I

112TH CONGRESS
1ST SESSION

H. R. 2205

To improve the medical justice system by encouraging the prompt and fair resolution of disputes, enhancing the quality of care, ensuring patient access to health care services, fostering alternatives to litigation, and combating defensive medicine, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 16, 2011

Mr. DENT (for himself and Mr. PAULSEN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To improve the medical justice system by encouraging the prompt and fair resolution of disputes, enhancing the quality of care, ensuring patient access to health care services, fostering alternatives to litigation, and combating defensive medicine, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Ending Defensive Medicine and Encouraging Innovative Reforms Act of 2011''.

SEC. 2. TABLE OF CONTENTS.

The table of contents is as follows:

TITLE I—NATIONWIDE REFORMS

Subtitle A—In General

SEC. 101. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) COMPENSATING PATIENT INJURY.—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 judg-

ment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

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

SEC. 102. 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. 103. CERTIFICATE OF MERIT.

(a) PRELIMINARY PROCEDURE.—Within 30 days of the filing of a health care lawsuit, the court shall appoint a qualified specialist whose appointment is agreed to by

one qualified specialist chosen by the claimant and one qualified specialist chosen by the defendant. If a qualified specialist is not agreed to by the qualified specialist chosen by the claimant and the qualified specialist chosen by the defendant within such 30 days, then the court shall appoint such qualified specialist at its discretion. The qualified specialist appointed by the court shall, within 45 days of such appointment, submit to the court an affidavit that includes such specialist's statement of opinion whether, based on a review of the available medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant. If such specialist does not submit such affidavit to the court within 45 days of such appointment, the court shall dismiss such health care lawsuit. Such affidavit shall also contain a statement by the qualified specialist of specific breaches in the standard of care and the approximate negligence causation. Such affidavit shall not be admissible in any health care lawsuit or other court proceedings, or any arbitration proceeding. However, such affidavit, and information relevant to the determinations made by such specialist in such affidavit, shall be discoverable by the plaintiff and the defendant. In the case of multiple defendants, a separate affidavit shall be required for each defendant. The court shall set a reasonable fee that shall

be paid by the claimant for the preparation of such affidavit by such qualified specialist. The plaintiff's attorney shall be given 90 days to obtain the certificate of merit affidavit in cases where the period to file the claim is due to expire because of the statute of limitations. If a case is filed without a certificate of merit affidavit, dismissal of the case is automatic without an extension permitted under the applicable statute of limitation exemption provision.

(b) LOSER PAYS.—In a health care lawsuit, in the event the statement of opinion by a qualified specialist appointed by the court in an affidavit is that there is no reasonable and meritorious cause for the filing of the action against the defendant, and the claimant does not substantially prevail by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution, the court shall order the claimant, or such claimant's attorneys, to pay the costs and reasonable attorneys fees incurred by the defendant as a direct result of the health care lawsuit in which such qualified specialist's opinion was filed. Claimants and their attorneys shall share liability for such costs and reasonable attorneys fees incurred, as determined by the court in the interests of justice.

(c) DEFINITION.—In this section, the term ''qualified specialist'' means, with respect to a health care lawsuit—

(1) a health care professional who—

(A) is appropriately credentialed or licensed in one or more States to deliver health care services;

(B) typically treats the diagnosis or condition or provides the type of treatment under review;

(C) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the health care professional is substantially familiar with applicable standards of care and practice on the date of the incident as they relate to the act or omission which is the subject of the lawsuit; and

(D) has not been out of practice for more than 5 consecutive years; and

(2) if the claim in the health care lawsuit involved treatment that is recommended or provided by a physician (allopathic or osteopathic), with respect to issues of negligence concerning such treatment, a physician whose medical specialty or subspecialty is the same as the defendant's or in addi-

tion to a showing of substantial familiarity in accordance with this section, there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

SEC. 104. PRACTICE GUIDELINES.

Notwithstanding any other provision of Federal, State, or local law the following shall apply:

(1) In a health care lawsuit or proceeding brought against a health care provider, such provider shall not be liable for the care provided if, in delivering such care, such provider acted consistent with accepted clinical practice guidelines established by the specialty of which the defendant is board certified or if guidelines established by the specialty are not available, accepted clinical practice guideline listed in the National Guideline Clearinghouse. Noncompliance with accepted clinical practice guidelines established by the specialty of which the defendant is board certified, or if guidelines established by the specialty are not available, accepted clinical practice guidelines listed in the National Guideline Clearinghouse shall not, in a health care lawsuit or proceeding brought against a health care provider, constitute a breach of the applicable medical standard of care, or be otherwise admissible to prove a breach

of the standard of care, negligence or other tortious conduct.

