.

Mr. GALLEGLY. No.

The CLERK. Mr. Gallegly votes no.

Mr. Goodlatte.

Mr. GOODLATTE. No.

The CLERK. Mr. Goodlatte votes no.

Mr. Chabot.

Mr. CHABOT. No.

The CLERK. Mr. Chabot votes no.

Mr. Jenkins.

Mr. JENKINS. No.

The CLERK. Mr. Jenkins votes no.

Mr. Cannon.

[no response.]

The CLERK. Mr. Bachus.

Mr. BACHUS. No.

The CLERK. Mr. Bachus votes no.

Mr. Hostettler.

[no response.]

The CLERK. Mr. Green.

Mr. GREEN. No.

The CLERK. Mr. Green votes no.

Mr. Keller.
Mr. KELLER. No.
The CLERK. Mr. Keller votes no.
Ms. Hart.
[no response.]
The CLERK. Mr. Flake.
Mr. FLAKE. No.
The CLERK. Mr. Flake votes no.
Mr. Pence.
Mr. PENCE. No.
The CLERK. Mr. Pence votes no.
Mr. Forbes.
Mr. FORBES. No.
The CLERK. Mr. Forbes votes no.
Mr. King.
Mr. KING. No.
The CLERK. Mr. King votes no.
Mr. Carter.
Mr. CARTER. No.
The CLERK. Mr. Carter votes no.
Mr. Feeney.
Mr. FEENEY. No.
The CLERK. Mr. Feeney votes no.
Mrs. Blackburn.
Mrs. BLACKBURN. No.
The CLERK. Mrs. Blackburn votes no.
Mr. Conyers.
Mr. CONYERS. Aye.
The CLERK. Mr. Conyers votes aye.
Mr. Berman.
Mr. BERMAN. Aye.
The CLERK. Mr. Berman votes aye.
Mr. Boucher.
[no response.]
The CLERK. Mr. Nadler.
Mr. NADLER. Aye.
The CLERK. Mr. Nadler votes aye.
Mr. Scott.
Mr. SCOTT. Aye.
The CLERK. Mr. Scott votes aye.
Mr. Watt.
Mr. WATT. Aye.
The CLERK. Mr. Watt votes aye.
Ms. Lofgren.
Ms. LOFGREN. Aye.
The CLERK. Ms. Lofgren votes aye.
Ms. Jackson Lee.
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee votes aye.
Ms. Waters.
Ms. WATERS. Aye.
The CLERK. Ms. Waters votes aye.
Mr. Meehan.
Mr. MEEHAN. Aye.
The CLERK. Mr. Meehan votes aye.

Mr. Delahunt.
Mr. DELAHUNT. Aye.
The CLERK. Mr. Delahunt votes aye.
Mr. Wexler.
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler votes aye.
Ms. Baldwin.
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin votes aye.
Mr. Weiner.
Mr. WEINER. Aye.
The CLERK. Mr. Weiner votes aye.
Mr. Schiff.
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff votes aye.
Ms. Sanchez.
Ms. SANCHEZ. Aye.
The CLERK. Ms. Sanchez votes aye.
Mr. Chairman.
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman votes no.
Chairman SENSENBRENNER. Are there Members who wish to cast or change their vote? The gentleman from Utah, Mr. Cannon.
Mr. CANNON. No.
Chairman SENSENBRENNER. The gentleman from Tennessee, Mr. Jenkins.
Mr. JENKINS. No.
Chairman SENSENBRENNER. Are there further Members in the chamber who wish to cast or change their votes? The gentlewoman from Pennsylvania, Ms. Hart.
Ms. HART. No.
Chairman SENSENBRENNER. Anybody else who wishes to cast or change their vote? If not, the Clerk will report.
The CLERK. Mr. Chairman, there are 15 ayes and 19 nays.
Chairman SENSENBRENNER. And the amendment is not agreed to.
Are there further amendments? The gentleman from California, Mr. Berman.
Mr. BERMAN. Mr. Chairman, I have an amendment at the desk.
Chairman SENSENBRENNER. The Clerk will report the amendment.
The CLERK. Amendment to the amendment in the nature of a substitute to H.R. 5 offered by Mr. Berman. At the end of the bill, add the following new section: section, applicability.
Mr. BERMAN. Mr. Chairman, I ask unanimous consent that this amendment be considered as read.
Chairman SENSENBRENNER. Without objection, and the gentleman is recognized for 5 minutes.
[The amendment follows:]

AMENDMENT TO H.R. 5

OFFERED BY MR. BERMAN

At the end of the bill, add the following new section:

1 **SEC. __. APPLICABILITY.**

2 (a) Nothing in this Act shall apply in a State unless the agency of
3 the State responsible for licensing or disciplining health care providers
4 has in effect policies and procedures ensuring the following:

5 (1) That such agency must promptly make available to the
6 public the identity of the provider or organization, the amount
7 of the obligation, and the basis of the claim, whenever

8 (A) a health care provider or health care
9 organization becomes obligated, by judgment or
10 settlement, to pay more than $10,000 on any claim, or

11 (B) a health care provider or organization revokes,
12 terminates, or restricts employment or privileges of a
13 doctor for a medical disciplinary reason, denies a doctor's
14 application for staff privileges for a medical disciplinary
15 reason, or receives a doctor's resignation following notice
16 of an impending investigation based on a medical
17 disciplinary reason.

18 (2) That whenever a health care provider or health care
19 organization fails to disclose to such agency information
20 covered by paragraph (1), such agency must impose on the
21 provider or organization one or more significant disciplinary
22 measures.

23 (b) The Secretary of Health and Human Services shall certify
24 State compliance with this section on an annual basis.

Mr. BERMAN. Mr. Chairman, the concept of this amendment was addressed by the gentleman from California, Mr. Schiff. One can debate whether we should federalize tort liability or not, one can debate the extent to which the serious constraints imposed by this bill taken from MICRA to a large extent will have effects on insurance premiums, but the one thing I know is that this bill keeps referencing the reforms in California and then cherry picks those reforms to not take any of the reforms on medical discipline that were contained in the MICRA law, or any of the insurance company reforms.

My amendment deals with one aspect of that, and that is the medical discipline reforms, and what it does is simply say that for this bill to go into effect we maintain the concept of State control of the discipline process, but we say that the States responsible for licensing and disciplining health care providers have to make public the identity and mandate a reporting of the judgment or settlement of any case of medical malpractice over $10,000 and any actions by a hospital to deny or suspend hospital privileges for that very small percentage of bad actors, doctors who are repeatedly the objects of medical malpractice lawsuits, doctors and other health care providers. These are all modeled on the California law, except that we raise the standard from $3,000 to $10,000 in terms of settlements and judgments, and we impose the obligation to be public.

It seems to me philosophically you have to go one of two ways on this. If we are going to reduce the accountability for the conduct by virtue of these changes, some of which, by the way, at least in the State context, I support, things like periodic payments provisions and, to the dismay of my friend from Virginia, Mr. Scott, I think the collateral source rule makes some sense, but if you accept those premises even on the State level that they are going to reduce the level of accountability, then you have to provide the public with another avenue to deal with the problem of that 5 percent that Mr. Conyers talked about, that 5 percent or less of physicians who are responsible for the majority of the medical malpractice cases. And all this does is say, report the judgments and settlements over $10,000 to your disciplinary board—hospitals report decisions about suspending or revoking privileges of physicians and other health care providers in your hospitals to the State medical disciplinary board, and make those reports and decisions available to the public so that a patient can have an informed choice. If you are limiting his ability to recover, then at least give him more access to information, and if you do that, then this bill in its entirety can operate in your State.

That is it, sort of plain and simple. Rather than cherry picking the MICRA reforms, many States have no reporting requirements or very weak reporting requirements. Do not touch the issue of revocation of privileges. California did at the very same time it passed all those tort reforms. I would suggest that logic makes the same sense here.

I yield back the balance of my time.

Chairman SENSENBRENNER. I yield myself 5 minutes in opposition to the amendment.

First of all, today the gentleman from California has a very soft spot in my heart, because we could have dunked your amendment on germaneness grounds because you are imposing a duty on the

Department of Health and Human Services rather than the Attorney General. HHS is outside the jurisdiction of this Committee. But I think we ought to beat your amendment on the merits rather than on a point of order.

Mr. BERMAN. Would the gentleman yield?

Chairman SENSENBRENNER. Of course.

Mr. BERMAN. I am stunned to hear and sorry to see the gentleman, for the first time, ever conceding any jurisdiction of this Committee.

Chairman SENSENBRENNER. Well, I am simply acquiescing to the erosion of the jurisdiction of this Committee that appears to have taken hold on my left. But again this amendment ought to be defeated on its merits.

First, I don't think that we should be changing State reporting and State open records requirements here. The licensing function has not been touched by this bill. I will grant you that there are problems with bad actors in the medical profession, just like there are problems with bad actors in practically every other profession. But I simply don't want to see, for example, an entire hospital's license to function be yanked as a result of the fact that there were mistakes that occurred in the hospital, because that will simply make the hospital much less willing to deal with risky medical procedures that some patients might require in order to attempt to try to bring them back to health.

Also, the amendment of the gentleman from California, you know, it doesn't deal with consent decrees. The consent decree is not admitting liability, but offering the payment that is requested. The consent decree type of settlement is something that would encourage cases to be settled before trial. If cases go to trial, it is much more expensive, particularly to the insurance carrier where the lawyer is paid on an hourly basis. All of that gets folded into the liability premiums that all physicians have to pay.

What this does is this ends up having a financial disincentive to physicians that really practice medicine ethically, honestly, and unnegligently, because any insurance is a risk-sharing scheme, and it is the good doctors and the good hospitals that are going to end up having to pay for the bad ones.

So for all of these reasons I would urge that the gentleman's amendment, nongermane though it is, be rejected.

I yield back the balance of my time.

Mr. CONYERS. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from Michigan.

Mr. CONYERS. I rise in support of the amendment, and I yield to the gentleman from California.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. BERMAN. I thank the gentleman for yielding.

I simply want to point out that this amendment does not preempt anything, and I think there should be at least a little humility about an amendment which says to the States you want the Federal—you want us to federalize your traditional jurisdiction in tort reform, in tort liability; all we say is if you want that, then you, in a process, and we lay it out, we don't preempt anything, if you want to take advantage of the federalization of that, then provide the compensating processes by which people can learn about

what is happening to the physicians, the hospitals, the other health care providers, that they are utilizing.

In the mid-1970's, I carried a bill in the legislature and it was fought by the medical association like mad, but we managed to get it through, that said patients had a right to see their medical records. People are not stupid. They are going to understand that a physician may have settled something for a few thousand—and remember the bar here, the floor is $10,000, not just a small payoff, they are not going to necessarily make decisions automatically on the basis that one physician or one hospital had one malpractice liability case over the course of their whole history. Trust the people. We do not preempt anything. We simply say, the corollary of federalizing and constraining tort liability and, therefore, that kind of accountability, is beefing up the discipline system to ensure that the public has the right to know the history of malpractice claims, settlements, and judgments. We cover settlements. I am not sure what the Chairman is referring to when he says we don't cover consent settlements. We cover all settlements over $10,000, and judgments and decisions by peer review boards on hospitals to discipline a particular physician.

I think it is a very sensible and reasonable approach that does not open up the issue of whether we should be federalizing or not and does not get into this great debate about whether tort liability limitations will reduce premiums. It simply says, if you want to take the MICRA example, do it on at least two of the sides. This does not touch insurance regulation, but do it on two sides, limits on tort liability, but beefing up the information and the strength of your medical disciplinary processes.

Mr. DELAHUNT. Will the gentleman yield? I thank the gentleman for yielding and I rise to support the amendment. I think it is an important amendment for many reasons. It might, I don't know, because I haven't seen any studies or have access to any data, but it might impact the levels of medical malpractice premiums that are causing us all concern. But as importantly, even more importantly, it could have a positive impact in terms of the quality of medical care that is being rendered to patients.

We have another crisis in this country, and that is that there are an unacceptable level of medical care errors. I would point out a 1999 study by the Institute of Medicine, which is an arm of the National Academy of Sciences, that blamed medical mistakes for the deaths of 44,000 to 98,000 hospitalized Americans each year. We have a real crisis on our hands. I would suggest that the gentleman's amendment would go to protect those Americans that take advantage of our health care system and particularly our hospital system.

I would think that given the statistics that have been mentioned here today in terms of 5 percent of the physicians who are responsible for some, I think it was 54 percent of malpractice claims——

Chairman SENSENBRENNER. The time of the gentleman from Michigan has expired.

Mr. DELAHUNT. Mr. Chairman, I move to strike the last word.

Chairman SENSENBRENNER. The Chair said he would recess the Committee at noon. The Chair is prepared to recess the Committee. The votes are scheduled at 1 o'clock. The Committee will reconvene

at either 1:30 p.m. or 10 minutes after the end of the last vote on suspensions.

The committee is recessed.

[Whereupon, at 12:00 p.m., the Committee was recessed, to reconvene at 2:20 p.m. This same day.]

[2:20 p.m.]

Chairman SENSENBRENNER. The Committee will be in order. When the Committee recessed, pending was a motion to report the bill H.R. 5 favorably. Also pending——

Mr. NADLER. Mr. Chairman.

Chairman SENSENBRENNER. The Chair has to put the question first.

Also pending was an amendment by the Chairman in the nature of a substitute and an amendment to the amendment in the nature of a substitute offered by the gentleman from California, Mr. Berman. The pending question is on the Berman amendment.

Now, for what purpose does the gentleman from New York seek recognition?

Mr. DELAHUNT. Mr. Chairman, if Mr. Nadler will yield, I thought you had recognized me.

Chairman SENSENBRENNER. No. I recessed the Committee.

Would you like to be recognized now?

Mr. DELAHUNT. Yes, I would, Mr. Chairman.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. DELAHUNT. I just want to suggest that this particular amendment makes eminently good sense. It would appear that the proponents of the underlying bill are using the California statute, its acronym is MICRA, as an example of how to reduce or at least stabilize medical insurance, medical malpractice premiums. Yet, as the gentleman from California pointed out, and I know, or I believe that he served in the California legislature at that point in time, the only provision of MICRA that is culled is the cap on damages, on noneconomic damages. I would suggest that this amendment is part of that California statute, as Mr. Berman explained it, and it could very well be a critical component of whatever, if any, success California has achieved with the passage of that particular legislation.

Why should we hesitate, and I ask this looking for an answer, why should we hesitate to inform and educate the public? If the proponents are truly concerned about a comprehensive effort, then this amendment should be passed. We should not simply take one particular aspect of the California law and think that it is a panacea, as has been reported in numerous professional trade publications. This is an unanswered and complex issue.

It could also presumably serve as a tool to weed out those physicians who happen to be responsible for a disproportionate share of medical errors. What we have now, I would submit, is a system where good physicians, those who deliver quality health care, are subsidizing the bad doctors, those who again, while they are a small percentage, 5 percent to be exact, are responsible for some 54 percent of malpractice claims, according to the National Protection Database.

So let's end that subsidy, and maybe this is a tool that will help us go in that direction. I would hope at the same time that if we

have an educated public and an informed public, that it might help reduce the up to 98,000 deaths caused by medical errors each year, 98,000 medical errors that result in death each year. That is a crisis, and the amendment being proposed by Mr. Berman again is a tool that might result in the saving of lives, if you will. I can't see why there should be any opposition to the amendment.

To respond to the Chair's observation, I would suggest that his argument supports a selective federalism. In other words, when it comes to the statute of limitations, when it comes to caps, we will observe federalism. But when it comes to protections or possible protection for the public, we won't.

I yield to Mr. Berman.

Mr. BERMAN. I am wondering if there is some kind of doctrine of Gestapo that should be applied. If the other side wants to argue in some bills you have to preserve the laboratory of the States, to create a federalism, a dynamic State action and quit trying to preempt and federalize everything, and in other bills argue for federalizing traditional State roles and nationalizing things that essentially can be addressed at the local or State level. That is fine, but should the Gestapo doctrine apply that says in the same bill, you can't argue both sides of the issue?

Mr. COBLE. [Presiding.] The gentleman's time has expired, but I will permit him to respond to that.

Mr. DELAHUNT. Well, it is a very interesting concept and listening to our colleague from Florida and their Supreme Court, maybe if it was one that was put forth before the Florida Supreme Court it might even be recognized.

Mr. COBLE. The gentleman's time has expired. Anybody on my right want to be heard? If not, I recognize the gentlewoman from Wisconsin.

Ms. BALDWIN. Mr. Chairman, I move to strike the last word.

Mr. COBLE. The gentlewoman from Wisconsin is recognized for 5 minutes.

Ms. BALDWIN. I want to thank Mr. Berman for his amendment. It raises the key issue in this debate: accountability. We must have a health care system that is accountable to its citizens. Recourse to the court system is fundamental to accountability, but this amendment helps clarify that there are other protections that also promote accountability.

Soaring malpractice insurance rates need to be addressed with two principles in mind. First, do no harm to the victims of medical errors. Second, start by addressing the problems of inadequate or expensive malpractice insurance.

If we adopt these two fundamental principles, narrow Federal caps on noneconomic damages are not the way to address the problems with malpractice insurance.

I want to start by talking just a moment about the medical liability insurance situation in my home State of Wisconsin. In short, we do not have any sort of crisis in Wisconsin. When Wisconsin first addressed this issue in 1975, we started from the premise that you don't deal with malpractice insurance costs by blaming the victims, you start by addressing the insurance issues, and that is what Wisconsin attempted to do. We did three key things.

First, we required that all doctors have malpractice insurance. Second, we created an insurer of last resort, the Wisconsin Health

Care Liability Insurance Plan, to provide affordable malpractice insurance to those who could not find any in the private marketplace. It is known as WHCLIP and WHCLIP has been very successful with rate increases at or near inflation in recent years.

Finally, we created something called the Wisconsin Patients' Compensation Fund. The Patients' Compensation Fund covers all economic damages exceeding $1 million per occurrence or $3 million per year. The Patients' Compensation Fund, the PCF, rates were down, and let me emphasize this, rates were down 45 percent over the past 4 years. This year, there was an increase, it was just 5 percent.

By pooling risk and making sure that all doctors have coverage Wisconsin has successfully addressed this issue, and these actions controlled malpractice insurance costs long before Wisconsin ever debated or looked at or ultimately did cap noneconomic damages.

As I have said, we did three things in Wisconsin to specifically address the insurance problems; however, we really did a lot more in this arena. We have had numerous safeguards for providing accountability to our health care system. The State of Wisconsin protects pay in manners beyond recourse to the courts, which brings me to my final point: this really should be a State issue. Each State has the authority and capacity to address the problems they have. H.R. 5 provides a one-size-fits-all approach that is overly broad and encroaches on traditional State authority. Application of nationwide caps does not account for different patient protections in each State. At the very least, the provisions of H.R. 5 should be combined with commensurate measures to ensure accountability, and Mr. Berman's amendment brings that important process forward.

I urge the Members of the Committee to adopt the Berman amendment, and I yield back any remaining time.

Chairman SENSENBRENNER. [presiding.] For what purpose does the gentleman from Wisconsin seek recognition?

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

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman.

With due respect to my friend and colleague, I am also from the State of Wisconsin, and we served together during the period in time when the Patients' Compensation Fund was fixed. In the early 1990's, as a result of not having the very types of limits that this legislation would put into place, our Patients' Compensation Fund was actuarially in great debt. In fact, it was on the verge of going out of business without a dramatic escalation of premiums by health care providers who pay into the fund.

If we had not taken action, if we had not put into place some of the very limits that we are talking about with the legislation before us today, that Patients' Compensation Fund for which my colleague is rightly proud would be out of business. We would have the type of malpractice liability crisis which other States do.

The American Medical Association produced a report not so very long ago in which it said that the State of Wisconsin was one of seven States that did not have a crisis and they pointed specifically to the types of changes and limitations that this legislation before

us would do. It pointed to those changes as being the reason why our State was not in crisis.

If we do not take the action today before us, we will see the liability crisis spread to other States. It will hurt access to care. We have learned that firsthand in Wisconsin. Had we not imposed caps like we are talking about today, we would be among the States in health care crisis.

Ms. BALDWIN. Will the gentleman yield?

Mr. GREEN. I would be happy to yield to my colleague from Wisconsin.

Ms. BALDWIN. As this debate unfolds here and certainly as it unfolded in Wisconsin, I know that the sides take very strict interpretation of the facts before it. But I think many would argue that in the State of Wisconsin we were reacting to an actuarial misjudgment about the state of that fund and, in fact, they recalculated only a few years later and found a $110 million miscalculation, essentially. We reacted——

Mr. GREEN. Well, reclaiming my time, the board of directors of the Patients' Compensation Fund would strenuously disagree with your interpretation. In fact, just recently, as you know, the Governor of the State of Wisconsin is seeking to take $200 million out of that fund, and if he does that, according to the board of directors of the Patients' Compensation Fund, he will put it back dramatically into deficit.

This fund is what stabilizes malpractice premiums. There are not many States that have this, but it stabilizes premiums, and this again is all due to the fact that we placed reasonable limitations on noneconomic damages.

The truth of the matter is, in the Wisconsin experience, we had a crisis. We had rapidly rising rates. We had health care practitioners talking about leaving the State or leaving the higher risk specialties. It was the Patients' Compensation Fund which was stabilized by the legislation that we created which had restrictions similar to what we are talking about today that solved that crisis. Had we not, Wisconsin would not be one of the States that rightfully boasts of its situation; it would be one of the States in crisis.

So with due respect, I strenuously disagree with your interpretation. In fact, that simply is not borne out by history.

With that, I yield back my time.

Mr. WATT. Mr. Chairman.

Chairman SENSENBRENNER. For what purpose does the gentleman from North Carolina seek recognition?

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

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. WATT. Mr. Chairman, I was going to stay out of this, but this debate has reached the point of almost being surreal at the level that we were talking about this morning.

What Wisconsin did, regardless of whether you accept Ms. Baldwin's analysis or whether you accept Mr. Green's analysis, is that they, on a State level, came to grips with this matter in their State and dealt with it in a way that fit the State of Wisconsin, not on a one-size-fits-all, not without honoring the federalism level, not presuming that the State legislators, these two brilliant people who

came out of there were stupid and not going to do what was in the State's interest.

The point I keep making over and over again is, you know, sure, Wisconsin does not have a crisis now, some States have a crisis. But there is no rationale for us trying to think that we can solve whatever that crisis is, or for that matter, that we should try to solve whatever that crisis is. And it is absolutely inconsistent with everything else that you all say you stand for. To have us here debating about how Wisconsin fixed it and the pros and cons of it illustrates that better than anything else.

With that, I will yield to Mr. Berman.

Mr. BERMAN. Well, I just, along the lines of the gentleman from North Carolina, I thought the discussion between the two Members from Wisconsin was fascinating. It was the perfect illustration of an agreement that this was not a crisis in Wisconsin, a disagreement about which of the measures taken was responsible for keeping it not a crisis, and a model that certainly is applicable to all 50 States. Wisconsin was the pioneer of States that used the concept of the States as laboratories to pioneer things like workers' compensation, if my memory serves me correctly, and a whole variety of other measures, rather than waiting for a Federal solution.

Let these 50 States deal with an issue. This is not product liability legislation where a manufacturer is distributing products to 50 different States. We are talking primarily in this bill, not exclusively but primarily, about health care providers operating in a State under State laws, under State disciplinary processes, and in a State tort system which can be amended at the State level. I thought the debate between the two Members from Wisconsin illustrated Mr. Watt's point just perfectly.

Mr. WATT. Mr. Chairman, if I can reclaim my time for just a moment, I am going to try to illustrate my goodwill by voting against Mr. Berman's amendment.

Mr. BERMAN. Is that the way you——

Mr. WATT. Because really, the very point I made this morning was once you get on this slippery slope—what Mr. Berman is proposing to do probably is a wonderful idea and the States ought to be doing that, they ought to be thinking about it. But the problem is once you get on this slippery slope of us trying to define what the States ought to be doing, there is no way to get off it, and that is the problem with this bill. You all are putting us on this slippery slope as if we have some magic solution to every State's problem as opposed to worrying about what our own issues ought to be. I am going to give you a chance to vote on that. Let's do this in the Federal courts on Federal matters and let the States do what they want to do.

Mr. BERMAN. Will the gentleman yield for just one moment?

Mr. WATT. I am happy to yield to him.

Mr. BERMAN. I am wondering, when you are on a slippery slope it is sometimes better to sit up and be ready to slide down well rather than tumble head over heels.

Mr. WATT. You want to know why I am voting against it. Because it is going to lose anyway, and it is not going to affect outcome, and I am trying to make a point here.

Mr. BERMAN. Fair enough.

Mr. WATT. I am trying to be consistent.

Chairman SENSENBRENNER. The question is on the Berman amendment. Those in favor say aye, those opposed, no. The noes appear to have it.

Mr. BERMAN. Mr. Chairman, I request a rollcall.

Chairman SENSENBRENNER. Those in favor of the amendment will answer as your names are called "aye" and those opposed "no."

The Clerk will call the roll.

The CLERK. Mr. Hyde.

[No response.]

The CLERK. Mr. Coble.

[No response.]

