Tanner	Turner	Watt (NC)
Tauscher	Udall (CO)	Watts (OK)
Tauzin	Udall (NM)	Waxman
Taylor (MS)	Upton	Weiner
Taylor (NC)	Velazquez	Weldon (FL)
Terry	Visclosky	Weldon (PA)
Thomas	Vitter	Weller
Thompson (MS)	Walden	Wexler
Thune	Walsh	Wicker
Tiahrt	Wamp	Wilson (NM)
Tiberi	Waters	Wilson (SC)
Tierney	Watkins (OK)	Wolf
Towns	Watson (CA)	Woolsey

NAYS—16

Barr	Goode	Paul
Bonilla	Hostettler	Thornberry
Collins	Kerns	Toomey
Culberson	Miller, Jeff	Young (AK)
Duncan	Myrick	
Flake	Norwood	

NOT VOTING—31

Bachus	Hulshof	Roukema
Baldwin	Hunter	Schaffer
Barcia	John	Stump
Bonior	Jones (NC)	Thompson (CA)
Callahan	Kennedy (RI)	Thurman
Capuano	Larson (CT)	Whitfield
Clay	Maloney (NY)	Wu
English	McCrery	Wynn
Fletcher	McDermott	Young (FL)
Fossella	Mink	
Hastings (WA)	Murtha	

□ 1147

Mr. DUNCAN changed his vote from ‘‘yea’’ to ‘‘nay.’’

So the motion to instruct was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Ms. BALDWIN. Mr. Speaker, I was absent during rollcall vote No. 418. However, if I would have been present on the Johnson of Texas Motion to Instruct Election Reform Conferees, I would have voted, ‘‘yea.’’

PERSONAL EXPLANATION

Mr. JONES of North Carolina. Mr. Speaker, on rollcall Nos. 416, 417, and 418, I was unavoidably detained. Had I been present, I would have voted ‘‘aye’’ on Nos. 416 and 417, and ‘‘nay’’ on No. 418.

HELP EFFICIENT, ACCESSIBLE, LOW COST, TIMELY HEALTH CARE ACT OF 2002

Mr. REYNOLDS. Madam Speaker, by direction of the Committee on Rules, I call up House Resolution 553 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 553

Resolved, That upon the adoption of this resolution it shall be in order without intervention of any point of order to consider in the House the bill (H.R. 4600) to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system. The bill shall be considered as read for amendment. In lieu of the amendments recommended by the Committees on the Judiciary and on Energy and Commerce now printed in the bill, the amendment in the nature of a substitute printed in the report of the Committee on Rules accompanying this resolution shall be considered as adopted. The previous question shall be considered as ordered on the bill, as amended, to final passage without intervening motion except: (1) one hour of debate on the bill, as amended, with 40 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on the Judiciary and 20 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Energy and Commerce; and (2) one motion to recommit with or without instructions.

The SPEAKER pro tempore (Mrs. BIGGERT). The gentleman from New York (Mr. REYNOLDS) is recognized for 1 hour.

(Mr. REYNOLDS asked and was given permission to revise and extend his remarks.)

Mr. REYNOLDS. Madam Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Florida (Mr. HASTINGS), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Madam Speaker, House Resolution 553 is a closed rule providing for the consideration of H.R. 4600, the Help Efficient, Accessible, Low Cost, Timely Health Care Act of 2002, more commonly known as the HEALTH Act. The rule waives all points of order against consideration of the bill and provides one motion to recommit, with or without instructions.

Madam Speaker, when it comes to health care, there is nothing more hallowed than the quality of patient care and the integrity of patient choice. However, there is an unfortunate and rising trend in our country that is not only threatening patient care and choice, but is obstructing the way in which doctors and other providers administer that care, and it is collectively costing patients, their families, doctors and taxpayers billions of dollars every year.

In recent years, medical liability insurance premiums have soared to the highest rates since the mid-1980s. These devastating increases have forced health care professionals to limit services, relocate their practices, or retire early. Meanwhile, affordability and availability of insurance is in grave jeopardy, and, in the end, patients are the ones shortchanged.

One might assume that the generous lawsuit judgment awards and settlements would bode well for injured patients seeking redress. However, studies show that most injured patients receive little or no compensation at all. Alarmingly, there is clear evidence indicating that skyrocketing medical liability premiums are a direct result of increases in both lawsuit awards and litigation expenses, and, according to a study compiled by the United States Department of Health and Human Services, excessive litigation is impeding efforts to improve the quality of care and raising the cost of health care that all Americans pay.

By placing modest limits on unreasonable awards for economic damages, an estimated $60 billion to $108 billion, that is $60 billion to $108 billion, could be saved in health care costs each year. Reclaiming this money would lower premiums for doctors and patients, allowing millions of Americans the opportunity to obtain affordable health insurance. Currently, runaway litigation expenses are getting in the way.

Take into consideration my home State of New York. In most instances New York physicians are paying the highest medical liability premiums in the country and are likely to pay at least 20 percent more in premiums over the next year alone. My region of the State is especially feeling the impact.

‘‘The number of doctors leaving Erie last year doubled from the previous year, a trend that continues to 2002,’’ wrote Donald Copley, M.D., an officer of the Erie County Medical Society in the Business First of Buffalo newspaper. The Medical Society of New York says the trend of physicians leaving New York State or retiring early is happening all across the State.

When exorbitant litigation goes unchecked, as it has, premiums escalate, leaving doctors either unable to afford insurance or unable to provide a variety of services, thereby leaving Americans at risk of not being able to find a doctor.

Madam Speaker, this is completely unacceptable.

The legislation before us today will halt the exodus of providers from the health care industry, stabilize premiums, limit staggering attorney fees, and, above all, improve patient access to care.

The HEALTH Act is modeled after legislation adopted by a Democratic legislature and a Democratic Governor in the State of California over 27 years ago. Since that time, insurance premiums in the rest of the country have increased over 500 percent, while California's has only risen 167 percent.

California's insurance market has stabilized, increasing patient access to care and saving more than $1 billion per year in liability premiums. Equally important, California doctors are not leaving the State.

In scaling this model into a national standard, the sponsors of the HEALTH Act included a critical component, state flexibility. The HEALTH Act respects States rights by allowing States that already have damages caps, whether larger or smaller than those provided in the HEALTH Act, to retain such caps.

Madam Speaker, right now this crisis is affecting every State in its own way, but the Nation as a whole is suffering.

President Bush has said that the lawsuit industry is devastating the practice of medicine. Let us not pass up our opportunity to step up to the plate. Doctors should not be afraid to practice medicine and patients should not be afraid of losing their doctor.

I urge my colleagues to support this rule and the underlying legislation.

Madam Speaker, I reserve the balance of my time.

Mr. HASTINGS of Florida. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I thank my friend the gentleman from New York (Mr. REYNOLDS) for yielding me time.

Madam Speaker, I rise today in strong opposition to the closed rule for H.R. 4600. This is an extremely complex piece of legislation and certainly one that requires a full and open debate. The closed rule denies us a much-needed opportunity to discuss its pros and cons.

To start, I have received, as I am sure other Members have, a number of phone calls from physicians in the district that I am privileged to serve urging me to support this legislation. Most of them expressed their readiness to close their doors because of the high premiums they currently pay for malpractice insurance and erroneously, in my judgment, believe that H.R. 4600 will relieve them of high malpractice insurance premiums.

There is no question that medical liability insurance rates are out of control and doctors, as well as other health care providers, often abandon high-risk patients for fear of being sued. However, what many, if not all, of the physicians who have called my office fail to realize is that H.R. 4600 will not lower doctors' premiums.

Despite a wide consensus, skyrocketing premiums are not due to bad politics. Hiked premiums are the result of insurers' failed profits on their market investments. When insurance companies began to make sound investments with the insured's money, and when our friends on the other side of the aisle allow an open rule so sensible amendments from Democrats and Republicans can be heard, then and only then will premiums be lowered.

The fact is, this bill would restrict the amount of money that malpractice insurance companies will have to pay. But nowhere in this legislation, and I invite my colleagues on the other side to point to the place, nowhere in this legislation are any of these savings going to be passed along to physicians.

Had this been an open rule, we could offer amendments similar to that of my colleague the gentleman from Massachusetts (Mr. MARKEY) that would require savings realized by the insurers as a result of the $250,000 cap be passed on to health care providers in the form of lower premiums. There are other Members who are going to speak here that had this been an open rule, their amendments would have been included as well.

Medical malpractice is the fifth leading cause of death in the United States, where an estimated 98,000 people die annually in United States hospitals because of negligent medical errors. The medical malpractice system is important because it compensates victims injured by negligence, deters future medical misconduct, punishes those who cause injury and death through negligence and removes and informs the public of harmful products and practices.

While a $250,000 cap on punitive and non-economic damages may suffice for the men and women on the other side of the aisle, my constituents and all Americans deserve more. This is a one-size-fits-all bureaucratic approach that objectifies victims and the uniqueness of their suffering.

I told the story yesterday of my grandmother's death. In the ''halcyon'' days of segregation, when she died at the hands of a physician, we could not sue for the reason we were black. That is not the issue here. But I can tell you this, there was no price that anybody could have put on my grandmother, and there is no price that anybody can put on your sister or your brother, whether you are a doctor or a lawyer or an insurer.

□ 1200

This bill sends a clear and distinct message that lawmakers are more concerned with abating insurance companies' malpractice problems instead of reducing the pain and suffering of the American people.

Let us call this bill what it really is, and that is another poor attempt by my friends on the other side to give financial breaks to their corporate friends. One would think that they would learn from previous incidents of corporate mishaps; but I guess, Madam Speaker, some things never change.

Madam Speaker, H.R. 4600 is a health care immunity act that benefits insurance companies, HMOs, manufacturers and distributors of defective products and pharmaceutical companies, not physicians. It is a tort reform effort of the worst kind. Stunting the judicial process by disallowing the public to litigate unrestricted malpractice suits is not only biased, but it is un-American. I am in strong opposition to this measure. I urge a ''no'' vote on the rule and the underlying bill.

Madam Speaker, I reserve the balance of my time.

Mr. REYNOLDS. Madam Speaker, I yield myself such time as I may consume.

Nothing in the HEALTH act denies injured plaintiffs the ability to obtain adequate redress, including compensation for 100 percent of their economic losses, their medical costs, their lost wages, their future lost wages, rehabilitation costs, and any other economic out-of-pocket loss suffered as a result of a health care injury. Ceilings on noneconomic damages limit only the inherently unquantifiable element damages, such as those awarded for pain and suffering, loss of enjoyment, and other intangible items. When we look at health care, the reality is, and CBO estimates, that under this bill premiums of medical malpractice ultimately will be on an average of 25 to 30 percent below what they would be under current law. It is time for action.

Madam Speaker, I yield 3 minutes to the gentleman from California (Mr. COX).

Mr. COX. Madam Speaker, I want to thank the gentleman from New York for yielding me this time.

He is exactly right. What we are talking about doing here is making sure that all of us who have agreed to pay the cost of this system through the insurance system, we all pay for it; that is where the money comes from, to make sure that we all agree that we will pay for unlimited compensation for people who are the victims of medical malpractice, that we will pay for 100 percent of any imaginable cost, 100 percent of all medical costs, 100 percent of lost wages, 100 percent of lost future earnings, 100 percent of any rehabilitation costs; obviously, 100 percent of any medical expenses, doctors, nurses, hospitals, prescription drugs, nursing home care, assisted living, whatever it is, 100 percent of all of these things.

But what we are trying to do is save the patients from a system right now that is falling down all around them. Doctors are getting out of practice; whole hospitals are shutting down, OB-GYNs are not delivering babies any more. People are not getting care. There is a crisis in this country. We had extraordinary testimony before the Committee on Energy and Commerce. We heard that in Nevada, for example, southern Nevada is without a trauma center right now; and it is directly attributable to this malpractice crisis. We want to do what we have done in California. The law has worked, as the gentleman from New York described.

On June 30 of this year, Methodist Hospital in south Philadelphia, which has been delivering babies since 1892, closed its doors because of this crisis. They are not going to be delivering babies any more. Women need health care; men need health care. We need doctors, we need care, we need treatment. The Congressional Budget Office, as the gentleman from New York pointed out, said that if we pass this bill, we will have $14 billion more available to help our hospitals, available for health care, available to keep the cost of health care down so more people will have insurance. That is what this is all about. The only people who will suffer if this bill is passed are those in their enormous mansions right now that are skimming the top in the gold-plated tort system by faking more than all of the costs that I described for themselves.

In California, what has happened, our premiums, of course, they have gone up; they have gone up 140 percent, but at the same time, the rest of the country has gone up over 5 percent, so we have a system that is much more under control. People are healthier in California. In lawsuits, plaintiffs are getting a greater share of the recoveries in California than they are in other States. And they are getting the recoveries faster. There is no question that the HEALTH act is good for everyone, for patients, for doctors, for the whole health care system, for hospitals, for

nurses, for everyone that has come to this Congress.

Madam Speaker, I urge the enactment of this rule and passage of the legislation.

Mr. HASTINGS of Florida. Madam Speaker, I am very pleased and privileged to yield 2½ minutes to the gentleman from Pennsylvania (Mr. HOEFFEL), my good friend.

Mr. HOEFFEL. Madam Speaker, I thank the gentleman for yielding me this time and for his leadership on this issue.

The doctors in my district in Montgomery County, Pennsylvania, and all in the Philadelphia area, face a financial crisis, the same as many doctors around the country, as we have heard here today. This bill will not solve their crisis. This bill does not reflect a comprehensive effort to solve the medical malpractice crisis that we face in southeastern Pennsylvania and across many parts of this country. Nobody wants a compromise. Nobody wants to come together in a reasonable way to find a middle ground. That has happened at various State levels, but it is not happening here in Washington. It is not happening because the Washington representatives of the doctors do not want to compromise; the Washington representatives of the lawyers do not want to compromise. The Committee on Rules has brought forward a closed rule so the House of Representatives cannot be involved in working our will.