(2) Compliance or non-compliance with regulations, directives, or guidelines established by or on behalf of the Secretary of Health and Human Services pursuant to authority set forth in title XVIII of the Social Security Act (42 U.S.C. 1395–1395ccc) shall not, in a health care lawsuit or proceeding brought against a health care provider, constitute a breach of the medical standard of care, or be otherwise admissible to prove a breach of the medical standard of care, negligence or other tortious conduct.

(3) Compliance or non-compliance with regulations, directives, or guidelines established by or on behalf of the Secretary of Health and Human Services or any State official or entity administering Medicaid programs under title XIX of the Social Security Act (42 U.S.C. 1396–1396v) and Children's Health Insurance Programs under title XXI of the Social Security Act (42 U.S.C. 1397aa–1397jj) shall not, in a health care lawsuit or proceeding brought against a health care provider, constitute a breach of the applicable medical standard of care, or be other-

wise admissible to prove a breach of the standard of care, negligence or other tortious conduct.

(4) Compliance or non-compliance with Comparative Effectiveness Research and any regulations, directives, or guidelines based in whole or in part upon such research shall not, in a health care lawsuit or proceeding brought against a health care provider, constitute a breach of the applicable medical standard of care, or be otherwise admissible to prove the medical standard of care, negligence or other tortious conduct.

SEC. 105. PAYMENT DETERMINATION.

Notwithstanding any other provision of Federal, State, or local law the following shall apply:

(1) Evidence of payments and reimbursements made to health care providers pursuant to title XVIII of the Social Security Act (42 U.S.C. 1395–1395ccc) and evidence of payment rates, payment mechanisms, and payment policies established on or behalf of the Secretary of Health and Human Services for services provided pursuant to the programs set forth in title XVIII of the Social Security Act (42 U.S.C. 1395–1395ccc) shall not, in a health care lawsuit or proceeding brought against a health care provider, constitute a determination that a health

care provider has or has not met the medical standard of care or be otherwise admissible to prove breach of the medical standard of care, negligence or other tortious conduct.

(2) Compliance or non-compliance with payment rates, payment mechanisms, or payment policies established by or on behalf of the Secretary of Health and Human Services or any State official or entity administering Medicaid programs under title XIX of the Social Security Act (42 U.S.C. 1396–1396v) and Children's Health Insurance Programs under title XXI of the Social Security Act (42 U.S.C. 1397aa–1397jj) shall not, in a health care lawsuit or proceeding brought against a health care provider, constitute a determination that a health care provider has or has not met the applicable medical standard of care or be otherwise admissible to prove a breach of the medical standard of care, negligence or other tortious conduct.

SEC. 106. DEFINITIONS.

In this subtitle:

(1) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services or any medical product affecting inter-

state commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. 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; or which is grounded in antitrust.

(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) HEALTH CARE PROVIDER.—The term 'health care provider' means any person or entity—

(A) required by State or Federal law or regulations to be licensed, registered, or certified to provide health care services; and

(B) being either so licensed, registered, or certified, or exempted from such requirement by other law or regulation.

Subtitle B—Safety Net Providers

SEC. 121. PROTECTION FOR EMERGENCY AND RELATED SERVICES FURNISHED PURSUANT TO EMTALA.

Section 224(g) of the Public Health Service Act (42 U.S.C. 233(g)) is amended—

(1) in paragraph (4), by striking ''An entity'' and inserting ''Subject to paragraph (6), an entity''; and

(2) by adding at the end the following:

''(6)(A) For purposes of this section—

''(i) an entity described in subparagraph (B) shall be considered to be an entity described in paragraph (4); and

''(ii) the provisions of this section shall apply to an entity described in subparagraph (B) in the same manner as such provisions

apply to an entity described in paragraph (4), except that—

"(I) notwithstanding paragraph (1)(B), the deeming of any entity described in subparagraph (B), or of an officer, governing board member, employee, contractor, or on-call provider of such an entity, to be an employee of the Public Health Service for purposes of this section shall apply only with respect to items and services that are furnished to an individual pursuant to section 1867 of the Social Security Act and to post stabilization services (as defined in subparagraph (D)) furnished to such an individual;