The CLERK. Mr. Smith.

Mr. SMITH. No.

The CLERK. Mr. Smith votes no.

Mr. Gallegly.

[no response.]

The CLERK. Mr. Goodlatte.

Mr. GOODLATTE. No.

The CLERK. Mr. Goodlatte votes no.

Mr. Chabot.

Mr. CHABOT. No.

The CLERK. Mr. Chabot votes no.

Mr. Jenkins.

Mr. JENKINS. No.

The CLERK. Mr. Jenkins votes no.

Mr. Cannon.

[no response.]

The CLERK. Mr. Bachus.

[no response.]

The CLERK. Mr. Hostettler.

Mr. HOSTETTLER. No.

The CLERK. Mr. Hostettler votes no.

Mr. Green.

Mr. GREEN. No.

The CLERK. Mr. Green votes no.

Mr. Keller.

[no response.]

The CLERK. Ms. Hart.

Ms. HART. No.

The CLERK. Ms. Hart votes no.

Mr. Flake.

[no response.]

The CLERK. Mr. Pence.

Mr. PENCE. No.

The CLERK. Mr. Pence votes no.

Mr. Forbes.

Mr. FORBES. No.

The CLERK. Mr. Forbes votes no.

Mr. King.

Mr. KING. No.

The CLERK. Mr. King votes no.

Mr. Carter.

[no response.]

The CLERK. Mr. Feeney.

Mr. FEENEY. No.

The CLERK. Mr. Feeney votes no.
Mrs. Blackburn.
[no response.]
The CLERK. Mr. Conyers.
Mr. CONYERS. Aye.
The CLERK. Mr. Conyers votes aye.
Mr. Berman.
Mr. BERMAN. Aye.
The CLERK. Mr. Berman votes aye.
Mr. Boucher.
[no response.]
The CLERK. Mr. Nadler.
Mr. NADLER. Aye.
The CLERK. Mr. Nadler votes aye.
Mr. Scott.
Mr. SCOTT. Aye.
The CLERK. Mr. Scott votes aye.
Mr. Watt.
Mr. WATT. No, with an asterisk.
The CLERK. Mr. Watt votes no.
Ms. Lofgren.
Ms. LOFGREN. Aye.
The CLERK. Ms. Lofgren votes aye.
Ms. Jackson Lee.
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee votes aye.
Ms. Waters.
[no response.]
The CLERK. Mr. Meehan.
[no response.]
The CLERK. Mr. Delahunt.
Mr. DELAHUNT. Aye.
The CLERK. Mr. Delahunt votes aye.
Mr. Wexler.
Mr. WEXLER. Aye.
The CLERK. Mr. Wexler votes aye.
Ms. Baldwin.
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin votes aye.
Mr. Weiner.
[no response.]
The CLERK. Mr. Schiff.
[no response.]
The CLERK. Ms. Sanchez.
Ms. SANCHEZ. Aye.
The CLERK. Ms. Sanchez votes aye.
Mr. Chairman.
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman votes no.
Chairman SENSENBRENNER. Are there Members in the chamber who wish to cast their vote?
The gentleman from North Carolina.
Mr. COBLE. No.
Chairman SENSENBRENNER. Mr. Keller.
Mr. KELLER. No.

Chairman SENSENBRENNER. Are there further Members who wish to cast or change their vote?

The gentleman from California, Mr. Gallegly.

Mr. GALLEGLY. No.

Chairman SENSENBRENNER. The Clerk will report.

The CLERK. Mr. Chairman, there are 10 ayes and 16 noes.

Chairman SENSENBRENNER. The amendment is not agreed to.

Are there further amendments?

Mr. NADLER. Mr. Chairman, I have two amendments, the first is number——

Chairman SENSENBRENNER. Do you wish to have them considered en bloc?

Mr. NADLER. No, no, no.

Chairman SENSENBRENNER. Okay.

Mr. NADLER. The first amendment is Nadler 030.

Chairman SENSENBRENNER. The Clerk will report Nadler 030.

The CLERK. Amendment to the amendment in the nature of a substitute to H.R. 5 offered by Mr. Nadler. After section 11, insert the following new section and redesignate——

Mr. NADLER. Mr. Chairman, I move to waive the reading.

Chairman SENSENBRENNER. Without objection, the amendment is considered as read and the gentleman from New York is recognized for 5 minutes.

[The amendment follows:]

H.L.C.

the amendment in the nature of a substitute to

AMENDMENT TO H.R. 5

OFFERED BY MR. NADLER

After section 11, insert the following new section and redesignate the succeeding sections accordingly:

1 **SEC. 12. AVAILABILITY OF COURT RECORDS.**

2 (a) GENERAL RULE.—No order or opinion of the
3 court in the adjudication of a health care lawsuit may be
4 sealed, except as provided in this section.

5 (b) EXCEPTION.—Any court record in a health care
6 lawsuit, including a record obtained through discovery,
7 whether or not formally filed with the court, may be sealed
8 or subjected to a protective order, and access to such
9 record may otherwise be restricted, only if the court makes
10 a finding of fact in writing that—

11 (1) the order that would restrict access to a
12 court record would not restrict the disclosure of in-
13 formation which is relevant to public health or safe-
14 ty; or

15 (2)(A) the public interest in disclosing potential
16 health or safety hazards is clearly outweighed by a
17 specific and substantial interest in maintaining the
18 confidentiality of the information or records in ques-
19 tion; and

1 (B) the order that would restrict access to a
2 court record is no broader than necessary to protect
3 the privacy interest asserted.

Mr. NADLER. Thank you, Mr. Chairman.

This amendment is designed to prevent the often dangerous practice of sealing information from malpractice lawsuits that could be used to protect the health and safety of others. Too often a doctor who may be guilty of a 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. It also ensures that doctors who may be not the most competent cannot be avoided by future victims.

I remind Members of the heartbreaking story we heard yesterday from Sherry Keller. She went into the hospital for a routine hysterectomy and wound up with a spinal cord injury. We are fortunate that she was able to share her story with us yesterday and that she will be able to tell others of the malpractice she suffered. But for those injured patients who enter into secret settlements, their stories will never come to light and the doctors who ruin their lives will go on to treat other patients, their dangerous practices hidden from the public.

If we really want to reduce the incidence of malpractice lawsuits, the place to begin would be to reduce the incidence of malpractice itself. Without full disclosure of these cases, medical boards will not know which doctors to monitor and patients will not know which doctors to avoid. It is 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.

When critical information is sealed from the public, other people may be harmed as a result.

Some Members may remember that this past fall, South Carolina's Federal judges recognized the danger inherent in sealed settlements and moved to end this disgraceful practice, except in extraordinary circumstances. As the New York times wrote in praising this decision, quote, "The main loser in secret settlements is the public consumers of the private information they need to protect themselves from unsafe products," unquote. In this case, unsafe doctors.

I hope that this will signal the beginning of a trend toward openness in the courts across the country. But we should take the 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 is appropriate. It 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 interest is broader than the public interest, then the judgment must issue the gag order. If the judge finds the public interest and the health and safety outweighs the privacy interests asserted, the judge may not issue such an order.

The judge also has to make the order drafted as tight as possible. This will prevent the unnecessary disclosure of confidential information, but will not allow the sealing of information whose sealing may harm the public. When it comes to health and safety, public access to malpractice lawsuit materials is essential.

I urge my colleagues to support this amendment. And I yield back the balance of my time.

Chairman SENSENBRENNER. The Chair recognizes himself for 5 minutes in opposition to the amendment. This is another federalization amendment which I am sure my friend from North Carolina will vigorously oppose.

I think that the best way to deal with what is sealed and what is not sealed is on a case-by-case basis and to leave that up to the judge that is presiding over each individual case. He can decide under what circumstances matters can be placed under seal, what type of protective orders can be placed under seal, and sometimes this is to help ensure the privacy of the plaintiff from having people snoop around in court records.

I would hope this amendment would be rejected. It is much broader than the amendment that was previously rejected, offered by Mr. Berman of California.

I yield back the balance of my time. Gentleman from California.

Mr. BERMAN. Mr. Chairman, I move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. BERMAN. I yield to the gentleman from New York.

Mr. NADLER. Thank you. I thank the gentleman from California for yielding to me and I would comment that the Chairman said this should be done on a case-by-case basis, which is exactly what this amendment does. The amendment says that such records may be sealed if the court makes a finding of fact, in writing, that the order would restrict access to a court record would not restrict the disclosure of information which is relevant to public health and safety, or that the public interest in disclosing potential health or safety hazards is clearly outweighed by a specific and substantial interest in maintaining the confidentiality information of records in question. That is what this amendment says.

So it is the—the judge would make a finding of fact in each case. It is specific case by case, as the Chairman suggested. All the amendment prohibits is an automatic sealing, because the plaintiff and the—a plaintiff says I will give a million dollars—I am sorry—defendant says I will give a million dollars but you have got to seal the record; the defendant says okay, and the judge rubber-stamps it. That is what is forbidden here. The judge still has the authority to seal the information if he finds that the public interest is outweighed by some specific privacy interest and that the information—or that the information is not necessary for public health and safety.

As for federalization, this whole bill federalizes, you know, medical malpractice and that is not an argument against this. Much of what we have heard today, much of what we have heard today and at the hearing yesterday, is that a lot of the problem with high premiums come from the fact that a relatively small number of doctors commit a relatively large percentage of the malpractice, and this would go a long way toward solving that problem.

Mr. DELAHUNT. Would the gentleman yield for a question?

Mr. NADLER. Yes, I will yield.

Mr. DELAHUNT. The Chair indicated a concern for the privacy of the plaintiff. Would the gentleman from——

Mr. NADLER. I am sorry.

Mr. DELAHUNT. The Chair indicated in his response on the amendment that it very well might violate a privacy interest of the plaintiff. Would the gentleman from New York insert a friendly amendment to make the issue of confidentiality at the option of the plaintiff to address the concerns by the——

Mr. NADLER. No, because the—no, because once you—I thank the gentleman. Once you make it the option of the plaintiff or the defendant, the defendant is going to say to the plaintiff, you can have the million dollars only if you exercise this option.

What we have done in this amendment is to say that if there is a privacy interest asserted, the judge makes the decision whether that—the public interest overcomes that privacy interest. It says specifically the judge must make a finding of fact, in writing, that the public interest is clearly outweighed by a specific and substantial interest in maintaining the confidentiality. If he makes that finding, it goes the other way.

Mr. DELAHUNT. I appreciate the response and I think it is a valid one; yet at the same time, think it is important that we understand that these confidentiality agreements are usually concluded not because of a decision by the plaintiff, and not because of a concern on—with privacy issues by the plaintiff—but, rather, because of the position of the defendant.

Mr. NADLER. Reclaiming my time, I agree with you. But if we allow the plaintiff the option, that will be a condition imposed upon him by the defendant.

Mr. DELAHUNT. Well, I daresay that that would be a stretch. But I am trying to see whether—if an amendment to your amendment would meet the concerns that were expressed by the Chairman so that possibly we could have a unanimous amendment.

Mr. NADLER. I would point out also that the bill says—the third requirement that I didn't read is that the judge must find that the order to restrict access to a court record is no broader than necessary to protect the privacy interest asserted. It is taken care of by the judge here. You have to let the judge decide it because otherwise the amendment wouldn't do anything at all because the defendant would always demand——

Mr. DELAHUNT. Well I am glad that you, you know, read the language relative to the privacy interest because it possibly—I think it changed the opinion.

Mr. NADLER. Well, the privacy interest is completely protected as long as—the judge has to find that the public interest and the public health and safety outweighs the privacy interest asserted. The privacy interest must be specifically asserted.

And I would simply say that all this amendment does is change the defaults. Under current law it is presumed it can be sealed. Under this amendment it would presume you can't presume it either way. But the judge can make the finding if you assert a privacy interest and he asserts a public health interest.

Chairman SENSENBRENNER. The time of the gentleman from California has expired.

Mr. NADLER. I thank the gentleman.

Chairman SENSENBRENNER. For what purpose does the gentleman from Virginia, Mr. Scott, seek recognition?

Mr. SCOTT. Move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. SCOTT. Mr. Chairman, on page 3, line 18 of the bill under discussion, one of the purposes is to provide increased sharing of information in the health care system which will reduce unintended injury and improve patient care. I found nothing in the bill, other than this potential amendment, that would fulfill that purpose.

And I would therefore support the amendment. Yield back.

Chairman SENSENBRENNER. Thank you. The gentleman's time has expired. The question is on the Nadler amendment 030.

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. A rollcall is demanded and will be ordered. Those in favor of Nadler 030 will, as your names are called, answer aye. Those opposed, no. And the clerk will call the roll.

The CLERK. Mr. Hyde.

[No response.]

The CLERK. Mr. Coble.

[No response.]

The CLERK. Mr. Smith.

[No response.]

The CLERK. Mr. Gallegly.

[No response.]

The CLERK. Mr. Goodlatte.

[No response.]

The CLERK. Mr. Chabot.

Mr. CHABOT. No.

The CLERK. Mr. Chabot, no.

Mr. Jenkins.

[No response.]

The CLERK. Mr. Cannon.

Mr. CANNON. No.

The CLERK. Mr. Cannon, no.

Mr. Bachus.

[No response.]

The CLERK. 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.

Ms. Hart.

Ms. HART. No.

The CLERK. Ms. Hart, no.

Mr. Flake.

Mr. FLAKE. No.

The CLERK. Mr. Flake, no.

Mr. Pence.

Mr. PENCE. No.
The CLERK. Mr. Pence, no.
Mr. Forbes.
Mr. FORBES. No.
The CLERK. Mr. Forbes, no.
Mr. King.
Mr. KING. No.
The CLERK. Mr. King, no.
Mr. Carter.
[No response.]
The CLERK. Mr. Feeney.
Mr. FEENEY. No.
The CLERK. Mr. Feeney, no.
Mrs. Blackburn.
[No response.]
The CLERK. Mr. Conyers.
[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.
Mr. WATT. Aye.
The CLERK. Mr. Watt, aye.
Ms. Lofgren.
[No response.]
The CLERK. Ms. Jackson Lee.
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee, aye.
Ms. Waters.
Ms. WATERS. Aye.
The CLERK. Ms. Waters, aye.
Mr. Meehan.
[No response.]
The CLERK. Mr. Delahunt.
Mr. DELAHUNT. Aye.
The CLERK. Mr. Delahunt, aye.
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. Ms. Sanchez.

Ms. SANCHEZ. Aye.
The CLERK. Ms. Sanchez, aye.
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? Gentleman from Virginia, Mr. Goodlatte.
Mr. GOODLATTE. No.
The CLERK. Mr. Goodlatte, no.
Chairman SENSENBRENNER. Gentleman from Tennessee, Mr. Jenkins.
Mr. JENKINS. No.
The CLERK. Mr. Jenkins, no.
Chairman SENSENBRENNER. Gentleman from North Carolina, Mr. Coble.
Mr. COBLE. No.
The CLERK. Mr. Coble, no.
Chairman SENSENBRENNER. Gentleman from Texas, Mr. Smith.
Mr. SMITH. No.
The CLERK. Mr. Smith no.
Chairman SENSENBRENNER. Gentleman from California, Mr. Gallegly.
Mr. GALLEGLY. No.
The CLERK. Mr. Gallegly, no.
Chairman SENSENBRENNER. Gentleman from Michigan, Mr. Conyers.
Mr. CONYERS. Aye.
The CLERK. Mr. Conyers, aye.
Chairman SENSENBRENNER. Further Members who wish to cast or change their votes? Gentleman from Texas, Mr. Carter.
Mr. CARTER. No.
The CLERK. Mr. Carter, no.
Chairman SENSENBRENNER. Gentlewoman from Tennessee, Mrs. Blackburn.
Mrs. BLACKBURN. No.
The CLERK. Mrs. Blackburn, no.
Chairman SENSENBRENNER. Anybody else? Going once, going twice, and the clerk will report. Gentleman from California, Mr. Schiff.
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff, aye.
Chairman SENSENBRENNER. Gentleman from Massachusetts, Mr. Meehan.
Mr. MEEHAN. Aye.
The CLERK. Mr. Meehan, aye.
Chairman SENSENBRENNER. Let's try again. The clerk will report.
The CLERK. Mr. Chairman, there are 13 ayes and 19 nays.
Chairman SENSENBRENNER. The amendment is not agreed to.
Are there further amendments? Gentleman from New York.
Mr. NADLER. Mr. Chairman.
Chairman SENSENBRENNER. Gentleman from New York.
Mr. NADLER. Thank you. I have my amendment number 31.
Chairman SENSENBRENNER. The clerk will report amendment number 31.

The CLERK. Amendment to the amendment in the nature of a substitute to H.R. 5 offered by Mr. Nadler:

Sections 4(b), 4(c), and 7(b)(2), insert after "$250,000"——

Mr. NADLER. Mr. Chairman , move to dispense with the reading.

Chairman SENSENBRENNER. Without objection, the reading is dispensed with. The gentleman is recognized for 5 minutes.

[The amendment follows:]

H.L.C.

the amendment in the nature of a substitute to

AMENDMENT TO H.R. 5

OFFERED BY MR. NADLER

Sections 4(b), 4(c), and 7(b)(2), insert after "$250,000" each place such term appears the following: "(adjusted annually according to the adjustments in the consumer price index to the nearest thousand dollar)".

Mr. NADLER. Thank you, Mr. Chairman. This is a very simple amendment that merely indexes the $250,000 cap on noneconomic and punitive damages in the bill. This amendment last year got an even vote. There was not a bipartisan—it got a bipartisan vote; it was defeated on a tie vote.

So I hope people will listen carefully. It simply indexes, the amendment, the $250,000 cap for the cost of living. Providing for a cost-of-living adjustment whenever there is a dollar amount in a bill is simply responsible legislating, whatever the issue. And in this case I think it is especially appropriate. Perhaps $250,000 was a reasonable cap in 1975 when MICRA was enacted in California more than 27 years ago. But that was not indexed. So the people who voted for a $250,000 cap in 1975, it is still 75,000—$250,000 today; and it is the equivalent in 1975 dollars of a little less than $39,000, $38,877 for pain and suffering. If the MICRA cap had kept pace with inflation, it would be about $850,000 today, a more reasonable place to start.

Given that we are already beginning with such a stringent cap in this bill, namely, 27 years behind MICRA, it certainly makes sense to provide for an increase to allow for inflation so that the very modest compensation available does not become, with the passage of time, absolutely meaningless. I hope that is not what the supporters of this bill ultimately intend. This is a commonsense change that would ensure at least some measure of basic fairness in the bill so that people with noneconomic damages, especially if you are talking about older people or children who have no job loss, you know, no income loss, just because they were killed and the only damage is pain and suffering, loss of companionship, whatever, if you set a $250,000 now, 15 years from now it is going to be $50,000. That shouldn't be.

So I urge people to consider this seriously and to vote for this amendment to simply index the $250,000 cap on noneconomic dam-

ages and on punitive damages, to index it according to the cost of living, as we do so many other things.

I thank the Chairman and I yield back the balance of my time.

Chairman SENSENBRENNER. The Chair recognizes himself for 5 minutes in opposition of the amendment.

This amendment should be opposed because it severely weakens the cap on noneconomic damages. Caps on noneconomic damages are essential to the success of the HEALTH Act's reform. The key to the success of the MICRA reforms in California is its cap on noneconomic damages of $250,000 which are not indexed to inflation. In the NAIC study, liability premiums show that from 1976 to 2000 the premiums in California increased 167 percent, whereas in the rest of the country they have been increased by 505 percent. I think that very clearly shows that not indexing the pain and suffering damages in California has had a distinct affect on controlling medical liability premiums.

The California cap has stood the test of time and remains an effective check on medical professional liability rates precisely because it was not indexed to inflation back in 1975. Perhaps some graduates of the California legislature will shortly be admitting their mistake for not indexing it to inflation; but it wasn't, and we have seen what has happened with the premiums. What may be described by some as an arbitrary figure in 1975 has become the keystone of the only proven long-term legislative solution for the current crisis in access to medical care. Indexing that figure to inflation would throw a wrench into the long-term medical professional liability premium-reducing machine that is California's MICRA reforms.

I will tell you what: Show me where the Consumer Price Index measures pain and suffering and I will support indexing to inflation. The simple fact is that pain and suffering can't be measured and therefore it makes no sense to index it to the CPI. Quantifiable economic damages are not limited by H.R. 5 because those damages can be measured and are adjusted upward for future years to account for inflationary effects on economic goods and services that can be quantified. Pain and suffering can't be quantified so it makes no sense to tie it to the quantification of things that have nothing to do with pain and suffering. It is mixing apples and oranges.

Keep this in mind. California, where a cap on noneconomic damages that has not been indexed to inflation and which has been the law for over 25 years, has healthier people than the Nation as a whole. According to California health statistics for the year 2000, the overall mortality rate in California is 24 percent below the national average and the infant mortality rate in California is 19 percent below the national average. Lower economic damage awards in California have led to healthier people.

And I yield back the balance of my time.

Mr. BERMAN. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from California, for what purpose do you seek recognition?

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

Chairman SENSENBRENNER. You are recognized for 5 minutes.

Mr. BERMAN. First of all, California is healthier because the Democrats have controlled the legislature there for the last 40 or 50 years.

Chairman SENSENBRENNER. Will the gentleman yield?

Mr. BERMAN. Yes, sir.

Chairman SENSENBRENNER. Are all the tax increases that are on the docket there, are they raising people's blood pressure out there?

Mr. BERMAN. We are a people—a laid-back people.

Secondly, pain and suffering can't be quantified and, dammit, let's accept this $250,000 cap in pain and suffering. The quantification works when it serves your purpose.

And third, I yield to the gentleman from New York, Mr. Nadler, for further comments on this.

Mr. NADLER. Thank you. I am really astounded, I must say. I thank the gentleman for yielding. I am astounded at the Chairman's argument. What you are really saying is the California bill, which includes among other provisions a $250,000 cap has succeeded in keeping down premiums. Therefore, it should be—and it is not indexed. And if we indexed it, maybe premiums would go up and maybe they wouldn't; and maybe people would be healthier and maybe they wouldn't; because, Mr. Berman said, maybe people are healthy in California because the Democrats have controlled the legislature, because it is sunnier, or for whatever reason. I mean you have to establish some causal relationship to what you assert.

But the fact of the matter is what you are really saying is why don't we allow people zero recovery for pain and suffering; because if you index something at whatever number, take 50,000, 250,000, 550,000, and you don't index it, eventually that number is going to be almost zero. It is going to be almost worthless depending how long you want to go.

Now, yes, it is impossible to quantify pain and suffering. But are you going to say to me—is anyone really going to say that someone such as the witness who was sitting in that chair yesterday, who will never walk again, whose spine was injured by injury, who didn't—who had no great economic loss because she wasn't working, but she shouldn't be compensated for her loss of the ability to walk or the fact that she will be confined to a wheelchair forever? That the death of a child should not be compensated at all?

I think most of us agree, I hope everybody in this room agrees that pain and suffering should be compensated to some extent. Once you have said that, I don't know how you set it at 250 or 500, or what the cap is, but once you set a cap, if you don't index it for inflation, that cap gradually becomes worthless and it becomes for all practical purposes zero.

And frankly, if you are trying to pass a bill—now, I disagree with you on this bill, obviously. But hopefully the proponents of this bill, hopefully the supporters of this bill think it is a fair and a balanced bill, and a fair and a balanced bill may say that some people will recover less in the interests of keeping insurance premiums down because that is the proper balance. So, other people will say they have nothing to do with each other. That is the debate on the bill. But even if they do have something to do with each other, even if you assume that it is terrible high malpractice awards that are resulting in high insurance premiums and other evils, therefore we

have got to cap them, fine. But you still have to balance it. You are not going to say that in order to cap—in order to keep insurance rates from going too high, we are going to say that people who are injured by someone's negligence can recover nothing, should get nothing for their injury, for their pain and suffering, for their noneconomic injuries. And that is what the argument of the Chairman really says.

I would come back and say again, if you think that $250,000 is a fair amount today and will help cap malpractice insurance rates today, then the equivalent in real dollars, $250,000 10 years from now, or what is worth $250,000 in today's dollars 10 years from now, will be just as fair or unfair and will be just as effective or ineffective in helping malpractice rates.

I hope the argument isn't we will start at 250 and we will get everybody gullible enough to vote for it, knowing that eventually it is going to go down, year by year, to 200 and 150 and 100 and 50 and 30,000 and eventually be worth less than nothing, and maybe we will keep insurance rates down at the price of people who are injured by someone else's negligence getting nothing back. That is just not right and I hope people will seriously think of this. And if $250,000, in real dollars, in today's dollars, is fair today, then the same amount of money in real dollars is fair tomorrow and 10 years from now and that is what this amendment does.

I yield back to——

Ms. JACKSON LEE. Mr. Chairman.

Chairman SENSENBRENNER. For what purpose dos the gentlewoman from Texas, Ms. Jackson Lee, seek recognition?

Ms. JACKSON LEE. I would like to strike the last word.

Chairman SENSENBRENNER. The gentlewoman is recognized for 5 minutes.

