108TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 108–32
Part 2

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

MARCH 11, 2003.—Ordered to be printed

Mr. TAUZIN, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 5]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, 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, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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85–573

AMENDMENT

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, nothing in this Act shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, 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 injury.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), 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. Whenever a judgment of liability is rendered as to any party, 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. The requirement for court supervision in the first two sentences of subsection (a) applies only in judicial proceedings.

SEC. 6. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, 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 involving injury or wrongful death. 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 IN COMPLIANCE WITH FDA STANDARDS.—

(1) PUNITIVE DAMAGES.—

(A) IN GENERAL.—In addition to the requirements of subsections (a) and (b), 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 product 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, section 351 of the Public Health Service 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, or who dispenses pursuant to a prescription, a medical product approved, licensed, 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. Nothing in this paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims against the manufacturer, distributor, or product seller of such medical product.

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

(A) a person knowingly misrepresented to the Food and Drug Administration information which 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); or

(B) a person made an illegal payment to a governmental official for the purpose of either (i) securing or maintaining approval, clearance, or licensure of such medical product or (ii) preventing an enforcement action.

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.

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

SEC. 9. DEFINITIONS.

In this Act:

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

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

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

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

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

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

(D) any other publicly or privately funded program.

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

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

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

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

regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; which is grounded in antitrust; or in which the dispute is over the price of health care goods or services.

(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 or care 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, device, or biological product intended for humans, and the terms "drug", "device", and "biological product" 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) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), 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 Pa-

cific 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 AND OTHER LAWS.—(1) 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.

(2) This Act shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this Act or create a cause of action.

(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

H.R. 5 seeks 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.

BACKGROUND AND NEED FOR LEGISLATION

One of the primary purposes of the tort system is to provide an avenue for compensation for injured victims. The tort system also serves to deter behaviors that can cause harm to individuals and society as a whole. Nevertheless, excessive litigation can distort these useful functions, and lead to impacts that are the opposite of what is intended—harming the very people the system aims to protect. In the health care sector, excessive litigation has been extremely harmful to patient access to care.

Medical liability insurance rates have skyrocketed in several states across the country causing major insurers to drop coverage or raise premiums. St. Paul's Companies, the largest malpractice carrier in the United States covering 9 percent of doctors, announced in December 2001 that it would no longer offer coverage to health care providers. In addition, MIXX, PHICO, Frontier Insurance Group, and Doctors Insurance Reciprocal have either limited their coverage or left the medical liability insurance market. States that had not enacted meaningful medical liability reforms (such as Nevada, Georgia, Oregon, Mississippi, Ohio, Pennsylvania, and Washington) were particularly affected.

In some cases, the new premiums are more than the actual income a health care provider accumulates annually. Even doctors that have never lost a single medical malpractice judgment or ever had a claim filed against them are seeing huge increases in medical liability premiums. The Medical Liability Monitor reports that medical liability insurance premiums are increasing at the highest rate since the mid-1980's. In Florida, medical liability insurance coverage for pregnancy-related care is as high as $202,000 in some counties. Medical liability insurance rates are up 81 percent in Pennsylvania, and higher for some health care specialties.

Doctors unable to afford medical liability insurance are being forced to drop part of their specialty practice, retire early, or move to another state to practice. In several states patients are being left without access to high-quality care. For example, the University of Nevada Medical Center closed its trauma center in Las Vegas for ten days, causing the most severely injured patients to be transported to the next nearest Level I trauma center, located five hours away. The trauma center was only able to re-open because some of the surgeons agreed to become county employees for a limited time, which capped their liability for non-economic damages if they were sued. In Mississippi, over a third of the neurosurgeons have left the state in the past year. In rural areas of West Virginia, such as Putnam and Jackson counties, the sole community provider hospitals have closed their obstetrics units because the price of medical malpractice insurance is unaffordable. Without access to an obstetrician, women will be without access to prenatal care and the support of specialists if pregnancy complications arise.

The mere threat of a health care lawsuit is so perverse that many doctors engage in defensive medicine. Stanford economists Daniel Kessler and Mark McClellan have conducted studies using national data on Medicare populations and concluded that patients from states that adopted medical liability reforms—such as a reasonable limit on non-economic damage awards (pain and suffering)—incur significantly lower hospital costs while suffering no

increase in adverse health outcomes associated with the illness for which they were treated. Based on these studies, the authors have quantified the cost of "defensive medicine" in which doctors perform tests and prescribe medicines that are not necessary to better the health of the patient, but rather serve as a precautionary step just in case the doctor is named in a lawsuit. Published in the Quarterly Journal of Economics, their study, "Do Doctors Practice Defensive Medicine," estimates that direct medical care litigation reforms could lead to reductions of well over $50 billion per year in health care expenditures without serious adverse consequences for patients.

In 1975, California Governor Jerry Brown signed into law California's Medical Injury Compensation Reform Act (MICRA), which has helped to stabilize the California medical liability insurance market. MICRA reforms permit recovery of 100 percent of economic loss and up to $250,000 in non-economic loss. In order to ensure the complete recovery of damages for injured patients, MICRA prevents bankruptcies in which plaintiffs would receive only pennies on the dollar by authorizing courts to require periodic payments for future damages. To instill fairness and prevent double recoveries, MICRA provides authorization for defendants to introduce evidence showing the plaintiff received compensation for losses from outside sources. MICRA's reforms also allow more money to go directly to injured patients by including limits on contingency fees lawyers can charge in health care cases.