"(II) nothing in paragraph (1)(D) shall be construed as preventing a physician or physician group described in subparagraph (B)(ii) from making the application referred to in such paragraph or as conditioning the deeming of a physician or physician group that makes such an application upon receipt by the Secretary of an application from the hospital or emergency department that employs or contracts with

the physician or group, or enlists the physician or physician group as an on-call provider;

''(III) notwithstanding paragraph (3), this paragraph shall apply only with respect to causes of action arising from acts or omissions that occur on or after January 1, 2010;

''(IV) paragraph (5) shall not apply to a physician or physician group described in subparagraph (B)(ii);

''(V) the Attorney General, in consultation with the Secretary, shall make separate estimates under subsection (k)(1) with respect to entities described in subparagraph (B) and entities described in paragraph (4) (other than those described in subparagraph (B)), and the Secretary shall establish separate funds under subsection (k)(2) with respect to such groups of entities, and any appropriations under this subsection for entities described in subparagraph (B) shall be separate from the amounts authorized by subsection (k)(2);

"(VI) notwithstanding subsection (k)(2), the amount of the fund established by the Secretary under such subsection with respect to entities described in subparagraph (B) may exceed a total of $10,000,000 for a fiscal year; and

"(VII) subsection (m) shall not apply to entities described in subparagraph (B).

"(B) An entity described in this subparagraph is—

"(i) a hospital or an emergency department to which section 1867 of the Social Security Act applies; and

"(ii) a physician or physician group that is employed by, is under contract with, or is an on-call provider of such hospital or emergency department, to furnish items and services to individuals under such section.

"(C) For purposes of this paragraph, the term 'on-call provider' means a physician or physician group that—

"(i) has full, temporary, or locum tenens staff privileges at a hospital or emergency department to which section 1867 of the Social Security Act applies; and

''(ii) is not employed by or under contract with such hospital or emergency department, but agrees to be ready and available to provide services pursuant to section 1867 of the Social Security Act or post stabilization services to individuals being treated in the hospital or emergency department with or without compensation from the hospital or emergency department.

''(D) For purposes of this paragraph, the term 'post stabilization services' means, with respect to an individual who has been treated by an entity described in subparagraph (B) for purposes of complying with section 1867 of the Social Security Act, services that are—

''(i) related to the condition that was so treated; and

''(ii) provided after the individual is stabilized in order to maintain the stabilized condition or to improve or resolve the condition of the individual.

''(E)(i) Nothing in this paragraph (or in any other provision of this section as such provision applies to entities described in subparagraph (B) by operation of subparagraph (A)) shall be construed as authorizing or requiring the Secretary to make pay-

ments to such entities, the budget authority for which is not provided in advance by appropriation Acts.

''(ii) The Secretary shall limit the total amount of payments under this paragraph for a fiscal year to the total amount appropriated in advance by appropriation Acts for such purpose for such fiscal year. If the total amount of payments that would otherwise be made under this paragraph for a fiscal year exceeds such total amount appropriated, the Secretary shall take such steps as may be necessary to ensure that the total amount of payments under this paragraph for such fiscal year does not exceed such total amount appropriated.''.

Subtitle C—Community Health Center Volunteers

SEC. 131. PROTECTION FOR HEALTH CENTER VOLUNTEER PRACTITIONERS.

(a) IN GENERAL.—Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended—

(1) in subsection (g)(1)(A)—

(A) in the first sentence, by striking ''or employee'' and inserting ''employee, or (subject to subsection (k)(4)) volunteer practitioner''; and

(B) in the second sentence, by inserting ''and subsection (k)(4)'' after ''subject to paragraph (5)''; and

(2) in each of subsections (g), (i), (j), (k), (l), and (m)—

(A) by striking the term ''employee, or contractor'' each place such term appears and inserting ''employee, volunteer practitioner, or contractor'';

(B) by striking the term ''employee, and contractor'' each place such term appears and inserting ''employee, volunteer practitioner, and contractor'';

(C) by striking the term ''employee, or any contractor'' each place such term appears and inserting ''employee, volunteer practitioner, or contractor''; and

(D) by striking the term ''employees, or contractors'' each place such term appears and inserting ''employees, volunteer practitioners, or contractors''.