Ms. JACKSON LEE. Thank you very much. Let me rise to support Mr. Nadler's I think very reasonable response to the pain and the hurt and the loss of life that many of the victims expressed to us yesterday. One of the concerns that I have had in even bringing this legislation to the point that it is now, listening to the President's remarks yesterday that this is couched as a fight between lawyers and doctors.

Now, in this august room with these very esteemed Members, some of whom are lawyers, who have taken the oath as I have—some have not, and we are very gratified for their presence to bring a breath of fresh air. I think it should be clear that lawyers have their duty and obligations under the constitution and the laws of this land and doctors have their role and responsibilities.

It seems to me that we are hypocrites if we cannot at the same time that this legislation proposes to be reasonable and responsible in the area of caps, and we can't be sufficiently responsible to acknowledge the pain and that $250,000 without an accelerator clause, if you will, makes sense, because of the fact that we are talking about people who have been devastated.

Mr. President, this is not a fight between lawyers and doctors, as we would all say. There are doctors who are my best friend. I hope lawyers can say the same thing. But it is to John McCormick who did not testify here yesterday, who lost his 13-month-old daughter because of clear malfeasance and incompetence that could be attributable to some of the providers he had to deal with in his

State of Massachusetts; or to the lack of a physician being present, or however the situation occurred to the witness from Mississippi; or the other witness, Mrs. Keller I believe her name was, who came here in a wheelchair.

So this seems to me that this is pushing the envelope when you can't even add to legislation a clause that responds to the fact that $250,000 20 years from now is a joke. And frankly, you can go back to California and take this bill with you, because the California relief did not come until they put in price controls in 1988. It did not occur with this legislation. I am appalled that when you find most of my constituents and others in this country shut out of the judiciary system, literally without the ability to get counsel, no dollars to be able to go into the courthouse, most plaintiff cases thrown out of court, and most of my constituents literally hanging outside the courtroom door, short of contingency fees, and the structure that we have, blocked away from the judicial system, that we would even entertain this kind of legislation when men and women are on the front lines fighting for our freedom who have had to give up cars and homes because they have had to go off into the military, which I bless them for doing because they can't afford it. And I think that this is an outrage.

I would be happy to yield to the distinguished gentlelady from California as I continue. This is outrageous and I would yield to the gentlelady.

Ms. LOFGREN. I just want to thank the gentlelady for her passionate comments and I oppose this bill. I don't think the Federal Government ought to be in the job of preempting the tort laws of the 50 States. But I will say for those who disagree with me, you should be looking for this kind of an amendment because should this ever become law, the pressure to change the law is going to be immense. That is what is happening in California right now. Because what everyone thought about $250,000 in 1975, it is a small percentage today.

And so if you really want this bill to last, you should approve this amendment. I thank the gentlelady for yielding.

Ms. JACKSON LEE. Well, thank the distinguished gentlelady from California who is actually living the experience.

Mr. Chairman, what I say about Mr. Nadler's amendment—and the gentlelady is absolutely right. This is an amendment that should be passed in a bipartisan way, because I hope that we leave this room and we clarify to the American people this is not a fight between two professionals, doctors and lawyers. I would rather be fighting for the victims who have lost babies, lost limbs, lost their ability to function and lost their loved one.

And so this small clause actually speaks to the fairness that this bill suggests that it is attempting. And I think it is nothing but a payout to the insurance industry. It doesn't help doctors and it doesn't help lawyers, and I hope that you support the Nadler——

Chairman SENSENBRENNER. The time of the gentlelady has expired.

Ms. JACKSON LEE. I hope that you support the Nadler amendment. Thank you, Mr. Chairman.

Chairman SENSENBRENNER. The question is on——

Mr. DELAHUNT. Mr. Chairman.

Chairman SENSENBRENNER. Who seeks recognition?

Mr. DELAHUNT. Mr. Chairman, down here.

Chairman SENSENBRENNER. The gentleman from Massachusetts, Mr. Delahunt.

Mr. DELAHUNT. I thank the Chair for recognizing me. I will be submitting an amendment that will make an adjustment from 1975, but I am pleased that we finally have determined where the $250,000 figure came from. For a while, I just thought that it came—was pulled out of the air. But it would appear that that figure was adopted from the California bill. And if any of the proponents of the legislation differ with that statement, I would call on them to respond, because I think it is important.

I don't know what the methodology was back in 1975 to achieve the figure of $250,000. But somehow the California legislature in 1975 was able to quantify pain and suffering. Now, maybe there was some magic to it. But $250,000 today is the equivalent of $38,000 back in 1975. I think it is important for a moment to address this issue of pain and suffering and, really, what does it mean in terms of reduction of malpractice premiums.

There was a report that was undertaken in behalf of the New Jersey Medical Association by a consultant firm. They estimated—and this was done for the New Jersey Medical Association, not for a trade association of trial lawyers, but physicians. They estimated that a State cap of $250,000 for pain and suffering might result in a 5 to 7 percent savings for physicians for premiums. Five to 7 percent.

If we accept the argument that it is solely the cap, the $250,000, that is exclusively responsible for the experience in California, then we ignore all of the other aspects of the provisions of that law that were previously enumerated when Mr. Berman put forth his amendment. I don't think that anybody will—can unequivocally state, because there is no evidence. There is no data that show that simply a cap on noneconomic damages is responsible. Of course, jury verdicts are going up because the cost of health care has gone up over 27 years. Wages have gone up over 27 years. But to not adjust the cap for noneconomic damages I suggest is cruel, particularly when I remember the testimony of a woman from California whose son is blind as a result of a shunt and a medical error that was involved in his medical care; who is blind, who will never see, be able to talk; is for all intents and purposes someone that will never lead a normal life; that the jury awarded him in California $7 million, but he was only able to receive 250,000 because of that limitation. Is that fair? It is cruel.

I yield back.

Chairman SENSENBRENNER. The question is on the Nadler amendment.

Those in favor will say aye.

Opposed, no.

Noes appear to have it. Noes have it.

Mr. NADLER. Mr. Chairman, I ask for the ayes and nays.

Chairman SENSENBRENNER. The rollcall will be ordered. Those in favor of Nadler amendment number 31 will, as your name is called, answer aye. Those opposed, no. The clerk will call the roll.

The CLERK. Mr. Hyde.

Mr. HYDE. No.

The CLERK. Mr. Hyde, no.

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.
[No response.]
The CLERK. Mr. Chabot.
Mr. CHABOT. Aye.
The CLERK. Mr. Chabot, aye.
Mr. Jenkins.
Mr. JENKINS. Aye.
The CLERK. Mr. Jenkins, aye.
Mr. Cannon.
Mr. CANNON. No.
The CLERK. Mr. Cannon, no.
Mr. Bachus.
[No response.]
The CLERK. Mr. Hostettler.
Mr. HOSTETTLER. No.
The CLERK. Mr. Hostettler, no.
Mr. Green.
[No response.]
The CLERK. Mr. Keller.
Mr. KELLER. No.
The CLERK. Mr. Keller, no.
Ms. Hart.
[No response.]
The CLERK. 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. King.
Mr. KING. No.
The CLERK. Mr. King, no.
Mr. Carter.
Mr. CARTER. No.
The CLERK. Mr. Carter, no.
Mr. Feeney.
Mr. FEENEY. No.
The CLERK. Mr. Feeney, no.
Mrs. Blackburn.
[No response.]
The CLERK. Mr. Conyers. Oh I am sorry. Mrs. Blackburn.
Mrs. BLACKBURN. No.
The CLERK. Mrs. Blackburn, no.
Mr. Conyers.
Mr. CONYERS. Aye.

The CLERK. Mr. Conyers, 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.
[No response.]
The CLERK. Ms. Lofgren.
Ms. LOFGREN. Aye.
The CLERK. Ms. Lofgren, aye.
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.
Mr. DELAHUNT. Aye.
The CLERK. Mr. Delahunt, aye.
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.
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff, aye.
Ms. Sanchez.
Ms. SANCHEZ. Aye.
The CLERK. Ms. Sanchez, aye.
Mr. Chairman.
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman, no.
Chairman SENSENBRENNER. Are there additional Members in the room who wish to cast or change their vote? Gentleman from Texas, Mr. Smith.
Mr. SMITH. Mr. Chairman I vote no.
The CLERK. Mr. Smith, no.
Chairman SENSENBRENNER. Gentleman from Alabama, Mr. Bachus.
Mr. BACHUS. Yes.
The CLERK. Mr. Bachus, yes.
Chairman SENSENBRENNER. The gentlewoman from Pennsylvania, Ms. Hart.

Ms. HART. No.

The CLERK. Ms. Hart, no.

Chairman SENSENBRENNER. Gentleman from Indiana, Mr. Pence.

Mr. PENCE. No.

The CLERK. Mr. Pence, no.

Chairman SENSENBRENNER. Gentleman from North Carolina, Mr. Watt.

Mr. WATT. Aye.

The CLERK. Mr. Watt, aye.

Chairman SENSENBRENNER. The gentleman from Massachusetts, Mr. Meehan.

Mr. MEEHAN. Aye.

The CLERK. Mr. Meehan, aye.

Chairman SENSENBRENNER. Gentleman from Virginia, Mr. Goodlatte.

Mr. GOODLATTE. No.

The CLERK. Mr. Goodlatte, no.

Chairman SENSENBRENNER. Further Members who wish to cast or change their votes? If not, the clerk will report.

The CLERK. Mr. Chairman, there are 16 ayes and 17 nays.

Chairman SENSENBRENNER. And the amendment is not agreed to.

Are there further amendments? Gentleman from North Carolina, Mr. Watt.

Mr. WATT. I have an amendment at the desk, Mr. Chairman.

Chairman SENSENBRENNER. Clerk will report the amendment.

The CLERK. Amendment to the amendment in the nature of a substitute.

Mr. WATT. I ask unanimous consent that the amendment be considered as read.

Chairman SENSENBRENNER. Will the gentleman forbear until the amendment is passed out? The clerk will continue to report.

The CLERK. Amendment to the amendment in the nature of a substitute to H.R. 5 offered by Mr. Watt:

In section 9——

Chairman SENSENBRENNER. Without objection, the amendment is considered as read. The gentleman will be recognized for 5 minutes.

[The amendment follows:]

AMENDMENT TO
AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 5
OFFERED BY MR. WATT

In Section 9, subsection (7), on page 16, lines 24 and 25, strike "State or Federal court or pursuant to an alternative dispute resolution system" and insert "Federal court".

In Section 9, subsection (8), on page 17, lines 11 and 12, strike "State or Federal court or pursuant to an alternative dispute resolution system" and insert "Federal court".

Mr. WATT. Thank you Mr. Chairman. Let me first of all make a couple of disclaimers. Number one, the Members of the Committee should be aware that I plan to vote against this bill even if this amendment passes, because I think this whole concept of what we are doing is a bad idea, whether we are doing it at the Federal level or whether we are doing it at the State level. It seems to me to run contrary to the whole concept of personal responsibility. We hold everybody else in our society personally responsible for negligence and the conduct that they engage in, and I see no reason that we should make an exception for physicians, lawyers, other professionals that we don't make in general.

But if there is a rational place to do this, and if we can do it within the constitutional framework in which we are operating, without doing harm to the whole concept of federalism under which our constitutional framework was set up and which we have bought into for years, I guess I concede that we have the authority, even though I think it is a bad idea, to do it with respect to imposing these caps with respect to Federal cases, cases that are in the Federal court, where there is a clear Federal jurisdiction.

And that is what this amendment would do. Basically it would limit the effect of this legislation to cases that are brought into Federal court. Presumably, then, there would be a rational Federal connection; otherwise the case wouldn't be in Federal court. There would be diversity of citizenship. There would be some rational Federal basis.

As I said this morning, I have not seen a malpractice or a negligent act performed by a physician that overlapped State lines, that—and I do not believe that we have any monopoly on what works. I confess that I used to think that the Federal Government was guardian of certain things, that it stood for something more important perhaps than what the States stood for. My position on that has evolved over the years. I used to think, before I got here, that Members of Congress had some superior intellectual prowess perhaps over the people who served in the State legislature. My opinion on that has certainly evolved in the last 11 years that I have been here. And I just don't see a rational basis for federalizing tort law in the way that this bill does it. If there is a rationale for it—and I think that this has been illustrated more than

anything else in the discussion about Florida and what is taking place in Florida, earlier in the discussion about Wisconsin, and the debate between Ms. Baldwin and Mr. Green—if there is a rationale for doing something, that rationale exists at the State level and we should not undo our whole system of federalism to impose a one-size-fits-all solution to this problem at the Federal level. So I would ask my colleagues to try to exercise some analytical——

Chairman SENSENBRENNER. The gentleman's time has expired.

Ms. JACKSON LEE. Mr. Chairman.

Chairman SENSENBRENNER. The Chair recognizes himself in opposition to the amendment. This amendment eviscerates the bill because it only applies the reforms to lawsuits that are filed in Federal court, not in State court, not pursuant to some type of alternative dispute resolution. That means——

Mr. WATT. Is the Chairman running the clock for himself?

Chairman SENSENBRENNER. Well, the clock didn't start——

Mr. WATT. Thank you, Mr. Chairman.

Chairman SENSENBRENNER. The Chair never talks for 5 minutes. You know that.

Mr. WATT. I was just wondering whether you were operating under a different set of rules.

Chairman SENSENBRENNER. No. The Chair operates under more restrictive rules than the gentleman from North Carolina.

But what this amendment does, it eviscerates the bill because it only applies to actions brought in Federal court, not the State court, not in alternative dispute resolutions. So a plaintiff's lawyer that is looking to get the medical liability jackpot will simply steer away from Federal court. And I think that that would eviscerate this law because you would end up having no lawsuits filed in Federal court. You would still have the same problems that this bill is designed to correct. And the ultimate bottom line of correcting this is to provide for accessibility of quality medical care throughout the country.

Now, I don't know what the redistricting has done in the gentleman from North Carolina's district, but if the only place can you find qualified highly skilled neurosurgeons in North Carolina is either in Durham or in Charlotte, I would submit that there will probably be a lot of the gentleman's constituents that will be underserved should they need the services of a very highly skilled neurosurgeon. And that is what the bottom line is, should amendments like this be adopted.

I would urge the defeat of the gentleman's amendment, and I yield back the balance of my 3 minutes and 15 seconds.

For what purpose does the gentleman from Virginia seek recognition?

Mr. SCOTT. Mr. Chairman, to speak in favor of the amendment, Mr. Chairman.

Chairman SENSENBRENNER. Gentleman is recognized for 5 minutes.

Mr. SCOTT. Mr. Chairman, I think it is a good amendment and I yield the balance of my time to the gentleman from North Carolina.

Mr. WATT. I just—I want to complete the sentence that I was in the middle of when my 5 minutes expired and the rules were ap-

plied to me. I don't mind abiding by the same rules that the Chairman is abiding by. As long as they apply equally, I play by them.

The Chairman should understand that the most recent egregious medical negligence case in America was in North Carolina at Duke University Medical School. The notion that we could impliedly, implicitly, expressly, or otherwise sanction that kind of irresponsibility, capping the pain that the parents or the patient experienced having the wrong organs with the wrong blood type put into a person's body and then seeing her wither away, and watching it play out in the national press, we ought to be sick about the prospect of even thinking that we should hold welfare moms accountable and then excuse in some way that kind of irresponsibility.

And that is what I think about this bill in the final analysis. I mean I have tried to—you know, you all are always standing up talking about personal responsibility and people having responsibility for what they do in life when it is convenient for you to do it. That is when you stand up and do it. Well, it ain't convenient for you in this case because somebody contributed to a campaign fund or this person got more power than that person. It ain't convenient for you to think about the compromise and the bargain that was made between the States and the Federal Government when our Nation was formed. It ain't convenient for you all of a sudden because it serves some kind of political purpose and agenda that you are playing out. You ought to get responsible for what we are doing here today.

That is what this bill is about. And I say to you, and I say it up front, I am not voting for it, whether you pass this amendment or not. I said it. Because it would be irresponsible for me to vote for it and say to doctors, no, you don't have any responsibility, while at the same time we are saying to welfare moms, yeah, you have got to have responsibility for everything you do.

If you are going to apply a standard of responsibility, apply the same standard and apply the same standard to yourself as you think about these votes that we are casting in this Committee. And I say to you that this is irresponsible. That is what this bill is. It is irresponsible. And I say it to you as somebody who has seen a woman—represented a woman who walked into surgery for a simple hysterectomy and stayed in a coma for 10 years. I am going to reward some doctor who was responsible for that?

Ms. JACKSON LEE. Would you yield, Mr. Scott?

Mr. SCOTT. I yield.

Ms. JACKSON LEE. Let me just say that the question simply is should it be the State's prerogative. And I just recount that California's law was fixed by Californians when they fixed the rates. This should be a State's issue and we should not be doing this legislation today.

I yield back. I support the amendment.

Mr. FEENEY. Mr. Chairman.

Chairman SENSENBRENNER. The time of the gentleman has expired. The gentleman from Florida, Mr. Feeney.

Mr. FEENEY. Thank you, Mr. Chairman. I appreciate the intent of the amendment and want to address that. On the issue of convenience, I respect the fact that what we do here is we balance different interests. And I will tell you that it is not convenient for the people in 33 counties that are losing their trauma center in central

Florida to fly to Jacksonville or Miami when they have a head injury or an emergency. It is certainly not convenient for the people of Florida as they are turned away by their neurosurgeons, by their OB-GYNs, by an increasing number of health professionals, to go to, say, California, which has a fairly healthy health care system with respect to medical malpractice rates. And the fact of the matter is that we are seeing patients with serious treatment needs being turned away in many places across the State of Florida, as they are in other crisis States.

Now, I do think that the gentleman has some interesting points with respect to his amendment about the federalism issues. I happen to be a big advocate of the 10th amendment, and I wrestled with the issue because I think being intellectually honest and consistent is something that, as difficult as it is in a process like this, is important to strive for. I will suggest to you that if there are true libertarians on the Committee who take the position that the Federal Government ought to get out entirely of the health care business, then I think that they would be perfectly appropriate to oppose this bill.

But the fact of the matter is we provide health care services to our current Armed Forces, to our veterans, to patients served in the Indian health care system. We provide an enormous Medicare system for all of our seniors, and we—through tax dollars. We have a significant Medicaid system for people in need. We have tax credits, that I approve of, to encourage individuals to take care of their own health care needs, and we have tax credits for employers, which I approve of, to encourage them to cover the people that work for them. Those tax credits, by the way, maybe $4,000 for a family of four if you have got a responsible medical malpractice system, but they may be 5 or 6 or $7,000 in costs if you have an irresponsible system.

I think we owe it to taxpayers, if we are going to be in the health care subsidy business, I don't think we have any choice but to make sure that the tax dollars in our Medicare, our Medicaid, treatment of the armed services, treatment of the veterans, and through the tax credits are dealt with responsibly. The estimates are anywhere between 25 and a $100 billion that can be saved to Federal taxpayers if we will have a responsible civil litigation system that will hold doctors responsible for negligence on all of the economic damages, all of the actual medical costs.

And one last thing I would tell the gentleman is that we do have a problem in the State of Florida. We have a very active judiciary that is perfectly happy—by the way, several of whom are former trial attorneys and perhaps their view of this is colored by their background—but they are very happy to substitute their biases and their prejudices on political issues like this for those of the elected representatives.

We don't have a choice, and I don't think the Federal taxpayers have a choice, other than to do the responsible thing.

Mr. WATT. Will the gentleman yield?

Mr. FEENEY. I would be pleased to.

Mr. WATT. I appreciate the gentleman yielding. And I certainly appreciate his having internalized what I am saying, to at least think about what it is we are doing here. I agree with you, if we wanted to apply a cap to Medicaid recipients, Medicare recipients,

veterans who receive the benefit of our Federal largesse, we have the right to do that. There is at least some Federal nexus there.

That is why I did this amendment, because there are cases in which there is a Federal nexus that would justify us—I wouldn't think it was—I wouldn't think it would be a good idea to do it, but I—at least you wouldn't come face to face with this States rights rhetoric that most people conveniently walk away from.

This bill is way overboard beyond what you are talking about, and I hope the gentleman will think carefully about it.

Mr. FEENEY. Well, I am grateful for the concession with respect to things that we pay for or subsidize. We do have a right to do away with injustices in the malpractice system. And I therefore would suggest that maybe if you would take a look at the tax credit provisions in our Code that cover all the private insurance issues out there and would suggest that between the defense I have medical practices that are necessitated by an overactive trial bar and between the tax credit costs for high jury verdicts, the bottom line is we are giving larger credits than we need to, and the Federal Treasury is losing the opportunity to pay for things like Medicare prescription drug coverage, et cetera, because we are giving larger credits than we would have to give without the out-of-balance——

Chairman SENSENBRENNER. The gentleman from Florida's time has expired.

Mr. DELAHUNT. Move to strike the last word, Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from New York, Mr. Weiner was waiving his hand.

Mr. WEINER. Thank you Mr. Chair. I move to strike the last word. I would point out that in response to the gentleman's comments, one thing was not responded to, and it is the notion that individuals have responsibility. And one of the ways that we enforce that responsibility is through the justice system. You know, to think that—to listen to some of this debate, you would think that the people that these laws were written to protect were everyone as a group. In fact, it is to try to give individuals who were harmed a place to go—and some the stories that Mr. Delahunt mentioned.

And I guess there is also another current here, not so much that the States can't do it themselves; there is utter contempt apparent on the part of the sponsors of this legislation and its supporters for regular Americans who sit on juries. They are apparently incapable of figuring out these issues. They are incapable of drawing conclusions about what a reasonable amount for pain and suffering is. They are incapable of saying, you know, what, a 16-year-old person who's had a botched transplant may have different pain and suffering than a 70-year-old who has had a botched transplant. They are completely incapable of making that decision.

Where did that contempt for regular Americans who sit on juries come from? What makes you think, what makes you so contemptuous of the people in your districts that sit on juries every day, who are able to listen to complex evidence, go back and forth, hear persuasion from lawyers, evidence? Why is it that there is such contempt for their ability to make these decisions? I mean, it is puzzling to me that for folks that talk all the time about returning accountability and returning responsibility to individual Americans that, when it comes to these types of decisions oh, no, they can't

do it; we have got to do it for them. We have got to come up with one bill that has one number here in the Federal Government that is going to make these decisions.

I can tell you, you know, the idea that people who get their jury notices and go and sit on these trials and listen to the evidence back and forth, that they are too dumb to figure it out is essentially the undercurrent of this legislation. I mean, what—why do you have such contempt for your constituents that way? They can figure it out. There are smart people in your districts. They elected you. They must be smart people.

You know, why is it that not only are we taking authority from the States under all of this, we are taking authority away from people's ability to judge what went on to their neighbors and people within their own State. And I don't share that level of contempt. I don't share that sense that, so, we can't figure out pain and suffering, that 9 or 12 of my constituents can't figure it out.

And the previous speaker, the distinguished gentleman from Florida, talked about overactive judges. Well, do you only want to make this bill for judges, for juries before judges? I mean, then maybe we can talk about that. And let juries be able to figure out these things if you don't trust the judges. And the juries aren't elected to anything; they are Democrats, they are Republicans, they are independents. They are people with common sense, with "seychel." I don't know how to spell it, but it is a Yiddish word for common sense, and I apologize in advance for violating the rules of the Committee for speaking a foreign language.

[3:45 p.m.]

Mr. WEINER. But the—except in Brooklyn, it arguably is not a foreign language, but that is a whole other story.

Chairman SENSENBRENNER. The gentleman's intent is clear.

Mr. WEINER. Thank you, sir. I also apologize for spitting during my remarks.

But if you think that the State legislatures can't, okay. If you don't like them or if you don't think they can figure it out for themselves, as I think they can, fine. But at least you should have some confidence in the abilities of individuals to sort these matters out. They have been doing it for hundreds of years, and God willing, and with the wisdom of this Committee, they will be able to continue to do it.

I yield back the balance of my time.

Chairman SENSENBRENNER. The question is on the Watt amendment.

Mr. DELAHUNT. Mr. Chairman, I move to strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. DELAHUNT. I just want to pick up on what the gentleman from Florida said in terms of the closing of the hospitals. Again, I am not familiar with the particulars in Florida, nor specifically in his district, but again, I don't know what juries are like in Florida, and maybe there are runaway juries in Florida, but that is something for the Florida Legislature and the Florida political leadership to make a decision on.

But I am having a problem when I continue to hear that physicians are fleeing from certain jurisdictions, because there have been studies, I mean actual legitimate studies, that have been con-

ducted, again, not by trial lawyer associations, but by the American Medical Association. This one was done in 2001, so it is relatively up to date. I just want to read the conclusions that I have reached into the record, and these are from—this is from the research.

Despite plans by doctors' groups and the insurance industry, 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 percent more physicians in patient care per 100,000 of the population in States without damage caps, without damage caps. There are 5.8 percent more OB-GYN physicians per 100,000 women in States without caps. 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.