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 has experienced a 505% rate of increase. The price of some lines of medical liability insurance has even gone down significantly in California since MICRA was enacted. According to the Doctor's Company, in 1976 when California's MICRA law went into effect, the average medical malpractice premium was $23,698 in 2001 dollars. In 2001, the average premium was only $14,107. Furthermore, injured patients in California find that medical malpractice disputes in California are resolved 23 percent faster than the rest of the country. H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003 includes several provisions modeled after California's MICRA.

HEARINGS

The Subcommittee on Health held a hearing on "Assessing the Need to Enact Medical Liability Reform," on February 27, 2003. The Subcommittee received testimony from: Mr. Fred Hiestand, CEO and General Counsel, Californians Allied for Patient Protection; Mr. Jim Hurley, on behalf of the American Academy of Actuaries; Ms. Heather Lewinski; Donald J. Palmisano, MD, JD, President, American Medical Association; Ms. Sara Rosenbaum, Hirsch Professor of Health Law & Policy, George Washington University Medical Center School of Public Health and Health Services; Mr. Harvey Rosenfield, President, Foundation for Consumer and Taxpayer Rights; Mr. Lawrence E. Smarr, President, Physicians Insurers Association of America.

The Subcommittee on Oversight and Investigations held a field hearing on "The Medical Liability Insurance Crisis: A Review of the Situation in Pennsylvania" on February 10, 2003. The Subcommittee received testimony from: The Honorable Edward G. Rendell, Governor, Commonwealth of Pennsylvania; Julia W. Johansson, MD; Mr. Gregory Wozniak, President and Chief Executive Officer, St. Mary Medical Center; David J. Eskin, MD, Chief of Staff, Abington Memorial Hospital; Edward H. Dench, Jr., MD, President, Pennsylvania Medical Society; Donald J. Palmisano, MD, JD, Member, American Medical Association Board of Trustees; Ms. Leanne Dyess; Ms. Heather Lewinski; Mr. Lawrence E. Smarr, President, Physicians Insurers Association of America; Mr. James Hurley, ACAS, MAAA, Chairperson, Medical Malpractice Subcommittee, American Academy of Actuaries; Mr. Scott Diener, President and Chief Operating Officer, PMSLIC; Mr. Alan G. Rosenbloom, President & Chief Executive Officer, Pennsylvania Health Care Association and Center for Assisted Living Management; Thomas J. Nasca, MD, FACP, Dean of Jefferson Medical School, Senior Vice President Thomas Jefferson University; Mr. Harvey Rosenfield, President, Foundation for Consumer and Taxpayer Rights; Ms. Diane A. Menio, Executive Director, Center for Advocacy for the Rights and Interests of the Elderly (CARIE); Mr. John H. Reed; Neil Vidmar, Ph.D., Professor of Law, Duke Law School; and, Mr. James Mundy.

COMMITTEE CONSIDERATION

On March 4, 2003, the Subcommittee on Health met in open markup session and approved H.R. 5 for Full Committee consideration, as amended, by a voice vote, a quorum being present. On March 6, 2003, the Full Committee met in open markup session and favorably ordered H.R. 5 reported to the House, as amended, by a voice vote, a quorum being present.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following are the recorded votes taken on amendments offered to the measure, including the names of those Members voting for and against. A motion by Mr. Tauzin to order H.R. 5 reported to the House, as amended, was agreed to by a voice vote.

COMMITTEE ON ENERGY AND COMMERCE -- 108TH CONGRESS
ROLL CALL VOTE # 1

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

AMENDMENT: A substitute amendment to the amendment in the nature of a substitute by Mr. Dingell, No. 1a, to (1) create guidelines for medical malpractice reform, including the creation of a statue of limitations, an attorney certificate of merit, a limitation on punitive damages, and a reduction in premiums paid by physicians for medical malpractice insurance; (2) require the Secretary of Health and Human Services to promulgate rules pertaining to monies received from awards of punitive damages for activities to reduce medical errors and to improve patient safety; (3) establish an independent advisory commission on medical malpractice insurance; and, (4) provide grants and contracts to geographic areas that have a shortage of one or more health provider shortages resulting from costs of medical malpractice insurance.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 20 yeas to 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon	X		
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Norwood		X		Ms. Eshoo	X		
Mrs. Cubin		X		Mr. Stupak			
Mr. Shimkus		X		Mr. Engel			
Mrs. Wilson		X		Mr. Wynn			
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. John		X	
Mr. Pitts		X		Mr. Allen	X		
Ms. Bono		X		Mr. Davis		X	
Mr. Walden		X		Ms. Schakowsky	X		
Mr. Terry		X		Ms. Solis	X		
Mr. Fletcher		X					
Mr. Ferguson		X					
Mr. Rogers		X					
Mr. Issa		X					
Mr. Otter		X					

3/06/2003

COMMITTEE ON ENERGY AND COMMERCE -- 108TH CONGRESS
ROLL CALL VOTE # 2

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

AMENDMENT: An amendment to the amendment in the nature of a substitute by Mr. Pallone, No. 1b, to add a new section to the bill to state that this Act does not apply to claims or action against health maintenance organizations or the manufacturer of a drug or device.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 22 yeas to 25 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman			
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon	X		
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Norwood	X			Ms. Eshoo	X		
Mrs. Cubin		X		Mr. Stupak			
Mr. Shimkus		X		Mr. Engel	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg				Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella				Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich				Mr. Doyle	X		
Mr. Bass		X		Mr. John			
Mr. Pitts		X		Mr. Allen	X		
Ms. Bono		X		Mr. Davis	X		
Mr. Walden		X		Ms. Schakowsky	X		
Mr. Terry		X		Ms. Solis	X		
Mr. Fletcher		X					
Mr. Ferguson		X					
Mr. Rogers		X					
Mr. Issa		X					
Mr. Otter		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 108TH CONGRESS
ROLL CALL VOTE # 3