(b) APPLICABILITY; DEFINITION.—Section 224(k) of the Public Health Service Act (42 U.S.C. 233(k)) is amended by adding at the end the following paragraph:

''(4)(A) Subsections (g) through (m) apply with respect to volunteer practitioners beginning with the first fiscal year for which an appropriations Act provides that amounts in the fund under paragraph (2) are available with respect to such practitioners.

''(B) For purposes of subsections (g) through (m), the term 'volunteer practitioner' means a practitioner who, with respect to an entity described in subsection (g)(4), meets the following conditions:

''(i) In the State involved, the practitioner is a licensed physician, a licensed clinical psychologist, or other licensed or certified health care practitioner.

''(ii) At the request of such entity, the practitioner provides services to patients of the entity, at a site at which the entity operates or at a site designated by the entity. The weekly number of hours of services provided to the patients by the practitioner is not a factor with respect to meeting conditions under this subparagraph.

''(iii) The practitioner does not for the provision of such services receive any compensation from such patients, from the entity, or from third-party payers (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program).''.

Subtitle D—Disaster Relief Volunteers

SEC. 141. PROTECTION FOR DISASTER RELIEF VOLUNTEERS.

(a) LIABILITY OF DISASTER RELIEF VOLUNTEERS.—A disaster relief volunteer shall not be liable for any injury (including personal injury, property damage or loss, and death) caused by an act or omission of such volunteer in connection with such volunteer's providing or facilitating the provision of disaster relief services if—

(1) the injury was not caused by willful, wanton, or reckless misconduct by the volunteer; and

(2) the injury was not caused by the volunteer's operating a motor vehicle, vessel, aircraft, or other vehicle for which the state requires the operator or the owner of the vehicle, craft, or vessel to—

(A) possess an operator's license; or

(B) maintain insurance.

(b) LIABILITY OF EMPLOYER OR PARTNER OF DISASTER RELIEF VOLUNTEER.—An employer or business partner of a disaster relief volunteer shall not be liable for any act or omission of such volunteer in connection with such volunteer's providing or facilitating the provision of disaster relief services.

(c) LIABILITY OF HOST OR ENABLING PERSON, ENTITY, OR ORGANIZATION.—A person or entity, including a governmental entity, that works with, accepts services from, or makes its facilities available to a disaster relief volunteer to enable such volunteer to provide disaster relief services shall not be liable for any act or omission of such volunteer in connection with such volunteer's providing such services.

(d) LIABILITY OF NONPROFIT ORGANIZATIONS.—A nonprofit organization shall not be liable for any injury (including personal injury, property damage or loss, and death) caused by an act or omission in connection with such nonprofit organization's providing or facilitating the provision of disaster relief services if the injury was not caused by willful, wanton, or reckless misconduct by the nonprofit organization.

(e) LIABILITY OF GOVERNMENTAL AND INTERGOVERNMENTAL ENTITIES FOR DONATIONS OF DISASTER RELIEF GOODS.—A governmental or intergovernmental entity that donates to an agency or instrumentality of the United States disaster relief goods shall not be liable for any injury (including personal injury, property damage or loss, and death) caused by such donated goods if the injury was not caused by willful, wanton, or reckless mis-

conduct by such governmental or intergovernmental entity.

(f) LIMITATION ON PUNITIVE AND NONECONOMIC DAMAGES BASED ON ACTIONS OF DISASTER RELIEF VOLUNTEERS AND GOVERNMENTAL DONORS.—

(1) PUNITIVE DAMAGES.—Unless the claimant establishes by clear and convincing evidence that its damages were proximately caused by willful, wanton, or reckless misconduct by either—

(A) a disaster relief volunteer in any civil action brought for injury caused by the volunteer's providing or facilitating the provision of disaster relief services; or

(B) a governmental or intergovernmental entity in any civil action brought for injury caused by disaster relief goods donated by such governmental or intergovernmental entity;

punitive damages may not be awarded in any civil action against such a volunteer or governmental entity.

(2) NONECONOMIC DAMAGES.—

(A) GENERAL RULE.—In any civil action brought against—

(i) a disaster relief volunteer for injury caused by such volunteer's providing

or facilitating the provision of disaster relief services; or

(ii) a governmental or intergovernmental entity for injury caused by disaster relief goods donated by such governmental entity;

liability for noneconomic loss, if permitted under subsection (a) or (e) of this section, shall be determined in accordance with this subparagraph.