So rather than just simply, as we have during the course of this debate, accept these statements that people are fleeing and hospitals are closing, according to the American Medical Association that is not the case. Now, it might be the case in Florida, and obviously it is an issue that has to be addressed, but it doesn't rely exclusively, as this bill would, on capping noneconomic losses. I am sure there are multiple reasons why that is happening; I dare say the limited—the limited reimbursements to hospitals under Medicaid and Medicare. I mean, that I know is an issue, because when I talk to my physicians, that is what I am hearing. I am not hearing about malpractice premiums, I am hearing about the fact that Medicare does not adequately cover the cost to health care providers, and that is clearly part of the problem also, and we ignore it, just like we ignore the fact that a disproportionate number of physicians are responsible for the majority of malpractice claims. Yet if one accepts this bill, it is really all about caps and noneconomic damages.

I yield back.

Chairman SENSENBRENNER. The question is on the Watt amendment. Those in favor will say aye.

Those opposed, no.

The noes appear to have it.

Mr. WATT. Mr. Chairman, I ask for a recorded vote.

Chairman SENSENBRENNER. A rollcall is ordered. Those in favor of the Watt amendment will, as your names are called, answer aye; those opposed, no.

The Clerk will call the roll.

The CLERK. Mr. Hyde.

Mr. HYDE. No.

The CLERK. Mr. Hyde votes no.

Mr. Coble.

Mr. COBLE. No.

The CLERK. Mr. Coble votes no.

Mr. Smith.

Mr. SMITH. No.

The CLERK. Mr. Smith votes no.

Mr. Gallegly.

Mr. GALLEGLY. No.

The CLERK. Mr. Gallegly votes no.

Mr. Goodlatte.

[no response.]

The CLERK. Mr. Chabot.
Mr. CHABOT. No.
The CLERK. Mr. Chabot votes no.
Mr. Jenkins.
Mr. JENKINS. No.
The CLERK. Mr. Jenkins votes no.
Mr. Cannon.
Mr. CANNON. No.
The CLERK. Mr. Cannon votes no.
Mr. Bachus.
[no response.]
The CLERK. Mr. Hostettler.
[no response.]
The CLERK. Mr. Green.
[No response.]
The CLERK. Mr. Keller.
Mr. KELLER. No.
The CLERK. Mr. Keller votes no.
Ms. Hart.
[no response.]
The CLERK. Mr. Flake.
Mr. FLAKE. No.
The CLERK. Mr. Flake votes no.
Mr. Pence.
Mr. PENCE. No.
The CLERK. Mr. Pence votes no.
Mr. Forbes.
Mr. FORBES. No.
The CLERK. Mr. Forbes votes no.
Mr. King.
Mr. KING. No.
The CLERK. Mr. King votes no.
Mr. Carter.
Mr. CARTER. No.
The CLERK. Mr. Carter votes no.
Mr. Feeney.
Mr. FEENEY. No.
The CLERK. Mr. Feeney votes no.
Mrs. Blackburn.
[no response.]
The CLERK. Mr. Conyers.
Mr. CONYERS. Aye.
The CLERK. Mr. Conyers votes aye.
Mr. Berman.
Mr. BERMAN. Aye.
The CLERK. Mr. Berman votes aye.
Mr. Boucher.
[no response.]
The CLERK. Mr. Nadler.
Mr. NADLER. Aye.
The CLERK. Mr. Nadler votes aye.
Mr. Scott.
Mr. SCOTT. Aye.
The CLERK. Mr. Scott votes aye.
Mr. Watt.

Mr. WATT. Aye.
The CLERK. Mr. Watt votes aye.
Ms. Lofgren.
[no response.]
The CLERK. Ms. Jackson Lee.
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee votes aye.
Ms. Waters.
[no response.]
The CLERK. Mr. Meehan.
[no response.]
The CLERK. Mr. Delahunt.
Mr. DELAHUNT. Aye.
The CLERK. Mr. Delahunt votes aye.
Mr. Wexler.
[no response.]
The CLERK. Ms. Baldwin.
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin votes aye.
Mr. Weiner.
Mr. WEINER. Aye.
The CLERK. Mr. Weiner votes aye.
Mr. Schiff.
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff votes aye.
Ms. Sanchez.
Ms. SANCHEZ. Aye.
The CLERK. Ms. Sanchez votes aye.
Mr. Chairman.
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman votes no.
Chairman SENSENBRENNER. Are there Members in the chamber who wish to cast or change their votes? The gentleman from Wisconsin, Mr. Green.
Mr. GREEN. No.
The CLERK. Mr. Green votes no.
Chairman SENSENBRENNER. The gentlewoman from Pennsylvania, Ms. Hart.
Ms. HART. No.
The CLERK. Ms. Hart votes no.
Chairman SENSENBRENNER. The gentleman from Indiana, Mr. Pence.
Mr. PENCE. No.
The CLERK. Mr. Pence votes no.
Chairman SENSENBRENNER. Anybody else? The gentleman from Massachusetts, Mr. Meehan.
Mr. MEEHAN. Aye.
The CLERK. Mr. Meehan votes aye.
Chairman SENSENBRENNER. Are there other Members in the chamber who wish to cast or change their vote?
The gentleman from Virginia, Mr. Goodlatte.
Mr. GOODLATTE. No.
The CLERK. Mr. Goodlatte votes no.
Chairman SENSENBRENNER. The Clerk will report.
Ms. JACKSON LEE. Mr. Chairman, how am I recorded?

Chairman SENSENBRENNER. How is the gentlewoman from Texas recorded?

The CLERK. Ms. Jackson Lee is reported as aye.

Ms. JACKSON LEE. Aye.

Chairman SENSENBRENNER. The Clerk will report.

The CLERK. Mr. Chairman, there are 12 ayes and 18 nays.

Chairman SENSENBRENNER. And the amendment is not agreed to.

Further amendments?

Mr. DELAHUNT. Mr. Chairman, I have an amendment at the desk.

Chairman SENSENBRENNER. The Clerk will report the amendment.

The CLERK. Amendment to the amendment in the nature of a substitute to H.R. 5, offered by Mr. Delahunt. Section 4, strike $250,000 each place such term appears and insert $1,600,000.

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

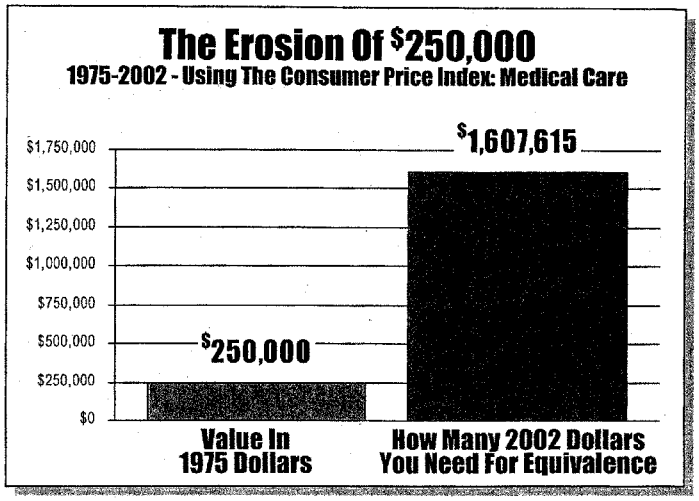
[The amendment follows:]

AMENDMENT TO THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 5 OFFERED BY MR. DELAHUNT

Section 4, strike "$250,000" each place such term appears and insert "$1,600,000".

California's Medical Malpractice Cap

How Many 2002 Dollars Would You Need?

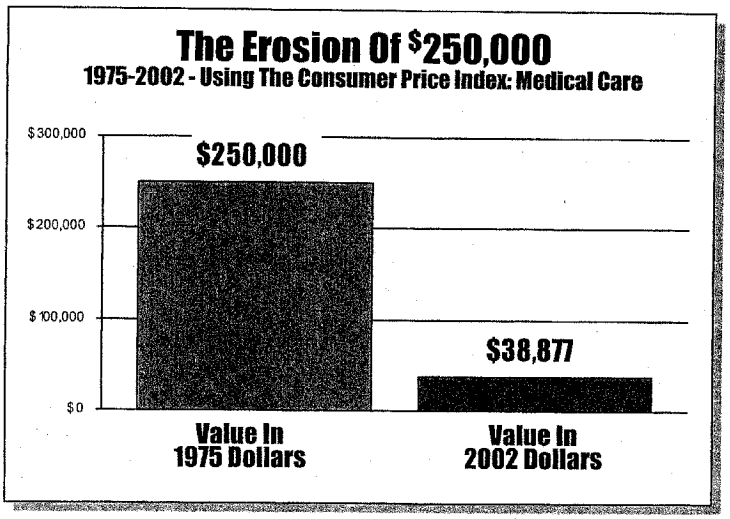


- **Inflation Has Severely Eroded The $250,000 Cap**
- **You Need $1,607,615 In 2002 For The Equivalent Medical Purchasing Power Of $250,000 In 1975**
- **We Should Focus On Solutions That Work And Demand Insurance Reform**

The value of $250,000 was adjusted for changes in prices based upon Consumer Price Index - all items - data from January 1975 to February 2002 (latest available). Bureau of Labor Statistics: http://stats.bls.gov

California's Medical Malpractice Cap

What Has Inflation Done To The Cap?



- ► **Inflation Has Severely Eroded The $250,000 Cap**
- ► **The Medical Care Value Of $250,000 Has Dropped To Just $38,877 Over The 27 Years From 1975**
- ► **We Should Focus On Solutions That Work And Demand Insurance Reform**

The value of $250,000 was adjusted for changes in prices based upon Consumer Price Index - all items - data from January 1975 to Dec 2002 (latest available). Bureau of Labor Statistics: http://stats.bls.gov

Mr. DELAHUNT. Thank you, Mr. Chairman.

The bill, as has been discussed repeatedly, places a cap on noneconomic damages in the amount of $250,000, a number which I think we have discovered comes from the so-called MICRA legislation adopted in California in 1975, 23 years ago now. This amendment would adjust that number for inflation, including medical inflation, to reflect the value of $250,000 in today's terms. If it worked then, I guess that we can adjust it for inflation and it would work now.

As the charts indicate, and I have asked them to be distributed, that when the amount is adjusted to reflect the changes in the Consumer Price Index over the last quarter century, it turns out that $250,000 was worth just $38,877 in 1975. In fact, it would have taken $1,600,000 to purchase the same amount of medical care in 2002 that $250,000 would have bought in 1975, therefore this $1,600,000 figure in the amendment.

Under section 4 of the bill as written the defendant only gets $250,000, as we have discussed. That does not go very far, obviously, if you have a catastrophic illness with attendant expenses. In fact, the bill provides that the jury should not even be told about the limitation, perhaps because jurors would be shocked today at that number. Jurors can award whatever they wish, but unbeknownst to them this bill instructs the court to reduce the award to $250,000. If we are going to limit noneconomic damages, let's at least place the limit at a level that will allow patients to get the care that they need.

I urge support for the amendment.

Chairman SENSENBRENNER. The gentleman's time has expired.

The Chair recognizes himself for 5 minutes in opposition to the amendment.

This amendment attempts to do something that the Democrats that control the California legislature apparently have neglected to do in the years that have passed since the cap of $250,000 was placed in the MICRA legislation; that is, increase it. Increasing the cap, in my opinion, is simply going to increase premiums and restrict access to quality medical care, as we are seeing the crisis occur in other States that do not have caps on noneconomic damages.

Let me say that there is nothing in this legislation that limits economic damages by one penny, and in his argument the gentleman from Massachusetts has stated that if there were a lot of damages involved which were, by implication, economic in nature, this would fall under the cap. That is not true. The economic damages under this bill and under MICRA in California are unlimited. If someone is made a vegetable and has rehabilitation expenses and pain medication expenses and all of the attendant problems involved that can be quantified and receipts are attached to it, those damages will be included in the judgment without limitation.

I urge the defeat of this amendment.

The question is on the Delahunt amendment. Those in favor will say aye. Those opposed, no. The noes appear to have it.

Mr. DELAHUNT. rollcall, please.

Chairman SENSENBRENNER. Those in favor of the Delahunt amendment will as your names are called answer aye, those opposed no.

The Clerk will call the roll.
The CLERK. Mr. Hyde.
Mr. HYDE. No.
The CLERK. Mr. Hyde votes no.
Mr. Coble.
Mr. COBLE. No.
The CLERK. Mr. Coble votes no.
Mr. Smith.
Mr. SMITH. No.
The CLERK. Mr. Smith votes no.
Mr. Gallegly.
Mr. GALLEGLY. No.
The CLERK. Mr. Gallegly votes no.
Mr. Goodlatte.
[no response.]
The CLERK. Mr. Chabot.
[no response.]
The CLERK. Mr. Jenkins.
Mr. JENKINS. Aye.
The CLERK. Mr. Jenkins votes aye.
Mr. Cannon.
Mr. CANNON. No.
The CLERK. Mr. Cannon votes no.
Mr. Bachus.
[no response.]
The CLERK. Mr. Hostettler.
[no response.]
The CLERK. Mr. Green.
Mr. GREEN. No.
The CLERK. Mr. Green votes no.
Mr. Keller.
Mr. KELLER. No.
The CLERK. Mr. Keller votes no.
Ms. Hart.
Ms. HART. No.
The CLERK. Ms. Hart votes no.
Mr. Flake.
Mr. FLAKE. No.
The CLERK. Mr. Flake votes no.
Mr. Pence.
[no response.]
The CLERK. Mr. Forbes.
Mr. FORBES. No.
The CLERK. Mr. Forbes votes no.
Mr. King.
Mr. KING. No.
The CLERK. Mr. King votes no.
Mr. Carter.
[no response.]
The CLERK. Mr. Feeney.
Mr. FEENEY. No.
The CLERK. Mr. Feeney votes no.
Mrs. Blackburn.
Mrs. BLACKBURN. No.
The CLERK. Mrs. Blackburn votes no.

Mr. Conyers.
Mr. CONYERS. Aye.
The CLERK. Mr. Conyers votes aye.
Mr. Berman.
Mr. BERMAN. Aye.
The CLERK. Mr. Berman votes aye.
Mr. Boucher.
[no response.]
The CLERK. Mr. Nadler.
Mr. NADLER. Aye.
The CLERK. Mr. Nadler votes aye.
Mr. Scott.
Mr. SCOTT. Aye.
The CLERK. Mr. Scott votes aye.
Mr. Watt.
Mr. WATT. Aye.
The CLERK. Mr. Watt votes aye.
Ms. Lofgren.
[no response.]
The CLERK. Ms. Jackson Lee.
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee votes aye.
Ms. Waters.
Ms. WATERS. Aye.
The CLERK. Ms. Waters votes aye.
Mr. Meehan.
Mr. MEEHAN. Aye.
The CLERK. Mr. Meehan votes aye.
Mr. Delahunt.
Mr. DELAHUNT. Aye.
The CLERK. Mr. Delahunt votes aye.
Mr. Wexler.
[no response.]
The CLERK. Ms. Baldwin.
[no response.]
The CLERK. Mr. Weiner.
Mr. WEINER. Aye.
The CLERK. Mr. Weiner votes aye.
Mr. Schiff.
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff votes aye.
Ms. Sanchez.
Ms. SANCHEZ. Aye.
The CLERK. Ms. Sanchez votes aye.
Mr. Chairman.
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman votes no.
Chairman SENSENBRENNER. Members who wish to cast or change their vote? The gentleman from Indiana, Mr. Pence.
Mr. PENCE. No.
The CLERK. Mr. Pence votes no.
Chairman SENSENBRENNER. The gentlewoman from Wisconsin, Ms. Baldwin.
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin votes aye.

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 14 ayes and 15 nays.

Chairman SENSENBRENNER. And the amendment is not agreed to.

Ms. JACKSON LEE. Mr. Chairman.

Chairman SENSENBRENNER. The gentlewoman from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. Mr. Chairman, I would like to bring up en bloc amendments Jackson Lee 31, 32, and number 5.

Chairman SENSENBRENNER. The Clerk will report the amendments and without objection, they will be considered en bloc.

The CLERK. Amendment to the amendment in the nature of a substitute to H.R. 5 offered by Ms. Jackson Lee of Texas. At the end of the bill add the following section: section, limitation on malpractice insurance rate increases. No medical malpractice insurer shall increase its rates for the 12-month period beginning on the date of the enactment of this act, except to the extent necessary to enable such insurer to earn a fair rate of return.

Ms. JACKSON LEE. Mr. Chairman, I ask unanimous consent that the amendments be accepted as read.

Chairman SENSENBRENNER. Well, accepted means they are adopted, so.

Ms. JACKSON LEE. Considered as read. Thank you for the clarification, Mr. Chairman. I was trying to see if you were paying attention. Considered as read, Mr. Chairman, thank you.

Chairman SENSENBRENNER. Without objection, the amendments are considered as read.

The gentleman from Texas.

[The amendments follow:]

AMENDMENT TO H.R. 5

OFFERED BY MS. JACKSON-LEE OF TEXAS

At the end of the bill, add the following new section:

1 SEC. ____. LIMITATION ON MALPRACTICE INSURANCE RATE
2 INCREASES.
3 No medical malpractice insurer shall increase its
4 rates for the 12-month period beginning on the date of
5 the enactment of this Act, except to the extent necessary
6 to enable such insurer to earn a fair rate of return.

AMENDMENT TO H.R. 5

OFFERED BY MS. JACKSON-LEE OF TEXAS

At the end of the bill, add the following new section:

SEC. ___. IMPAIRED PHYSICIANS FUND AND PARTICIPATING PHYSICIANS FUND.

(a) FUNDS REQUIRED.—The agency regulating insurance of each State shall establish the following funds:

(1) An Impaired Physicians Fund to provide services, including but not limited to drug and alcohol treatment counseling, for physicians.

(2) A Participating Physicians Fund to provide training for physicians treating indigent populations.

(b) USE OF SAVINGS.—Not later than March 31 of each year, each medical malpractice insurer shall file with the agency regulating insurance of each State in which such insurer is licensed for medical malpractice new rates reflecting the savings, if any, attributable to each provision of this Act. Each such insurer shall contribute 2 percent of such savings for the preceding calendar year to the Impaired Physicians Fund of that State.

Amendment offered by Ms. Jackson Lee

At the end of the bill add the following new section:

Sec. ____ REDUCTION IN PREMIUMS PAID BY PHYSICIANS FOR MEDICAL MALPRACTICE INSURANCE COVERAGE.

(a) In General - Not later than 180 days after the date of the enactment of this Act, each medical malpractice liability insurance company shall –

(1) develop a reasonable estimate of the annual amount of financial savings that will be achieved by the company as a result of this Act;

(2) develop and implement a plan to annually dedicate at least 50 percent of any annual savings to reduce the amount of premiums that the company would otherwise charge physicians for medical malpractice liability coverage; and

(3) submit to the Secretary of Health and Human Services a written certification that the company has complied with paragraphs (1) and (2).

(b) Reports - Not later than one year after the date of the enactment of this Act and annually thereafter, each medical malpractice liability insurance company shall submit to the Secretary a report that identifies the percentage by which the company has reduced medical malpractice coverage premiums relative to the date of the enactment of this Act.

(c) Enforcement - A medical malpractice liability insurance company that violates a provision of this section is liable to the united States for a civil penalty in an amount assessed by the Secretary, not to exceed $10,000 for each such violation.

(d) Definition - For purposes of this section, the term "medical malpractice liability insurance company" means an entity in the business of providing an insurance policy under which the entity makes payment in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim.

Mr. SMITH. Mr. Chairman, I would like to reserve a point of order.

Chairman SENSENBRENNER. A point of order is reserved. The gentlewoman is recognized for 5 minutes.

Mr. WATT. Mr. Chairman, parliamentary inquiry.

Chairman SENSENBRENNER. The gentleman will state it.

Mr. WATT. I thought Ms. Jackson Lee had listed three amendments for consideration en bloc.

Chairman SENSENBRENNER. She wanted two considered en bloc. I guess she——

Mr. WATT. She said three.

Ms. JACKSON LEE. Yes, number 5 as well. It is reduction in premiums paid by physicians for medical malpractice. Do you have that one? Yes. He has all three, right? All three are here. I am taking all three en bloc.

Chairman SENSENBRENNER. We only had two passed out.

Ms. JACKSON LEE. He is going to do so. He will be coming shortly.

Chairman SENSENBRENNER. The Clerk will report the third amendment.

Chairman SENSENBRENNER. Does the Clerk have the third amendment?

The CLERK. Amendment to the amendment in the nature of a substitute to H.R. 5 offered by Ms. Jackson Lee. At the end of the bill add the following new section: section, reduction in premiums——

Chairman SENSENBRENNER. Without objection, the amendment is considered as read.

Mr. WATT. Reserving the right to object, Mr. Chairman, I would like to see it, too.

Chairman SENSENBRENNER. The Clerk will read.

The CLERK. Reduction in premiums paid by physicians for medical malpractice insurance coverage. A, in general, not later than 180 days after the date of enactment of this act, each medical malpractice liability insurance company shall (1) develop a reasonable estimate of the annual amount of financial savings that will be achieved by the company as a result of this act; (2) develop and implement a plan to annually——

Mr. WATT. I withdraw my objection, Mr. Chairman.

Chairman SENSENBRENNER. Without objection, the amendment is considered as read.

Without objection——

Ms. JACKSON LEE. Mr. Chairman, I want to change the proposal, Mr. Chairman.

Chairman SENSENBRENNER. Without objection, the third amendment will be considered en bloc with the other two amendments. Without objection——

Ms. JACKSON LEE. Mr. Chairman.

Chairman SENSENBRENNER. You will be recognized in due course.

Without objection, the reservation against the first two amendments en bloc by the gentleman from Texas, Mr. Smith, will apply to the tripartite amendment en bloc.

Now that we have gotten the appropriate parliamentary procedure out of the way, for what purpose does the gentlewoman from Texas seek recognition?

Ms. JACKSON LEE. And that is the reason I wanted to inquire, Mr. Chairman. I would like to have 3 and 4 en bloc, and I would like to have the third one separately. So 3 and 4.

Chairman SENSENBRENNER. There are only three.

Ms. JACKSON LEE. There are 31 and 32, Mr. Chairman, en bloc, and then what is labeled reduction in premiums paid by physicians for medical malpractice separately.

Chairman SENSENBRENNER. Well, that is what we were doing before we had the confusion.

Ms. JACKSON LEE. I understand, Mr. Chairman. I beg your pardon.

Chairman SENSENBRENNER. The gentlewoman from Texas now asks to sever out the third amendment, and any Member has the right to demand a separate vote.

So there will be a separate vote on the third amendment, but the reservation of the gentleman from Texas, Mr. Smith, against all three amendments is preserved, and the gentlewoman from Texas, Ms. Jackson Lee, is recognized for 5 minutes.

Ms. JACKSON LEE. Mr. Chairman, thank you for your kindness and the clarification procedurally of where we stand at this point.

Let me pursue the line of reasoning that I have presented earlier about the question of making this not a debate or an argument between physicians and between lawyers, particularly in this time of need as relates to first responders, homeland security. We are quite aware of the importance that the medical community, medical professionals are to our community, but I think that we have missed the boat. I say that because in listening to the testimony of the victim witnesses yesterday, each and every one of them had a compelling story of why what we are doing today is misguided and misdirected. This is, in fact, a State question.

Mr. Chairman, I would like to include into the Record letters from Patricia Donnelly, Richard Flag, Jody Johns, Sherry Keller, John McCormick, Kyle Reynolds and Ms. Stein to President Bush dated March 3, 2002 where the victims asked to meet with the President. To date, I do not know whether they have gotten a response, but I do believe, and I would ask unanimous consent for that to be submitted for the Record.

Chairman SENSENBRENNER. Without objection.

[The material referred to follows:]

Patricia Donnelly
Richard Flagg
Jodi Johns
Sherry Keller
John McCormack
Kyle Reynolds
Jupirena Stein

March 3, 2003

President George W. Bush
The White House
Washington, DC

Dear President Bush:

We are a group of medical negligence victims representing hundreds of thousands killed or injured by medical negligence each year. Today, we asked to meet with you. By phone message relayed from your scheduling office, you said no.

On March 4, you will be addressing the Washington Meeting of American Medical Association, an organization of doctors who have teamed up with the insurance industry to push laws that would take away injured patients' legal rights. In January, you met with doctors and hospital staff in Scranton Pennsylvania, after which you gave a public speech denouncing patients who bring legal actions against malpracticing doctors and hospitals.

For the third time in less than two months, you have refused to meet with us, survivors of medical malpractice who traveled to Washington to tell you our stories. These communications have been relayed to the White House by letters or phone calls of January 23, February 5 and again today, March 3. Although we are staying in the very hotel where you will address AMA, you will not spare a minute for us, while allowing plenty of time for the country's chief medical lobby.

You are constantly describing yourself as a "compassionate conservative." We are hard working Americans, many of whom voted for you in the last election, who simply want to meet with you and tell you our stories. We have experienced extraordinary loss, horrible disfigurement, devastating pain, ruined hopes and dreams that most people take for granted. The proposals that you, the AMA and the insurance industry propose would hurt us and millions of others like us.

We are the forgotten faces in this debate – faces you seem particularly determined to ignore. We implore you to change your mind and allow a meeting with victims of medical negligence. Please contact us through our representative, Joanne Doroshow of the Center for Justice & Democracy, 80 Broad St., 17th Floor, New York, NY 10004 to follow up. You can reach her at (212) 267-2801 or (917) 548-5263. Thank you for your time and attention.