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

AMENDMENT: An amendment to the amendment in the nature of a substitute by Ms. Degette, No. 1c, to strike subsections (b) and (c) of section 4 pertaining to additional noneconomic damages and no discount of award for noneconomic damages. The amendment strikes (b)(2) of section 7, which establishes the maximum award of punitive damages may be as much as $250,000 or two times the amount of economic damages, whichever is greater.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 20 yeas to 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Norwood		X		Ms. Eshoo		X	
Mrs. Cubin		X		Mr. Stupak			
Mr. Shimkus		X		Mr. Engel	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. John		X	
Mr. Pitts		X		Mr. Allen	X		
Ms. Bono		X		Mr. Davis	X		
Mr. Walden		X		Ms. Schakowsky	X		
Mr. Terry				Ms. Solis	X		
Mr. Fletcher		X					
Mr. Ferguson		X					
Mr. Rogers		X					
Mr. Issa		X					
Mr. Otter		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 108TH CONGRESS
ROLL CALL VOTE # 4

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

AMENDMENT: An amendment to the amendment in the nature of a substitute by Mr. Waxman, No. 1d, to strike subsection (c) of section 7, which would remove the exception for not allowing punitive damages for products in compliance with Food and Drug Administration Standards.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 20 yeas to 29 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall		X	
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns			
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield				Mr. Rush	X		
Mr. Norwood		X		Ms. Eshoo	X		
Mrs. Cubin		X		Mr. Stupak			
Mr. Shimkus		X		Mr. Engel	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. John		X	
Mr. Pitts				Mr. Allen	X		
Ms. Bono		X		Mr. Davis	X		
Mr. Walden		X		Ms. Schakowsky	X		
Mr. Terry		X		Ms. Solis	X		
Mr. Fletcher		X					
Mr. Ferguson		X					
Mr. Rogers		X					
Mr. Issa		X					
Mr. Otter		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 108TH CONGRESS
ROLL CALL VOTE # 5

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

AMENDMENT: A substitute amendment to the amendment in the nature of a substitute by Mr. Wynn, No. 1e, to strike all after the enacting clause and establish a Commission on Medical Malpractice Insurance.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 19 yeas to 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman			
Mr. Barton				Mr. Markey	X		
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns			
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal				Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Norwood		X		Ms. Eshoo		X	
Mrs. Cubin		X		Mr. Stupak			
Mr. Shimkus		X		Mr. Engel	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle	X		
Mr. Bass		X		Mr. John		X	
Mr. Pitts				Mr. Allen	X		
Ms. Bono		X		Mr. Davis	X		
Mr. Walden		X		Ms. Schakowsky	X		
Mr. Terry		X		Ms. Solis	X		
Mr. Fletcher		X					
Mr. Ferguson		X					
Mr. Rogers		X					
Mr. Issa		X					
Mr. Otter		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 108TH CONGRESS
ROLL CALL VOTE # 6

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

AMENDMENT: A substitute amendment to the amendment in the nature of a substitute by Mr. Green, No. 1f, to strike all after the enacting clause and replace with a Sense of Congress stating that Congress should not substitute its judgment for that of the States concerning medical liability laws.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas to 26 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton				Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns			
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Norwood		X		Ms. Eshoo	X		
Mrs. Cubin		X		Mr. Stupak			
Mr. Shimkus		X		Mr. Engel	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer				Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. John	X		
Mr. Pitts				Mr. Allen	X		
Ms. Bono		X		Mr. Davis	X		
Mr. Walden		X		Ms. Schakowsky	X		
Mr. Terry	X			Ms. Solis	X		
Mr. Fletcher		X					
Mr. Ferguson		X					
Mr. Rogers		X					
Mr. Issa		X					
Mr. Otter		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 108TH CONGRESS
ROLL CALL VOTE # 7

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

AMENDMENT: An amendment to the amendment in the nature of a substitute by Mr. Engel, No. 1g, to strike section 2 concerning the findings and purpose, and insert language barring lawsuits unless they are filed within 3 years after the right of action accrues, and defines the accrual as (1) the date of the injury, (2) the date of discovery through the use of reasonable diligence, and (3) the date the claimant became 18.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 15 yeas to 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman			
Mr. Barton				Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns			
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr				Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush			
Mr. Norwood		X		Ms. Eshoo			
Mrs. Cubin		X		Mr. Stupak			
Mr. Shimkus		X		Mr. Engel	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella		X		Mr. Strickland			
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. John		X	
Mr. Pitts		X		Mr. Allen	X		
Ms. Bono		X		Mr. Davis	X		
Mr. Walden		X		Ms. Schakowsky	X		
Mr. Terry				Ms. Solis	X		
Mr. Fletcher		X					
Mr. Ferguson		X					
Mr. Rogers		X					
Mr. Issa		X					
Mr. Otter		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 108TH CONGRESS
ROLL CALL VOTE # 8

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

AMENDMENT: An amendment to the amendment in the nature of a substitute by Mr. Markey, No. 1i, to add a new section to the bill to create a trust for the amount of money awarded in a court that would require the company to pay an amount equal to the savings of an award beyond the limits on the amount of damages awarded by the court to the trust. The trust would distribute the funds in a manner to benefit health care providers insured by the company through reduced premiums for health care liability insurance.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 9 yeas to 27 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman			
Mr. Barton				Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns				Mr. Boucher			
Mr. Gillmor		X		Mr. Towns			
Mr. Greenwood		X		Mr. Pallone			
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr				Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush			
Mr. Norwood		X		Ms. Eshoo			
Mrs. Cubin		X		Mr. Stupak			
Mr. Shimkus		X		Mr. Engel	X		
Mrs. Wilson		X		Mr. Wynn			
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland			
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. John		X	
Mr. Pitts		X		Mr. Allen			
Ms. Bono		X		Mr. Davis			
Mr. Walden		X		Ms. Schakowsky	X		
Mr. Terry				Ms. Solis			
Mr. Fletcher		X					
Mr. Ferguson		X					
Mr. Rogers		X					
Mr. Issa		X					
Mr. Otter		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 108TH CONGRESS
ROLL CALL VOTE # 9