If we were to make a good-faith effort to address medical malpractice around the country, we would fundamentally have to address insurance industry reform, and that bill is completely silent on that issue. Frankly, we need to partially lift the antitrust exemption that the insurance industry has enjoyed for 55 years, that allows them to collude, to engage in anticompetitive practices. Those are the problems that are driving up medical malpractice insurance rates, in addition to their losses in the stock market that the gentleman from Florida (Mr. HASTINGS) has already described.

We need to give the Attorney General the ability to regulate national insurance companies because the States are not doing it, and we are not, we are not having these anticompetitive practices investigated and resolved. If we are going to make a good-faith effort regarding caps which are, by their nature, inflexible and arbitrary, we need to add judicial discretion, at a minimum, to any cap, so that a court can make a judgment that could allow an award to reflect what the jury has found in that particular case, not what this body chooses to impose here in Washington as an inflexible one-size-fits-all.

Madam Speaker, this bill does not resolve the problem. We are failing here today. I ask for a negative vote on the rule and against the bill.

Mr. REYNOLDS. Madam Speaker, I yield 3 minutes to the gentleman from Illinois (Mr. KIRK).

Mr. KIRK. Madam Speaker, I rise today in support of the rule and the bill. We have a medical malpractice crisis in America and especially in my home State of Illinois. I am particularly worried about malpractice rates for obstetricians and gynecologists who are leaving the practice of medicine, rather than ensure the delivery of healthy babies.

I spoke with Dr. Gina Wehramann, an Evanston OB-GYN, who reported that after malpractice payments were paid, she made just $35,000. Her office manager makes $90,000. She is leaving the practice of medicine to become a pharmacist where she can triple her income. She reports that OB-GYNs are leaving the field of medicine in Illinois in dozens and women in northern Illinois will find it hard to receive sufficient care for the delivery of their babies. Dr. Wehramann reported that 85 percent of OB-GYNs in northern Illinois are sued for malpractice. The plaintiffs' bar tells us that 85 percent of OB-GYNs in my State are bad doctors.

All of this adds up to a war on women by the plaintiffs' bar. The plaintiffs' bar killed contraceptive development in our country, with no vote in the Congress and no Presidential decision. European women have many more safe and effective options than Americans, but the plaintiffs' bar does not care. They believe that 85 percent of all OB-GYNs are bad doctors and must be sued out of existence.

The American Association of Neurological Surgeons recently designated 25 States as crisis States, including my home State of Illinois. A constituent of mine, Dr. Jay Alexander, recently told me that his group of 17 cardiologists paid $250,000 in premiums last year, but the bill this year is $800,000. The stories are not limited to physicians. In 2001, Lake Forest Hospital paid $734,000 in malpractice coverage, but that cost will go up to $1.5 million this year. These costs deprive patients of health care at Lake Forest Hospital, and Lake Forest Hospital delivers more babies than any other hospital in Lake County, Illinois; but they will soon have to deny care to these women because of these costs.

With the passage of H.R. 4600 we will end the plaintiffs' bar's war on women. Without this bill, we will continue to see greater distances for deliveries, fewer screening services, and less training for women's health and health care.

Madam Speaker, we must restore the doctor-patient relationship. Today we have a genuine opportunity to pass this legislation and make sure that the women of Illinois and every other State have access to obstetric care.

I urge passage for the bill, and I applaud the gentleman for bringing it to the floor.

Mr. HASTINGS of Florida. Madam Speaker, I yield myself 15 seconds.

No reflection on my young colleague from Illinois, but as a 40-year lawyer and one involved in the process, I find it difficult to believe that I participated in something dealing with the elimination of contraception, because I protected the rights of women who were victims. My belief is it is the right-to-life group that had as much to do with the elimination of contraception.

Madam Speaker, I am pleased to yield 2 minutes to the gentleman from New Jersey (Mr. PASCRELL), my distinguished friend and colleague.

Mr. PASCRELL. Madam Speaker, I rise to speak against this unfair rule and against this flawed legislation.

It is really unfortunate that the rule will not allow any amendments to improve the bill. My primary concern is that nowhere in H.R. 4600 does it limit health care lawsuits to just medical malpractice. In fact, health care lawsuits applies to any health care liability claim, quote unquote.

H.R. 4600 would undermine the 11 States of the Union, including my State of New Jersey, that hold HMOs accountable. We arrived at that in a very bipartisan way. It would decimate what we have done in New Jersey, what we have worked so hard to do. In my memory, if my memory serves me correctly, last summer, a majority in this Congress, on both sides of the aisle, voted to hold HMOs accountable when they make medical decisions that kill or permanently maim patients.

So we are on the floor today doing the exact opposite of what most of us supported just last summer. In looking at what happened in California, I have heard that mentioned a few times this afternoon, H.R. 4600 probably would not accomplish its goal of reducing premium costs or increasing the availability of medical malpractice insurance, either. Premiums in California rose 190 percent in the 12 years following the enactment of their claim limitation bill. In its present form, H.R. 4600 is not good for patients, and it does not work.

□ 1215

So I ask that we vote against H.R. 4600. Let us focus on real solutions, such as making the Patients' Bill of Rights law. It is good to be back on domestic issues.

Mr. REYNOLDS. Madam Speaker, I yield 3½ minutes to the gentlewoman from Connecticut (Mrs. JOHNSON).

Mrs. JOHNSON of Connecticut. Madam Speaker, I thank the gentleman for yielding time to me.

If we are out there talking to our constituents, if we keep in touch with the medical communities, not just the doctors but the hospitals, the little home health agencies, and if we listen, we will know that our Nation is galloping toward a health care crisis of dimensions we have never faced before, a crisis of cost and a crisis of access.

There are whole States in America where a woman cannot find an obstetrician who will take a high-risk pregnancy. If we talk to the specialty surgeons, many will not take the high-

risk cases. Very quietly, access to sophisticated, high-risk care is declining in America. That is the unique strength of the American medical system and it is becoming inaccessible to more and more Americans.

Just in going about my rounds, a five-town area is losing its ENT practice. ENT is a relatively low pickup specialty. Their liability premiums last year were only $22,000. Next year they are going to be closer to $50,000. There are not enough hours in the day for these physicians to see enough patients to pay the increase in those premiums. They are being forced to leave practice.

I had a meeting at a senior citizen center in Brookfield, Connecticut. A gentleman came in and sat all through the senior citizens' questions, and then rose to say that in fact he could not stay in practice after 14 years invested in education and training. He was leaving in 2 years because there were not enough hours in the day for him to see enough patients to pay a $150,000 malpractice premium over this year's $100,000.

My home hospital, in a small little urban community, has all the uncompensated care costs and all the difficulties urban hospitals face: this year, $300,000 malpractice premiums; next year, $1 million. We cannot close our eyes. If this House and our Senate can send a malpractice reform bill to the President, we will lower premiums.

The evidence has been given from California. In California, OB–GYN premiums across the board on average are $43,000; nationally, $107,000. How can doctors continue, how can hospitals continue, without pushing costs up tremendously when their premiums are going to double and triple?

One practice in Waterbury, in the last 7 years the doctors have taken a 50 percent pay cut. Why? Because they are paying their people more, they are investing in technology and medical supplies. They are doing all the right things to provide quality care, to their people. This is in Waterbury, Connecticut. They are doing all the right things. Their own pay has gone down 50 percent.

We in this House were unable to protect them from a 5 percent cut last year, and the Senate is refusing to act, to protect them from another 5% cut this next year. We must protect them from extraordinary malpractice increases that will reduce their ability to provide care to the women of the Waterbury region.

Madam Speaker, this is not something Members can close their eyes to. It does not do any good to say on a grand scale that we have to reform our insurance laws; this is today. It is today women cannot find obstetricians to cover high-risk pregnancies. It is today doctors are being forced to retire by our failure to provide common sense malpractice reform legislation!

Mr. HASTINGS in Florida. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I still point out to the gentlewoman that there is nowhere in this bill that says that insurance premiums are going to go down as a result of this. We could have passed the measure of the gentleman from Massachusetts (Mr. MARKEY) and would have accomplished that.

Madam Speaker, I yield 1½ minutes to my good friend, the distinguished gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Madam Speaker, I thank the gentleman for yielding time to me.

Madam Speaker, I rise in opposition to the rule and the bill. I had hoped to offer amendments, as did others, that are not being allowed to improve this legislation and deal realistically with this problem.

Even if we believe the preemption of the laws of the 50 States with tort reform, something the Republicans, of course, the States rights party, does not normally believe in, would resolve this problem, we have to question, why is the pharmaceutical industry in this bill? Are they buying malpractice insurance? No. This is an incredible gift to the pharmaceutical industry.

Why is the HMO industry in this bill? Why are the nursing homes in this bill? Guess what? It is all about campaign fundraising on that side of the aisle. They know this bill is so radical, and is not a solution. It is not going anywhere in the Senate, but they want to bring it up today with no amendments and no attempt to really resolve this.

No savings are required to be passed on to the doctors in their premiums. In fact, the insurers never promised that tort reform would achieve specific premium savings. That is the American Insurance Association. That is a quote from them.

The premiums are excessive. Are they excessive because of a cyclical change in settlements? No. We have had four crises in 20 years. Guess what, there have not been four up-and-down cycles in settlements in lawsuits and malpractice; there have been four cycles in the investment losses of the insurance industry, bad underwriting, and bad accounting on their practice.

This is another corporate bailout by the Republicans, plain and simple. This is not going to help my docs. My docs really want a solution. They are desperate. Some of them are even biting on this stuff they are shoveling out. They are going to do nothing to resolve this problem long-term in this country.

Mr. REYNOLDS. Madam Speaker, I yield 2½ minutes to the gentlewoman from Wyoming (Mrs. CUBIN).

Mrs. CUBIN. Madam Speaker, I thank the gentleman from New York for yielding time to me.

Madam Speaker, the vast majority of physicians across this country are highly qualified medical doctors who look out for the best interests of their doctors. My husband has been in the practice of medicine in a sole practice for over 30 years. My son now is in his second year of medical school, and I know this insurance problem intimately.

The very principle that governs the medical profession is the concept of "do no harm." So what does it say about our society when one of the greatest preoccupations for physicians these days is fear of being sued? In fact, a survey conducted by the organization known as Common Good found that 87 percent of physicians now fear potential medical malpractice lawsuits more than they did when they started their careers, 87 percent.

Health care costs are drastically inflated when doctors order tests that they feel are truly not medically necessary, but they have to order those tests in case a lawsuit should be brought against them. What they want is to do the right thing by their patient healthwise and pocketbook-wise.

We are not talking about limiting economic damages, we are talking about limiting punitive damages. The median medical liability award jumped 43 percent in 1 year, from $700,000 in 1999 to $1 million in the year 2000. This is having a critical effect on health care in many States, many of the lower-populated States, such as Nevada, Oregon, and my home State of Wyoming.

Wyoming goes far beyond what is traditionally known as a rural State. The vast majority of Wyoming has the designation of "frontier," which means there are fewer than 6 people per square mile. Wyoming's population is sparse, with roughly 490,000 spread out over 100,000 square miles. Providers are few and far between, and health care facilities are very limited.

Madam Speaker, what it means when excessive malpractice litigation takes hold is professional liability insurance skyrockets and physicians scramble for coverage. There are only two companies in the State of Wyoming that provide coverage. What happens is the doctors close their doors and have to go to other places to find a job.

This is a travesty of twofold dimensions: Wyoming loses a good physician; but even worse, patients in frontier Wyoming lose access to vital primary care. That is unacceptable to me. I urge everyone to support this rule and support this legislation for physicians and patients alike.

Mr. HASTINGS of Florida. Madam Speaker, I am privileged to yield 3 minutes to my good friend, the gentlewoman from Nevada (Ms. BERKLEY), who has a considerable amount of experience in her State, as I do in mine, with this problem.

Ms. BERKLEY. Madam Speaker, I thank the gentleman for yielding time to me.

Madam Speaker, I rise in strong opposition to the closed rule for H.R. 4600. Nevada's health care crisis reached alarming proportions this past year. Malpractice insurance premiums jumped as much as $150,000 a year for many of our doctors. At least 150 Nevada doctors closed their practices, and

1 in 10 obstetricians have stopped delivering babies. Others are limiting their practices.

Pregnant women find it difficult to get care. Our largest emergency center closed temporarily when huge malpractice rates forced doctors out the door. So, Madam Speaker, I know firsthand the problems caused by runaway insurance rates, but H.R. 4600 is not the answer.

Let me tell the Members how this harms this Nation's health care. It caps noneconomic damages in the aggregate, barring punitive damages even in the most gross acts of malpractice. It caps noneconomic damages in a way that hits low-income Americans the hardest.

There is no provision for enhancing patient safety. Judicial discretion of egregious circumstances does not exist, or streamlining our court cases. This bill wipes out all of the hard work that Nevada's legislature and its carefully-crafted solution and legislation would solve.

The State of Nevada has passed a reform plan that is a far better starting point than H.R. 4600. This measure, signed by the Governor last month, is a product of hard negotiations and compromise, hard work by the medical and the legal and the insurance professionals. It passed a bipartisan legislature unanimously.

I find it very interesting that many of my colleagues on the other side of the aisle keep talking about Nevada's health care crisis. Not one of them will stand with me and suggest that Nevada's health care solution might be an answer to the problem.

The Nevada plan holds both doctors and lawyers accountable while setting limits on noneconomic damages. It allows judges discretion to make higher awards in the most egregious cases of malpractice. It does not let medical products manufacturers or HMOs or the pharmaceutical companies off the hook.

Madam Speaker, in an unwise rush to vote on H.R. 4600, my amendment that brings the Nevada plan to the floor was denied. My husband is a physician. I know firsthand the crisis facing the medical profession. I live with it every day. This Congress has an obligation to help ease the crisis so doctors can continue to treat their patients.

This legislation is so extreme it has no chance, no chance of passing and getting to the President's desk for signature. While this Congress is playing games with medical malpractice problems, the problem only gets worse, and this legislation will do nothing, absolutely nothing, to help because it will never be passed. This is an election year ploy, and it is shameful in its transparency. I am embarrassed. I am embarrassed for the United States Congress. I am embarrassed for the other side of the aisle.