(B) AMOUNT OF LIABILITY.—(i) The amount of noneconomic loss allocated to the disaster relief volunteer or governmental or intergovernmental entity defendant shall be in direct proportion to the percentage of responsibility of that defendant (determined in accordance with clause (ii)) for the harm to the claimant with respect to which that defendant is liable. The court shall render a separate judgment against each defendant in an amount determined pursuant to this section.

(ii) For purposes of determining the amount of noneconomic loss allocated to a defendant, the trier of fact shall determine the percentage of responsibility of each person or

entity responsible for the claimant's harm, whether or not such person or entity is a party to the action.

(g) CONSTRUCTION.—Nothing in this section shall be construed to abrogate or limit any protection that a volunteer, as defined in the Volunteer Protection Act of 1997 (42 U.S.C. 14501 et seq.), may be entitled to under that Act. Neither shall anything in this section be construed to confer any private right of action or to abrogate or limit any protection with respect to either liability or damages that any disaster relief volunteer or governmental or intergovernmental entity may be entitled to under any other provision of law.

(h) SUPPLEMENTAL DECLARATION.—If a Disaster Declaration is issued, the President, the Secretary of Health and Human Services, or the Secretary of Homeland Security may issue a Supplemental Declaration under this section.

(1) TEMPORAL EFFECT.—Such Supplemental Declaration may provide that, for purposes of this section, such Disaster Declaration shall have such temporal effect as the President or the Secretary may deem necessary or appropriate to further the public interest, including providing that such Disaster Declaration shall have an effective date earlier

than the date of the declaration or determination of such Disaster Declaration.

(2) GEOGRAPHIC AND OTHER CONDITIONS.—Such Supplemental Declaration may provide that, for purposes of this section, such Disaster Declaration shall have such geographic or other conditions as the President or the Secretary may deem necessary or appropriate to further the public interest.

(i) LICENSING, CERTIFICATION, AND AUTHORIZATION.—This section shall not apply to a disaster relief volunteer where the disaster relief service such volunteer provides is of a type that generally requires a license, certificate, or authorization, and the disaster relief volunteer lacks such license, certificate, or authorization, unless—

(1) such volunteer is licensed, certified, or authorized to provide such services in any State to the extent required, if any, by the appropriate authorities of that State, even if such State is not the State in which the disaster relief volunteer provides disaster relief services; or

(2) otherwise specified in a Disaster Declaration or Supplemental Declaration under this section.

(j) DEFINITIONS.—For purposes of this section:

(1) The term ''Disaster Declaration'' means—

(A) a public health emergency declaration by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. 247d);

(B) a declaration of a public health emergency or a risk of such emergency as determined by the Secretary of Homeland Security in accordance with clause (i) or clause (ii) of section 2811(b)(3)(A) of such Act (42 U.S.C. 300hh–11(b)(3)(A)) and section 503(5) of the Homeland Security Act of 2002 (6 U.S.C. 313(5)); or

(C) an emergency or major disaster declaration by the President under section 401 or 501 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170 or 5191).

(2) The term ''disaster relief volunteer'' means an individual who provides disaster relief services in connection with a Disaster Declaration without expectation or receipt of compensation in exchange for providing such services.

(3) The term ''disaster relief services'' means services or assistance provided in preparation for, response to, or recovery from any event that is the

subject of a Disaster Declaration, including but not limited to health, medical, fire fighting, rescue, reconstruction, and any other services or assistance specified by a Supplemental Declaration under this section as necessary or desirable to prepare for, respond to, or recover from an event that is the subject of a Disaster Declaration.

(4) The term ''disaster relief good'' means either—

(A) those goods provided in preparation for, response to, or recovery from any event that is the subject of a Disaster Declaration and reasonably necessary to such preparation, response, or recovery; or

(B) those goods defined by a Disaster Declaration or Supplemental Declaration under this section.

(5) The term ''noneconomic loss'' means losses 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.

(6) 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, any other territory or possession of the United States, or any political subdivision of any such State, territory, or possession, and (for purposes of subsection (h)) any foreign country.

(7) The term ''compensation'' means monetary or other compensation of any kind provided in exchange for an individual's services, but does not include—

(A) reasonable reimbursement or allowance for expenses actually incurred by such an individual;

(B) provision of reasonable supplies, lodging, or transportation to such an individual; or

(C) such an individual's ordinary salary or compensation paid by his or her employer while such individual is on leave from his or her ordinary duties with such employer in order to provide disaster relief services.