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

AMENDMENT: An amendment to the amendment in the nature of a substitute by Mr. Capps, No. 11, to strike the $250,000 noneconomic damages figure located in section 4, and creates a subsection (e) creating a new maximum amount of either $250,000 noneconomic damages or the total compensation package of the CEO of the insurance company covering the defendant, which ever is greater.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 11 yeas to 27 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton				Mr. Markey			
Mr. Upton		X		Mr. Hall			
Mr. Stearns				Mr. Boucher			
Mr. Gillmor		X		Mr. Towns			
Mr. Greenwood		X		Mr. Pallone			
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield				Mr. Rush			
Mr. Norwood		X		Ms. Eshoo			
Mrs. Cubin		X		Mr. Stupak			
Mr. Shimkus		X		Mr. Engel	X		
Mrs. Wilson		X		Mr. Wynn			
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Buyer		X		Ms. Capps	X		
Mr. Radanovich		X		Mr. Doyle			
Mr. Bass		X		Mr. John		X	
Mr. Pitts		X		Mr. Allen			
Ms. Bono		X		Mr. Davis			
Mr. Walden		X		Ms. Schakowsky	X		
Mr. Terry		X		Ms. Solis	X		
Mr. Fletcher		X					
Mr. Ferguson		X					
Mr. Rogers							
Mr. Issa		X					
Mr. Otter		X					

3/06/2003

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held oversight hearings and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal of H.R. 5 is 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.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 10, 2003.

Hon. W.J. "BILLY" TAUZIN,
Chairman, Committee on Energy and Commerce,
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), Leo Lex (for the state, local, and tribal impacts), and Stuart Hagen (for the private-sector impact).

Sincerely,

DOUGLAS HOLTZ-EAKIN,
Director.

Enclosure.

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 ($17 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

	By fiscal year, in millions of dollars—										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004–2013
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 three years after the injury alleged to have happened as a result of malpractice occurs or one 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 Association 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 ten-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 three-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 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 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 Center 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). 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-Section 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 the 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 three-year period. The estimate accounts for some loss in receipts because state health, sickness, income-disability, 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 inputs

The bill would impose a private-sector mandate on attorneys in malpractice cases by limiting the size of the awards they would 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; Federal outlays: Medicaid—Jeannee De Sa and Eric Rollins; Medicare—Julia Christensen and Alexis Ahlstrom; and FEHB—Alexis Ahlstrom.

Impact on State, local, and tribal governments: Leo Lex.

Impact on the private sector: Stuart Hagen.

Estimate approved by: Robert A. Sunshine, Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Authority Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 establishes the short title of the bill as the "Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2003."

Section 2. Findings and purpose

Section 2 states the findings and purpose of the bill.

Section 3. Encouraging speedy resolution of claims

Section 3 states that a health care lawsuit shall 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. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the 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. There is an exception for alleged injuries sustained by a minor before the age of 6, in which case a health care lawsuit may be commenced by or on behalf of the minor until the later of 3 years from the date of manifestation of injury, or the date on which the minor attains the age of 8. This time period is 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. The Committee does not intend the term injury to include business injuries. The term "manifestation of injury" means the injury has become reasonably evident. Thus, if someone unknowingly receives tainted blood, "manifestation of injury" is not the date of receiving the blood. Instead, it is the date on which adverse symptoms become reasonably evident.

Section 4. Compensating patient injury

Section 4 sets forth new guidelines regarding patients' ability to recover for certain types of damages. Subsection 4(a) provides that in any health care lawsuit, nothing in this Act shall limit a claimant's recovery for the full amount of available economic damages, notwithstanding the limitation in subsection (b). Under subsection 4(b), there can be no more than $250,000 in non-economic damages with respect to the same injury.

The cap in this section can apply separately to each party with a direct personal injury. For example, if there is a single class-action lawsuit where a drug manufacturer sold drugs that were taken by several individuals and those individuals suffered adverse events, each of those individuals could receive up to $250,000 in non-economic damages. Similarly, if a pregnant mother and her baby sustain physical injuries during an operation and a health care provider is found liable, then the mother and the baby could each recover damages up to the cap permitted in subsection 4(b).

The Committee notes that the limitation on damages in subsection 4(b) does not necessarily apply per claimant. Under section 9, the term claimant may include numerous parties who do not suffer direct injuries, including parties with derivative claims.

Subsection 4(c) makes clear that courts should apply the $250,000 cap for non-economic damages without calculations that include discounting to present value. Whether a given award below the cap involves discounting, however, remains a function of separate state and Federal law. Juries will not be informed about the maximum award for non-economic damages.

Subsection 4(d) provides that each party shall be liable for the amount of damages allocated to such party. This allocation shall be determined in direct proportion to such party's percentage of responsibility for the damages. The Committee notes that this subsection does not override principles of vicarious liability. Furthermore, the "fair share" rule only applies when a judgment of liability is rendered.