Mr. REYNOLDS. Madam Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. PETERSON).

Mr. PETERSON of Pennsylvania. Madam Speaker, I thank the gentleman from New York for yielding time to me.

Madam Speaker, I have been involved in legislative issues for 25 years at the State and in Congress. Most of the time, my number one issue has been health care. I chaired health at the State for 10 years. I believe this is the greatest health care crisis facing my State, Pennsylvania, and this country that we will see.

Let me give a little Pennsylvania information. Pennsylvania hospital malpractice premiums in the last 12 months have increased an aggregate of 220 percent. One-third of the hospitals have increased over 300 percent.

Forty percent of the hospitals in Pennsylvania have closed or curtailed services; number one, OB–GYN; number two, trauma, when people are the most seriously ill or traveling further and further; three, neurosurgery and other surgical specialties.

Half of the hospitals in Pennsylvania cannot recruit a physician and are losing the physicians that they have. Fifty percent of teaching programs are finding out that almost all of their students are leaving Pennsylvania. Three-fourths of hospital physicians were denied coverage from an insurance company, and the only reason in Pennsylvania they have coverage is because we have a high-risk pool, at outrageous prices.

Thirty-two rural hospitals in my district, the most rural part of Pennsylvania, had to form their own insurance company because no one would insure them. Eighteen additional hospitals in Pennsylvania are forming their own insurance company. These people have no idea where this is going to take them and what their long-term risks are.

Hospital coverage alone for medical malpractice in Pennsylvania is in excess of one-half billion dollars and rising daily. That does not include physician costs, it does not include nursing homes and health agencies. That is over half a billion dollars that does not treat a patient.

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The worst part of the crisis is OB-GYNs and the poorest of American women are going to be denied; those who cannot travel long distances are going to be denied prenatal care, and we will pay for that decades ahead. Any struggling rural hospital that loses their surgeons or OB-GYNs will soon close.

Let me tell my colleagues what they have not heard about this morning. The real opposition to this bill. It limits trial lawyers' rewards. That is what the opposition to this bill is about. But let us see if it is fair. Fifty percent of a $50,000 reward they can still get. That is pretty good pay; 33 1/3 percent of the next $50,000. So that is 42 percent on a $100,000 claim. I think that is pretty good pay. Twenty-five percent on the next half a million. So on a $600,000 claim, they get 28 percent reward. Pretty good pay. Fifteen percent on anything thereafter. So a million dollar reward, they will still make 23 percent that will not go to the victim. I think that is darn good pay.

If we do not address this issue in this country, we are going to be doing the biggest disservice to those who need health care because it will not be available in rural areas, and they are not even a high-risk area. It will not be available in urban areas. I am told the Philadelphia sports teams are having to leave Philadelphia for orthopedic care. A tragedy. Let us fix it.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 3 minutes to my good friend and thoughtful legislator, the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Speaker, I thank my friend and colleague from the Committee on Rules for yielding me this time.

I am going to try to keep the volume down and talk about what is in this bill. There is no question, my colleagues, that we have a problem in the country. No Member of Congress can say that the status quo is all right. It is not okay for those that are coming into this world not to have the best services of a doctor, of an OB–GYN, of pediatricians; nor is it fair for those who are in the autumn of their lives not to have the right kind of medical assistance.

I think there is unanimity in recognizing what the problem is and that we should be unified in how we resolve this. As a Californian, I know what the MICRA law is. For those who do not know what it stands for, it is the Medical Injury Compensation Reform Act. It has been on the books in California for more than a quarter of a century. Democrats put it into place. Democratic Governors have not repealed it. Republican legislators, Democratic Governors, regardless of what that combination has been, for those who take shots at lawyers and Democrats, a Democratic legislature, and for over a quarter of a century, they have kept this law in place.

In the Congress we have looked at MICRA; and the general consensus has been that MICRA is good, MICRA works. To the gentleman and my friend from Pennsylvania (Mr. GREENWOOD), I told him I will not only be a cosponsor, I will be an original cosponsor of MICRA. This is not MICRA. MICRA places a $250,000 cap on economic damages and malpractice cases. This bill does that as well, and I think that is right. But it also does on product liability cases against drug and medical device manufacturers. How can any Member say to their constituents that that is all right, that they have no recourse? This is not about lawyers. This is about injured patients. We have to stand next to them as well.

The gentlewoman from Connecticut said do not close your eyes; do not close your eyes to that part of the bill.

This bill is overburdensome. It is not MICRA, no matter how they advertise it to be such. It does not honor the people we represent. It should be rejected. It is a closed rule because it is closed thinking. I urge a ''no'' vote.

Mr. REYNOLDS. Mr. Speaker, I yield 1 minute to the gentlewoman from Illinois (Mrs. BIGGERT).

Mrs. BIGGERT. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, I rise in strong support of the rule on H.R. 4600. Malpractice lawsuits are spiraling out of control. Too many doctors are settling cases even though they have not committed a medical error, and good doctors are ordering excessive tests and procedures and treatments out of fear.

These were the primary issues a panel of experts highlighted at a medical forum I hosted last month in my congressional district. The experts said these issues, or cracks in our medical system, are driving physicians and hospitals out of business.

Are some malpractice lawsuits necessary? Absolutely. Patients must have access to justice and restitution. But it is wrong when excessive costs of malpractice suits and excessive costs of malpractice insurance drive out health care providers.

Mr. Speaker, Congress had the opportunity to fix the malpractice system last summer, but we failed to do so. The good news is that we have another chance today to take the big step towards preserving the long-term viability of the medical system in Illinois and around the country. I urge my colleagues to support the rule on H.R. 4600.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 2 minutes to my very good friend, the gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, I rise today in opposition to the rule and the underlying bill. This legislation, H.R. 4600, says if we cap lawsuit damages, everything will be okay; but in this bill, once again, the majority party has gone way too far. In this area, as they have in so many other areas, the right to sue is being attacked as the root of all evil and stopping Americans from having access and their day in court. It is not the magic cure-all as the majority party would make it out to be. In fact, when we eliminate and take away the incentive to behave or to be sued, we eliminate deterrence.

And we have gone too far. This is not just malpractice. This is product liability. This is nursing home care. It is all rolled into this one big bill. I understand and I sympathize with those doctors facing huge premiums, but this bill is not the answer they are seeking. We went to offer an amendment, the antitrust, to take the antitrust exemption that insurance companies enjoy so they cannot jack up those premiums 200, 300 percent.

They can because they can all get together. They are not subject to monopoly laws and anti-trust laws. And of course we were denied because this is a closed rule.

Also we heard the gentlewoman from California (Ms. ESHOO) say that if you think that this bill is the answer to the malpractice problem, we need to look no further than California, which has a law in place for the last 26 years and this bill is claimed to be done and modeled after that California law. California medical malpractice insurance problems have not disappeared because of the law they passed 26 years ago. They still have it. It did not work.

The focus should not be just this simplistic answer of putting a cap on lawsuits and everything would be okay.

In Michigan we did this 10 years ago. Many of the provisions of this bill were in Michigan's bill passed in the early 90's. Michigan is now considered one of the States, once again, in medical malpractice crisis because the premiums have risen so much. If caps do not work, it is time we look at this crisis from a new focus, a new set of eyes; and what we have to do is start looking at why and look for ways to prevent malpractice.

Mr. REYNOLDS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I just disagree with my friend, the gentleman from Michigan (Mr. STUPAK). One cannot argue with the facts that in California the premiums in the last 27 years have gone up 167 percent. The rest of the country is 500 percent. Doctors are not leaving California like they are in New York, and we have heard testimony from other States like Pennsylvania. So the reality is there is a result based on the acts of that Democratic legislature and Governor 27 years ago. And in addition, we know the CBO in scoring this says that this legislation versus the current law as it is today would reduce the premiums paid by 25 to 30 percent for medical malpractice.

Mr. Speaker, I reserve the balance of my time.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 30 seconds to the gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, since the last speaker brought up Michigan, I thought I would bring it up. Even with our caps in Michigan, our premiums for our doctors are higher than those States without caps. If California has gone up 167 percent in the last few years and the rest of country has gone up 500 percent for malpractice premiums, is it not time we took away the anti-trust exemption for the insurance companies so they cannot go up 500 percent when the rate of inflation is 2 or 3 percent? Why are they going up 500 percent? It is not the lawsuits. It is the stock market, the Enrons and all the other things.

When St. Paul pulls $1.5 billion out of their reserves, they have to make it up someway, and they make it up on the backs of doctors.

Mr. HASTINGS of Florida. Mr. Speaker, how much time remains?

The SPEAKER pro tempore (Mr. ISAKSON). The gentleman from Florida (Mr. HASTINGS) has 10 minutes remaining. The gentleman from New York (Mr. REYNOLDS) has 6½ minutes remaining.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Virginia (Mr. SCOTT).

Mr. SCOTT. Mr. Speaker, if we talk about malpractice, we ought to talk about malpractice. If this bill passes, there is no commitment from any insurance company to actually reduce rates. There are some provision in here that have nothing to do with malpractice rates.

The previous speaker mentioned attorneys' fees and how reducing attorneys' fees will reduce attorneys' fees. It did not have anything to do with malpractice insurance. He said if you have a $1 million settlement, that if you limit lawyers' fees to 23 percent that will do some good. He did not say that the malpractice carrier will pay a million dollars. If it is a one-third fee, they will pay a million dollars. If it is no fee, they will pay a million dollars. This does not have anything to do with malpractice.

We ought to focus on the malpractice problem, not just gratuitously hurt the innocent victims of malpractice.

Mr. REYNOLDS. Mr. Speaker, we have heard from a lot of lawyers today and a few business people. I would like to now have an opportunity to hear from a medical doctor educated in the University of Buffalo and then moved to Florida.

Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. WELDON).

(Mr. WELDON of Florida asked and was given permission to revise and extend his remarks.)

Mr. WELDON of Florida. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I rise in support of this rule and the underlying bill. I just want to touch on a very, very important issue and that is defensive medicine, the incorrect costs of liability on the practice of medicine in the United States. Now, I practiced medicine for 15 years prior to being elected. I still see patients once a month. I practice defensive medicine. I know it is real.

I want to share with my colleagues who think this is not a Federal issue. A study was done, it was published in the Journal of Economics in May of 1996, looking at the impact of the California tort reforms on health care costs and specifically they looked in the Medicare plan. And they discovered that there was a 5 to 9 percent reduction in health care costs brought about in the Medicare plan in the State of California attributable to the caps on non-economic damages and less defensive medicine.

This is an excellent study, and I would encourage all of my colleagues

to read it. What this study also looked at was morbidity and mortality. They said it is not enough to just look at a decline in health care charges, but was it having an adverse effect on patients; were there more complications; were there more deaths. And lo and behold there were not. The researchers out of Stanford University, it is an excellent study published by Kessler and McClellan, they extrapolated this data and concluded that defensive medicine, because of liability, costs us $50 billion a year.

How can that be? I can tell you the patients came in my office. I thought they had this; I would order that test. And then I would say to myself, What if they have something else? What if they have this or that? What if they sue me? So I would start ordering the additional tests to prevent myself from being sued.

Mr. Speaker, I encourage my colleagues to support this rule and support the underlying bill. It is a Federal issue.

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DO DOCTORS PRACTICE DEFENSIVE MEDICINE?

[By Daniel Kessler; Mark McClellan]

''Defensive medicine'' is a potentially serious social problem: if fear of liability drives health care providers to administer treatments that do not have worthwhile medical benefits, then the current liability system may generate inefficiencies much larger than the cost of compensating malpractice claimants. To obtain direct empirical evidence on this question, we analyze the effects of malpractice liability reforms using data on all elderly Medicare beneficiaries treated for serious heart disease in 1984, 1987, and 1990. We find that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications. We conclude that liability reforms can reduce defensive medical practices.

INTRODUCTION

The medical malpractice liability system has two principal roles: providing redress to individuals who suffer negligent injuries, and creating incentives for doctors to provide appropriately careful treatment to their patients [Bell 1984]. Malpractice law seeks to accomplish these goals by penalizing physicians whose negligence causes an adverse patient health outcome, and using these penalties to compensate the injured patients [Danzon 1985]. Considerable evidence indicates that the current malpractice system is neither sensitive nor specific in providing compensation. For example, the Harvard Medical Practice Study [1990] found that sixteen times as many patients suffered an injury from negligent medical care as received compensation in New York State in 1984. In any event, the cost of compensating malpractice claimants is not an important source of medical expenditure growth: compensation paid and the costs of administering that compensation through the legal system account for less than 1 percent of expenditures [OTA 1993].

The effects of the malpractice system on physician behavior, in contrast, may have much more substantial effects on health care costs and outcomes, even though virtually all physicians are fully insured against the financial costs of malpractice such as damages and legal defense expenses. Physicians may employ costly precautionary treatments in order to avoid nonfinancial penalties such as fear or reputational harm, decreased self-esteem from adverse publicity, and the time and unpleasantness of defending a claim [Charles, Pyskoty, and Nelson 1988; Weiler et al. 1993].

On the one hand, these penalties for malpractice may deter doctors and other providers from putting patients as excessive risk of adverse health outcomes. On the other hand, these penalties may also drive physicians to be too careful—to administer precautionary treatments with minimal expected medical benefit out of fear of legal liability—and thus to practice ''defensive medicine.'' Many physicians and policy-makers have argued that the incentive costs of the malpractice system, due to extra tests and procedures ordered in response to the perceived threat of a medical malpractice claim, may account for a substantial portion of the explosive growth in health care costs [Reynolds, Rizzo, and Gonzalez 1987; OTA 1993, 1994]. The practice of defensive medicine may even have adverse effects on patient health outcomes, if liability induces providers either to administer harmful treatments or to forgo risky but beneficial ones. For these reasons, defensive medicine is a crucial policy concern [Sloan, Mergenhagen, and Bovbjerg 1989].