TITLE II—STATE REFORM INCENTIVES

SEC. 201. PUBLIC HEALTH SERVICE ACT AMENDMENT.

The Public Health Service Act is amended by adding at the end the following:

"TITLE XXXIV—MEDICAL LIABILITY ALTERNATIVES

"Subtitle A—Incentive Payments

"SEC. 3401. INCENTIVE PAYMENTS FOR MEDICAL LIABILITY REFORM.

''(a) ELIGIBILITY.—A State that has enacted and is implementing an alternative medical liability law is eligible to receive an incentive payment in an amount determined by the Secretary, subject to the availability of appropriations for that purpose.

''(b) CONTENTS OF ALTERNATIVE MEDICAL LIABILITY LAW.—An alternative medical liability law shall contain any one or a combination of the following litigation alternatives:

''(1) EARLY OFFER.—Within a time period to be determined by the State, a health care provider may offer to pay economic damages to an injured party. The injured party must be provided an equal amount of time to accept or reject the offer. Notification would not constitute an admission of liability.

Evidence of an offer would be inadmissible in a health care lawsuit. Providers should be incentivized to make good faith offers as early as possible and patients should be incentivized to accept legitimate offers of compensation.

''(2) HEALTHCARE COURT.—Health Courts would provide a forum, either a bench or jury trial, where medical liability actions could be heard by judges specially trained in medical liability matters and who hear only medical liability cases.

''(3) I'M SORRY PROVISION.—In any medical liability action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, fault, or a general sense of benevolence which are made by a healthcare provider to the plaintiff or a relative of the plaintiff which relate solely to the discomfort, pain, suffering, injury, or death as the result of the unanticipated outcome of the medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

''(4) VOLUNTARY ALTERNATIVE DISPUTE RESOLUTION.—Alternatives to medical liability trials would be pursued through binding and nonbinding dispute processes and techniques, including but not

limited to mediation and arbitration. Mediation is a private, facilitated negotiation in which parties discuss their dispute with the help of a neutral third party, whose role is to help the parties communicate with one another to reach an agreement or settlement. Arbitration is different from mediation in that the neutral arbitrator actually has the authority to make a decision about the dispute.

''(5) EXPERT WITNESS QUALIFICATIONS.—Amendments to State statutory qualifications for those who may serve as medical expert witnesses at trial, including the creation of additional standards that medical expert witnesses must meet in order to ensure the testimony juries receive is presented by an individual with particularized expertise in the matter in question.

''(6) OTHER ALTERNATIVES APPROVED BY THE SECRETARY.—Any other alternative the Secretary approves by rule as carrying out the purposes of this subtitle.

''(c) USE OF INCENTIVE PAYMENTS.—The State shall, not later than 3 years after receipt of an incentive payment under this title, use that incentive payment to improve health care in that State.

"SEC. 3402. STATE REPORTS.

"(a) DUTY TO REPORT.—Each State that accepts an incentive payment under this title shall thereafter submit annual reports to the Secretary describing the progress of that State in the implementation of that State's alternative medical liability law.

"(b) REQUIRED CONTENTS OF REPORTS.—Each such report shall contain, for the period covered by the report—

"(1) the number of health care lawsuits initiated in the State;

"(2) the average amount of time taken to resolve each lawsuit that is resolved in the State; and

"(3) the average cost of malpractice insurance in the State.

"SEC. 3403. REPORTS BY SECRETARY TO CONGRESS.

"(a) ANNUAL REPORTS BY SECRETARY.—Beginning not later than one year after the date of the enactment of this title, the Secretary shall submit to Congress an annual report on the effect of the laws of each State that has received an incentive payment under this title in restoring reliability to that State's medical justice system. Such report shall include any determination made by the Secretary under subsection (b).

"(b) DETERMINATION OF EFFECTIVENESS OF LAWS.—

''(1) GENERAL RULE.—Except as provided in paragraph (2), after a State makes 3 reports under section 3402, the Secretary shall determine whether, during the period covered by such reports, those laws have brought about—

''(A) a reduction in the number of health care lawsuits initiated in the State;

''(B) a reduction in the amount of time required to resolve lawsuits in the State; and

''(C) a reduction in the cost of malpractice insurance in the State.