Section 5. Maximizing patient recovery

Section 5 requires that courts supervise the arrangements for payment of damages to protect against conflicts of interests. This section also establishes a sliding fee schedule for the payment of attorneys' contingency fees. Payments are allocated as follows: 40 percent of the first $50,000 recovered by the claimant; 33⅓ percent of the next $50,000 recovered by the claimant; 25 percent of the next $500,000 recovered by the claimant; and 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

The requirements for court supervision in the first paragraph do not apply outside of judicial proceedings. Thus, disputes settled prior to filing a lawsuit would not necessitate court supervision. The sliding fee schedule, by contrast, applies in all cases.

Section 6. Additional health benefits

Section 6 ensures that in any health care lawsuit involving injury or wrongful death, a party may introduce evidence of collateral source benefits received—or reasonably likely to be received—from other parties. This section also restricts a provider of collateral

source benefits from subrogating a claimant's recovery or obtaining any lien or credit against the claimant's damage award.

Section 7. Punitive damages

Section 7 specifies new guidelines for the awarding of punitive damages. Under this section, punitive damages may be awarded, if otherwise permitted by applicable state or Federal law, against any person in a health care lawsuit. The amount of punitive damages awarded may be as high as two times the amount of economic damages awarded or $250,000, whichever amount is greater.

This section does not permit juries to be informed of the formula for calculating punitive damages. Moreover, punitive damages may only be awarded if it is first proven by clear and convincing evidence that a defendant 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. This section states that no demand for punitive damages shall be included in a health care lawsuit as initially filed. Further, punitive damages in healthcare lawsuits may not be awarded if compensatory damages are not awarded.

Paragraph 7(c)(1) shields manufacturers and distributors of medical products from punitive damages in certain instances. The provision is intended to shield those companies that are fully compliant with all Federal Food, Drug, and Cosmetic Act (FFDCA) laws and regulations (in the case of biological medical products, full compliance with the FFDCA and section 351 of the Public Health Service Act (PHSA) is required). The FFDCA ensures the safety and effectiveness of drugs, devices, and biological products, all of which are covered by this section. Unless a claimant can demonstrate by clear and convincing evidence a lack of compliance with any FFDCA or PHSA section 351 law or regulation, then a manufacturer, distributor or supplier is shielded from punitive damages. All other damages, if proven, are still available to the claimant.

Under paragraph 7(c)(1), if a claimant can prove by clear and convincing evidence that a manufacturer, distributor or supplier has not complied with the FFDCA or section 351 of the PHSA, the claimant must then further prove that the harm attributed to the medical product resulted from the proven compliance failure. A technical violation of the Act that is wholly unrelated to the harm will not remove the shield provided for in this section. Rather, punitive damages will only be available to claimants who prove both a violation of the Act or regulations, and then draw the nexus between failed compliance and harm.

Paragraph 7(c)(1) applies to medical products, as defined in section 9. Included in this definition are nonprescription, over-the-counter (OTC) drugs. Many OTC drugs are marketed after approval of a new drug application (NDA) or abbreviated new drug application (ANDA). Many OTC drugs are also marketed pursuant to monographs or tentative final monographs promulgated by the Agency. While a final monograph is a regulation, a tentative final monograph represents the Agency's current position on the requirements for safe and effective labeling, formulation and marketing of the OTC drug product. In some instances, tentative final monographs have been in existence for decades, yet have never been finalized. Companies follow these so-called "tentative" monographs

and deliver safe and effective drug products. The Committee believes that the mere fact that the FDA has not taken the last step to finalize monographs in existence for decades should not preclude a manufacturer, distributor or supplier of such products from claiming the protections afforded by section 7(c).

Subsection 7(c) does not create an affirmative obligation on the part of the FDA to demonstrate compliance or noncompliance for the purposes of private litigation. The section also revokes the shield for persons: (1) who knowingly misrepresent information to the FDA; (2) who bribe government officials for the purpose of obtaining approval of medical products; or, (3) who prevent governmental enforcement actions.

Paragraph 7(c)(2) prohibits a health care provider who prescribes, or who dispenses pursuant to a prescription, a medical product that is approved by the FDA from being named as a party in a product liability lawsuit. Nothing in the paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims.

Section 8. Authorization of payment of future damages to claimants in health care lawsuits

Section 8 requires the court, at the request of any party, to order that the award of future damages equaling or exceeding $50,000 be paid by periodic payments.

Section 9. Definitions

Section 9 defines many of the terms included in the legislation. The term "health care lawsuit" does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State or local government; which is grounded in antitrust; or in which the dispute is over the price of health care goods or services. The latter exclusion addresses cases concerning price-fixing or over charging, not cases involving personal injury. Finally, the Committee intends the term "health care goods and services" to include those involving "the assessment or care of the health of human beings." Such terms include the monitoring, supervision, and provision of direct assistance to claimants.

Section 10. Effect on other laws

Section 10 states that this legislation does not apply to civil actions brought for a vaccine-related injury or death which is covered under provisions of the Public Health Service Act. It also states that nothing in the Act should 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 state's rights

Section 11 specifies many of the rules governing the relationship between the HEALTH Act and state and Federal laws. Specifically, subsection 11(a) provides that provisions governing health care lawsuits outlined in the legislation preempt state law to the extent that state law prevents the application of these provisions. The legislation also supersedes the Federal Tort Claims Act (FTCA) to the extent that the FTCA 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 application of periodic payments of future damages. The FTCA is also superseded if it prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

Under subsection 11(b), if an issue is not addressed by a provision of law established by this legislation, it shall be governed by otherwise applicable state or Federal law. The subsection further states that the Act does not preempt or supersede any law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages.

Subsection 11(c) states that this legislation does not preempt any state law (enacted before, on, or after the date of enactment of H.R. 5) that specifies a particular amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit. The subsection also provides that the Act does not preempt any defense available to a party in a health care lawsuit under any other provision of state or Federal law.