Despite this policy importance, there is virtually no direct evidence on the existence and magnitude of defensive medical practices. Such evidence is essential for determining appropriate tort liability policy. In this paper we seek to provide such direct evidence on the prevalence of defensive medicine by examining the link between medical malpractice tort law, treatment intensity, and patient outcomes. We use longitudinal data on all elderly Medicare recipients hospitalized for treatment of a new heart attack (acute myocardial infarction, or AMI) or of new ischemic heart disease (IHD) in 1984, 1987, and 1990, matched with information on tort laws from the state in which the patient was treated. We study the effect of tort law reforms on total hospital expenditures on the patient in the year after AMI or IHD to measure intensity of treatment. We also model the effect of tort law reforms on important patient outcomes. We estimate the effect of reforms on a serious adverse outcome that is common in our study population: mortality within one year of occurrence of the cardiac illness. We also estimate the effect of tort reforms on two other common adverse outcomes related to a patient's quality of life; whether the patient experienced a subsequent AMI or heart failure requiring hospitalization in the year following the initial illness.

To the extent that reductions in medical malpractice tort liability lead to reductions in intensity but not with increases in adverse health outcomes, medical care for these health problems is defensive; that is doctors supply a socially excessive level of care due to malpractice liability pressures. Put another way, tort reforms that reduce liability also reduce inefficiency in the medical care delivery system to the extent that they reduce health expenditures which do not provide commensurate benefits. We assess the magnitude of defensive treatment behavior by calculating the cost of an additional year of life or an additional year of cardiac health achieved through treatment intensity induced by specific aspects of the liability system. If liability-induced precaution results in low expenditures per year of life saved relative to generally accepted costs per year of life saved of other medical treatments, then the existing liability system provides incentives for efficient care. But if liability-induced precaution results in high expenditures per year of life saved, then the liability system provides incentives for socially excessive care. Because the precision with which we measure the consequences of reforms is critical, we include all U.S. elderly patients with heart diseases in 1984, 1987, and 1990 in our analysis.

Section I of the paper discusses the theoretical ambiguity of the impact of the current liability system on efficiency in health care. For this reason, liability policy should be guided by empirical evidence on its consequences for ''due care'' in medical practice. Section II reviews the previous empirical literature. Although the existing evidence on the effectiveness of alternative liability rules has provided considerable insights, direct evidence on the crucial effects of the tort system on physician behavior is virtually nonexistent. Section III presents our econometric models of the effects of liability rules on treatment decisions, costs, and patient outcomes, and formally describes the test for defensive medicine used in the paper. We identify liability effects by comparing trends in treatment choice, costs, and outcomes in states adopting various liability reforms to trends in those that did not. We also review a number of approaches to enriching the model, assisting in the evaluation of its statistical validity and providing further insights into the tort reform effects. Section IV discusses the details of our data, and motivates our analysis of elderly Medicare beneficiaries for purposes of assessing the costs of defensive medicine. Section V presents the empirical results. Section VI discusses implications for policy, and Section VII concludes.

I. Malpractice liability and efficient precaution in health care

In general, malpractice claims are adjudicated in state courts according to state laws. These laws require three elements for a successful claim. First, the claimant must show that the patient actually suffered an adverse event. Second, a successful malpractice claimant must establish that the provider caused the event: the claimant must attribute the injury to the action or inaction of the provider, as opposed to nature. Third, a successful claimant must show that the provider was negligent. Stated simply, this entails showing that the provider took less care than that which is customarily practiced by the average member of the profession in good standing, given the circumstances of the doctor and the patient [Keeton et al. 1984]. Collectively, this three-part test of the validity of a malpractice claim is known as the ''negligence rule.''

In addition to patient compensation, the principal role of the liability system is to induce doctors to take the optimal level of precaution against patient injury. However, a negligence rule may lead doctors to take socially insufficient precaution, such that the marginal social benefit of precaution would be greater than the marginal social cost. Or, it may lead doctors to take socially excessive precaution, that is, to practice defensive medicine, such that the marginal social benefit of precaution would be less than the marginal social cost [Farber and White 1991]. The negligence rule may not generate socially optimal behavior in health care because the private incentives for precaution facing doctors and patients differ from the social incentives. First, the costs of accidents borne by the physician differ from the social costs of accidents. Because malpractice insurance is not strongly experience rated [Sloan 1990], physicians bear little of the costs of patient injuries from malpractice. However, physicians bear significant uninsured expenses in response to a malpractice claim, such as the value of time

and emotional energy spent on legal defense [OTA 1993, p. 7]. Second, patients and physicians bear little of the costs of medical care associated with physician precaution in any particular case because most health care is financed through health insurance. Generally, insured expenses for drugs, diagnostic tests, and other services performed for precautionary purposes are much larger than the uninsured costs of the physician's own effort. Third, physicians bear substantial costs of accidents only when patients file claims, and patients may not file a malpractice claim in response to every negligent medical injury [Harvard Medical Practice Study 1990].

The direction and extent of the divergence between the privately and socially optimal levels of precaution depends in part on states' legal environments. Although the basic framework of the negligence rule applies to most medical malpractice claims in the United States, individual states have modified their tort law to either expand or limit malpractice liability along various dimensions over the past 30 years. For example, several states have imposed caps on malpractice damages such that recoverable losses are limited to a fixed dollar amount, such as $250,000. These modifications to the basic negligence rule can affect both the costs to physicians and the benefit to patients from a given malpractice claim or lawsuit, and thereby also affect the frequency and average settlement amount (''severity'') of claims. We use the term malpractice pressure to describe the extent to which a state's legal environment provides high benefits to plaintiffs or high costs to physicians or both. (Malpractice pressure can be multidimensional.)

If the legal environment creates little malpractice pressure and externalized costs of medical treatment are small, then the privately optimal care choice may be below the social optimum. In this case, low benefits from filing malpractice claims and lawsuits reduce nonpecuniary costs of accidents for physicians, who may then take less care than the low cost of diagnostic tests, for example, would warrant. However, if the legal environment creates substantial malpractice pressure and externalized costs of treatment are large, then the privately optimal care choice may be above the social optimum: privately chosen care decisions will be defensive. For example, increasing technological intensity (with a reduced share of physician effort costs relative to total medical care costs) and increasing generosity of tort compensation of medical injury would lead to relatively more defensive medical practice.

Incentives to practice defensively may be intensified if judges and juries impose liability with error. For example, the fact that health care providers' precautionary behavior may be ex post difficult to verify may give them the incentive to take too much care [Cooler and Ulen 1986; Craswell and Calfee 1986]. Excessive care results from the all-or-nothing nature of the liability decision: small increases in precaution above the optimal level may result in large decreases in expected liability.

Because privately optimal behavior under the basic negligence rule may result in medical treatment that has marginal social benefits either greater or less than the marginal social costs, the level of malpractice pressure that provides appropriate incentives is an empirical question. In theory, marginal changes to the negligence rule can either improve or reduce efficiency, depending on their effects on precautionary behavior, total health care costs, and adverse health outcomes. Previous studies have analyzed effects of legal reforms on measures of malpractice pressure, such as the level of compensation paid malpractice claimants. To address the potentially much larger behavioral consequences of malpractice pressure, we study the impact of changes in the legal environment on health care expenditures to measure the marginal social cost of treatment induced by the liability system, and the impact of law changes on adverse health events to measure the marginal social benefit of law-induced treatment. As a result, we can provide direct evidence on the efficiency of a baseline malpractice system and, if it is inefficient, identify efficiency-improving reforms.

II. Previous empirical literature

The previous empirical literature is consistent with the hypothesis that providers practice defensive medicine, although it does not provide direct evidence on the existence or magnitude of the problem. One arm of the literature uses surveys of physicians to assess whether doctors practice defensive medicine [Reynolds, Rizzo, and Gonzalez 1987; Moser and Musaccio 1991; OTA 1994]. Such physician surveys measure the cost of defensive medicine only through further untestable assumptions about the relationship between survey responses, actual treatment behavior, and patient outcomes. Although surveys indicate that doctors believe that they practice defensively, surveys only provide information about what treatments doctors say that they would administer in a hypothetical situation: they do not measure behavior in real situations.

Another body of work uses clinical studies of the effectiveness of intensive treatment [Leveno et al. 1986; Shy et al. 1990]. These studies find that certain intensive treatments which are generally thought to be used defensively have an insignificant impact on health outcomes. Similarly, clinical evaluations of malpractice control policies at specific hospitals have found that intensive treatments thought to serve a defensive purpose are ''overused'' by physicians [Master et al. 1987]. However, this work does not directly answer the policy question of interest: does intensive treatment administered out of fear of malpractice claims have any effect on patient outcomes? Few medical technologies in general use have been known to be ineffective in all applications, and the average effect of a procedure in a population may be quite different from its effect at the margin in, for example, the additional patients who receive it because of more stringent liability rules [McClellan 1995]. Evaluating malpractice liability reforms requires evidence on the effectiveness of intensive treatment in the ''marginal'' patients.

A third, well-developed arm of the literature estimates the effects of changes in the legal environment on measures of the compensation paid and the frequency of malpractice claims. Danzon [1982, 1986] and Sloan, Mergenhagen, and Bovbjerg [1989] find that tort reforms that cap physicians' liability at some maximum level or require awards in malpractice cases to be offset by the amount of compensation received by patients from collateral sources reduce payments per claim. Danzon [1986] also finds that collateral-source-rule reforms and statute-of-limitations reductions reduce claim frequency. Based on data from malpractice insurance markets, Zuckerman, Bovbjerg, and Sloan [1990] and Barker [1992] reach similar conclusions: Zuckerman, Bovbjerg, and Sloan find that caps on damages and statute-of-limitations reductions reduce malpractice premiums, and Barker finds that caps on damages increase profitability.

Despite significant variety in data and methods, this literature contains an important unified message about the types of legal reforms that affect physicians' incentives. The two reforms most commonly found to reduce payments to and the frequency of claims, caps on damages and collateral-source-rule reforms, share a common property: they directly reduce expected malpractice awards. Caps on damages truncate the distribution of awards; mandatory collateral-source offsets shift down its mean. Other malpractice reforms that only affect malpractice awards indirectly, such as reforms imposing mandatory periodic payments (which require damages in certain cases to be disbursed in the form of an annuity that pays out over time) or statute-of-limitations reductions, have had a less discernible impact on liability and hence on malpractice pressure.

However, estimates of the impact of reforms on frequency and severity from these analyses are only the first step toward answering the policy question of interest: do doctors practice defensive medicine? Taken alone, they only provide evidence of the effects of legal reforms on doctors' incentives; they do not provide evidence of the effects of legal reforms on doctors' behavior. Identifying the existence of defensive treatment practices and the extent of inefficient precaution due to legal liability requires a comparison of the response of costs of precaution and the response of losses from adverse events to changes in the legal environment.

A number of studies have sought to investigate physicians' behavioral response to malpractice pressure. These studies generally have analyzed the costs of defensive medicine by relating physicians' actual exposure to malpractice claims to clinical practices and patient outcomes [Rock 1988; Harvard Medical Practice Study 1990; Localio et al. 1993; Baldwin et al. 1995]. Rock, Localio et al., and the Harvard Medical Practice Study find results consistent with defensive medicine; Baldwin et al. do not. However, concerns about unobserved heterogeneity across providers and across small geographic areas qualify the results of all of these studies. The studies used frequency of claims or magnitude of insurance premiums at the level of individual doctors, hospitals, or areas within a single state over a limited time period to measure malpractice pressure. Because malpractice laws within a state at a given time are constant, the measures of malpractice pressure used in these studies arose not from laws but from primarily unobserved factors at the level of individual providers or small areas, creating a potentially serious problem of selection bias. For example, the claims frequency or insurance premiums of a particular provider or area may be relatively high because the provider is relatively low quality, because the patients are particularly sick (and hence prone to adverse outcomes), because the patients had more ''taste'' for medical interventions (and hence are more likely to disagree with their provider about management decisions), or because of many other factors. The sources of the variation in legal environment are unclear and probably multifactorial. All of these factors are extremely difficult to capture fully in observational data sets and could lead to an apparent but noncausal association between measured malpractice pressure and treatment decisions or outcomes.

Thus, while previous analyses have provided a range of insights about the malpractice liability system, they have not provided direct empirical evidence on how malpractice reforms would actually affect physician behavior, medical costs, and health outcomes.

III. Econometric modes

Our statistical methods seek to measure the effects of changes in an identifiable

source of variation in malpractice pressure influencing medical decision making—state tort laws—that is not related to unobserved heterogeneity across patients and providers. We compare time trends across reforming and nonreforming states during a seven-year period in inpatient hospital expenditures, and in outcome measures including all-cause cardiacmortality as well as the occurrence of cardiac complications directed related to quality of life. We model average expenditures and outcomes as essentially nonparametric functions of patient demographic characteristics, state legal and political characteristics, and state- and time-fixed effects. We model the effects of state tort law changes as differences in time trends before and after the tort law changes. We test for the existence and magnitude of defensive medicine based on the relationship of the law-change effects on medical expenditures and health outcomes.

While this strategy fundamentally involves differences-in-differences between reforming and nonreforming states to identify effects, we modify conventional differences-in-differences estimation strategies in several ways. First, as noted above, our models include few restrictive parametric or distributional assumptions about functional forms for expenditures or health outcomes. Second, we do not only model reforms as simple one-time shifts. Malpractice reforms might have more complex, longer term effects on medical practices for a number of reasons. Law changes may not have instantaneous effects because it may take time for lawyers, physicians, and patients to learn about their consequences for liability, and then to re-establish equilibrium practices. Law changes may affect not only the static climate of medical decision making, but also the climate for further medical interventions by reducing pressure for technological intensity growth. Thus, the long-term consequences of reforms may be different from their short-term effects. By using a panel data set including a seven-year panel, our modeling framework permits a more robust analysis of differences in time trends before and after adoption.