''(2) EXCEPTION.—If the Secretary finds that litigation about the implementation of a State's alternative medical liability laws has prevented those laws from having their expected effect, the Secretary may defer making the determination under paragraph (a) until the Secretary finds that 3 years have passed since that litigation ceased preventing those laws from having their expected effect.

''SEC. 3404. APPLICATION OF SUBTITLE B TO STATES WITH INEFFECTIVE LAWS.

''(a) GENERAL RULE.—Except as otherwise provided in this section, if the Secretary determines under section 3403(b) that a State's alternative medical liability laws have not brought about the results described in that sec-

tion, beginning on the first day of the next succeeding year after that determination, that State, and any health care lawsuit commenced under the law of that State on or after that day, shall be subject to the provisions of subtitle B.

''(b) STATUTE OF LIMITATION FOR CERTAIN CASES.—Any health care lawsuit commenced in a State while that State is subject to subtitle B, but arising from an injury that occurred before subtitle B began to apply in that State, shall continue to be governed by the statute of limitations in effect at the time the injury occurred.

''SEC. 3405. APPLICATION REQUIRED FOR PAYMENT.

''(a) APPLICATION REQUIRED.—Each State seeking an incentive payment under this title shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(b) TIME LIMIT FOR SUBMISSION OF APPLICATIONS.—The Secretary may not accept any application under this subtitle later than 5 years after the date of the enactment of this Act.

''SEC. 3406. TECHNICAL ASSISTANCE.

''The Secretary may provide technical assistance to the States applying for or awarded an incentive payment under this title.

"SEC. 3407. RULEMAKING.

''The Secretary may make rules to carry out this title.

"SEC. 3408. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated to carry out this title such sums as may be necessary, to remain available until expended.

"SEC. 3409. DEFINITIONS.

''In this title—

''(1) the term 'Secretary' means the Secretary of Health and Human Services; and

''(2) the term 'State' includes the District of Columbia, Puerto Rico, and each other territory or possession of the United States.

"Subtitle B—Liability Limits for States With Ineffective Laws

"SEC. 3411. APPLICATION.

''This subtitle applies only in those States to which it is made applicable by subtitle A.

"SEC. 3412. 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. 3413. COMPENSATING PATIENT INJURY.

''(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle 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. 3414. 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) Forty percent of the first $50,000 recovered by the claimant(s).

''(2) Thirty-three and one-third percent of the next $50,000 recovered by the claimant(s).

''(3) Twenty-five percent of the next $500,000 recovered by the claimant(s).

''(4) Fifteen 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 civil actions.

''SEC. 3415. 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. 3416. PUNITIVE DAMAGES.

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

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

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

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

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

''(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

''(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

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

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

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

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

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

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

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

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

''(1) IN GENERAL.—

''(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any compo-

nent or raw material of such medical product, based on a claim that such product caused the claimant's harm where—

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

"(II) such medical product was so approved, cleared, or licensed; or

"(ii) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with appli-

cable Food and Drug Administration statutes and regulations.

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

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

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

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

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

taining approval, clearance, or licensure of such medical product.

"SEC. 3417. DEFINITIONS.

"In this subtitle:

"(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 claim-

ant, as a result of the injury or wrongful death, pursuant to—

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

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

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

"(D) any other publicly or privately funded program.

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

impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term 'compensatory damages' includes economic damages and noneconomic damages, as such terms are defined in this section.

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

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

''(7) HEALTH CARE LAWSUIT.—The term 'health care lawsuit' means any health care liability claim concerning the provision of health care goods or services or any medical product affecting inter-

state commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. 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; or which is grounded in antitrust.

''(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(g)(1) and (h)) and section 351(i) 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' has the same meaning as that term has for the purposes of subtitle A.

"SEC. 3418. EFFECT ON OTHER LAWS.

''(a) VACCINE INJURY.—

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

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

''(B) any rule of law prescribed by this subtitle in conflict with a rule of law of 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 this Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

''(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle 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. 3419. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

"(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle 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 subtitle. The provisions governing health care lawsuits set forth in this subtitle 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 subtitle; 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 subtitle (including

State standards of negligence) shall be governed by otherwise applicable State or Federal law.

''(2) This subtitle 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 subtitle or create a cause of action.

''(c) STATE FLEXIBILITY.—No provision of this subtitle 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 subtitle, 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.''.

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