Finally, the Committee notes the interrelationship of a number of provisions of H.R. 5. H.R. 5 does not create a cause of action or provide for a remedy or recovery that is not available or permitted under other provisions of applicable law. Moreover, any protections, defenses, or restrictions that are legally enforceable or available under contracts would still apply. Before applying the provisions of H.R. 5, courts should first review the law applicable to the appropriate claim or cause of action without reference to H.R. 5. Courts should then apply the limitations of H.R. 5 where appropriate.

Section 12. Applicability; effective date

Section 12 states that the provisions of the legislation apply to any health care lawsuit brought in Federal or state court, or subject to alternative dispute resolutions system, that is initiated on or after the date of the enactment of the Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of the Act is governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Section 13. Sense of Congress

Section 13 states 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. Because section 13 is a sense of Congress, this provision has no direct legal impact.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

This legislation does not amend any existing Federal statute.

DISSENTING VIEWS

We are concerned that many health care providers face difficulty obtaining reasonably priced medical malpractice insurance. This is a serious problem that could restrict patient access to care, and it merits attention. The Majority, however, rushed this legislation through the Committee in a partisan fashion. The legislation is unclear with respect to many important points of law, and it does not reflect a deliberative effort to craft a comprehensive and workable legislative solution. Since H.R. 5 would preempt the tort laws of all 50 states, its poorly drafted and ambiguous provisions will lead to excessive litigation for years to come.

The Subcommittee on Health held only one hearing on this matter in February. The Subcommittee received testimony about the detrimental effect this legislation would have on injured patients, the need to understand all factors that contribute to insurance premium increases, and the confusion resulting from many unclear provisions of the bill. Minimal changes were made to the legislation, leaving many questions unanswered. During full Committee Markup, every one of over a dozen amendments offered by the Minority was defeated on a partisan basis. This was not a process of bipartisan collaboration nor one that would lend itself to addressing the problem thoroughly. The legislation is now being rushed to the House Floor less than one week after being reported.

The bill offers a "solution" prior to having discovered the root of the problem. Instead of reducing the occurrence of frivolous lawsuits, providing direct assistance to health care providers and communities, and examining every aspect of the problem, this legislation restricts the legal rights of those who have been truly wronged.

We do not dispute that there is a problem. Providers have seen insurance rates increase dramatically in recent years, and some specialties are finding it impossible to secure coverage. The situation is leaving doctors with few options. Those who can afford it will pay the increased cost of providing medical services. Those who cannot afford the increase are forced to assume significant personal liability, leave high-risk specialties, or leave the profession altogether. At best, health care will become more expensive for patients. At worst, in addition to higher prices, patients will be denied access to care, and lifesaving treatments will not be provided.

While the rising cost of malpractice insurance is a real concern for doctors and patients alike, we have serious reservations about the proposed "solution" for three primary reasons. *First,* what has caused the increase in malpractice insurance premiums is not easily identified. Moreover, it is not clear that this legislation will reduce the medical malpractice premiums that providers must pay to insurance companies. *Second,* the scope and severity of the provisions in H.R. 5 impose unreasonable restrictions on an injured pa-

tient's ability to hold wrongdoers accountable. *Third,* the legislation is over-broad, protecting the interests of large corporations, such as Health Maintenance Organizations (HMO's) and drug companies, at the expense of health care providers and patients. The legislation provides nothing more than a shield for bad actors rather than meaningful reforms for overburdened doctors and providers.

To find an effective solution, we must closely examine the insurance industry and how its conduct affects medical malpractice premiums, an activity not undertaken by this Committee. We know that many factors completely unrelated to jury verdicts and the civil justice system affect insurance rates: changes in state law and regulatory requirements; competitiveness of the insurance market; the types of policies issued within the industry; interest rates; and national economic trends. Moreover, there is scant evidence to date that various state tort reforms have realized appreciable premium savings. In a comparison of states that enacted severe tort restrictions during the mid-1980's and those that resisted enacting tort reform, a recent study found no correlation between tort reform and insurance rates.

Insurance markets are subject to cycles, periods of underpricing of premiums to increase market share and book premium dollars, followed by a hardening of the market. Once the market hardens, competition intensifies, underwriting results deteriorate, and investment incomes fall. Insurance companies then need to raise premiums to cover losses. We are now in the midst of a "hard" phase of the insurance cycle and increases in malpractice premiums are consistent with overall market trends. This problem is not unique to malpractice insurance. While medical malpractice insurance premiums for the three riskiest specialties increased 10% from 2000 to 2001, auto insurance premiums saw similar increases of 8.4% during that same period.

A serious effort to provide relief to providers from high malpractice premiums would have looked at these and other issues. A number of Congressional Democrats have requested the General Accounting Office look into these questions. The Committee, however, chose to take a one-sided approach. Reps. Brown, Pallone, and Capps offered amendments that would encourage insurance reforms both on the state and federal levels. Each of those amendments was defeated on a partisan basis. Rep. Dingell offered an amendment in the nature of a substitute during the full Committee Markup of H.R. 5. The Democratic substitute would have provided direct assistance to health care providers and communities, reduced frivolous lawsuits, and established an independent advisory commission to thoroughly examine the problem and propose long-term solutions. It was also defeated on a partisan basis.

There are many flaws in the legislation, but our dissenting views will focus on three of the most egregious: the cap on non-economic damages, the cap on punitive damages, and the overly restrictive and ambiguous statute of limitations.