We use a panel-data framework with observations on successive cohorts of heart disease patients for estimating the prevalence of defensive medicine. In state s=1, S during year t=1, T, our observational units consist of individual T=1, [N.sub.st] who are hospitalized with new occurrences of particular illnesses such as a heart attack. Each patient has observable characteristics [X.sub.ist], which we describe as a fully interacted set of binary variables, as well as many unobservable characteristics that also influence both treatment decisions and outcomes. The individual receives treatment of aggregate intensity [R.sub.ist], where R donates total hospital expenditures in the year after the health event. The patient has a health outcome [O.sub.ist], possibly affected by the intensity of treatment received, where a higher value denotes a more adverse outcome (O is binary in our models).

We define state tort systems in effect at the time of each individual's health event based on the existence of two categories of reforms from a maximum-liability regime: direct and indirect malpractice reforms. Previous studies, summarized in Section II, found differences between these types of reforms on claims behavior and malpractice insurance premiums (Section IV below discusses our reform classification in detail). We denote the existence of direct reforms in state s at time t using two binary variables [L.sub.mst]: [L.sub.1st] = 1 if state s has adopted a direct reform at time t, and [L.sub.2st] = 1 if state s has adopted an indirect reform at time t. [L.sub.st] = [[L.sub.1st][L.sub.2st]] is thus a two-dimensional binary vector describing the existence of malpractice reforms.

We first estimate linear models of average expenditure and outcome effects using these individual-level variables. The expenditure models are of the form, (1) [R.sub.ist] = [[theta].sub.t] + [[alpha].sub.s] + [X.sub.ist][beta] + [W.sub.st][gamma] + [L.sub.st][[phi].sub.m] + [V.sub.ist], where [[theta].sub.t] is a time-fixed effect, [[alpha].sub.s] is a state-fixed effect, [W.sub.st] is a vector of variables described below which summarize the legal-political environment of the state over time, [beta] and [gamma] are vectors of the corresponding average-effect estimates for the demographic controls and additional state-time controls, [[phi].sub.m] is the two-dimensional average effect of malpractice reforms on growth rate, and [v.sub.ist] is a mean-zero independently distributed error term with E([v.sub.ist] [pipe] [X.sub.ist], [L.sub.st],[W.sub.st]) = 0. Because legal reforms may affect both the level and the growth rate of expenditures, we estimate different baseline time trends [[theta].sub.t] for states adopting reforms before 1985 (which were generally adopted before 1980) and non-adopting states. Our data set includes essentially all elderly patients hospitalized with the heart diseases of interest for the years of our study, so that our results describe the actual average differences in trends associated with malpractice reforms in the U.S. elderly population. We report standard errors for inferences about average differences that might arise in potential populations (e.g., elderly patients with these health problems in other years). Our model assumes that patients grouped at the level of state and time have similar distributions of unobservable characteristics that influence medical treatments and health outcomes. Assuming that malpractice laws affect malpractice pressure, but do not directly affect patient expenditures or outcomes, then the coefficients [phi] identify the average effects of changes in malpractice pressure resulting from malpractice reforms.

To distinguish short-term and long-term effects of legal reforms, we estimated less restrictive models of the average effects of legal reforms that utilize the long duration of our panel. These ''dynamic'' models estimate separate growth rate effects [[phi].sub.md] based on time-since-adoption: (2) [Mathematical Expression Omitted] where we include separate short-term average effects [[phi].sub.m0] and long-term average effects [[phi].sub.m1]. We estimate the short-term effect of the law (within two years of adoption) [[phi].sub.m0] by setting [d.sub.st0] = 1 for 1985–1987 adopters in 1987 and 1988–1990 adopters in 1990, and we estimate the long-term effect (three to five years since adoption) by setting [d.sub.st] = 1 for 1985–1987 adopters in 1990.

The estimated average effects [[phi].sub.md]d in these models form the basis for tests of the effects of malpractice reforms on health care expenditures and outcomes, and thus for tests of the existence and magnitude of defensive medicine. In all of these models, there is evidence of defensive medicine if, for direct or indirect reforms m, [[phi].sub.md] < 0 in our models of medical expenditures and [[phi].sub.md] = 0 in our models of health outcomes. In other words, if a state law reform is associated with a reduction in the growth rate of medical expenditures and does not adversely affect the growth rate of adverse heath outcomes through its impact on treatment decisions, then malpractice pressure is too high from the perspective of social welfare, and defensive medicine exists. More generally, defensive medicine exists if the effect of malpractice reforms on expenditures is ''large'' relative to the effect on health outcomes. Thus, in the results that follow, we test both whether expenditure and outcome effects of reforms differ substantially from zero, as well as the ratio of expenditure to outcome effects.

The power of the test for defensive medicine depends on the statistical precision of the estimated effects of law reforms on outcomes. Consequently, we evaluate the confidence intervals surrounding our estimates of outcome efforts carefully. It is not feasible to collect information on all health outcomes that may matter to some degree to individual patients. Instead, our tests focus on important health outcomes, including mortality and significant cardiac complications, which are reliably observed in our study population. Because the cardiac complications we consider reflect the two principal ways in which poorly treated heart disease would affect quality of life (e.g., through further heart attacks or through impaired cardiac function), estimates of effects on these health outcomes along with mortality would presumably capture any important health consequences of malpractice reforms.

We estimated additional specifications of our models to test whether reform adoption is not in fact correlated with unobserved trends in malpractice pressures or patient characteristics across the state-time groups. One set of specification tests was based on the inclusion of random effects for state-time interactions. To account for any geographically correlated variations in costs or expenditures over time, we included Huber-White [1980] standard error corrections for zip code-time error correlations. We also tested whether our estimated standard errors were sensitive to Huber-White corrections for state-time error correlations.

Another set of specification tests involved evaluating a range of variables [W.sub.st] summarizing the political and regulatory environment in each state at each point in time, to test whether various factors that might influence reform adoption influence our estimates of reform effects on either expenditure or health outcomes. Since the main cause of the tort reforms that are the focus of our study was nationwide crisis in all lines of commercial casualty insurance, it is unlikely that endogeneity of reforms is a serious problem [Priest 1987; Rabin 1988]. However, Campbell Kessler, and Shepherd [1996] show that the concentration of physicians and lawyers in a state and measures of states' political environment are correlated with liability reforms, and Danzon [1982] shows that the concentration of lawyers in a state is correlated with both the compensation paid to malpractice claims and the enactment of reforms. Consequently, we control for the political party of each state's governor, the majority political party of each house of each state's legislature, and lawyers per capita in all of the regressions, and we tested the sensitivity of our results to these controls.

A third set of specification tests relied on other tort reforms enacted in the 1980s which should have had a minimal impact on malpractice liability cases in the elderly during the time frame of our study. However, these reforms might be correlated with relevant malpractice reforms if, for example, general concerns about liability pressures in all industries led to broad legal reforms. If such reforms were correlated with included reforms, then our estimates might overstate the impact of the malpractice law reforms that we analyze.

Along these lines, we investigate the validity of our assumption of no omitted variable bias by estimating the impact of reforms to

states' statuses of limitations. Statutes of limitations are most relevant in situations involving latent injuries. Malpractice arising out of AMI in the elderly would involve an injury of which the adverse consequences would appear before any statute of limitations would exclude an injured patient. Nonetheless, statutes of limitations are the potentially most important reform not included in our study (23 states shortened their statutes of limitations between 1985 and 1990, and Danzon [1986] finds that shorter statutes of limitations reduced claims frequency). If our models are correctly specified, then statute-of-limitations reforms sohuld have no effect on the treatment intensity and outcome decisions that we analyze. If omitted variable bias is a problem, however, statute-of-limitations reforms may show a significant estimated effect.

Finally, because all of our specifications control for fixed differences across states, they do not allow us to estimate differences in the baseline levels of intensive treatment and adverse health outcomes. Thus, we also estimate additional versions of all of our models with region effects only, to explore baseline differences in treatment rates, costs, and outcomes across legal regimes.

IV. Data

The data used in our analysis come from two principal sources. Our information on the characteristics, expenditures, and outcomes for elderly Medicare beneficaries with heart disease are derived from comprehensive longtiudinal claims data for the vast majority of elderly Medicare beneficiaries who were admitted to a hospital with a new primary diagnosis (no admission with either health problem in the preceding year) of either acute myocardial infraction (AMI) or ischemic heart disease (IHD) in 1984, 1987, and 1990. Data on patient demographic characteristics were obtained from the Health Care Financing Administration HISKEW enrollment files, with death dates based on death reports validated by the Social Security Administration. Measures of total one-year hospital expenditures were obtained by adding up all reimbursement to acute-care hospitals (including copayments and deductible not paid by Medicare) from insurance claims for all hospitalizations in the year following each patient's initial admission for AMI or IHD. Measures of the occurrence of cardiac complications were obtained by abstracting data on the principal diagnosis for all subsequent admissions (not counting transfers) in the year following the patient's initial admission. Cardiac complications included re-hospitalizations within one year of the initial event with a primary diagnosis (principal cause of hospitalization) of either subsequent AMI or heart failure. Treatment of IHD and AMI patients is intended to prevent subsequent AMIs if possible, and the occurrence of heart failure requiring hospitalization is evidence that the damage to the patient's heart from ischemic disease has serious functional consequencies. The programming rules used in the data set creation process and sample exclusion criteria were virtually identical to those reported in McClellan and Newhouse [1995, 1996].

We analyze cardiac disease patients because the choice of a particular set of diagnoses permits detailed exploration of the health and treatment consequences of policy reforms. Cardiac disease and its complications are the leading cause of medical expenditures and mortality in the United States. A majority of AMIs and IHD hospitalizations occurs in hte elderly, and both mortality and subsequent cardiac complications are relatively common occurrences in this population. Thus, this condition provides both a relatively homogeneous set of patients and outcomes (to analyze the presence of defensive medicine with reasonable clinical detail), and medical expenditures are large enough and the relevant adverse outcomes common enough that the test for defensive medicine can be a precise one. Furthermore, because AMI is essentially a severe form of the same underlying illness as is IHD, we can assess whether reforms affect more or less severe cases of a health problem differently by comparing AMI with IHD patients.

In addition, cardiovascular illness is likely to be sensitive to defensive medical practices. In a ranking of illnesses by the frequency of and payments to the malpractice claims that they generate. AMI is the third most prevalent and costly, behind only malignant breast cancer and brain-damaged infants [PIAA 1993]. AMI is also disinctive because of the severity of medical injury associated with malpractice claims: conditional on a claim, patients with AMI suffer injury that rates 8.2 on the National Association of Insurance Commissioners nine-point severity scale, the second-highest severity rating of any malpractice-claim-generating health problem [PIAA]. Cardiovascular illnesses and associated procedures also include 7 of the 40 most prevalent and costly malpractice-claim-generating health problems [PIAA].

We focus on elderly patients in part because no comparable longitudinal microdata exist for nonelderly U.S. patient populations. However, there are other advantages to concentrating on this population. Several studies have documented that claims rates are lower in the elderly than in the nonelderly population, presumably because losses from severe injuries would be smaller given the patients' shorter expected survival [Weller et al. 1993]. This hypothesis suggests that physicians are least likely to practice defensively for elderly patients. Thus, treatment decisions and expenditures in this population would be the least sensitive to legal reforms. Similarly, relatively low baseline incentives for defensive practices and the relatively high frequency of adverse outcomes in the elderly imply that this population can provide the most sensitive tests for adverse health effects of reforms. These considerations suggest that analysis of elderly patients provides a lower bound on the costs of defensive medicine. In any event, trends in practice patterns over time have been similar for elderly and nonelderly patients (e.g., intensity of treatment has increased dramatically and survival rates have improved for both groups [National Center for Health Statistics 1994]). Thus, we would expect the findings for this population to be qualitatively similar to results for the nonelderly, if such a longitudinal empirical analysis were possible.

Table I describes the elderly population with AMI and IHD from the years of our study. Between 1984 and 1990 the elderly AMI population aged slightly, and the share of males in the IHD population increased slightly, but the characteristics of AMI and IHD patients were otherwise relatively stable. The number of AMI patients in an annual cohort declined slightly (from 233,000 to 221,000), while the number of IHD patients increased (from 357,000 to 423,000). Changes in real hospital expenditures in the year following the AMI or IHD event were dramatic. For example, one-year average hospital expenditures for AMI patients rose from $10,880 in 1984 to $13,140 in 1990 (in constant 1991 dollars), a real growth rate of around 4 percent per year. These expenditure trends are primarily attributable to changes in intensity. Because of Medicare's ''prospective'' hospital payment system, reimbursement given treatment choice for Medicare patients actually declined during this period. This growth in expenditures and treatment intensity was associated with significant mortality reductions, from 39.9 percent to 35.3 percent for AMI patients (with the bulk of the reduction coming after 1987) and from 13.5 percent to 10.8 percent for IHD patients (with the bulk coming before 1987). However, the AMI survival improvements—but not the IHD improvements—were associated with corresponding increases in recurrent AMIs and in heart failure complications. This underscores that the role of changes in intensity versus other factors—as well as any role of changes in liability—is difficult to identify directly in all of these trends.

Second, building on prior efforts to collect information on state malpractice laws (e.g., Sloan, Mergenhagen, and Bovbjerg [1989]), we have compiled a comprehensive database on reforms to state liability laws and state malpractice-control policies that contain information on several types of legal reforms from 1969 to 1992(8). The legal regime indicator variables are defined such that the level of liability imposed on defendants in the baseline is at a hypothetical maximum.

Eight characteristics of state malpractice law, representing divergences from the baseline legal regime, are summarized in Table IIA. We divide these eight reforms into two groups of four reforms each: reforms that directly reduce malpractice awards and reform that only reduce awards indirectly. ''Direct'' reforms include reforms that truncate the upper tail of the distribution of awards, such as caps on damages and the abolition of punitive damages, and reforms that shift down the mean of the distribution, such as collateral-source-rule reform and abolition of mandatory prejudgment interest. ''Indirect'' reforms include other reforms that have been hypothesized to reduce malpractice pressure but only affect awards indirectly, for instance, through restricting the range of contracts that can be enforced between plaintiffs and contingency-fee attorneys. As discussed in Section II above, we chose this division because the previous empirical literature generally found the impact of direct reforms to be larger than the impact of indirect reforms on physicians' incentives through their effect on the compensation paid and the frequency of malpractice claims. Each of the observations in the Medicare data set was matched with a set of two tort law variables that indicated the presence or absence of direct or indirect malpractice reforms at the item of their initial hospitalization.