Sincerely,

Patricia Donnelly
Richard Flagg
John McCormack
Jodi Johns
Sherry Keller
Kyle Reynolds
Jupirena Stein

Ms. JACKSON LEE. I do believe that we need to address the question of whether or not this is about the profits of insurers or whether or not this is a crisis.

Mr. Chairman, in order to support my amendments that have to do with limitation on malpractice insurance rate increases and also investing into a counseling pool for a physicians impaired fund to provide services, including but not limited to drug and alcohol treatment counseling for physicians. This will allow the insurance companies to, in essence, address the question of whether or not they are in the business for profits or in the business to serve the physicians and the community.

In data that was presented to us by the physicians' insurance companies themselves, they acknowledge that 61 percent of these medical malpractice lawsuits are dropped, 61 percent. Thirty-two percent are in settlement, and only 6 percent, if you will—only 1 percent, plaintiffs prevail, and 6 percent, defense verdicts prevail.

What is the crisis? In their own testimony they said in the current approximately 2 to 1 ratio these carriers in aggregate are still in sound financial shape.

I would say to my colleagues there is no crisis in the medical malpractice insurance industry other than the fact that these insurers are looking for profits way beyond reason and they are penalizing doctors, some of whom may have their problems, some of whom may have made egregious mistakes, but some of whom who have never had a charge against them by high and usurious premium rates, and they are therefore the ones that are responsible for closing the doors of doctors in Texas, California, North Carolina, and elsewhere.

Doctors will tell us that they themselves want to weed out those doctors who are failing to meet the standard of care. If we remove from that standard of care the actual punitive aspect, the penalty aspect of those who fail to do their duty, then we are no better than those who do not do their duty, and we have failed the little girl in North Carolina who lost her life and her chance, we failed the 13-month-old baby, we failed the citizen in Florida who lost the wrong limb, and we failed the countless wheelchair victims who are not here, not able to be in the condition that they would like to be in.

The last amendment which I speak to, which is to be voted on separately, is the question of reduction in premiums paid by physicians for premium medical malpractice insurance.

Mr. Chairman, I have already said to you that there is no crisis, that the insurers themselves say that they are aggregately in sound financial condition, that 61 percent of these cases are dropped. If that is the case, and if my doctors come to me and simply say it is not an argument with lawyers and those who need to petition the courts and those who legitimately have a grievance, it is our premiums that are closing the doors, I believe that we can work together and have an amendment that says develop a reasonable estimate of the annual amount of financial savings that will be achieved by the company as a result of this act, develop and implement a plan to annually dedicate at least 50 percent of any annual savings to reduce the amount of premiums that the company would otherwise charge physicians for medical malpractice liability if we are in this together.

If we have chosen to ignore the Constitution on States rights and what is left to the States, if we are going to accept the challenge of amending laws that really should remain in the State, and if the argument or the cry from the American Medical Association is regarding the premiums that are keeping them from doing their business, if the testimony from the witness from Mississippi was that she did not have a doctor to attend her husband because they had to move out of Mississippi, then this amendment, the last amendment should be a bipartisan amendment that we all should support.

Overall we have no crisis, but I would think that we would want to help doctors who are impaired, and finally, Mr. Chairman, I would hope that we would be able to vote on capping of these medical premiums and providing some relief to our doctors.

Chairman SENSENBRENNER. The gentlewoman's time has expired.

Does the gentleman from Texas insist upon his point of order?

Mr. SMITH. Mr. Chairman, I do.

Chairman SENSENBRENNER. The gentleman will state his point of order.

Mr. SMITH. Mr. Chairman, I do insist on my point of order because these amendments are nongermane. In all instances they deal with an attempt to regulate or impact the insurance industry, and that is the jurisdiction of another Committee. More particularly, one bill asks the State insurance agencies to set up a fund, another amendment deals with insurance premiums, and the other amendment deals with insurance rates. None of these pertain to the underlying critical mass of the bill, which is liability and, for that reason, they are nongermane. Perhaps the gentlewoman from Texas would consider withdrawing her amendments.

Chairman SENSENBRENNER. Does the gentlewoman from Texas wish to be heard on the point of order?

Ms. JACKSON LEE. I certainly do, Mr. Chairman. I will follow in the footsteps and the spirit of the Ranking Member and I think Mr. Berman said earlier, I didn't know that there was any jurisdiction that this Committee would concede.

These amendments are at the end of the bill, frankly. I believe that they go to the question of liability. It indicates that if the insurance companies find that this act has impacted positively on their bottom line rate of return, that they have the ability to develop a plan that could invest in the reduction of premiums. Likewise, it says develop a study, and that is the last amendment which I ask to be voted on separately.

Secondarily, I would think that we are talking about questions of liability on the grounds of malfeasance of physicians who have not met the standard of care. I would think that we would want to insure with funds that the insurance company might have to invest in aiding impaired physicians. So I cannot imagine that this is so far off of the question of liability that these amendments could not be added at the end of the legislation.

Chairman SENSENBRENNER. The Chair is prepared to rule.

The three amendments that have been offered by the gentlewoman from Texas each fail the test of germaneness in two respects. First, one of the tests of germaneness for consideration of legislation in Committee is whether the subject discussed in the

amendment is within the jurisdiction of the Committee. Each of the three amendments relate to insurance regulation or the setting up of an insurance fund, as described by the gentleman from Texas, Mr. Smith, in his point of order. That subject is under the jurisdiction of the Committee on Energy and Commerce and not under the jurisdiction of the Committee on the Judiciary.

Secondly, the amendments have to relate to the overall subject matter of the bill. The subject matter of this bill is not insurance regulation, it is medical liability litigation reform and, consequently, the amendments do not relate to the overall subject matter of the bill and thus are not germane.

The gentleman from Texas' point of order is sustained.

Are there further amendments? The gentleman from Virginia, Mr. Scott.

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

Chairman SENSENBRENNER. The Clerk will report the amendment.

Mr. SCOTT. Amendment number 8.

The CLERK. Amendment in the nature of a substitute to H.R. 5.

Chairman SENSENBRENNER. Without objection, the amendment is considered as read. The gentleman is recognized for 5 minutes.

[The amendment follows:]

AMENDMENT TO H.R. 5
OFFERED BY MR. SCOTT Of VIRGINIA
#8

Page 7, line 19, strike all after the period through the period on line 23.

Mr. SCOTT. Mr. Chairman, this is what I am calling the small business protection amendment. It deals with collateral source.

Mr. Chairman, the collateral source rule provides that the benefit of insurance should go to the plaintiff who paid for the insurance and if there are two different plaintiffs, each with identical cases, one with insurance and one without insurance, the one with insurance ought to end up better off at the end. And if the defendant caused the damage, the defendant ought to pay, and then how the plaintiff covers his expenses ought not be the defendant's concern. So if the plaintiff's has insurance, so be it. On the other hand, if he set aside his money into a medical savings account or regular savings account, that is the plaintiff's business, even if he relies on a rich uncle. How the plaintiff pays his bills is the plaintiff's business, and if insurance is how he has arranged to pay that ought not benefit the defendant.

Now, since some are troubled by the existence of health insurance, then one has to consider the three parties at interest. You have the plaintiff, the defendant, and you have Blue Cross/Blue Shield.

Now, the contract between the plaintiff and Blue Cross/Blue Shield is between them. The contract could say if there is malpractice injury and you recover, you can keep the Blue Cross/Blue Shield money, and then they will charge a premium. Or the con-

tract could say that you can't keep the money, you have to give it back, but you don't have to pay as much. Whatever the contract is really ought to be between the plaintiff and Blue Cross/Blue Shield.

This bill hijacks the insurance proceeds and hands the benefits over to the wrongdoer. By allowing evidence of the insurance to be introduced, you have to assume that the jury will deduct the insurance payment from the amount owed.

Now, of the three parties at interest, a good case could be made that the plaintiff would be able to keep the insurance proceeds since he paid for it. A good case can be made to prohibit the plaintiff from benefiting from his insurance and allowing Blue Cross/Blue Shield to keep the money but charge less premium. It is hard to imagine any rationale that will allow the defendant of the three parties at interest to be the beneficiary of the plaintiff's insurance, but that is what this bill does, and it incredibly prohibits the subrogation agreement where Blue Cross/Blue Shield can get their money back.

Now, this has the bizarre effect of having the employer, the victim's employer end up having to pay the malpractice expenses, because the bill says if you have a health care policy and the employee stays in the hospital because of malpractice the employer has to pay the hospital bill.

Now, if the defendant has a $1 million malpractice insurance, he doesn't have to pay for the injury, the employer has to pay.

Now, let's look at the case that the gentleman from North Carolina mentioned when someone went into the hospital and was in the hospital for 10 years in a coma because of malpractice. In that case the employer, if he is self-insured, has to pay the bill. If he is experience rated, the employer has to pay all the bill and the doctor's malpractice insurance policy will get the benefit of all of those payments over all of those years. That is bizarre. You ought to at least provide, as this amendment does, to allow subrogation. If you don't want the victim to get the benefit of his insurance, then, okay, then let Blue Cross/Blue Shield get its money back, or let the employer get his money back; don't make the employer pay for the malpractice.

Now, if you don't pass the amendment, that is exactly what you are doing. You are making the employer pay for the malpractice, and if he is experience rated, as long as that small business employee has somebody, has a family member in the hospital, his insurance rates will be jacked up year after year so long as that person stays in a coma.

Now, you tell your small business, your small businessmen that they can get caught in that trap because of malpractice. You can avoid that if you pass this amendment.

I yield back.

Chairman SENSENBRENNER. The Chair recognizes himself for 5 minutes in opposition to the amendment.

This is not a complete repeal of the collateral source rule, but it is a very limited modification of the collateral source provisions that are contained in the bill.

The provisions of the Health Act prohibiting collateral sources from obtaining reimbursement for medical malpractice defendants or their insurers is taken directly from the MICRA law and is designed to reduce upward pressure on medical professional liability

insurance rates that would result if providers of collateral source benefits such as those providing insurance for health care costs can sue doctors or their insurers a second time to recover such costs they paid to the plaintiff.

The purpose of this provision in the MICRA law was described in an opinion signed by former California 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." this is in the case of *Barme* v. *Wood*, 689 Pacific 2nd 446 at page 450, California Supreme Court, 1984.

Justice Reynoso I think hit the nail on the head why this amendment should be rejected, and I urge the Members to follow his advice.

I yield back the balance of my time.

Mr. WATT. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from North Carolina.

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

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. WATT. Mr. Chairman, this strikes me as being yet another example of the proponents of this bill deciding who to protect and who not to protect and coming up with just a bizarre adverse impact on employers who have gone out of their way, many of them small businesses, to provide insurance coverage or health care coverage, self-insured, to their employees. And the only justification I heard the Chairman say was okay, MICRA did it that way. I guess MICRA is going to drive you right off the edge of the cliff, you are going to fall off the edge of the cliff following MICRA, just because MICRA did it that way. It makes absolutely no sense to do this in the way that the bill does it.

Mr. Scott's amendment corrects that situation, and I just cannot believe that we are sitting here talking about spreading risk to the employer, who had no responsibility for the plaintiff's injury, and protecting the insurance carrier of the person who did wrong or the doctor who did wrong, and we have the nerve to talk about holding people responsible for the conduct that they are responsible for. I mean this is insane. This provision, I mean it makes absolutely no sense, and the public policy that underlies it makes no sense.

So I hope that you all will at least consider what you are doing, and I yield the balance of my time to Mr. Scott.

Mr. SCOTT. Mr. Chairman, I don't know what happened in California, but the fact that it is legal to have this kind of provision doesn't mean it is good policy.

We have choice on who is going to pay the hospital bill, the doctor's insurance that created the malpractice, or the employer that happened to self-insure and is covering his employees, and if he is experience-rated, he is essentially self-insured. So if a person goes into a coma because of malpractice, somebody is going to pay. You already decided that you don't want the plaintiff to benefit from the insurance, so what happens? The employer will pay the bill or the malpractice coverage will pay the bill, and if you have a small busi-

ness that is experience-rated, you take a hit like this, they won't be able to afford health insurance for the rest of their employees.

So tell your small businesses what you did.

Mr. WATT. I yield back the balance of my time.

Chairman SENSENBRENNER. The question is on the Scott amendment. Those in favor will say aye, opposed, no. The noes appear to have it.

Mr. SCOTT. Recorded vote, Mr. Chairman.

Chairman SENSENBRENNER. A recorded vote is ordered. Those in favor of the Scott amendment will as your names are called answer aye, those opposed, no.

The Clerk will call the roll.

The CLERK. Mr. Hyde.

[No response.]

The CLERK. Mr. Coble.

Mr. COBLE. No.

The CLERK. Mr. Coble votes no.

Mr. Smith.

Mr. SMITH. No.

The CLERK. Mr. Smith votes no.

Mr. Gallegly.

Mr. GALLEGLY. No.

The CLERK. Mr. Gallegly votes no.

Mr. Goodlatte.

[no response.]

The CLERK. Mr. Chabot.

Mr. CHABOT. No.

The CLERK. Mr. Chabot votes no.

Mr. Jenkins.

[no response.]

The CLERK. Mr. Cannon.

[no response.]

The CLERK. Mr. Bachus.

[no response.]

The CLERK. Mr. Hostettler.

[no response.]

The CLERK. Mr. Green.

Mr. GREEN. No.

The CLERK. Mr. Green votes no.

Mr. Keller.

Mr. KELLER. No.

The CLERK. Mr. Keller votes no.

Ms. Hart.

Ms. HART. No.

The CLERK. Ms. Hart votes no.

Mr. Flake.

[no response.]

The CLERK. Mr. Pence.

[no response.]

The CLERK. Mr. Forbes.

Mr. FORBES. No.

The CLERK. Mr. Forbes votes no.

Mr. King.

Mr. KING. No.

The CLERK. Mr. King votes no.

Mr. Carter.
Mr. CARTER. Yes.
The CLERK. Mr. Carter votes yes.
Mr. Feeney.
Mr. FEENEY. No.
The CLERK. Mr. Feeney votes no.
Mrs. Blackburn.
Mrs. BLACKBURN. No.
The CLERK. Mrs. Blackburn votes no.
Mr. Conyers.
Mr. CONYERS. Aye.
The CLERK. Mr. Conyers votes aye.
Mr. Berman.
[no response.]
The CLERK. Mr. Boucher.
[no response.]
The CLERK. Mr. Nadler.
[no response.]
The CLERK. Mr. Scott.
Mr. SCOTT. Aye.
The CLERK. Mr. Scott votes aye.
Mr. Watt.
Mr. WATT. Aye.
The CLERK. Mr. Watt votes aye.
Ms. Lofgren.
[no response.]
The CLERK. Ms. Jackson Lee.
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee votes aye.
Ms. Waters.
[no response.]
The CLERK. Mr. Meehan.
[no response.]
The CLERK. Mr. Delahunt.
Mr. DELAHUNT. Aye.
The CLERK. Mr. Delahunt votes aye.
Mr. Wexler.
[no response.]
The CLERK. Ms. Baldwin.
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin votes aye.
Mr. Weiner.
Mr. WEINER. Aye.
The CLERK. Mr. Weiner votes aye.
Mr. Schiff.
[no response.]
The CLERK. Ms. Sanchez.
Ms. SANCHEZ. Aye.
The CLERK. Ms. Sanchez votes aye.
Mr. Chairman.
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman votes no.

Chairman SENSENBRENNER. Are there Members in the chamber who wish to cast or change their votes? The gentleman from Tennessee, Mr. Jenkins.

Mr. JENKINS. No.

The CLERK. Mr. Jenkins votes no.

Chairman SENSENBRENNER. The gentleman from Utah, Mr. Cannon.

Mr. CANNON. No.

The CLERK. Mr. Cannon votes no.

Chairman SENSENBRENNER. The gentleman from Alabama, Mr. Bachus.

Mr. BACHUS. No.

The CLERK. Mr. Bachus votes no.

Chairman SENSENBRENNER. The gentleman from Indiana, Mr. Hostettler.

Mr. HOSTETTLER. No.

The CLERK. Mr. Hostettler votes no.

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

Mr. BERMAN. I will put a statement in the record when I realize my mistake.

Chairman SENSENBRENNER. Okay. How is the gentleman from California, Mr. Berman, recorded?

The CLERK. Mr. Chairman, I don't have him recorded.

Mr. BERMAN. I said no.

The CLERK. Mr. Berman votes no.

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

Mr. NADLER. Mr. Chairman, how am I recorded?

The CLERK. Mr. Nadler, you are not recorded.

Mr. NADLER. I vote aye.

The CLERK. Mr. Nadler votes aye.

Chairman SENSENBRENNER. The gentleman from Massachusetts, Mr. Meehan.

Mr. MEEHAN. Aye.

The CLERK. Mr. Meehan votes aye.

Chairman SENSENBRENNER. Any other Members in the chamber who wish to cast or change their votes? If not, the Clerk will report.

The CLERK. Mr. Chairman, there are 11 ayes and 17 nays.

Chairman SENSENBRENNER. The amendment is not agreed to.

Are there further amendments? The gentleman from Virginia, Mr. Scott.

Mr. SCOTT. I have an amendment at the desk, number 6.

Chairman SENSENBRENNER. The Clerk will report the amendment.

The CLERK. Amendment to the amendment in the nature of a substitute to H.R. 5 offered by Mr. Scott of Virginia. Strike section 4, subsection (d).

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

[The amendment follows:]

AMENDMENT TO H.R. 5

OFFERED BY MR. SCOTT OF VIRGINIA

Section 4, strike subsection (d).

Mr. SCOTT. Mr. Chairman, this deals with the so-called fair share rule which eliminates joint and several liability.

Under present law, if there is a malpractice case, the plaintiff has to prove that there was malpractice, that the malpractice caused the damages, and then you have to prove your damages in total. This creates a bizarre and impossible standard. It requires that you have to show such person's proportion of the responsibility, whatever that means. If all the plaintiff knows is that he has a res ispa case where he went in and got malpractice inflicted on him, how does a plaintiff prove who did what? That is the whole point of a res ipsa case. If this bill passes, the plaintiff will have to have a separate lawsuit against each and every person that had anything to do with the malpractice. You will have to establish the standard of care for the doctor, for the anesthesiologist, for the nurse.

In the case of the person we heard from yesterday who was transported to another hospital and had additional malpractice inflicted, you would have to prove the ambulance carrier and the emergency room and the physicians in the new hospital. You would have to establish a standard of care, you would have to show how they violated the standard of care, you would have to show causation. I don't know how you apportion what damage in the case we heard from yesterday, who did what and what responsibility they may have had. One could say that I was responsible for the original malpractice, but it was the subsequent malpractice that caused the stroke and paralyzed him. So who knows what?

With separate experts for each case, you have separate fees. This converts a simple case like the one at Duke University, where the wrong organs were transplanted, to an impossible quagmire where you have to show each and every person that had anything to do with it, where was the fault. How much did the surgeon have to do with it, how much did the transplant people have to do with it, and what about the second transplant? It converts a cap, the $250,000 cap into something impossible, because with each case, you have about $10,000 worth of costs against the doctor, against the hospital, against the transplant people.

In fact, the wrong organ transplant is exactly the kind of case where you probably won't even get anybody to handle the case, because with a cap on damages, a cap on attorneys' fees, and excess number of defendants, you will never be able to prove your case.

There is no need for all of this. Health care providers already can agree in advance how to apportion responsibility and they provide insurance accordingly. If there is a clear case of malpractice, they

have already agreed which insurance company will pay, and that would be the end of it.

This bill requires separate suits against everybody, and there is no excuse for having that kind of quagmire imposed on someone.

So I would hope, Mr. Chairman, that we would not abolish the joint and several liability which has been the law in just about every State that I know of for a very long time.

I yield back.

Chairman SENSENBRENNER. The Chair recognizes himself for 5 minutes in opposition to the amendment.

The gentleman from Virginia is correct in saying that this amendment repeals the fair share rule in the bill and goes back to joint and several liability. The result is that it puts full responsibility on those who may have only been marginally at fault. I would commend the gentleman from Virginia to the case of *Walt Disney World Company* v. *Wood*, the Florida Supreme Court, 1987, where Disney was required to pay an entire damages award even though it was found only 1 percent at fault for the claimant's harm.

Joint and several liability, although motivated by a desire to ensure that plaintiffs are made whole, has led to a surge by plaintiffs' attorneys with deep pockets and a proliferation of lawsuits against those minimally liable or not liable at all. This bill, by providing a fair share rule, it apportions damages in proportion of 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 drug deal goes bad. The surgeon that works on him does the best he can, but is not perfect. The drug dealer sues. The jury finds the drug dealer 99 percent responsible for his own injuries, but it also finds the hospital 1 percent responsible because the physician was fatigued after having worked too long. Today, in many States the hospital can be made to pay 100 percent of the damages because the drug dealer is without means, and that is unfair.

Now, this hypothetical is not fanciful. There was an article in the Scranton Time Tribune on May 29, 2002, by an author or a journalist named Ray Flanagan. He says, "Mrs. Tailor 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 accused the doctors and their employers of not adequately responding as she became more psychotic, delusional and depressed as the end of her pregnancy neared. If the doctors were found 1 percent negligent by the trier of fact, they could end up paying the whole freight.

Senator Lieberman has noted, 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, 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.

I urge the defeat of the amendment, and I yield back the balance of my time.

Mr. WATT. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from North Carolina, Mr. Watt.

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

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. WATT. I think we must have a different system in North Carolina, because I think what the gentleman, the Chairman, just described under North Carolina law would not be joint and several liability, but contributory negligence. It is kind of bizarre, it is not fair, but even if in that case you just described where the drunk staggered in, if he was only 1 percent negligent in North Carolina, the defendant could plead contributory negligence and avoid any liability for 100 percent, even his 99 percent.

I am not sure that this language would cover that or not, whether you are talking about only joint and several liability of defendants, or this does not seem to me to deal with the plaintiffs contributing to the injury. Maybe it does; maybe the word "party" is broad enough to cover that. But if that is the objective you are trying to achieve, you might ought to look at it between now and the floor, because I am not sure your language is going to cover what you just described anyway.

What I do know is that this is going to have exactly the opposite effect of what you all purport to be your public policy interest, because what is going to happen at this point is everybody is going to be pointing the finger at everybody else, and nobody is going to acknowledge what their percentage share is, and you are never ever going to have any settlement of any of these cases. All of them, regardless of how minor or how major they are, will be litigated all the way to the end, not necessarily on the question of liability but on the question of who contributed to it, and you will be in litigation for years and years and years on the most simple kind of proposition.

Mr. DELAHUNT. Would the gentleman yield for a question?

Mr. WATT. Can you get your own time? I wanted to yield the balance of my time to Mr. Scott, because he had another response to make to this.

Mr. SCOTT. Mr. Chairman, I would just add to the points that the gentleman from North Carolina made, and that is that all of the insurance can be done in the health care system. The hospital can require everybody to have insurance, or the hospital can cover everybody. That is a decision that can be made in advance. The final judgment, I don't know if you have final judgment on any of those cases, I have never heard of them, but I would hate to think that because there is a speculative possibility that you are going to ruin the malpractice case law for everybody and convert what is really a res ipsa loquitur case into one where nobody can ever get to the end of a trial.

The purpose of insurance is to cover the damage. When damage occurs, it ought to be paid. That could be arranged in advance, and I would hope that we would not, that we would not set aside centuries of law just because somebody can imagine something that has never happened.

The kind of case where you pick and choose between possible defendants is not the kind of case that happens in health care because you go to one hospital. The kind of case where Disney may

be involved is a case where you have product liability, something else going on, somebody over here, somebody over there, in a totally different situation. It doesn't have anything to do with medical malpractice where you go to the hospital and the hospital's insurance will be the one paying the bill if there is malpractice.

Ms. JACKSON LEE. Will you yield? Mr. Scott, will you yield?

Mr. WATT. I yield the balance to Ms. Jackson Lee.

Ms. JACKSON LEE. I plan to go to the Rules Committee because of several of these issues that have not been addressed in this Committee, particularly on these noneconomic damages, but the point that Mr. Scott is making with this amendment is so crucial because we are always complaining about ambulance-chasing lawyers. This will be patient-chasing perpetrators of the harm or the injury, and therefore, what this legislation does is completely extinguish the consistency that we have found.

Chairman SENSENBRENNER. The time of the gentleman from North Carolina has expired.

The question is on the Scott amendment. Those in favor will say aye, those opposed, no. The noes appear to have it. Noes have it.

Mr. SCOTT. Mr. Chairman, rollcall.

Chairman SENSENBRENNER. A rollcall is ordered. Those in favor of the Scott amendment will as your name is called answer aye, those opposed, no.

The Clerk will call the roll.

The CLERK. Mr. Hyde.

[No response.]

The CLERK. Mr. Coble.

Mr. COBLE. No.

The CLERK. Mr. Coble votes no.

Mr. Smith.

[no response.]

The CLERK. Mr. Gallegly.

Mr. GALLEGLY. No.

The CLERK. Mr. Gallegly votes no.

Mr. Goodlatte.

[no response.]