NON-ECONOMIC DAMAGES

H.R. 5 limits non-economic damages to $250,000 for all claims against negligent hospitals and doctors, drug and device manufacturers, nursing homes, HMOs and other insurers. This cap is an

aggregate cap; no matter how many defendants participated in causing the injury or the severity of the injury, the most an injured patient can recover is $250,000. Non-economic damages compensate patients for very real injuries such as the loss of a limb or eyesight, the loss of mobility, the loss of brain or organ function, the loss of fertility, severe disfigurement and excruciating, chronic pain. Juries are not informed of this cap, presumably because proponents of this legislation do not want them to compensate for such a harsh limit by increasing the amount of damages in other areas.

The severity of this cap is astounding. The intent is to parallel the cap in California's MICRA law, which was enacted in 1975 and never indexed to inflation. The value of this cap has declined to a mere $40,389 in 2002 dollars. Using the Consumer Price Index for medical care, this cap today would be more than $1,500,000. In addition, the California law only applies to medical malpractice cases and not claims against drug and device manufacturers, HMO's, insurance companies, or nursing homes covered under H.R. 5. Rep. Rush offered an amendment that would have indexed the cap to the rate of inflation, and Rep. Pallone offered an amendment that would have prohibited HMO's and drug and device manufacturers from benefiting from the protections of this legislation. Both amendments were defeated on a partisan basis.

In addition, by capping non-economic damages, H.R. 5 discriminates against women, children, the elderly, minorities, the unemployed and others who cannot show substantial economic loss (e.g., lost wages or salary). A child who suffers brain damage or other catastrophically debilitating injury would recoup little in economic damages, and would be left with a maximum of $250,000 for the remainder of his life, which could exceed 70 or 80 years.

Non-economic damages are also an important measure of compensatory damages for older persons, and in particular nursing facility residents. These individuals have neither long life expectancies nor large earning capacities, the traditional measures of economic damages. By so stringently limiting non-economic damages, H.R. 5 would remove a strong financial incentive to nursing facilities to provide residents with decent care. Rep. DeGette offered an amendment to remove the cap on non-economic damages from the bill, and Ms. Schakowsky offered an amendment that prohibited nursing homes from benefitting from the protections of the legislation. Both amendments were defeated on party-line votes.

PUNITIVE DAMAGES

The legislation sets a nearly impossible standard for awarding punitive damages and then limits such damages to twice economic damages or $250,000, whichever is greater. By basing punitive damages on the level of economic losses, the bill discriminates against injured women, children, elderly and others who tend to have lower incomes. For example, if a CEO of one of the drug companies that this legislation protects were injured, his economic damages would be worth millions upon millions of dollars. If a stay-at-home mother were injured, she would have minimal economic damages awarded to her.

In order to assess punitive damages, H.R. 5 imposes a federal standard of "clear and convincing" evidence that (1) the defendant

acted with malicious intent to injure or (2) the defendant understood the plaintiff was substantially certain to suffer unnecessary injury yet deliberately failed to avoid such injury. This standard of "malicious intent" requires more than criminal misconduct; such a standard would likely protect a drunk doctor who kills a patient because a court would likely hold that the doctor was unable to form the necessary intent.

The bill also could increase the length and cost of malpractice actions because it prohibits plaintiffs from seeking punitive damages in an initial suit. Only at the court's discretion, after a finding by the court that there is a substantial probability that the plaintiff will prevail, may the plaintiff file an amended proceeding to request punitive damages be awarded. This requirement for a separate proceeding in essence turns one trial into two.

STATUTE OF LIMITATIONS

H.R. 5 also sets a stringent federal statute of limitations on state tort cases. The statute of limitations for bringing an action is the earlier of three years after the date of manifestation of injury or one year after the date of discovery, but in no event shall the time for commencement of a lawsuit exceed three years. This provision also was subject to considerable debate in Committee, with particular focus on the meaning of manifestation. Proponents of the legislation were not certain what manifestation meant, but referred to Blacks Law Dictionary for guidance. In response to questioning by Rep. Dingell, Legislative Counsel noted that manifestation is not a term used in Federal law nor is it defined in the legislation. Since H.R. 5 includes one time frame from the reasonable discovery of an injury (one year) and a separate time frame from the manifestation of an injury (three years), manifestation of an injury must be something different than the reasonable discovery of that injury. Exactly what manifestation means remains unanswered.

While some injuries are discovered immediately, often malpractice or product defects are not discovered or diagnosed for some time. For example, a hemophiliac who contracts HIV from tainted blood may not learn of the disease until five years later. Certainly it can be argued that HIV may manifest itself long before anyone could reasonably be expected to discover that injury. By establishing an absolute time limit for filing a case, this legislation would completely preclude many injured patients from any recourse and would therefore shield negligent practitioners, facilities, and manufacturers from any liability whatsoever. Moreover, use of the ambiguous term, manifestation, will lead to years of excessive and unnecessary litigation in both state and Federal courts. Rep. Engel offered an amendment to replace the statute of limitations with a clear and equitable alternative that was defeated on a party-line vote.

DEMOCRATIC SUBSTITUTE

Unlike H.R. 5, the Democratic substitute directly addressed the needs of health care providers. Unlike H.R. 5, the Democratic substitute directly addressed the issue of frivolous law suits. Unlike H.R. 5, the Democratic substitute sought to find the true causes

and the best long-term solutions to this problem by establishing an independent advisory commission.

The scope of liability reforms in the Democratic substitute were limited to hospitals, physicians, nurses and other health professionals who pay malpractice insurance premiums. Unlike H.R. 5, it did not protect HMO's, insurance companies and drug and device manufacturers.

The amendment established an equitable statute of limitations that would begin three years from the date an injury is discovered or reasonably should have been discovered. For children who discover their injury while under the age of 18, they would have three years after turning 18 to file an action.