Table IIB contains the effective date for the adoption of direct and indirect reforms for each of the 50 states. The table shows that a number of states have implemented legal reforms at different times. For example, 13 states never adopted any direct reforms, 23 states adopted direct reforms between 1985 and 1990, and 18 states adopted direct reforms 1984 or earlier (adoptions plus nonadoptions exceed 50 because some states adopted both before and after 1985). Similarly, 16 state never adopted any indirect reforms, 23 states adopted indirect reforms between 1985 and 1990, and 18 states adopted indirect reforms 1984 or earlier. Adoption of direct and indirect reforms is not strongly related: sixteen states that never adopted reforms of one type have adopted reforms of the other.

V. Empirical results

Table III previews our basic difference-in-difference (DD) analysis by reporting unadjusted conditional means for expenditures and mortality for four patient groups, based on the timing of malpractice reforms. Expenditure levels in 1984 (our base year) were slightly higher in states passing reforms between 1985–1987 and lower in states passing reforms between 1988–1990. Baseline

mortality rates were slightly lower for AMI and higher for IHD in the 1985–1987 reform states, and conversely for the 1988–1990 reform states. Thus, overall, reform states looked very similar to nonreform states in terms of baseline expenditures and outcomes. States with earlier reforms (pre-1985) had slightly higher base year expenditures but similar base year mortality rates. The table shows that expenditure growth in reform states was smaller than in nonreform states during the study years. Altogether, growth was 2 to 6 percent slower in the reform compared with the nonreform states for AMI, and trend differences were slightly greater for IHD. Although mortality trends differed somewhat across the state groups, mortality trends on average were quite similar for reform and nonreform states. These simple comparisons do not account for any differences in trends in patient characteristics across the state groups, do not account for any effects of other correlated reforms, and do not readily permit analysis of dynamic malpractice reform effects. Nonetheless, they anticipate the principal estimation results that follow.

Table IV presents standard DD estimates of the effects of tort reforms between 1985 and 1990 on average expenditures and outcomes for AMI, that is, no dynamic reform effects are included. In this and subsequent models, we include fully interacted demographic effects—for patient age (65–69, 70–74, 75–79, 80–89, 90–99), gender, black or nonblack race, and urban or rural residence—and controls for contemporaneous political and regulatory changes described previously. For each of the four outcomes—one-year hospital expenditures, mortality, and AMI and CHF readmissions—two sets of models are reported. The first set includes complete state and year fixed effects. The second set, intended to illustrate the average differences of states that had adopted reforms before our study began as well as the sensitivity of the results to a more complete fixed-effect specification, includes only time and census region effects. As described in Section II, both specifications are linear, the dependent variable in the expenditure models is logged, all coefficient estimates are multiplied by 100 and so can be interpreted as average effects in percent (for expenditure models) or percentage points (for outcomes models), and the standard errors are corrected for heteroskedasticity and grouping at the state/zip-code level.

The estimates of average expenditure growth rates in both specifications are substantial showing an increase in real expenditures of over 21 percent between 1984 and 1990. The estimated DD effects show that expenditures declined by 5.3 percent in states that adopted direct reforms relative to nonreforming states. The corresponding DD estimate of the effect of indirect reforms, 1.8 percent, is positive but small; these reforms do not appear to have a substantial effect on expenditures. In the region-effect models, the estimated DD reform effects are slightly larger but qualitatively similar States that adopted reforms prior to our study period had 1984–1990 growth rates in expenditures that were slightly larger, by around 3 percent. The region-effect model shows that these states as a group also had slightly higher expenditure levels in 1984. Because these states generally adopted reforms at least five years before our panel began, our results suggest that direct reforms do not result in relatively slower expenditure growth more than five years after adoption. However, lack of a pre-adoption baseline for and adoption-time heterogeneity among the early-adopting states, as well as the sensitivity of the early-adopter/nonadopter differential growth rates to alternative specifications (as discussed below), complicates interpreting estimates of differential early-adopter/nonadopter growth rates as a long-term effect. In any event, in no case would the differential 1984–1990 expenditure growth rate between adopters and nonadopters offset the difference-indifference ''levels'' effect. In total, malpractice reforms always result in a decline in cost growth at least 10 percent.

The remaining columns of Table IV describe the corresponding DD estimates of reform effects on AMI outcomes. Mortality rates declined, but readmission rates with cardiac complications increased during this time period, confirming the results of Table I. Outcome trends were very similar in reform and nonreform states: the cumulative difference in mortality and cardiac complication trends was around 0.1 percentage points. These small estimated mortality differences are not only insignificantly different from zero, they are estimated rather precisely as well. For example, the upper 95 percent confidence limit for the effect of direct reforms on one-year mortality trends between 1984 and 1990 is 0.64 percentage points. Coupled with the estimated expenditure effect, the expenditure effect, the expenditure/benefit ratio for a higher pressure liability regime is over $500,000 per additional one-year AMI survivor in 1991 dollars.

Even a ration based on the upperbound mortality estimate translates into hospital expenditures of over $100,000 per additional AMI survivor to one year. The estimates in the corresponding region-effect models are very similar. Indirect reforms were also associated with estimated mortality effects that were very close to zero. Results for outcomes related to quality of life, that is, rehospitalizations with either recurrent AMI or heart failure, also showed no consequential effects of reforms. In this case, the point estimates (upper bound of the 95 percent confidence interval) for the estimated effected of direct reforms were −0.18 (0.21) percentage points for AMI recurrence and −0.07 (0.28) percentage points for the occurrence of heart failure. Again, compared with the estimated expenditure effects, these differences are not substantial.

Table V presents estimated effects of malpractice reforms on IHD expenditures and outcomes, with results qualitatively similar to those just described for AMI. IHD expenditure also grew rapidly between 1984 and 1990. Direct reform led to somewhat larger expenditure reductions for IHD (9.0 percent) and indirect reforms were again associated with relatively smaller increases in expenditures (3.4 percent). The effects of reform on IHD outcomes are again very small: the effect of direct reforms on mortality rates was an average difference of −0.19 percentage points (95 percent upper confidence limit of 0.10), and the effects on subsequent occurrence of AMI or heart failure hospitalizations were no larger. Estimates from the models with region effects were very similar. Thus, directly liability reforms appear to have relatively larger effect on IHD expenditures, without substantial consequences for health outcomes.

As we noted in Section III, the simple average effects of liability reforms estimated in the DD specifications of Tables IV and V may not capture the dynamic effects of reforms. Table VI presents results form model specifications that estimate reform effects less restrictively. In these specifications we use our seven-year panel to estimate short-term and long-term effects of direct and indirect reforms on expenditures and outcomes, to determine whether the ''shift'' effect implied by the DD specification is adequate. The models retain our state and time fixed effects.

We find the same general patterns as in the simple DD models, but somewhat larger effects of malpractice reforms three to five years after adoption compared with the short-term effects. In particular, Table VI shows that direct reforms lead to short-term reductions in AMI expenditures of approximately 4.0 percent within two years of adoption, and that the reduction grows to approximately 5.8 percent three to five years after adoption. This specification also shows that the positive association between indirect reforms and expenditures noted in Table IV is a short-term phenomenon: the long-term effect on expenditures is approximately zero.

As in Table IV, both direct and indirect reforms have trivial effects on mortality and readmissions with complications, both soon and later after adoption. For example, the average difference in mortality trends between direct-reform and nonreform states is −0.22 percentage points (not significant) within two years of adoption, with a 95 percent upper confidence limit of 0.39 percentage points. At three to five years the estimated effect is 0.12 percentage points (not significant) with a 95 percent upper confidence limit of 0.75 percentage points. These points estimates translate into very high expenditures per reduction in adverse AMI outcomes.

The results for the corresponding model of IHD effects over time are presented in the right half of Table VI. Direct reforms are associated with a 7.1 percent reduction in expenditures by two years after adoption (standard error 0.5) and an 8.9 percent reduction by five years after (standard error 0.5). In contrast, mortality tends for states with direct reforms do not differ significantly by two years (point estimate of −0.15 percentage points, 95 percent upper confidence limit 0.18) or five years after adoption (point estimate −0.11 percentage points, 95 percent upper confidence limit 0.22). Direct reforms also have no significant or substantial effects on cardiac complications, either immediately or later. Indirect reforms are again associated with small positive effects on expenditure growth (3.1 percent within two years), but these effects decline over time to a relative trivial level (1.4 percent at three to five years). Indirect reforms are also associated with slightly lower mortality rates and slightly higher rates of cardiac complications, but the size of these effects is very small (e.g., the upper limit of the 95 percent confidence interval around the estimated effect of indirect reforms three to five years after adoption is 0.47 percentage points for AMI recurrence and 0.29 percentage points for heart failure occurrence). Thus, the pattern of reform effects for IHD is again qualitatively similar to that for AMI, with direct reforms having a somewhat larger effect on expenditures.

Taken together, the estimates in Tables IV through VI consistently show that the adoption of direct malpractice reforms between 1984 and 1990 led to substantial relative reductions in hospital expenditures during this period—accumulating to a reduction of more than 5 percent for AMI and 9 percent for IHD by five years after reform adoption—and that these expenditure effects were not associated with any consequential effects on mortality or on the rates of significant cardiac complications.

We estimated a variety of other models to explore the robustness of our principal results. We tested the sensitivity of our results to alternative assumptions about the excludability of state/time interactions. One set of tests reestimated the models with random state/time effects to determine whether correlated outcomes at the level of state/time interactions might affect our conclusions. Our estimated effects of reforms did not differ substantially or significantly with these

methods. Using the model presented in Tables IV and V, the estimated difference-indifference effect of direct reforms on expenditures for AMI patients, controlling for random state/time effects, is −4.9 percent (standard error 2.1), and for indirect reforms, the estimated effect is −0.6 percent (standard error 2.0). The estimated DD effect of direct reforms on mortality for AMI patients, controlling for random state/time effects, is 0.15 percentage points (standard error 0.32) and for indirect reforms, the estimated effect is −0.19 percentage points (standard error 0.32). We obtained similar results for IHD patients: direct reforms showed a negative and statistically significant effect on expenditures with an insubstantial and precisely estimated effect on mortality, and indirect reforms showed no substantial effect on either expenditures or mortality. Estimated differential 1984–1990 expenditure growth rates between early-adopters and nonadopters were insignificant in the random effects specification. For AMI patients the differential growth rate for early adopters of direct reforms is 0.61 percent (standard error 3.1). For early adopters of indirect reforms the differential growth rate is 0.61 percent (standard error 2.3). For IHD patients the differential growth rate for early adopters of direct reforms is −1.9 percent (standard error is 3.0). For early adopters of indirect reforms the differential growth rate is −3.2 percent (standard error is 2.2). Another related diagnostic involved estimating the models with Huber-White [1980] corrections for state/time grouped errors instead of corrections for zipcode/ time grouped errors. Standard errors corrected for state/ time grouping were somewhat larger than those corrected for zipcode/ time grouping but smaller than those obtained under the random effects specification.

Although they did have a statistically significant influence on expenditures in some models, the broad set of political and regulatory environment controls that we used did not change our results substantially. Using the models presented in Tables IV and V but excluding controls for the regulatory and legal environment, the estimated DD effect of direct reforms on expenditures for AMI patients −9.1 percent (standard error is 0.44). For indirect reforms the estimated DD effect is 3.3 percent (standard error is 0.40). In addition, the difference in 1984–1990 growth rates between early-reforming and nonreforming states changes sign from positive to negative for enacting direct reforms before 1985 (Table IV: 3.1 percent with legal environment controls, −3.1 percent without them). The difference in growth rates for states enacting indirect reforms before 1985 remains about the same (Table IV: 2.8 percent with legal environment controls, 3.5 percent without them). These two specification checks, taken together, underscore the points made by Tables IV and V. Direct reforms reduce expenditure growth without increasing mortality, indirect reforms have no substantial effect on either expenditures or mortality, and differential 1984–1990 expenditure growth rates for early-adopting states are not robust estimates of the long-term impact of reforms.

Finally, we reestimated the models in Tables IV and V including controls for statute-of-limitations reforms. Statute-of-limitation reforms have a very small positive effect on expenditures and no effect on mortality, which is consistent with their classification as an indirect reform. Using the models presented in Tables IV and V, statute-of-limitations reforms are associated with a 0.96 percent increase in expenditures for AMI patients (standard error is 0.46), and a 0.003 percentage point increase in mortality (standard error is 0.28). Inclusion of statute-of-limitation reforms did not substantially alter the estimated DD effect of either direct or indirect reforms: for AMI patients the estimated effect of direct reforms went from −5.3 percent (Table IV) to −5.5 percent, and the estimated effect of indirect reforms remained constant at 1.8 percent (Table IV).

To explore the sources of our estimated reform effects more completely, we estimated additional specifications that analyzed effects on use of intensive cardiac procedures such as cardia catheterization, that used alternative specifications of time-since-adoption and calendar-year effects, and that estimated the effects of each type of tort reform separately (see Table IIA). These specifications produced results consistent with the simpler specifications reported here for both AMI and IHD. Specifically, reforms with a determinate, negative direct impact on liability led to substantially slower expenditure growth, somewhat less growth in the use of intensive procedures (but smaller effects than would explain the expenditure differences, suggesting less intensive treatments were also affected), and no consequential effects on mortality.