The CLERK. Mr. Chabot.

Mr. CHABOT. No.

The CLERK. Mr. Chabot votes no.

Mr. Jenkins.

Mr. JENKINS. No.

The CLERK. Mr. Jenkins votes no.

Mr. Cannon.

Mr. CANNON. No.

The CLERK. Mr. Cannon votes no.

Mr. Bachus.

[no response.]

The CLERK. Mr. Hostettler.

[no response.]

The CLERK. Mr. Green.

Mr. GREEN. No.

The CLERK. Mr. Green votes no.

Mr. Keller.

Mr. KELLER. No.

The CLERK. Mr. Keller votes no.

Ms. Hart.
Ms. HART. No.
The CLERK. Ms. Hart votes no.
Mr. Flake.
[no response.]
The CLERK. Mr. Pence.
Mr. PENCE. No.
The CLERK. Mr. Pence votes no.
Mr. Forbes.
Mr. FORBES. No.
The CLERK. Mr. Forbes votes no.
Mr. King.
Mr. KING. No.
The CLERK. Mr. King votes no.
Mr. Carter.
Mr. CARTER. No.
The CLERK. Mr. Carter votes no.
Mr. Feeney.
Mr. FEENEY. No.
The CLERK. Mr. Feeney votes no.
Mrs. Blackburn.
Mrs. BLACKBURN. No.
The CLERK. Mrs. Blackburn votes no.
Mr. Conyers.
[no response.]
The CLERK. Mr. Berman.
[no response.]
The CLERK. Mr. Boucher.
[no response.]
The CLERK. Mr. Nadler.
[no response.]
The CLERK. Mr. Scott.
Mr. SCOTT. Aye.
The CLERK. Mr. Scott votes aye.
Mr. Watt.
Mr. WATT. Aye.
The CLERK. Mr. Watt votes aye.
Ms. Lofgren.
[no response.]
The CLERK. Ms. Jackson Lee.
[no response.]
The CLERK. Ms. Waters.
[no response.]
The CLERK. Mr. Meehan.
[no response.]
The CLERK. Mr. Delahunt.
Mr. DELAHUNT. Aye.
The CLERK. Mr. Delahunt votes aye.
Mr. Wexler.
[no response.]
The CLERK. Ms. Baldwin.
Ms. BALDWIN. Aye.
The CLERK. Ms. Baldwin votes aye.
Mr. Weiner.
Mr. WEINER. Aye.

The CLERK. Mr. Weiner votes aye.
Mr. Schiff.
Mr. SCHIFF. Aye.
The CLERK. Mr. Schiff votes aye.
Ms. Sanchez.
Ms. SANCHEZ. Aye.
The CLERK. Ms. Sanchez votes aye.
Mr. Chairman.
Chairman SENSENBRENNER. No.
The CLERK. Mr. Chairman votes no.
Chairman SENSENBRENNER. Are there Members in the chamber who wish to cast or change their vote?
The gentleman from Arizona, Mr. Flake.
Mr. FLAKE. No.
The CLERK. Mr. Flake votes no.
Chairman SENSENBRENNER. The gentleman from Indiana, Mr. Hostettler.
Mr. HOSTETTLER. No.
The CLERK. Mr. Hostettler votes no.
Chairman SENSENBRENNER. The gentleman from California, Mr. Berman.
Mr. BERMAN. Aye.
The CLERK. Mr. Berman votes aye.
Chairman SENSENBRENNER. The gentleman from New York, Mr. Nadler.
Mr. NADLER. Aye.
The CLERK. Mr. Nadler votes aye.
Chairman SENSENBRENNER. The gentlewoman from Texas Ms. Jackson Lee.
Ms. JACKSON LEE. Aye.
The CLERK. Ms. Jackson Lee votes aye.
Chairman SENSENBRENNER. The gentleman from Massachusetts, Mr. Meehan.
Mr. MEEHAN. Aye.
The CLERK. Mr. Meehan votes aye.
Chairman SENSENBRENNER. The gentleman from Michigan, Mr. Conyers.
Mr. CONYERS. Aye.
The CLERK. Mr. Conyers votes aye.
Chairman SENSENBRENNER. The Clerk will report?
The CLERK. Mr. Chairman, there are 12 ayes and 16 nays.
Chairman SENSENBRENNER. And the amendment is not agreed to.
Are there further amendments? Gentleman from Virginia, Mr. Scott.
Mr. SCOTT. Mr. Chairman, I have an amendment at the desk, Number 7.
Chairman SENSENBRENNER. The Clerk will report the amendment.
The CLERK. Amendment to the amendment in the nature a substitute to H.R. 5 offered by Mr. Scott of Virginia. Strike section five.
Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.
[The amendment follows:]

AMENDMENT TO H.R. 5

OFFERED BY MR. SCOTT OF VIRGINIA

Strike section 5.

Mr. SCOTT. Mr. Chairman, This eliminates the section that limits attorney's fees. Mr. Chairman, if we are talking about malpractice insurance premiums, this amendment will have no effect and this provision has no effect on malpractice premiums because the defendant doesn't pay the attorneys, the plaintiffs' attorneys. The provision in the bill has no effect on defendant attorneys' fees, and the malpractice insurance carrier does pay those. So if you have a frivolous defense and the defense lawyer runs up unnecessary expenses, the malpractice premium pays those fees.

Now, let's be serious. Limitation on the plaintiffs' attorneys' fees, that is not being initiated or advanced by anybody representing the plaintiffs. There are no consumer groups out here asking for this. There are no victims groups asking for this. The check against frivolous lawsuits is already in place because if you bring a frivolous lawsuit, when you lose you get paid nothing. The complicated winning cases might not be able to be brought because with the other provisions in the bill they may be too complicated and by limiting attorneys' fees winning cases might not be able to be brought. So the effect of this is to deny some meritorious cases to be brought at all. That is not fair to those who are victims of malpractice, and so the amendment ought to pass and the limitation on attorneys' fees ought to be eliminated from the bill.

And I yield back.

Chairman SENSENBRENNER. The Chair recognizes himself for 5 minutes in opposition to the amendment. The gentleman from Virginia is correct, that under the Health Act, with the provision that the gentleman seeks to strike, there would be no reduction in payments on judges. What this amendment does is that it limits attorneys' fees and that means that the victims actually get more money and the attorneys actually get less money.

Now, we heard the gentleman from Virginia argue about with the collateral source rule, the gentleman from North Carolina as well, about how the actual damages would be apportioned amongst various insurers in the health insurance field. There is a policy judgment that was made in putting together this bill. There also is a policy judgment in this area, which means that those of us that favor the provision that the gentleman from Virginia wishes to amend out want to put more money in victims' pockets.

I would point out that this provision is also patterned after the California MICRA law and under the bill, without the Scott amendment, the Health Act would allow victims to keep roughly 75 percent of awards under $600,000 and 85 percent of awards over $600,000.

So I think that this is really truly an anti-victim amendment, and I would urge the Members of the Committee to reject it and yield back the balance of my time.

Mr. WATT. Mr. Chairman.

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

Mr. NADLER. Mr. Chairman, I will simply observe that this——

Chairman SENSENBRENNER. Do you want to strike the last word?

Mr. NADLER. I indeed would strike the last word.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. NADLER. Mr. Chairman, this is not an anti-victim amendment. It is a pro-victim amendment because the fact of the matter is when you do—these lawsuits are all done on contingent fees. It costs a great deal of money to do a lawsuit. It may cost a hundred, $200 thousand to bring the lawsuit, all of which has to be put up front by the attorney. The attorney is not going to do that unless he thinks it is a very good claim and he is very likely to win and unless the recovery is likely to get him at least to recover his costs plus a reasonable—whatever he regards as reasonable profit. By limiting the percentages and limiting the total of recovery, what you are saying is you are going to make it very difficult for people to get attorneys. In fact, for the first $100,000 recovery you are saying that the attorney can get 36,000 and 25 percent of the next 500,000. You are limiting as a practical—and by combining that with the $250,000 for pain and suffering, you are saying that a lot of lawsuits which may be very meritorious are simply not going to have attorneys because it doesn't pay for any attorney to take the case. So if a plaintiff has a meritorious lawsuit, by saying that the attorney can get a smaller percentage than perhaps otherwise would be the case, what you are really saying is there will be no attorney. And unless you want to set up a situation where the State would pay for the attorneys, which I might favor but I doubt most of the Committee Members here would, you are really saying that there should be no access to the courts for these attorneys at all, for these victims at all, and that is the practical effect of this.

Mr. BERMAN. Would the gentleman yield?

Mr. NADLER. Yes, I will.

Mr. BERMAN. I thank the gentleman for yielding. It is funny. If the purpose of the provision which the gentleman from Virginia seeks to strike is to put more money in the pockets of victims and if the premise of so many of the reforms of this bill is the belief that what the insurance companies have to pay out in these medical malpractice awards is reflected in higher premiums, I was wondering if the gentleman finds it strange that while here is an effort to legislate the relationship between the injured patient and his or her attorney on the plaintiffs side there is no effort to regulate what attorneys representing defendant insurance companies can charge on an hourly basis or in providing bonuses for victories which require insurance companies to pay out more money and, under the theory of the majority, would therefore cause higher payouts from the insurance company and higher premiums on the practitioners. It seems a little unbalanced to me.

Ms. HART. Mr. Chairman.

Chairman SENSENBRENNER. The time belongs to the gentleman from New York.

Mr. NADLER. I yield back. I think—well, let me just say before I yield back, I think I made my point but I think Mr. Berman's point was very well taken, and if you are worried about the total insurance premiums, how do we have a bill that doesn't regulate the very exorbitant premiums paid by the insurance companies to their attorneys?

I yield back.

Chairman SENSENBRENNER. For what purpose gentlewoman from Pennsylvania seek recognition?

Ms. HART. Move to strike the last word, Mr. Chairman.

Chairman SENSENBRENNER. Gentlewoman is recognized for 5 minutes.

Ms. HART. Thank you, Mr. Chairman. I also oppose the amendment, and I think that the arguments that the gentlemen are making are not taking into consideration what the awards actually are in a number of these cases. We had statistics from the Committee showing awards in the $20 and $30 and $40 million ranges for these clients who are deserving of money that will pay their bills and, you know, sustain them in the future that they have to live with an injury. It is unconscionable for an attorney to take 33 percent of such an award. In fact, it has no relationship or bearing whatsoever to the amount of work that the lawyer did for the case. In fact, and it also continues to basically extort more money away from the poorest client, who is stuck with that lawyer because nobody else will take the case in some situations. I think what we are doing is clearly the right thing for the injured patient. The arguments for this amendment are specious and it is clearly, if you look at California's awards, working out well for the legitimately injured patient who needs the recovery, keeping in mind the money that is awarded to the injured victim is awarded to the injured victim and we are preventing larger shares of that money from going into the pockets of attorneys. And I am one, but I think they should be awarded fair fees.

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

Ms. HART. I yield back.

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

Mr. DELAHUNT. I move to strike the last word, Mr. Chairman.

Mr. WATT. Move to strike the last word.

Chairman SENSENBRENNER. The gentleman from North Carolina is recognized for 5 minutes.

Mr. WATT. Thank you, Mr. Chairman. I subscribe to all the arguments that have been made by Mr. Scott, in particular that if this is about the cost of medical care, this provision is certainly misplaced in this bill because it had—this can't even—you can't even argue with a straight face has any impact on medical care.

I subscribe to Mr. Nadler's arguments, too, but I guess I approach this from a different vantage point because it seems to me that the only policy judgment that is being furthered by this provision in the bill is the whole concept of big brother.

I practiced law for 22 years, and most of the judgments that I got in cases were less than $50,000, and I never charged anybody a 40 percent contingency fee. So this whole notion that you are advancing that you are somehow doing something that benefits the

plaintiffs in the case is just wrong. I mean, you are playing big brother here and you are playing it in a way that is not even effective for that purpose. My standard contingent fee was 25 percent on a settlement and 33⅓ percent on a trial, and most of my recoveries were under $50,000. And now all of a sudden you are saying that you are going to—big brother is going to save me—save my clients by setting a national standard that says instead of charging 25 percent and 33 percent I ought to be charging 40 percent.

There is something perverse about this, and the only thing that this advances is the whole concept, again, which is absolutely inconsistent with everything you say you stand for, this is big brother if I have ever seen it, and it has nothing to do with the bill.

I will yield the balance of my time to Mr. Scott.

Mr. SCOTT. Thank you, Mr. Watt. I think the gentlelady from Pennsylvania had it exactly right. The cases are large. That is because if it is a $30,000 to $50,000 case you can't find a lawyer at all. You have to have a huge case even to bring it. What this does is it just ups the threshold of what can be brought. Small cases will just be out of luck. You won't be able to get a lawyer. But I think as you go through all of the rhetoric on both sides you will just notice that consumer groups and victims groups are not supporting this amendment, this provision. They are not trying to limit attorneys' fees and if it was good for victims and goods for consumers, you would think that they would be supporting limitations on attorneys' fees, which they are not.

Yield back.

Mr. DELAHUNT. Mr. Chairman.

Chairman SENSENBRENNER. Gentleman from Massachusetts.

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

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

Mr. DELAHUNT. I am really pleased. I shouldn't say pleased, but I am really surprised to hear the proponents of this bill, my friends to my right, embrace a system that is comparable to wage and price controls. It is really rather remarkable. But I want to remember this because it is so significant that when we have debates on a variety of other subjects we can refer to this particular moment in history.

You know, it is interesting that we don't have any caps on the salaries, the unconscionable salaries of CEOs, many of which have really plundered corporate America, have made bad management decisions, and have helped this economy go right into the tank with a variety of different practices that we are learning now were not in the best—were not made with sound judgment. But what we are doing in terms of the underlying bill is, I think it was Mr. Nadler that said, what we are really doing is we are denying access to justice for people who are hurt because there is no attorney that is going to take on a frivolous malpractice claim. It is just too expensive. And by the way, it is rather difficult to find a physician to testify against another physician. These kind of cases require substantial up-front costs.

I keep hearing about frivolous lawsuits, but I have yet to hear a definition. Can someone define for me what a frivolous lawsuit is? There are many cases that are taken by attorneys that have a

reasonable expectation of success. Oftentimes they don't prevail. But does that translate into a frivolous lawsuit?

Come on. We know why this provision is in there. Because it is perceived that this is a way to punish trial lawyers. Let's put it right out there. Well, you know what? I don't really care about trial lawyers although some of them are my best friends. This should be about the patient. It shouldn't be about doctors. It shouldn't be about trial lawyers. It should be about taking care of those who are the most vulnerable in our society.

I yield back.

Chairman SENSENBRENNER. The question is on the Scott amendment. Those in favor will say aye. Those opposed no. Noes appear to have it. Noes have it, and the Scott amendment is not agreed to.

Are there further amendments?

Mr. SCOTT. Mr. Chairman.

Chairman SENSENBRENNER. The gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Mr. Chairman, I have an amendment at the desk. Number 9.

Chairman SENSENBRENNER. The Clerk will report the amendment.

The CLERK. Amendment to the amendment in the nature of substitutes to H.R. 5 offered by Mr. Scott of Virginia. Strike section 2.

Chairman SENSENBRENNER. The gentleman is recognized for 5 minutes.

[The amendment follows:]

AMENDMENT OF H.R. 5
OFFERED BY MR. SCOTT OF VIRGINIA
#9

Strike Section 2.

Mr. SCOTT. Mr. Chairman, this strikes the findings and purposes part of the bill because frankly I don't agree with all of the findings and purpose. For example, on line 8 of the first page Congress finds that our current civil justice system is adversely affecting patient access to care, to health care services, when we know that of the health care expenses less than one-half of 1 percent goes to malpractice. If we didn't just cut back on malpractice payments but eliminated malpractice payments, you wouldn't be able to measure the effect it has on health care.

On Page 2 we have got the effect on Federal spending. Congress finds that the health care liability and litigation system existing throughout the United States has a significant effect on the amount, distribution and use of Federal funds. If you can't bring a malpractice claim you might end up destitute and on Medicaid. So this bill might have an adverse effect.

Under purpose, it says that the purpose of the bill is to reduce the incidence of defensive medicine. I don't want to reduce the effect of defensive medicine. I like defensive medicine. And if a doctor isn't going to do an important test on me, is only going to do an important test on me because of his fear of malpractice, good. Don't change it. I don't want to die because he didn't want to do a test. I would rather live because he had the malpractice claim over him and did defensive medicine. Now, if he is charging for tests that is not needed and blaming it on malpractice, he is stealing my money. That is fraud. But if it is a needed test that they will only do because he will be responsible in a malpractice claim, I want him to do the test.

It says it will lower the cost of health care liability insurance. Now, we have heard people go back and forth. We defeated the amendment from the gentlelady from Texas, or felt it out of order, I guess, that would have required some cost savings to be reflected in the premiums. But that didn't go anywhere. Another is to ensure that persons with meritorious health care injury claims receive fair and adequate compensation. But we just eliminated joint and several liability. We limited attorneys' fees and we make it less possible under the bill that they will receive a fair and adequate compensation.

Improve the fairness and cost effectiveness, reducing the uncertainty and the amount of compensation. Well, I don't know if it is fair to have a random $250,000 amount. I don't know if that is fair. It certainly reduces—I guess it reduces uncertainty that you can't get over a certain amount. But because of my problems with all of

those, Mr. Chairman, I would just assume that we eliminated section 2, and that is what the amendment does.

Yield back.

Chairman SENSENBRENNER. I recognize myself for 5 minutes in opposition of the amendment. If you don't like the bill, vote against it. But it seems to me that the authors of the bill ought to be able to determine their own findings in support of their legislation.

With that, I yield back the balance of my time. The question is on the Scott amendment. Those in favor of the Scott amendment will say aye, opposed no. The noes appear to have it. The noes have it. The Scott amendment is not agreed to.

Are there further amendments? If not, the question occurs on the amendment in the nature of a substitute. Those in favor as amended, those in favor will say aye, those opposed no. The ayes appear to have it. The ayes have it, and the amendment in the nature of a substitute is agreed too.

The question now occurs on the motion to report the bill H.R. 5 favorably, as amended. Those in favor will say aye, opposed no. The ayes appear to have it. The ayes have it, and the motion is——

Mr. WATT. rollcall.

Chairman SENSENBRENNER. rollcall is ordered. The question is on reporting H.R. 5 favorably, as amended. Those in favor will as your names are called answer aye, those opposed no. Clerk will call the roll.

The CLERK. Mr. Hyde.

[No response.]

The CLERK. Mr. Coble.

[No response.]

The CLERK. Mr. Smith.

[no response.]

The CLERK. Mr. Gallegly.

Mr. GALLEGLY. Aye.

The CLERK. Mr. Gallegly votes aye.

[no response.]

The CLERK. Mr. Chabot.

[no response.]

The CLERK. Mr. Jenkins.

Mr. JENKINS. Aye.

The CLERK. Mr. Jenkins votes aye.

Mr. Cannon.

[no response.]

The CLERK. Mr. Bachus.

[no response.]

The CLERK. Mr. Hostettler.

Mr. HOSTETTLER. Aye.

The CLERK. Mr. Hostettler votes aye.

Mr. Green.

Mr. GREEN. Aye.

The CLERK. Mr. Green votes aye.

Mr. Keller.

Mr. KELLER. Aye.

The CLERK. Mr. Keller votes aye.

Ms. Hart.

Ms. HART. Aye.

The CLERK. Ms. Hart votes aye.

Mr. Flake.
[no response.]
The CLERK. Mr. Pence.
Mr. PENCE. Aye.
The CLERK. Mr. Pence votes aye.
Mr. Forbes.
Mr. FORBES. Aye.
The CLERK. Mr. Forbes votes aye.
Mr. King.
Mr. KING. Aye.
The CLERK. Mr. King votes aye.
Mr. Carter.
Mr. CARTER. Aye.
The CLERK. Mr. Carter votes aye.
Mr. Feeney.
Mr. FEENEY. Aye.
The CLERK. Mr. Feeney votes aye.
Mrs. Blackburn.
Mrs. BLACKBURN. Aye.
The CLERK. Mrs. Blackburn votes aye.
Mr. Conyers.
Mr. CONYERS. No.
The CLERK. Mr. Conyers votes no.
Mr. Berman.
Mr. BERMAN. No.
The CLERK. Mr. Berman votes no.
Mr. Boucher.
[no response.]
The CLERK. Mr. Nadler.
Mr. NADLER. No.
The CLERK. Mr. Nadler votes no.
Mr. Scott.
Mr. SCOTT. No.
The CLERK. Mr. Scott votes no.
Mr. Watt.
Mr. WATT. No.
The CLERK. Mr. Watt votes no.
Ms. Lofgren.
Ms. LOFGREN. No.
The CLERK. Ms. Lofgren votes no.
Ms. Jackson Lee.
Ms. JACKSON LEE. No.
The CLERK. Ms. Jackson Lee votes no.
Ms. Waters.
Ms. WATERS. No.
The CLERK. Ms. Waters votes no.
Mr. Meehan.
Mr. MEEHAN. No.
The CLERK. Mr. Meehan votes no.
Mr. Delahunt.
Mr. DELAHUNT. No.
The CLERK. Mr. Delahunt votes no.
Mr. Wexler.
[no response.]
The CLERK. Ms. Baldwin.

Ms. BALDWIN. No.
The CLERK. Ms. Baldwin votes no.
Mr. Weiner.
Mr. WEINER. No.
The CLERK. Mr. Weiner votes no.
Mr. Schiff.
[no response.]
The CLERK. Ms. Sanchez.
Ms. SANCHEZ. No.
The CLERK. Ms. Sanchez votes no.
Mr. Chairman.
Chairman SENSENBRENNER. Aye.
The CLERK. Mr. Chairman votes aye.
Chairman SENSENBRENNER. Are there Members in the chamber who wish to cast or change their vote? Gentleman from Ohio Mr. Chabot.
Mr. CHABOT. Aye.
The CLERK. Mr. Chabot aye.
Chairman SENSENBRENNER. Gentleman from Utah, Mr. Cannon.
Mr. CANNON. Aye.
The CLERK. Mr. Cannon aye.
Chairman SENSENBRENNER. Further Members who wish to cast or change their vote?
The CLERK. Mr. Chairman, there are 15 ayes and 13 noes.
Chairman SENSENBRENNER. And the motion to report favorably is agreed to. 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 amendments 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 rule, in which to submit additional dissenting supplemental or minority views.
The Chair thanks the Members for their patience, and the Committee is adjourned.
[Whereupon, at 5:10 p.m., the Committee was adjourned.]

DISSENTING VIEWS

INTRODUCTION

H.R. 5[1] is among the most dangerous, one-sided liability limitation bills ever considered by the Congress—far worse than any measure considered during the Contract with America.

The most obvious problem with H.R. 5 is that it does not solve the problem it purports to address. Study after study have shown that draconian laws capping damages do not reduce insurance premiums. Comparisons of states that have enacted severe tort restrictions and those that have not found no correlation between liability limitation laws and insurance rates.[2] Indeed, some of the resisting states experienced lower increases in insurance rates, while some states that enacted liability limitation laws experienced higher rate increases relative to the national trends. For example, data from the 2002 Medical Liability Monitor shows that Michigan, a state with caps, had one of the highest average premiums in the country, while Minnesota and Oklahoma, two states without caps, had two of the three lowest average rates in the country.[3] Data from the 2001 Medical Liability Monitor showed that in the practice of internal medicine, states with caps on damages had higher premiums than states without caps.[4] For general surgeons, insurance premiums were 2.3% higher in states with caps on damages.[5] 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.[6]

So why are medical malpractice premiums rising? The principal culprit is the insurance industry. Insurers make their money from investment income, which is plummeting right now. During years of high stock market returns and interest rates, malpractice premiums go down. When investment income decreases—and we are in the middle of a 4-year bear market—the industry responds by sharply increasing premiums and reducing coverage, creating a "liability insurance crisis." This boom-bust cycle took place in the 70's and 80's, and its happening again now.[7]

There can be little doubt that H.R. 5 will work an obvious and irreparable unfairness on the hundreds of thousands of medical malpractice victims in this country. These victims include people like Linda McDougal, who received a double mastectomy when she didn't even have cancer, and Sherry Keller, who is now quad-

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[1] Help Efficient, Accessible, Low-Cost, Timely Health Care (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003).

[2] Robert J. Hunter and Joanne Doroshow, *Premium Deceit—the Failure of to Cut Insurance Prices*, Center for Justice & Democracy (1999).

[3] *Medical Liability Monitor* (Oct. 2002).

[4] *Medical Liability Monitor* (Vol. 26, #10—Oct. 2001).

[5] *Id.*

[6] Senate Congressional Record, July 30, 2002, S7534.

[7] *See infra* Section II.B.

riplegic because her doctor failed to properly stitch the incision from her hysterectomy and then left her on an examination table for 35–45 minutes, during which time she went into shock, fell off the table, and banged her head. At a victims' forum held on February 11, 2003, Democrats invited these individuals as well as scores of other victims of medical malpractice to tell their story and to discuss how H.R. 5 negatively impacts them. Each informed us how an arbitrary $250,000 cap on their pain and suffering would work a blatant unfairness in their situation.