As officers of the court, attorneys have an obligation to keep frivolous law suits from clogging the system. The Democratic substitute would have expanded that obligation by requiring attorneys to certify affirmatively that each of their medical malpractice actions has merit. If an attorney files a false certificate, the attorney would be subject to strict penalties by the courts. Unlike H.R. 5, this provision directly addresses the problem of frivolous law suits.

The Democratic substitute would have also limited the circumstances under which punitive damages can be awarded to the most egregious of circumstances—gross negligence, reckless indifference to life, or intentional acts such as intoxication or sexual abuse. If punitive damages are awarded, half of the proceeds will be directed into a fund to reduce medical errors and improve patient safety.

Where H.R. 5 does not provide any direct assistance to health care providers, the Democratic substitute included three provisions that were designed to help providers with their malpractice insurance costs. The first provision required malpractice insurance companies to pass along at least half of any savings achieved from this legislation to physicians on an annual basis. The second provision provided grants and contracts administered through the Department of Health and Human Services (HHS) to assist geographical regions of the country that are experiencing a shortage of physicians due to increased malpractice insurance costs. The third provision allowed HHS to send physicians from the National Health Service Corps to trauma centers that are about to close because of increased malpractice insurance costs.

To conclude, the legislation before us today focuses on drastic reforms of the judicial system and extends those draconian reforms beyond the realm of medical malpractice. Rather than focusing on the underlying causes of malpractice premium increases and providing immediate assistance to health care providers, H.R. 5 limits the legal rights of patients with meritorious claims. H.R. 5 also limits the legal rights of providers against insurance companies, HMO's and drug and device manufacturers. As the Democratic amendments demonstrated, any reforms of the judicial system should be narrowly tailored to reduce frivolous lawsuits and add stability to the courts. For example, Rep. Allen offered an amendment to encourage state pre-litigation screening panels, which was defeated on a partisan basis. H.R. 5 restricts claims with merit and brings uncertainty and confusion to the courts that will lead to excessive litigation for years to come.

The rise in malpractice premiums is a real problem that calls for real reform. Failure to examine all aspects of this problem is irresponsible, and in this instance will disproportionately harm women, children, the elderly, and others who are injured. Above all, any legislative solution should strike a careful balance that preserves an injured patient's right to just compensation and the delivery of health care without unreasonable costs of insurance.

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DISSENTING VIEWS

We believe that H.R. 5 is a gross violation of the constitutional concept of federalism. H.R. 5 would make many changes to the common law that severely limit the traditional rights of plaintiffs seeking damages from the malpractice of physicians and negligence from a variety of health related entities including Health Maintenance Organizations and pharmaceutical manufacturers and distributors. This bill is not a matter to be decided by Congress because it proposes tort reforms that are traditionally, and possibly constitutionally, areas for decisions by state legislatures.

Because this issue has a long tradition in the state courts, they have taken a wide variety of views on the issue. In 20 states, courts have ruled that caps on damages are unconstitutional and 18 state courts have ruled that their statutes of limitations are unconstitutional. It is inappropriate for Congress to limit the rights of individuals when state courts have ruled that those rights are protected under state constitutions.

Furthermore, H.R. 5 would make sweeping changes to common law traditions by eliminating joint and several liability, capping the amount of non-economic damages, limiting punitive damages, and severely restricting the time for recovery by victims of medical malpractice. Under common law, defendants are joint and severally liable for harm to plaintiffs to ensure that the victims can actually recover damages for their injuries. Yet, H.R. 5 entirely eliminates joint and several liability for medical malpractice lawsuits, which means victims are less likely to receive compensation for their injuries and the defendants who caused harm are insulted from having to pay for their mistakes.

Additionally, H.R. 5 caps non-economic damages at $250,000 in the aggregate. Non-economic damages compensate victims for injuries that are very real, like the loss of a leg, disfigurement, pain and suffering, and the loss of fertility. Under common law, non-economic damages are not capped. By limiting non-economic damages to $250,000, H.R. 5 ensures that victims receive arbitrary compensation for the horrendous and oftentimes permanent injuries they suffer, rather than allowing a jury to determine the appropriate level of compensation in each individual case.

High malpractice insurance rates are a problem for our nation's physicians. But capping damages to legitimate victims of medical malpractice will not solve the problem of high premiums. We believe other factors—like the cyclical nature of the insurance industry, the management of reserves, and the impact of increased medical costs on the ways that doctors provide care—significantly affect the rates of malpractice insurance. For example, the proponents of HR 5 credit MICRA with stabilizing rates in California. However, there is credible evidence that the stabilization of malpractice insurance rates resulted from the impact on the insurance industry

of Proposition 103, rather than any caps on damages in malpractice lawsuits.

Furthermore, there is no correlation between the level of malpractice insurance rates in a particular state and the caps on damages that state may have. For example, four of the five states with the highest malpractice premiums—Florida, Michigan, Texas, and Illinois—are states that have adopted some level of caps. H.R. 5 will not reduce malpractice insurance premiums for physicians, but it will significantly limit the rights of malpractice victims to receive fair compensation for their harm. We believe that is necessary to conduct a comprehensive examination of the many factors that impact the pricing of insurance rates in order to appropriately address the problem of high malpractice insurance costs.

H.R. 5 is an affront to the rights of states and malpractice victims. While H.R. 5 is silent on the very issue it purports to solve, malpractice insurance rates, it asks victims of medical negligence to accept arbitrary limits on the amount of compensation they may receive for their injuries. Congress should not act as an uber-state legislature by passing a bill to significantly restructure what is most appropriately a matter for state governments and take away the rights of citizens who have been harmed by medical malpractice.

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