VI. Policy implications

We have developed evidence on the existence and magnitude of ‘‘defensive’’ medical practices by studying the consequences of reforms limiting legal liability on health care expenditures and outcomes for heart disease in the elderly. These results provide a critical extension to the existing empirical literature on the effects of malpractice reforms. Previous studies have found significant effects of direct reforms on the frequency of and payments to malpractice claims. Because the actual costs of malpractice litigation comprise a very small portion of total health care expenditures, however, these litigation effects have only a limited impact on health care expenditure growth. To provide a more complete assessment of malpractice reforms, we have studied their consequences for actual health care expenditures and health outcomes. Our study is the first to use exogenous variation in tort laws not related to potential idiosyncrasies of providers or small geographic areas to assess the behavioral effects of malpractice pressure. Thus, our analysis fills a crucial empirical gap in evaluating the U.S. malpractice liability system, because the effects of malpractice law on physician behavior are both a principal justification for current liability rules and potentially important for understanding medical expenditure growth.

Our analysis indicates that reforms that directly limit liability—caps on damage awards, abolition of punitive damages, abolition of mandatory prejudgment interest, and collateral-source-rule reforms—reduce hospital expenditures by 5 to 9 percent within three to five years of adoption, with the full effects of reforms requiring several years to appear. The effects are somewhat smaller for actual heart attacks than for a relatively less severe form of heart disease (IHD), for which more patients may have ‘‘marginal’’ indications for treatment. In contrast, reforms that limit liability only indirectly—caps on contingency fees, mandatory periodic payments, joint-and-several liability reform, and patient compensation funds—are not associated with substantial effects on either expenditures or outcomes, at least by several years after adoption. Neither type of reforms led to any consequential differences in mortality or the occurrence of serious complications. As we described previously, the estimated expenditure/benefit ratio associated with direct reforms is over $500,000 per additional one-year survivor, with comparable ratios for recurrent AMIs and heart failure. Even the 95 percent confidence bounds for outcome effects are generally under one percentage point, translating into over $100,000 per additional one-year survivor. While it is possible that malpractice reforms have had effects on other outcomes valued by patients, this possibility must be weighed against the absence of any substantial effects on mortality or the principal cardiac complications that are correlated with quality of life. Thus, at the current level of malpractice pressure, liability rules that are more generous in terms of award limits are a very costly approach to improving health care outcomes.

Approximately 40 percent of patients with cardiac disease were affected by direct reforms between 1984 and 1990. Based on simulations using our effect estimates, we conclude that if reforms directly limiting malpractice liability had been applied throughout the United States during this period, expenditures on cardiac disease would have been around $450 million per year lower for each of the first two years after adoption and close to $600 million per year lower for each of years three through five after adoption, compared with nonadoption of direct reforms.

While our panel is relatively lengthy for a DD study, it is to long enough to allow us to reach equally certain conclusions about the long-term effects of malpractice reforms on medical expenditure growth and trends in health outcomes. Plausible static effects of virtually all outcomes. Plausible static effects of virtually all policy factors cannot explain more than a fraction of expenditure growth in recent decades [Newhouse 1992], and we have also documented that outcome trends may be quite important. Whether policy changes such as malpractice reforms influence these long-term trends through effects on the environment of technological change in health care is critical issue. Do reforms have implications for trends in expenditures and outcomes long after they are adopted, or do the trend effects diminish over time? Preliminary evidence on the question from early-adopted (pre-1985, mostly pre-1980) reforms suggest that long-term expenditure growth is not slower in states that adopt direct reforms. On the other hand, subsequent growth does not appear to offset the expenditure reductions that occur in the years following adoption. Moreover, we found no evidence that direct reforms adopted from 1985–1990 had smaller effects in states that had also adopted direct reforms earlier, suggesting that dynamic malpractice policies may produce more favorable long-term expenditure/benefit trends. In any event, our conclusions about long-term effects are speculative at this point, given the absence of baseline data on expenditures and outcome trends in reform states. Follow-up evaluations of longer term effects of malpractice reforms should be possible within a few years, and might help confirm whether liability reforms have any truly lasting consequences for expenditure growth or trends in health outcomes.

Hospital expenditures on treating elderly heart disease patients are substantial—over $8 billion per year in 1991—but they comprise only a fraction of total expenditures on health care. If our results are generalizable to medical expenditures outside the hospital, to other illnesses, and to younger patients, then direct reforms could lead to expenditure reductions of well over $50 billion per year without serious adverse consequences for health outcomes. We hope to address the generalizability of our results more extensively in future research. More detailed studies using both malpractice claims information and patient expenditure and outcome information, linking the analysis of the two

policy justifications for a malpractice liability system, should be particularly informative. Such studies could provide more direct evidence on how liability rules translate into effects on particular kinds of physician decisions with implications for medical expenditures but not outcomes. Thus, they may provide more specific guidance on which specific liability reforms—including ''nontraditional'' reforms such as no-fault insurance and mandatory administrative reviews—will have the greatest impact on defensive practices without substantial consequences for health outcomes.

Our evidence on the effects of direct malpractice reforms suggests that doctors do practice defensive medicine. Given the limited relationship between malpractice claims and medical injuries documented in previous research, perhaps our findings that less malpractice liability does not have significant adverse consequences for patient outcomes but does affect expenditures are not surprising. To our knowledge, however, this is the first direct empirical quantification of the costs of defensive medicine.

VII. Conclusion

We have demonstrated that malpractice liability reforms that directly limit awards and hence benefits from filing lawsuits lead to substantial reductions in medical expenditure growth in the treatment of cardiac illness in the elderly with no appreciable consequences for important health outcomes, including mortality and common complications. We conclude that treatment of elderly patients with hear disease does involve ''defensive'' medical practices, and that limited reductions in liability can reduce these costly practices. (*) We would like to thank Randall Bovbjerg, David Genesove, Jerry Hausman Paul Joskow, Lawrence Katz, W. Page Keeton, Gary King, A. Mitchell Polinsky George Shepherd, Frank Sloan, seminar participants at Northwestern University, the University of Michigan and the National Bureau of Economic Research, and two anonymous referees for advice, assistance, and helpful comments. Jeffrey Geppert and Mohan Ramanujan provided excellent research assistance. Funding from the National Institute of Aging, Harvard/MIT Research Training Group in Positive Political Economy, and the John M. Olin Foundation is greatly appreciated. All errors are our own. Reforms requiring collateral-source offset revoke the common-law default rule which states that the defendant must bear the full cost of the injury suffered by the plaintiff, even if the plaintiff were compensated for all or part of the cost by an independent or ''collateral'' source. Under the common-law default rule defendants liable for medical malpractice always bear the cost of treating a patient for medical injuries resulting from the malpractice even if the treatment were financed by the patient's own health insurance. Either the plaintiff enjoys double recovery (the plaintiff recovers from the defendant and his own health insurance for medical expenses attributable to the injury) or the defendant reimburses the plaintiff's (subrogee) health insurer, depending on the plaintiff's insurance contract and state or federal law. However, some states have enacted reforms that specify that total damages payable in a malpractice tort are to be reduced by all or part of the value of collateral source payments. Estimates of the impact of reforms on claim severity vary over time and across studies. Based on 1975–1978 data, Danzon [1982, p. 30] reports that states enacting caps on damages had 19 percent lower awards, and states enacting mandatory collateral source offsets had 50 percent lower awards. Based on 1975–1984 data, Danzon [1986, p. 26] reports that states enacting caps had 23 percent lower awards, and states enacting collateral source offsets had 11 to 18 percent lower awards. Based on 1975–1978 and 1984 data, Sloan, Mergenhagen and Bovbjerg [1989] find that caps reduced awards by 38 to 39 percent, and collateral-source offsets reduced awards by 21 percent. Again, because all elderly patients with serious heart disease during the years of our study are included, this consideration applies only to extending the results to other patient populations. Of course, if such state-time specific effects exist, there is no reason to expect that they would be normally distributed. Normality assumptions in error structures generally have not performed well in models of health expenditures and outcomes. However, incorporating such random effects permits us to explore the robustness of our estimation methods to possible state-time specific shifts. According to Danzon [1982, 1986], urbanization is a highly significant determinant both of claim payments to and the frequency of claims and of the enactment of tort reforms. We control for urbanization at the individual level, as discussed below. Although we did not include controls for the number of physicians per capita in the reported results because of concerns regarding the exogeneity of that variable, results conditional on physician density are virtually identical. We include both a current and a one-year-lagged effect to account for the possibility that past political environments influence current law. Data on lawyers per capita for 1980, 1985, and 1988 are from the American Bar Foundation [1985, 1991]. Intervening years are calculated by linear interpolation. Our data set is partially derived from Campbell, Kessler, and Shepherd [1966]. The baseline is defined as the ''negligence rule'' without any of the liability-reducing reforms studied here and with mandatory prejudgment. That is, (.063*$13,140)/.0064[nearly equal to]$108,000 using the 95 percent upper bound of the estimated mortality effect and (.053*$13,140)/.007[nearly equal to]$1,000,000 using the actual DD estimate. Both of these ratios are very large, the difference in absolute magnitude of the two estimates results from the denominator being very close to zero. Because we were concerned that reforms might affect the rate of IHD hospitalization as well as outcomes among patients hospitalized, we estimated models analogous to the specifications reported using population hospitalization rates with IHD as the dependent variable. We found no significant or substantial effects of either direct or indirect reforms on IHD hospitalization rates. Models with region effects only, analogous to the right halves of Tables IV and V, again showed very similar effect estimates. We also estimate separate time-trend effects for early-reform (pre-1984) states. This approach may permit the development of some evidence on ''longterm'' effects of reforms on intensity growth rates. As noted previously we find no evidence for such effects. Of course, our lack of a pre-adoption baseline for the early-adopting states precludes DD identification and makes the long-term conclusion more speculative. A follow-up study using more recent expenditure and outcome data would provide more convincing evidence on effects beyond five years. In contrast to AMI, the slower rate of expenditure growth between 1984 and 1990 for early-reform states (see Table V) suggests that reforms may have longer term effects on slowing IHD expenditure growth.

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Note.—Tables were not reproducible in the RECORD.

Mr. REYNOLDS. Mr. Speaker, I yield 2 minutes to the gentlewoman from West Virginia (Mrs. CAPITO).

Mrs. CAPITO. Mr. Speaker, West Virginia's health care system and the health care system of many States are facing many challenges. But medical liability insurance has caused a mass exodus of doctors from my State of West Virginia.

I live in Charleston, West Virginia, our capital city. We have one of the largest medical facilities in our State, the Charleston Area Medical Center, which was downgraded from a level one trauma center to a level three trauma center because we could not provide the 24 hour, 7-day-a-week emergency care.

Mr. Speaker, I challenge anybody to tell me about living in a capital city of any State in this Nation and you have to be air lifted out of your capital city, out of the largest medical facilities in your State if you have multiple injuries.

□ 1245

That is a sad story, but I can tell my colleagues what is going to be a sadder story if we do not fix this problem.

Last week, a young boy 6 years old had a pen lodged in his windpipe. His parents rushed him to the emergency room. What happened, the emergency physician had to call all around to find somebody to treat him. Did they find anybody? No. He drives 3 hours to Cincinnati, Ohio, to find a specialist that can help this young man. What if he could not endure a 3-hour car ride?

I challenge my colleagues, a tragedy is in the making. The perfect storm is created because of the high cost of medical liability insurance, and our doctors across the Nation and most especially in West Virginia are suffering, and the access and the quality care that we deserve as Americans is going to suffer as well.

Without this Federal legislation, the exodus of our health care providers from the practice of medicine will continue, and patients will find it increasingly difficult to find the care. I urge all of my colleagues to recognize this critical and growing problem and to pass H.R. 4600. It will go a long way to helping the health care system in our State and our Nation rise and stay at the level that we expect.

Mr. HASTINGS of Florida. Mr. Speaker, I yield myself the balance of our time, and I probably will not take it all.

I do ask a question, if this bill is supposed to be the end all, be all, then will someone please explain to me what would have been wrong with accepting the amendments that were very thoughtful, that were offered by Members of the House of Representatives, most of whom were Democrats? No, they did not get that opportunity.

I do not know whether the gentleman from New York (Mr. REYNOLDS) cares to indulge in this particular colloquy or any other Republican or any Member of the House of Representatives. I ask my colleague from New York when he closes to point to the place in this legislation where savings are going to be passed to physicians.

Let me give my colleagues what may not appear to be an exacting analogy. We pass a significant number of subsidies for farmers in the United States of America and I support those. We supported subsidies, for example, for the sugar industry and for wheat, but nowhere after those subsidies where sugar went down or wheat went down did we see Corn Flakes or candy go down. The consumer gets slapped every time, it does appear.

Let me set the record straight. This is modeled on California, and we have more Members from California in this House of Representatives than from any other State in the Nation. We had the gentlewoman from California (Ms. ESHOO) come down here to talk about California. Let me tell my colleagues what they are not saying about MICRA, it is referred to.

The California experience is perhaps in many respects the most telling fact having to do with this legislation since it is modeled on California. In 1975, California enacted into law the Medical Injury Compensation Reform Act, and this is the act after which many of the provisions of H.R. 4600 are modeled after, including caps on noneconomic damages, collateral source offsets and limitation on attorney's fees. Despite these reforms in California, premiums for medical malpractice in California grew more quickly between 1991 and 2000 than in the Nation, 3½ percent versus 1.9 percent respectively, and between 1975 and 1993, California's health care costs rose 343 percent, almost double the rate of inflation.

Not only does the evidence show that California's tort reform has failed to lower premiums for physicians, it also shows that California's insurance companies are reaping excessive profits in the aftermath of tort reform. In 1997, California's insurers earned more than $763 million, yet paid out less than $300 million to claims.

Mr. Speaker, the gentleman from Massachusetts (Mr. MARKEY) offered an amendment yesterday that would direct insurers to use any savings received as a result of H.R. 4600 to reduce the premiums they charge their health care providers. If within 2 years of that enactment, his legislation called for insurers not realizing cost savings, then the provisions of H.R. 4600 relating to liability lawsuits and liability claims would not apply to any lawsuits and claims against providers insured by the insurance companies. That was defeated in the Committee on Rules by 2 to 8 and never will see the light of day here, a measure that would have given an opportunity for physicians to receive the benefits that would be saved.