Beyond our concerns about the bill's unfair and unneeded limitations on medical malpractice, we have been given no justification for why the bill limits the liability of insurance companies and health maintenance organizatons (HMO's) for failure to provide coverage or for insulating drug and medical product manufacturers from liability.[8]

The bill takes no account of the fact that 5% of all health care professionals are responsible for 54% of all malpractice claims paid.[9] The bill also ignores the fact that between 44,000 and 98,000 people die each and every year from medical malpractice.[10] The last thing we need to do is exacerbate the problem, while ignoring the true causes of the medical malpractice crisis in America. Yet this is precisely what H.R. 5 does.

The following is a brief description of the bill and a more detailed itemization of our concerns with it.

Description of Legislation

H.R. 5 limits the amount of non-economic damages—damages for pain and suffering—to $250,000.[11]

In addition, H.R.5 eliminates joint and several liability, a longstanding common law doctrine that ensures that victims will be made whole.[12] Similarly, the bill alters the rules of evidence regarding a collateral source and eliminates the doctrine of subrogation, the effect of which is to shift the costs of malpractice from negligent defendants to innocent victims.[13]

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[8] *See infra* Section III.

[9] National Practitioner Data Bank, Sept. 1, 1990–Sept. 30, 2002.

[10] Kohn, Corrigan, Donaldson, eds., *To Err is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).

[11] H.R. 5, § 4(b). "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." *Id.* This provision does not apply if a state law "specifies a particular monetary amount of compensatory or punitive damages . . . that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provider for under this Act." *Id.* at § 11(c).

[12] Relief from joint and several liability is addressed under the Fair Share Rule:

> 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.

H.R. 5, § 4(d).

[13] The topic is addressed under the topic of 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

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 victim, or the defendant understood the victim was substantially certain to suffer unnecessary injury yet deliberately failed to avoid such injury.[14] It also limits punitive damages to two times the amount of economic damages or $250,000, whichever is greater.[15]

The second category of punitive damages affected by the bill relates 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.[16] It also extends this immunity to the manufacturers of drugs and devices that are not FDA-approved but are "generally recognized among qualified experts as safe and effective," and to manufacturers or sellers of drugs from punitive damages for packaging or labeling defects.[17] The only exceptions to this section, allowing a defendant to be held liable, are if the defendant knowingly misrepresented to or withheld from the FDA information that is required to be submitted, and that information caused the harm, or if the defendant made an illegal payment to an official of the FDA to secure market approval.[18]

H.R. 5 also 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 ⅓% of the next $50,000 recovered by the claimant(s); (3) 25% of the next $500,000 recovered by

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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. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

H.R. 5, § 6.

[14] H.R. 5, § 7(a).

[15] H.R. 5, § 7(b)(2).

[16] H.R. 5, § 7(c).

(1) 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;

H.R. 5, § 7(c)(1)(A).

[17] If manufacturers and distributors do not fall under Section 7(c)(1)(A), they are still exempt from punitive damages if:

(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, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.

H.R. 5, § 7(c)(1)(B).

[18] Section 7(c)(4) provides that a health care provider may be liable if the 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 . . . that is material and is casually related to the harm which the claimant allegedly suffered"; or

the claimant(s); and (4) 15% of any amount by which the recovery by the claimant(s) is in excess of $600,000.[19]

H.R. 5 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 manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, *whichever occurs first*."[20] (emphasis added). Although disguised as a 3-year statute of limitation, the effect of this provision is that the claimant has exactly 1 year from the date of discovering the injury to file suit. This is because the claimant will *discover* the injury on the same day the injury *manifests* itself.[21]

The bill also provides for periodic payments rather than a lump sum payment to victims.[22] And finally, H.R. 5 is not limited to medical malpractice actions but covers lawsuits for failure to cover against HMOs and other health insurers as well.[23]

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.[24]

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.[25]

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

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[19] H.R. 5, § 5(a).

[20] H.R. 5, § 3.

[21] The provision has two exceptions. The statute of limitations is tolled upon proof of fraud, intentional concealment, or the presence of a foreign body in the person injured. The second 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 manifestation of the injury, or the date on which the minor attains the age 8. H.R. 5, § 3.

[22] H.R. 5, § 8(a). "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." *Id.*

[23] H.R. 5, § 9(7) defines a as:

> [A]ny health care liability claim concerning the provision of health care goods or services, or any medical product, affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services, or any medical product, affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

[24] *Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes* (CRS Report 95–797 A), at 1.

[25] Joan Claybrook, *Consumers and Tort Law*, 34 Fed. B. News & J. 127 (1987).

of harm."[26] In medical malpractice cases, this legal standard is based on the practices of the medical profession,[27] 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, diminished quality of life, loss of a limb, loss of fertility, loss of a child or spouse, and loss of mobility; 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. 5 does not respond to the problem of rampant medical malpractice and ignores the principal reason for the "crisis" it purports to solve—the insurance industry's cycles and practices; and third, liability limitation laws have not reduced premiums for medical malpractice to any significant extent.

A. Medical malpractice is a serious problem in the United States.

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, and this does not even include malpractice committed at outpatient centers, physician offices and clinics.[28] 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).[29]

Study after study have 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.[30] 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, and about 100,000 such patients, or 1 in 400, die each year as a direct result of such injuries.[31] A new study in Pediatrics magazine found that medical errors occurred in more than one in 10 cases involving children with complex medical problems.[32]

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[26] Restatement (Second) of Torts § 282 (1965).

[27] David M. Harney, *Medical Malpractice* § 21.2, at 413 (2d ed 1987).

[28] *See* Kohn *et al., supra* note 10. 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.*

[29] *Id.*

[30] Harvard Medical Practice Study, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990).

[31] 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).

[32] Peter Eisler *et al., Hype Outraces Facts in Malpractice Debate*, USA Today, Mar. 5, 2003.

Another recent study from Harvard Medical School and the University of Ottawa examined medical errors affecting patients after they were discharged from an unnamed teaching hospital.[33] The study, reported in the February 4, 2003 issue of the Annals of Internal Medicine, found that nearly 20% of 400 patients discharged from the hospital suffered an "adverse event" that occurred after discharge but resulted from the care they received at the hospital, rather than from an underlying disease or condition.[34] Thirty percent of those patients were temporarily disabled, and two of them suffered permanent disability—one from a life-threatening infection that followed a procedure and was not recognized while the patient was at the hospital.[35]

Almost every day now we read a new story about a botched surgery, a mix-up in the medical records, an unnecessary amputation, or the discovery of medical objects inside patients.[36] However, despite the high amount of malpractice being committed, the number of lawsuits filed on behalf of malpractice's victims is quite low. The landmark Harvard Medical Practice 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.[37] In contrast, the 1999 IOM study found that total national cost of medical malpractice (lost income, lost household production, disability and health care costs) is quite high, estimated to be between $17 billion and $29 billion each year.[38]

There is no denying that medical malpractice is a serious problem in our country right now. H.R. 5, however, does nothing about this problem. According to data from the National Practitioner Data Bank, from 1990 to 2002, just 5% of doctors were involved in 54% of all medical malpractice payouts, including jury awards and settlements.[39] The data shows that of the 35,000 doctors with two or more payouts during that period, only 8% were disciplined by state medical boards. Among the 2,774 doctors who had made payments in five or more cases, only 463 (1 in 6) had been disciplined.[40] An amendment offered by Mr. Berman during the markup of H.R. 5 would have provided for greater accountability of doctors. The amendment would have required states to make public the identity and mandate a reporting of the judgment or settlement of any case of malpractice over $10,000. It also would have made public any actions by a hospital to deny or suspend hospital privileges for bad doctors. Unfortunately, the amendment was defeated by a vote of 16–10.[41] H.R. 5 simply is not concerned with fixing the root problem of medical malpractice.

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[33] *See* Sandra G. Boodman, *Medical Errors Come Home*, Wash. Post., Feb. 18, 2003 at HE01.
[34] *Id.*
[35] *Id.*
[36] *See, e.g.,* Shankar Vedantam, *Surgical Expertise, Undone by Error,* Wash. Post., Feb. 24, 2003, at A01; Rob Stein, *Teenage Girl in Botched Organ Transplant Dies*, Wash. Post., Feb. 23, 2003, at A01; *Mastectomy Mistake Fuels Debate*, CBSnews.com, Jan. 21, 2003; Denise Grady, *Forgotten Surgical Tools "Uncommon but Dangerous*," N.Y. Times, Jan. 21, 2003, at F5. (citing study that sponges or surgical instruments are left inside patients at least 1,500 times a year).
[37] *See supra* note 30.
[38] *See* Kohn *et al., supra* note 10.
[39] *See supra* note 9; *see also* Sidney M. Wolfe, *A Free Ride for Bad Doctors*, N.Y. Times, Mar. 4, 2003.
[40] *Id.*
[41] *See* Markup of H.R. 5, Transcript at pp. 62–82.

Along these same lines, a comparison of a recent report by the American Health Quality Association, which ranked states according to the quality of care delivered to Medicare beneficiaries, and the states that the AMA and PIAA say are in "crisis" shows that there is a significant relationship between those states in crisis and those states with the lowest quality of care rankings.[42] Specifically, a comparison shows that five of the twelve states (42%) currently in a medical liability "crisis" (according to the AMA/PIAA) ranked at the bottom 25% of all states for quality of care. Nine of the twelve states (75%) currently in a "crisis" rated in the bottom 50% of all states for quality of care.

Similarly, those states in "crisis" show a significant relationship to those states with poor doctor discipline records. For example, Pennsylvania—where doctors recently went on strike over insurance costs—has disciplined only 5% of the 512 doctors who had made payments in malpractice suits five or more times.[43] Moreover, Pennsylvania's 5.3% of the doctors in the United States makes up 18.5% of doctors nationally with five or more malpractice payments.[44] West Virginia, another state in crisis, has .57% of the country's physicians, but they make up 1.69% of doctors nationally who have made malpractice payments five or more times. Only one-fourth of those doctors have been disciplined by the medical review board.[45]

B. H.R. 5 ignores the principal cause of the "crisis"—the cyclical nature of the insurance industry and the investment practices of insurance companies.

Supporters of H.R. 5 claim that insurance companies have become insolvent or have left certain markets because of excessive litigation and unrestrained jury awards. This so-called "crisis" 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 to do 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.[46] During the first "crisis," medical malpractice insurance premiums increased by large margins and certain specialities were denied coverage.[47] 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

[42] *See* The American Health Quality Association, Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001 (JAMA, 2003; 289: 305–312).
[43] *See* Sidney M. Wolfe, *A Free Ride for Bad Doctors*, N.Y. Times, Mar. 4, 2003.
[44] *Id.*
[45] *Id.*
[46] 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].
[47] *Id.*

to traditional policy providers,[48] 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, however, insurance providers responded with considerable increases in medical malpractice insurance premiums.[49] 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.

As Joanne Doroshow, Executive Director of the Center for Justice and Democracy, testified at a 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 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." [50]

Raul King, an economist and insurance industry expert at Congressional Research Service described today's situation at the victims' forum held by House Democrats on February 11, 2003:

> What has happened in the 1990's, after the last medical malpractice crisis in the mid-'80's is that in the 1990's the markets were up. For an extended period of time interest rates were relatively low, but the bottom line is that investments were very, very high, and they can continue to price their business in such a way to maximize premium for investment purposes.
>
> Some would argue that starting in 2000 when not only the medical malpractice area but insurance in general, not just medical malpractice, but all P&C, property and casualty insurance, when the market cycle started to turn, investments were

[48] 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.

[49] *See* OTA Report on Legal Reforms at 15.

[50] *See* Help Efficient, Accessible, Low-Cost, Timely Health Care (HEALTH) Act of 2002: Hearing on H.R. 4600 before the House Subcomm. on Commercial and Admin. Law, 107th Cong. (June 1, 2002) (statement of Joanne Doroshow, Executive Director of the Center for Justice & Democracy) [hereinafter "Doroshow statement].

Another factor that affects insurance rates is the fact that since 1945 insurance companies have been exempt from antitrust laws. *See* McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015 (1945). 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.

not what they expected. Interest rates were low, and across the board rates started firming up.

Incidentally, when the market is considered soft, coverage is readily available. Prices are relatively low. The insurance company will make their products available in the marketplace, and they will aggressively sell as much as they can because they want the business, and it's intensely competitive.

Some would argue that this soft market that went beyond the 6 years but right up close to 10 years, and this what the consumer groups have argued as cash flow underwriting what Bob Hunter, for example, would argue is cash flow underwriting, they run into a problem. Their investments can't cover their premium losses and underwriting losses.

So what they have to do is to increase premiums dramatically. They have to in some cases withdraw from the marketplace, change the amount of insurance they'll make available in the marketplace. Rather than selling a $500,000 policy, they'll sell only a $250,000 policy, and that's all that's available in a given state.[51]

Thus, there are many factors, completely unrelated to jury verdicts and the civil justice system, that affect insurance rates, including: (1) changes in state law and regulatory requirements; (2) competitiveness within the insurance market; (3) the types of policies issued within the industry; (4) interest rates; (5) state socioeconomic factors, such as urbanization; (6) national economic trends; and (7) huge portfolio losses due to the falling stock market.[52] According to the National Association of Insurance Commissioners, these factors fall into three categories: (a) changes in interest rates, (b) underpricing in soft markets, and (c) adverse shock-losses that lead to super-competitive cycles.[53]

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[51] *See* Democratic Forum on Malpractice, February 11, 2003, Transcript at 32–33. Another insurer described the problem as well:

> 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.* (Emphasis added). 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 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.
>
> 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.

See Charles Klodkin, *Medical Malpractice Insurance Trends? Chaos!,* Gallagher Healthcare Insurance Services (Sept. 2001).

[52] 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* (GAO/T–HRD–90–24), 101st Cong. (Apr. 26, 1990) (Statement of Charles A. Bowsher, Comptroller General of the United States).

[53] Cummings *et al.*, eds. Cycles and Crises in Property/Casualty Insurance: Causes and Implications, NAIC, 1991 at 339; see also Risk Managers Blame Insurers for Renewal Woes, National Underwriter, Jan. 14, 2002.

All three factors are present in the current crisis. Well before September 11th, the Federal Reserve cut interest rates several times, while insurers engaged in underpricing of the soft market.[54] The attacks of September 11th accelerated the price increases that had already begun by providing the adverse shock-loss component of the equation.[55] For example, St. Paul Insurance Company withdrew from the medical malpractice market, creating major supply and demand problems.[56] Although St. Paul cited liability risks as the reason for its withdrawal, it is also noteworthy that St. Paul lost a lot of money in the Enron scandal.[57] In addition, St. Paul engaged in a premium price war in the 1990's, using the go-go stock market to cover the spread and 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.[58]

Both the American Medical Association and members of the insurance industry acknowledge the role the insurance industry has played in creating the latest medical malpractice crisis. In an internal memo from the AMA's Board of Trustees, the author states that "the insurance underwriting cycle is now at a point where insurers have both pricing power and a need to increase revenues through premiums as returns on investments are no longer able to subsidize underwriting losses and as insurers have suffered large claim losses in other areas."[59] The author also stated the following:

> For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market surged, investments by these historically conservative insurers rose to 10.6% in 1999, up from a more typical 3% in 1992. With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates. The industry reported realized capital gains of $381 million last year, down 30% from the high point in 1998, according to the A.M. Best Company, one of the most comprehensive sources of insurance industry data.[60]

Similarly, a bi-partisan committee of the West Virginia legislature stated that the "insurance industry has played a role in the continuing limitations on accessible and affordable insurance coverage for the health care providers" and that "any limitations placed on the judicial system will have no immediate effect on the cost of liability insurance for health care providers."[61] The National Conference of State Legislatures has stated that falling interest rates for bonds and stock prices weakened insurers' main source of profit—their investment income.[62] The Physician Insurers

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[54] *See Risk Managers Blame Insurers for Renewal Woes*, National Underwriter, Jan. 14, 2002.

[55] *See 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.).

[56] *See* The St. Paul Companies 2001 Annual Report at 3.

[57] Doroshow statement.

[58] Todd Sloane, *Back on the tort reform merry-go-round*, 32 Modern Healthcare 28, July 15, 2002.

[59] Report 35 of the Board of Trustees (A–02) on Liability Reform, at p.2.

[60] *Id.*

[61] *Final Report of the Insurance Availability and Medical Malpractice Industry Committee*, Jan. 7, 2003.

[62] *See* Eisler *et al., supra* note 32.

Association of America confirmed that investment income contributed 47% to its companies' revenue in 1995, but only 31% in 2001.[63]

Still, despite this history and the insurance industry and AMA's own admissions, H.R. 5 addresses none of these problems. It does nothing about the insurance companies' bad investment practices or the insurance companies' boom and bust cycles. It does nothing to repeal the anomalous McCarran-Ferguson antitrust exemption for the insurance industry.[64] It does nothing to require that medical malpractice premium increases be justified or to even permit health care providers to challenge these increases, despite the fact that many state laws are deficient in these areas.[65] Rather, as in every other cyclical insurance industry "crisis," the target and focus have been the legal system and restrictions on victims' rights to recovery.

C. Empirical evidence establishes that liability limitation laws have not had a significant impact in reducing insurance premiums.

Supporters of H.R. 5 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 Federal restrictions on victims' abilities to pursue and collect on malpractice claims will reduce these problems. A review of the empirical data indicates that the proponents' arguments are incorrect and legal restrictions like those contained in H.R. 5 will not increase consumer welfare.

First, the empirical data shows that settlements and jury awards, including 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,[66] the average malpractice payout has not changed much over the decade, and continues to hover at approximately $30,000 without any adjustment for inflation.[67] For the decade ending in December 2000, each closed claim for medical malpractice, including million dollar verdicts, averaged only $27,824.[68]

With regard to actual jury awards, data from the National Practitioner Data Bank shows that the average judgment declined in the first 9 months of 2002, dropping from $426,247 from $593,647

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[63] *Id.*

[64] *See supra* note 50.

[65] Only a handful of states, including Alabama, Arizona, Illinois, New York and Oklahoma require that rates be filed and approved by the state insurance department before they can be used. *See* National Association of Insurance Commissioners, Compendium of State Laws on Insurance Topics, Rate Filing Methods For Property/Casualty Insurance, Workers' Compensation, Title, 2002.

[66] *See* Letter from J. Robert Hunter, Director of Insurance for the Consumer Federation of America, to Joanne Doroshow, Executive Director of the Center for Justice & Democracy (Oct. 13, 2001) and attached spreadsheet [hereinafter]. 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.*

[67] *Id; see also Medical Malpractice Insurance: Stable Losses/Unstable Rates*, Americans for Insurance Reform, Oct. 10, 2002 ("Not only has there been no 'explosion' in medical malpractice payouts at any time during the last 30 years . . . payments (in constant dollars) have been extremely stable and virtually flat since the mid-1980s.").

[68] *Id.*

in 2001.[69] This startling statistic, the most recent empirical evidence on jury awards, cuts right to the heart of the rationale for the bill.

Supporters of H.R. 5 cite anecdotal evidence that jury awards are increasing. One such study, conducted by Jury Verdict Research ("JVR") and released in March 2002, showed that jury awards in medical malpractice cases jumped 43% from 1999 to 2000.[70] 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.[71] The JVR and similar studies are not adjusted for inflation and have no relation to what insurance companies actually pay out to claimants.[72]

Punitive damages, which are designed to deter willful and wanton misconduct, are infrequently awarded. According to Department of Justice statistics, in 1996 only 1.1% of medical malpractice plaintiffs who prevailed at trial were awarded punitive damages and juries awarded only 1.2% of those awards.[73]

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.[74] Average premiums per doctor climbed from $7,701 in 1991 to $7,843 in 2000, an increase of only 1.9%. When adjusted for inflation, these figures demonstrate premiums have actually decreased by 32.5%.[75] A recent USA Today study found that doctors spend less on malpractice insurance—3.2% of their revenue—than on rent.[76] Equally important, 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, and in 2000 the cost was 56 cents, the second lowest rate of the decade.[77]

Third, there is little evidence to support proponents' claim that doctors, fearing litigation, engage in the practice of defensive medicine. Less than 8% of all diagnostic procedures are performed because of liability fears, and most doctors who use aggressive diagnostic procedures do so because they believe the tests are medically

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[69] National Practitioner Data Bank.

[70] Jennifer E. Shannon and David Boxold, Medical Malpractice: Verdicts, Settlements and Statistical Analysis, Jury Verdict Research, 2002.

[71] 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. 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; 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).

[72] *Id.*

[73] Tort Trials and Verdicts in Large Counties, 1996, U.S. Department of Justice, Bureau of Justice Statistics, NCJ 179769 (August 2000), p. 7.

[74] Hunter Analysis, *supra* note 66.

[75] *Id.*

[76] *See* Eisler *et al., supra* note 32.

[77] Hunter Analysis, *supra* note 66.

indicated.[78] 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."[79] 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."[80] The effects of H.R. 5's limitations on defensive medicine are therefore likely to be small.

Fourth, studies show that, despite claims by doctors' groups and the insurance industry,[81] 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 of the population in states without damage caps.[82] There are 5.8% more ob/gyn physicians per 100,000 women in states without caps.[83] 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.[84]

Studies conducted in particular states make this clear. For example, Charleston Gazette reporters Lawrence Messina and Martha Leonard's series "The Price of Practice"[85] found that, contrary to claims by the West Virginia Medical Association that doctors had left the state because of its lack of liability limitation laws, 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%, a rate twenty times greater than the population.[86]

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%, while the population increased by only 3.4%.[87] Not only is Pennsylvania not losing doctors, it had more doctors in 2001 than it did in the preceding five to 10 years.[88] 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 every

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[78] OTA Report on Legal Reforms, *supra* note 46 at 74.

[79] *Id.*

[80] *Id.* at 92.

[81] *See* Statement of the American Medical Association to the House Committee on Energy and Commerce, 107th Cong. at 2–7 (July 17, 2002); Statement of the National Medical Liability Reform Coalition, before the House Committee on Energy and Commerce, July 17, 2002, 107th Cong., at 2 (July 17, 2002).

[82] American Medical Association, Physician Characteristics and Distribution in the U.S. (2001 ed.).

[83] Health Care State Rankings (Morgan Quitno Press, 2001).

[84] Senate Congressional Record, July 30, 2002, S7534.

[85] Martha Leonard, *State Has Seen Sharp Increase in Number of Doctors*, Sunday Gazette Mail, Feb. 25, 2001.

[86] *Id.*

[87] 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.

[88] Goldstein, *supra* note 87.

100,000 residents in 2000, according to the American Medical Association."[89]

Fifth, there is no evidence to support the claim that restrictions on malpractice litigation will bring about appreciable health care savings. One reason is that medical negligence recoveries in this country in 2001 added up to $4.5 billion. Amidst a health care system that has about $1.4 trillion worth or transactions, recoveries for malpractice constitute less than 1 percent of the cost of healthcare.[90]

Moreover, there is scant quantitative evidence that previous state attempts have accomplished this purported goal.[91] In a comparison of states that enacted severe tort restrictions during the mid-1980's and those that resisted enacting any liability limitation laws, no correlation

was found between such laws and insurance rates.[92] 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 liability limitation laws experienced high rate or loss cost increases relative to the national trends. For example, in 2002, Michigan, a state with caps, had one of the highest average premiums in the country. Minnesota and Oklahoma, two states without caps, had two of the three lowest average rates in the country.[93] Furthermore, 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.[94] For general surgeons, insurance premiums were 2.3% higher in states with caps on damages.[95] And for ob/gyn's, premiums were only 3.3% lower in states with caps on damages.[96] On average, malpractice premiums were no higher in the twenty-seven states that have no limitations on malpractice damages, than in the twenty-three states that have such limits.[97]

The vast majority of the evidence shows that liability limitation laws do little if anything to reduce medical malpractice premiums.[98] For example, one of Florida's largest malpractice insurers

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[89] Wlazelek, *supra* note 87. Studies done on the ob/gyn market in New York yield similar conclusions. *See* New York Public Interest Research Group Study (available at: http://www.nypirg.org/ health/malpractice—facts.html (last visited Feb. 1, 2003) (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).

[90] *See* Lorraine Woellert, *Commentary: A Second Opinion on the Malpractice Plague*, Business Week, Mar. 3, 2003.

[91] It is hardly a foregone conclusion that such restrictions will 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.

[92] *See Premium Deceit, supra* note 2.

[93] *See 2002 Medical Liability Monitor, supra* note 3.

[94] *See 2001 Medical Liability Monitor, supra* note 4.

[95] *Id.*

[96] *Id.*

[97] *See* Senate Congressional Record, supra note 6. 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 others have all increased between 24% and 56%. *See* Council of Insurance Agents and Brokers, 4th Quarter 2001 Survey, released January 2002.

[98] Insurance industry spokespersons practically admit this. As Sherman Joyce, President of the American Tort Reform Association (ATRA), stated, *Study Finds No Link Between Tort Reforms and Insurance Rates*, Liability Week, July 19, 1999. ATRA's General Counsel, Victor

recently acknowledged that a $250,000 cap on pain and suffering damages will not cure soaring insurance rates.[99] For example, a report from the New Jersey Medical Society estimated that a state cap of $250,000 for noneconomic damages might result in 5% to 7% savings for physicians.[100]

The California experience is perhaps the best example of this trend. In 1975, California enacted into law the "Medical Injury Compensation Reform Act" ("MICRA"), after which many provisions of H.R. 5 are modeled, including caps on non-economic damages, collateral source offsets, and limitations on attorneys' fees.[101] Despite these "reforms," premiums for medical malpractice insurance in California grew more quickly between 1991 and 2000 than the national average (3.5% vs. 1.9%, respectively).[102] Between 1975 and 1993, California's health care costs rose 343%, almost double the rate of inflation.[103]

A comprehensive study of MICRA's impact conducted in 1995 found the following: (1) 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; (2) California's medical malpractice liability premiums actually increased by 190% in the twelve years following enactment of MICRA; (3) hospital patient costs are higher in California than in other major states; and (4) California's health care costs have continued to increase at a rate faster than inflation since the passage of MICRA.[104]

Some of MICRA's supporters claim that MICRA caused California's insurance premiums to drop. To the extent that is true, the reduction has nothing to do with MICRA and more to do with Proposition 103, which passed the California legislature in 1988. Among other things, Proposition 103 prohibited annual increases greater than 15% by insurers without public hearing, and required insurers to rebate earlier premiums and led to a freeze on premiums for several years.[105] As a result of Proposition 103, insurance companies refunded over $1.2 million to policyholders, including doc-

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Schwartz, told Business Insurance that Michael Prince, *Tort Reforms Don't Cut Liability Rates, Study Says*, Business Insurance, July 19, 1999. Debra Ballen, the executive vice president of the American Insurance Association, stated that Press Release, *AIA Cites Fatal Flaws in Critic's Reports on Tort Reform*, Mar. 13, 2002. And Florida insurers, writing about Florida's omnibus tort reform law of 1986 said that the *Medical Professional Liability, State of Florida*, St. Paul fire and Marine Insurance Company, St. Paul Mercury Insurance Company.

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).

[99] *See* Phil Galewitz, *Dose of Reality for Doctors*, Palm Beach Post, Jan. 29, 2003.

[100] *See* Eisler *et al., supra* note 32. One study suggested that payouts may be rising not because of noneconomic damage awards but because of *Id.*

[101] *See* Cal. Civ. Proc. Code § 667.7 (West 1987) (providing for periodic payment of damages); id. § 1295 (West 1982) (allowing physicians and patients to contract for binding arbitration); Cal. Civ. Code § 3333.1 (West 1997) (allowing collateral source evidence); id. § 3333.2 (providing limitation on noneconomic damages); Cal. Bus. & Prof. Code § 6146(a) (West 1990) (limiting contingency fees).

[102] Hunter analysis, *supra* note 66.

[103] Data provided by Consumers' Union.

[104] *See* Proposition 103 Enforcement Project, MICRA: The Impact on Health Care Costs of California's Experiment With Restrictions on Medical Malpractice Lawsuits, 1995.

[105] *See* Testimony of Harvey Rosenfield, before the House Committee on Energy and Commerce, Feb. 10, 2003; *see also* Joseph B. Treaster, *Malpractice Insurance: No Clear or Easy Answers*, N.Y. Times, Mar. 5, 2003.

tors.[106] Within 3 years of passage of Proposition 103, total medical malpractice premiums had dropped by 20.2% from the 1998 high.[107]

Not only does the evidence show that California's attempt failed to lower premiums for doctors, it also shows that California's insurance companies are reaping excessive profits in the aftermath of MICRA. In 1997, California's insurers earned more than $763 million, yet paid out less than $300 million to claimants.[108] The National Association of Insurance Commissioners reported the following: (1) malpractice insurance profits are ten times greater than the profits of other lines of insurance in California; (2) the average profit for malpractice insurance in California was 25.40% of the collected premium; and (3) less than half of medical malpractice premiums are paid to claimants—only 38.4% of medical malpractice premiums collected in California since 1988.[109]

H.R. 5 Goes Beyond Medical Malpractice And Applies To Insulate HMO's Insurers, Drug Companies, And Manufacturers And Distributors Of Medical Devices.

Although H.R. 5'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.[110]

III. H.R. 5 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. 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 legislation preempts patients' bills of rights passed by some states. For example, Arizona's patients' bill of rights has no limits on damages for HMO lawsuits.[111] California, on which much of H.R. 5 is based, also has no HMO caps.[112] Georgia's statute has no caps for non-economic damages in lawsuits against HMOs.[113] Nor does Maine's HMO statute.[114] Finally, Oklahoma and Washington have no limitations on non-economic damages.[115] H.R. 5 completely eviscerates the protections specifically enacted by these states.

A. H.R. 5 also covers products liability lawsuits against manufacturers and distributors of medical devices and drugs.

H.R. 5 exempts from liability for punitive damages manufacturers and distributors of medical devices, as well as pharmaceutical

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[106] *Id.*
[107] *Id.*
[108] California Department of Insurance.
[109] National Association of Insurance Commissioners, Profitability By Line By State in 1997 (Dec. 1998).
[110] H.R. 5, § 9(7); *see supra* note 23.
[111] Az. Rev. Stat. § 20–3153 *et seq.* (2000).
[112] Ca. Civil Code § 3428 (West 1999).
[113] Ga. Code Ann. § 51–1–48 *et seq.*. (1999).
[114] Me. Rev. Stat. Ann. Tit. 24, § 4313 (West 1999).
[115] Okla. Stat. Tit. 36, § 6593 *et seq.*. (2000); Wash. Rev. Code § 48.43.545 (2000).

companies, who have obtained FDA approval.[116] If the FDA mistakenly allows a defective product on the market, the victims would not be able to sue at all. And, even if the FDA does not approve the device, manufacturers and distributors would still be shielded from punitive damage liability if the product is "generally recognized among qualified experts as safe and effective" pursuant to FDA regulations.[117]

Moreover, these Federal regulators approve the design of the product before it enters the manufacturing process only; they do 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. 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. Each of these deadly products was approved by the FDA.[118]

IV. H.R. 5 Raises Constitutional And Federalism Concerns

A. Constitutional Concerns

Among the many problems with H.R. 5, 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 recent Commerce Clause jurisprudence. There is a genuine issue as to whether H.R. 5 is a permissible exercise of Congress' power to regulate interstate commerce,[119] especially when applied to purely intrastate medical services. The bill contains no interstate commerce jurisdictional requirement, and merely makes a flat and unsubstantiated assertion that all of the activities it regulates affect interstate commerce.[120] The Supreme Court repeatedly has frowned upon Federal intervention into areas like medical malpractice law that have been traditionally reserved to the states.[121]

The bill also invites challenges that it violates the Fifth Amendment, which provides that no person shall be "deprived of life, lib-

[116] H.R. 5, § 7(c).

[117] H.R. 5, § 7(c)(1)(B); *see supra* note 17.

[118] The bill does provide exceptions where manufacturers or distributors knowingly misrepresented to or withheld from the FDA information that it was required to submit, and where a person made an illegal payment to an official at the FDA. This provision alleviates only one of many concerns we have about H.R. 5's extreme limitation on the availability of punitive damages.

[119] Article I, Section 8 of the Constitution provides, *inter alia*, U.S. Const. art I, § 8, cl. 3.

[120] 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."

[121] 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.

erty, or property without due process of law,"[122] a proscription which has been held to include an equal protection component.[123] 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."[124] Because the bill eliminates the right of a jury to determine the appropriate amount of punitive and non-economic damages, H.R. 5 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 liability limitation laws, 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.[125]

B. Federalism Concerns

We are also concerned that the bill imposes the will of Congress on what has traditionally been exclusively a state law issue. As such, H.R. 5 could undermine over two centuries of respect for federalism by superimposing a new set of Federal standards on the States.

Federalizing medical malpractice lawsuits will not result in uniformity. However well articulated, H.R. 5 will be applied in many different contexts and will be interpreted and implemented differently by both state and Federal courts.[126]

Moreover, H.R. 5 takes away the state Supreme Courts' role as the final arbiters of their tort laws. Yet, the Republican majority stated that this is precisely the goal H.R. 5 is trying to accomplish.

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[122] U.S. Const. amend. V.

[123] *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).

[124] U.S. Const. amend. VII.

[125] Specifically, thirty-one states (AL, AZ, CA, CO, FL, GA, ID, IL, IN, KS, KY, LA, MO, NE, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, 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 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 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.

[126] 1995 Product Liability Hearings, Statement of the Conference of Chief Justices at 6–7.

At the markup of H.R. 5, several members discussed the crisis in Florida and the fact that the Florida legislature has been unsuccessful in capping damages for medical malpractice cases. Mr. Wexler asked: "So what is it that we in this Congress are doing that is preventing the Florida legislature from adopting whatever tort reform it sees fit to do?"[127] Rep. Feeney (R-Fla.) responded as follows:

> Actually, Congress isn't doing anything to prevent the Republican or formerly Democratic legislature from doing the sorts of things that we need to do here. It is the six Democrats on the Florida Supreme Court. I would refer the gentleman to Smith v. the Department of Insurance, April 23, 1987, when the Supreme Court basically said that under [Florida's] right of access provisions, under the Florida Constitution, that a $450,000 cap would be unconstitutional.
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> So the point of the matter is that judges with certain partisan attitudes actually have prevented the people's legislature from enacting the very thing that we are trying to do here, and that is to preserve access to our doctors for the patients that I represent throughout the district.[128]

The argument Mr. Feeney makes is very problematic. Whatever reason he attributes to the Florida Supreme Court's decision to strike down the legislation imposing caps on damages in medical malpractice cases, the fact remains that the Florida Supreme Court should be the final arbiter of that issue. It violates principles of federalism for the United States Congress to decide that, because it does not like a decision made by the Florida Supreme Court, it should enact legislation that would overturn the court's decision.

H.R. 5 reaches far into state substantive civil law, forcing states to provide the necessary judicial structure to resolve medical malpractice disputes without permitting them to decide the social and economic questions in the law that their courts administer.

V. Specific Concerns

In addition to the general problems raised above concerning the overall purpose and effect of H.R. 5, we have a number of specific concerns relating to particular provisions of the legislation. Most importantly, we are concerned that H.R. 5 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. 5.

A. $250,000 aggregate cap on non-economic damages[129]

We particularly object to the $250,000 cap on non-economic damages for three reasons: it is manifestly unfair, it discriminates

[127] Markup of H.R. 5, Transcript at 45.
[128] *Id.* at 46.
[129] 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 impair-

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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 his or her suffering. An incident told by Kathy Olsen, who attended the victims' forum held by House Democrats on February 11, 2003,[130] illustrates the harsh reality of H.R. 5. Ms. Olsen told her son, Steve's, story. Steve Olsen 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 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, 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.

Ms. Olsen is outraged by President Bush's statement that the jury system looks like a "giant lottery." Ms. Olsen declares: "California's malpractice law has failed innocent victims, consumers, and taxpayers. Under this law people are victimized twice, once by the wrongdoer and again by the laws that deny them the right to hold the wrongdoer accountable."[131] As to the cap on damages, Ms. Olsen says that the "law is regressive by hurting the most seriously injured victims, those who are permanently and catastrophically injured by medical negligence. . . . In California, and now proposed nationwide, no matter how old you are or how disabled you become or how catastrophic your injuries are, there is a one size fits all limit on your pain and suffering."[132]

Second, the $250,000 cap discriminates against women, children, seniors, and the poor.[133] 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.[134]

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ment. These damages are not accounted for in damages for lost wages, which are unrestricted under H.R. 5.

[130] Democratic Forum on Malpractice, February 11, 2003, Transcript at 60.

[131] *Id.* at 62.

[132] *Id.*

[133] 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.).

[134] *Id.*

A striking example of how the one-size-fits-all cap harms victims without economic damages can be found in the case of Linda McDougal. Ms. McDougal went to the hospital for a biopsy after a routine mammogram disclosed a suspicious shadow on one breast. A few days later, her doctor called to tell her she had cancer and would need a double mastectomy. At the victims' forum, Ms. McDougal described the effect this news had on her: "My world was shattered."[135] After the operation, Ms. McDougal found out that she never had cancer—the pathologist mixed up Ms. McDougal's charts with another patient's. "The medical profession betrayed the trust I had in them. It's been very difficult for me to deal with this. My scars are not only physical, but emotional as well."[136] Ms. McDougal has not filed a lawsuit yet, but she knows that should Congress pass legislation capping non-economic damages, her recovery will be limited to $250,000 because she does not have economic damages. As Ms. McDougal said at the forum, she lost wages of about $8,000 and her hospital expenses were about $48,000, which her insurance company covered. But she went on: "My disfigurement from medical negligence is almost entirely noneconomic. . . . I could never have predicted or imagined in my worst nightmare that I would end up having both of my breasts removed needlessly because of a medical error. No one plans on being a victim of medical malpractice, but it happened."[137]

Another recent example is Jesica Santillan, a 17 year old girl from Mexico whose family moved to the United States so Jesica could receive a heart and lung transplant at Duke University Hospital.[138] The organs flown from Boston to Durham identified the donor's blood as Type-A blood, but the hospital mixed-up the paperwork and transplanted organs with Type-O-positive blood instead. As a result, Jesica, who had been waiting 3 years for the organs, suffered a near-fatal heart attack and a seizure. A machine kept her heart and lungs going for awhile, but on February 22, 2003, just 2 weeks after the initial surgery, Jesica died.[139] Like Linda McDougall, however, Jesica had no economic damages and, should her family decide to sue, would be capped at $250,000 under H.R. 5.

Third, the cap makes it hard for people with legitimate cases to find lawyers to represent them. As one attorney from California stated, "[e]ven in those cases resolved on the eve of trial, . . . [lawyers] typically have to invest up to $100,000 to hire experts and develop the cases. They would do the same work and invest the same amount of money to tackle a case with a potential payoff in the millions. So they choose the more lucrative cases."[140]

Finally, the $250,000 cap is based on MICRA's cap,[141] which was set in 1975 and has not been adjusted for inflation. A close look at

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[135] Democratic Forum on Malpractice, February 11, 2003, Transcript at 48.
[136] *Id.* at 49.
[137] *Id.* at 50–51.
[138] *See* AP, *Girl Near Death in Botched Transplant*, Wash. Post Feb. 19, 2003 at A02.
[139] *See* Shankar Vedantam, *Surgical Expertise, Undone by Error*, Wash. Post Feb. 24, 2003 at A01.
[140] *See* Joseph B. Treaster, *Malpractice Insurance: No Clear or Easy Answers*, N.Y. Times, Mar. 5, 2003.
[141] Although based on MICRA, H.R. 5's cap on non-economic damages is much more restrictive. For example, California courts recognize a separate claim for loss of consortium—claims

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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 $38,877 over the 27 years since MICRA was enacted. One would need about $1,600,000 in 2002 for the equivalent medical purchasing power of $250,000 in 1975.

Representatives Nadler and Delahunt both offered amendments that would allow for adjustment of the $250,000 to the consumer price index.[142] As Mr. Nadler pointed out, "[T]he fact of the matter is what you are really saying is why don't we allow people zero recovery for pain and suffering; because if you index something at whatever number, take 50,000, 250,000, 550,000, and you don't index it, eventually that number is going to be almost zero. It is going to be almost worthless depending how long you want to go."[143]

B. Abolition of joint and several liability

We oppose H.R. 5'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.[144] 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.[145] 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.[146]

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brought for loss to the marital relationship—brought by the spouse of an injured patient. The cap in H.R. 5 is a completely aggregate cap. Under H.R. 5, the amount of non-economic damages that can be recovered by an injured patient and his or her spouse cannot exceed $250,000 for non-economic losses.

[142] Mr. Nadler's amendment would have added the following language after $250,000 every time it appears in the bill: Mr. Delahunt's amendment would have struck $250,000 each place it appears in the bill and replaced it with $1,600,000. Mr. Nadler's amendment was defeated by a vote of 17–16; Mr. Delahunt's amendment was defeated 15–14.

[143] Markup of H.R. 5, Transcript at p. 108.

[144] *See* e.g. Michael L. Rustad and Thomas H. Koenig, *Taming the Tort Monster: The American Civil Justice System As A Battleground of Social Theory*, 68 Brook L. Rev. 1 (Fall 2002); Matthew W. Light, *Who's the Boss?: Statutory Damage Caps, Courts, and State Constitutional Law*, 58 Wash. & Lee L. Rev. 315 (Winter, 2001).

[145] Restatement (Third) of Torts § 23 (1999).

[146] At the 2002 markup of H.R. 4600, Chairman Sensenbrenner stated the crux of the issue when, after acknowledging that the rule is 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 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, possibily at fault" *Id.* at 31.

The majority's reasons for eliminating joint and several liability[147] in medical malpractice cases is nothing but an extreme reaction to mostly unsubstantiated anecdotal stories, rather than a moderate response to the facts. In the 2002 markup of H.R. 4600 Mr. Bachus gave a 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. Mr. Bachus raised the possibility that the drug dealer would 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.[148] As Mr. Frank correctly pointed 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."[149]

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 victim or knowingly committed fraud.[150] In addition, the Y2K Act provides that if portions of the victim's damage claim ultimately prove to be uncollectible, and the victim is an individual with a net worth of less than $200,000 and damages are greater than 10 percent of a victim'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."[151]

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 victims to prove,[152] 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 victim would suffer injury but failed to avoid such injury)—is so extreme it is practically criminal. This standard makes it almost impossible for victims who have been egregiously wronged to recover punitive damages.[153]

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[147] The issue did not come up at the 2003 markup of H.R. 5, but was discussed at length in the 2002 markup of H.R. 4600.

[148] *Id.* at 28.

[149] *Id.* at 34.

[150] 15 U.S.C. § 6605(c).

[151] *Id.* § 6605(d).

[152] H.R. 4600, § 7(a) ("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." (emphasis added)).

[153] We also think this provision is unnecessary because punitive damages are so rarely awarded in medical malpractice cases. In fact, a Westlaw search of punitive damage award cases to date since 1980 shows that punitive damages were awarded in only twelve cases, most of which involved egregious conduct by the health care professional.

Second, even victims 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 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.[154]

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.[155] 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.[156]

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. This means that a drug company distributing an FDA-approved product, which is manufactured in a flawed manner that harms consumers would be insulated from punitive damages, even if the flawed manufacture was intentional or reckless.

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

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[154] 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).

[155] 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.

[156] The bill response to one of our concerns from last year's H.R. 4600 by providing an exception to the provision for cases where the manufacturer or distributor knowingly misrepresented to or withheld from the FDA information it was required to submit, and where a person paid an FDA official to secure market approval. H.R. 5, § 7(c)(4).

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.[157]

E. Alteration of the collateral source rule and elimination of the doctrine of subrogation.

We dissent from the bill's alteration of the collateral source rule. The bill allows either party to introduce evidence to the jury of payment from a collateral source and eliminates the doctrine of subrogation.[158] The effect is to shift the costs of malpractice from negligent defendants to innocent victims.

The collateral source rule prevents a wrongdoer from reducing the amount of damages it must pay a victim by the amount the victim receives from outside sources.[159] 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.[160]

We oppose this provision because it allows the jury to hear evidence of a payment a victim may have received from his or her insurance company—payment for which the victim contracted and paid premiums—and may reduce the amount of damages the victim can collect from the negligent defendant by that amount. In essence, the negligent defendant gets the benefit of the victim's health insurance contract.

In addition to shifting costs to the victim, eliminating the collateral source rule would discourage prudent insurance planning by penalizing consumers for acting responsibly[161] and would undermine the deterrent effect of the malpractice system by enabling negligent health care providers to avoid liability for damages they inflict.[162]

F. Contingency fee limitations

In addition, we disagree with the provision in the bill limiting contingency fees for attorneys.[163] Contingency fee arrangements can serve a useful and essential function in the legal system.[164] They allow injured victims who could not otherwise afford legal representation access to the courts because the attorney agrees to

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[157] *See also* Koenig and Rustad, supra, at 38–46 () (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)).

[158] H.R. 5, § 6; *see supra* note 13.

[159] *See, e.g., Heflend* v. *Southern Cal. Rapid Transit Dist.*, 465 P.2d 61 (1970) for an analysis of the collateral source rule.

[160] *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).

[161] *See* James L. Branton, *The Collateral Source Rule*, 18 St. Mary's L.J. 883 (1987).

[162] *See* Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 Law & Contemp. Probs. 57, 72 (Spring 1986).

[163] H.R. 5, § 5.

[164] *See* Herbert M. Kritzer, *Lawyer Fees and Lawyer Behavior in Litigation: What does the Empirical Literature Really Say?*, 80 Tex. L. Rev. 1943 (2002); Herbert M. Kritzer, *Economic Policy Litigation Conference Seven Dogged Myths Concerning Contingency Fees*, 80 Wash. U. L.Q. 739 (Fall 2002).

take the case on behalf of an injured patient without obtaining any money up front from the client.[165] The attorney thus incurs a risk in taking on the case because if the client loses, the attorney never gets paid.[166] 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.[167]

H.R. 5'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 victims' 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.[168]

G. Periodic payments

As with the other provisions of the bill, the provision regarding periodic payments harms victims and protects wrongdoers.[169] 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 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 because it is a 1-year statute of limitations disguised as a 3-year statute of limitations. H.R. 5 provides that health care lawsuits must be commenced "3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first."[170]

Although this provision addresses one of our concerns from last year—that the statute of limitations does not account for injuries that have long incubation periods, such as HIV—it still is extremely restrictive and harmful to patients. The 3 year provision essentially is a sham because the bill calls for the earlier of 3 years from the date of manifestation or 1 year from the date of discovery.

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[165] *Id.*
[166] *Id.*
[167] *Id.*
[168] 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 marketplace. This provision could not be more
[169] H.R. 5, § 8; *see supra* note 22.
[170] H.R. 5, § 3. The bill tolls the statute of limitations upon proof of fraud, intentional concealment, or the presence of a foreign body in the person injured. *Id.* In addition, there is an exception for minors who have sustained injury before the age of six. 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 of eight. *Id.*

Those two dates will almost always be the same—a patient will discover a disease on the same date the disease begins to manifest itself. As Mr. Delahunt stated, "such victims would only have 1 year, once they become aware of the condition, to file suit; hardly a reasonable opportunity to consider their legal options and to find a lawyer that is willing to take the case on." [171]

CONCLUSION

Collectively, the supposed "reforms" included in H.R. 5 would severely limit victims' ability to recover compensation for damages caused by medical negligence, defective products, and irresponsible 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. 5, 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. 5 should be rejected.

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[171] Markup of H.R. 5, Testimony of Mr. Delahunt, Mar. 5, 2003, Tr. at p.27.

ADDITIONAL DISSENTING VIEWS

In addition to the dissenting views, I would add the following:

1. In addition to the comments on the bill's elimination of joint and several liability, I would add that this new burden on the plaintiff is administratively unfair to the plaintiff. The apportionment of malpractice responsibility is routinely made in the health care field by apportionment of insurance coverage. Health care providers can and do decide in advance who will pay for what coverage. The plaintiff, on the other hand, is not in a position to apportion damages, because the plaintiff often has no idea what happened, much less who was responsible. The entire concept of res ipsa loquitur is based on the fact that some cases are so obviously the result of malpractice that the general burden of proof is eased for such victims. With the elimination of joint and several liability, and without knowing exactly what happened, the plaintiff will have to make a separate case, including establishing a standard of care, violation of that standard and proximate cause for each conceivable participant in his care and always have the possibility of defendants pointing to an "empty chair" or an insolvent defendant at the trial. This burden comes with the costs of expert witnesses for each doctor, nurse and hospital even minimally involved in the most egregious and obvious cases. As the dissent mentions, any defendant can always seek contribution without the elimination of joint and several liability.

2. In addition to the comments in the dissent on the collateral source rule, I would add that there are three interested parties: the plaintiff, the health insurance company and the defendant. Good arguments can be made for the plaintiff to benefit from the provisions he has made to pay his bills. Some may have saved money over the years, including a medical savings account, and others may have paid for insurance. Those persons who have invested in insurance should be able to benefit from their thrift. If one is not persuaded by that argument, and is offended by the plaintiff "being paid twice" for the same bill, then one could reasonably say that the health insurance carrier should be able to get its money back though subrogation, and charge a smaller premium based on the anticipation that some of their claims will not ultimately have to be paid, because a tortfeasor will be responsible. The last person of interest who should benefit from the plaintiff's insurance should be the tortfeasor. In fact the prohibition against subrogation in the bill creates the bizarre situation in which a self-insured small business could have an employee in a malpractice induced coma, and have to pay all of the hospital bills, notwithstanding the fact that the negligent doctor is fully insured.

3. Finally, one of the reasons why the "average" malpractice award is increasing is because smaller cases are not brought. The complexity of the cases makes it impossible to hire an attorney if

the award is too small to generate a meaningful attorney's fee. This "average" will undoubtedly increase if this bill is enacted because of limitations on damages, limitations on attorney's fees, elimination of joint and several liability and elimination of collateral sources. A better measure of the impact of malpractice litigation has on the health care system is the fact that all malpractice awards and settlements have been approximately ½ of 1% of the national health care costs and have been recently increasing at the same rate as the health care costs generally.

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