I want to harken back to 1993 when my colleagues on the other side of the aisle very skillfully built an infrastructure on radio and all I could hear, I was a new Member of Congress, all I could hear was the Democrats are having closed rules. People that did not even know what a rule was were calling in to the talk shows and saying those Democrats are horrible about closed rules. So little did I know that time would pass and I would become a member of the Committee on Rules, and what I am experiencing and what we experienced here today is a closed rule. If it was bad in 1993, it is bad in 2002.

What closed rules have done and what they are doing is stopping the gentleman from Michigan (Mr. STUPAK), who we heard from, the gentlewoman from California (Ms. ESHOO), the gentleman from Pennsylvania (Mr. HOEFFEL) and the gentleman from New Jersey (Mr. PASCRELL). Very thoughtful amendments, that if this body worked its will could have gone about the business of attending to.

I am a lawyer for 40 years and I am proud of that, and what I learned in law school in torts, written by some of the more brilliant persons in the world, including those founders in England that gave us this great judicial system that we have, and that is that that process of punitive damages is embedded in our laws to make sure that people do not act grossly negligent.

That said, most physicians, most health care providers are honest. There is nothing that is going to stop the bad physician from being bad in this particular measure, and punitive damages are what alerts the entire profession that they need to be careful. It is just that simple. I invite my colleague from New York to show me where the insurance companies are going to pass on to the physicians any savings and where H.R. 4600 does anything to lower insurance premiums.

Mr. Speaker, I yield back the balance of my time.

Mr. REYNOLDS. Mr. Speaker, I yield myself the remainder of my time.

I thank the gentleman from Florida for some of his opportunity to share with passion his views on this legislation.

First, both the Committee on the Judiciary, which passed the legislation out by voice vote, and the Committee on Energy and Commerce have had ample debate on this legislation before it came to the Committee on Rules and now on to the floor for consideration of by the entire body.

Two Stanford University economists have conducted two extensive studies using national data on Medicare populations and concluded that patients from States that adopted direct medical care litigation reforms, and I will say that again for my Florida colleague, that the study which adopted and concluded that patients from States that adopted direct medical care litigation reforms, such as limits on damage awards, incur significantly lower hospital costs while suffering no increase in adverse health outcomes associated with the illness for which they were treated.

Mr. Speaker, in public opinion, by a survey conducted by Wirthlin Worldwide for Health Care Liability Alliance, 71 percent of Americans agree that the main reason health care costs are rising is because of medical liability lawsuits; 78 percent of Americans say they are concerned about the access to care being affected because doctors are leaving the practices due to rising liability costs; 73 percent of Americans support reasonable limits on awards for pain and suffering in medical liability lawsuits; and more than 76 percent of Americans favor a law limiting the percentage on contingent fees paid by the patient.

This legislation is intended to control escalation in lawsuit damage awards and slow the rising costs of medical malpractice insurance. The HEALTH Act would benefit patients because it will award injured patients unlimited economic damages. It will award injured patients noneconomic damages up to $250,000. It will award injured patients punitive damages of up to two times economic damages of $250,000 or whatever is higher. It establishes a fair share rule that allocates damage awards fairly and in proportion to a party's degree of fault, and it establishes a sliding scale of attorney's contingent fees, therefore maximizing the recovery for patients. It allows States the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in this bill.

I hear my time is expiring. I urge a yes vote on the rule and on the underlying legislation, a yes vote for patients and families all across America.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The SPEAKER pro tempore (Mr. ISAKSON). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. HASTINGS of Florida. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 221, nays 197, not voting 14, as follows:

[Roll No. 419]

YEAS—221

Aderholt
Akin
Armey
Baker
Ballenger
Barcia
Bartlett
Barton
Bass
Bereuter
Biggert
Bilirakis
Blunt
Boehlert
Boehner
Bonilla
Bono
Boozman
Brady (TX)
Brown (SC)
Bryant
Burr
Burton
Calvert
Camp
Cannon
Cantor
Capito
Castle
Chabot
Chambliss
Coble
Collins
Combest
Cooksey
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal
DeLay
DeMint
Diaz-Balart
Doolittle
Dreier
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goss
Graham
Granger
Graves
Green (WI)
Greenwood
Grucci
Gutknecht
Hall (TX)
Hansen
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
Kerns
King (NY)
Kingston
Kirk
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
McCrery
McHugh
McInnis
McKeon
Mica
Miller, Dan
Miller, Gary
Miller, Jeff
Moran (KS)
Moran (VA)
Morella
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Osborne
Ose
Otter
Oxley
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Reynolds
Riley
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schaffer
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sununu
Sweeney
Tancredo
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Tiberi
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins (OK)
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NAYS—197

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldacci
Baldwin
Barrett
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Crowley
Cummings
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley
Doyle
Duncan
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Gutierrez
Harman
Hastings (FL)
Hill
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind (WI)
Kleczka
Kucinich
LaFalce
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Lynch
Maloney (CT)
Markey
Mascara
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McGovern
McIntyre
McKinney
McNulty
Meehan
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Mollohan
Moore
Murtha
Nadler
Napolitano
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Phelps
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Ross
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Schiff
Scott
Serrano
Sherman
Shows
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Thompson (MS)
Tierney
Towns
Turner
Udall (CO)
Udall (NM)
Velazquez
Visclosky
Waters
Watson (CA)
Watt (NC)
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—14

Bachus
Barr
Bonior
Buyer
Callahan
Maloney (NY)
McDermott
Meek (FL)
Mink
Paul
Roukema
Stump
Thompson (CA)
Thurman

□ 1321

Mrs. JONES of Ohio changed her vote from "yea" to "nay."

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Mr. SENSENBRENNER. Mr. Speaker, pursuant to House Resolution 553, I call up the bill (H.R. 4600) to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. ISAKSON). Pursuant to House Resolution 553, the bill is considered read for amendment.

The text of H.R. 4600 is as follows:

H.R. 4600

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 3. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

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

SEC. 4. COMPENSATING PATIENT INJURY.

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

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

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

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

SEC. 5. MAXIMIZING PATIENT RECOVERY.

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

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

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

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

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

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

SEC. 6. ADDITIONAL HEALTH BENEFITS.

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

SEC. 7. PUNITIVE DAMAGES.

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

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

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 9. DEFINITIONS.

In this Act:

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

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

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

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

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

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

(D) any other publicly or privately funded program.

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

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

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

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

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

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

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

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

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

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause

physical injury other than providing health care goods or services.

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

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

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

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

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

SEC. 10. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

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

The SPEAKER pro tempore. In lieu of the amendments recommended by the Committee on the Judiciary and the Committee on Energy and Commerce, the amendment in the nature of a substitute printed in House Report 107–697 is adopted.

The text of the amendment in the nature of a substitute printed in House Report 107–697 is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

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

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 3. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

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

(1) Upon proof of fraud;

(2) Intentional concealment; or

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

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

SEC. 4. COMPENSATING PATIENT INJURY.

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

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

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

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

SEC. 5. MAXIMIZING PATIENT RECOVERY.

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

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

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

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

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

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

SEC. 6. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 7. PUNITIVE DAMAGES.

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

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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(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.

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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 non-economic damages, as such terms are defined in this section.

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

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

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

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

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

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

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

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

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

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

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

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

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

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

SEC. 10. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

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

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.

The SPEAKER pro tempore. The gentleman from Wisconsin (Mr. SENSENBRENNER) and the gentleman from Michigan (Mr. CONYERS) each will control 20 minutes and the gentleman from Pennsylvania (Mr. GREENWOOD) and the gentleman from Ohio (Mr. BROWN) each will control 10 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. SENSENBRENNER).

GENERAL LEAVE

Mr. SENSENBRENNER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to include extraneous material on the bill, H.R. 4600, currently under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. SENSENBRENNER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, a national insurance crisis is ruining the Nation's essential health care system. Medical professional liability insurance rates have soared, causing many insurers to either drop coverage or raise premiums to unaffordable levels. Doctors and other health care providers are being forced to abandon patients and practices, particularly in high-risk specialties such as emergency medicine and obstetrics and gynecology. This trend has had a particularly negative impact upon women, low-income neighborhoods and rural areas, and in medical schools large and small.

When California faced a similar crisis over 25 years ago, Democratic Governor Jerry Brown, following the recommendation of the gentleman from California (Mr. WAXMAN), then chairman of the California Assembly's Select Committee on Medical Malpractice, enacted the Medical Injury Compensation Reform Act, known as MICRA.

MICRA's reforms include a $250,000 cap on noneconomic damages, limits on the contingency fees lawyers can charge, and provisions that prevent double recoveries. According to the Los Angeles Times, ''Because of the 1975 tort reform, doctors in California are largely unaffected by increasing insurance rates. But the situation is dire in other States.'' Exhaustive research by two Stanford University economists has confirmed that direct medical care litigation reforms, including caps on noneconomic damage awards, generally reduce malpractice claims rates, insurance premiums and other stresses upon doctors that may impair the quality of medical care.

The HEALTH Act includes MICRA's reforms, while also creating a fair share rule by which defendants are only liable for the percentage of damages for which they are at fault. Additionally, H.R. 4600 sets reasonable guidelines, but not caps, on punitive damage awards. Under this legislation, a punitive damage award cannot exceed the greater of $250,000, or two times the amount of economic damages that are awarded.

The HEALTH Act will accomplish reform without limiting compensation for 100 percent, or all of plaintiffs' economic losses, meaning any loss which can be quantified and to which a receipt can be attached. These include their medical costs, lost wages, future lost wages, rehabilitation costs, and any other economic out-of-pocket loss suffered as a result of a health care injury.

Additionally, although this legislation places a cap on noneconomic damages, it also allows deserving victims to keep more of their jury awards by limiting the percentage that lawyers can take. This is accomplished according to a sliding scale that caps legal fees down to 15 percent of awards exceeding $600,000. Without such reforms, lawyers can take their standard one-third to 40 percent cut from whatever victims recover. Enactment of this bill will allow victims to keep roughly 75 percent of awards under $600,000 and 85 percent of awards over that amount. Under the HEALTH Act, the larger the demonstrable, real-life economic damages are, the more the victims will get to keep.

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

First, more than three-fourths of physicians feel that concern about malpractice litigation has hurt their ability to provide quality care in recent years; second, 79 percent of physicians report that fear of malpractice claims causes them to order more tests than they would based only on the professional judgment of what is medically needed.

As former Democrat Senator and Presidential candidate George McGovern and former Republican Senator Alan Simpson have written, ''Legal fear drives doctors to prescribe medications and order tests, even invasive procedures, that they feel are unnecessary. Reputable studies estimate that this defensive medicine squanders $50 billion a year. The Common Good survey also asked physicians the following question: Generally speak, how much do you think that fear of liability discourages medical professionals from openly discussing and thinking of ways to reduce medical errors?

□ 1330

An astonishing 59 percent of physicians replied ''a lot.''

Americans want to see their friends and loved ones receive the best and most accessible health care available, but, with greater and greater frequency, doctors are not there to deliver it because they have been priced out of the healing profession by unaffordable professional liability insurance rates.

Sound policy does not favor supporting one person's abstract ability to sue a doctor for unlimited and unquantifiable damages when doing so means that health care will become less accessible and less affordable to all Americans, particularly to women, to the poor and to those who live in rural areas.

The American Bar Association estimates that there are 1 million lawyers in the United States, but all of us, all 287 million Americans, are patients, and as patients and for patients, I urge my colleagues to support the HEALTH Act.

Mr. Speaker, I reserve the balance of my time.

Mr. CONYERS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I begin by commending the gentleman from Florida (Mr. HASTINGS) for conducting a very important and substantive debate on the rule governing this measure that is before us.

Now, let us begin with the fact that this medical malpractice reform bill, except for the fact that there are no caps on attorneys, is the same bill, amendment, brought forward by the gentleman from California (Chairman THOMAS) to the Patients' Bill of Rights last July, and it was turned down, for good reason.

The next thing I should point out is that there is a serious constitutional problem that the American Bar Association has written to me and members of the committee about, a letter that I have for those who still have that reverence for that document, that I am sure we all do.

Now, there has been constant reference to the Medical Injury Compensation Reform Act of 1975 in California. May I point out to all of those who assume that it has been enormously successful that the Consumers Federation of America in their report, which reinforces another California report, makes two points: That the per capita health expenditures in California have exceeded the national average every year between 1975 and 1993 by an average of at least 9 percent per year; and that the California health care costs have continued to skyrocket at a rate faster than inflation since the

passing of the Medical Injury Compensation Reform Act.

Inflation, as measured by the Consumer Price Index, rose 186 percent between 1975 and 1993, yet California's health care costs grew by 343 percent during the same period. Moreover, California's health care costs have grown at almost twice the rate of inflation since 1985.

Now, the problem with this bill is that rather than help doctors and victims, this bill really does a great favor to insurance companies, HMOs and the manufacturers of defective medical products and the pharmaceuticals, as usual.

In addition, it also is clear that a legislative solution focused on limiting victims' rights available under our State tort system will do little other than increase the incidence of medical malpractice, already the third leading cause of preventible deaths in the United States of America.

Finally, you should be aware that the drug companies have somehow gotten into this, as well as the producers of the infamous Dalcon Shield, the Cooper 7 IUD, high absorbancy Tampons, linked to toxic shock syndrome, and silicon gel implants, all of whom would have completely avoided billions of dollars that they have paid out in damages had this bill been law.

So, Mr. Speaker, I refer you finally to the Consumers Union Report, which points out in detail all of the basic things that have been reviewed here.

Please let us stick to our guns. This is too important a thing to let something as blatantly political go through in the name of helping the victims of medical malpractice in this country.

Mr. Speaker, I reserve the balance of my time.

Mr. SENSENBRENNER. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, the gentleman from Michigan (Mr. CONYERS) I think was in error when he was saying that all of these people would have avoided billions and billions of dollars of liability. The fact is that this bill does not limit liability for proven economic damages, such as lost wages, lost future wages, rehab expenses, medical expenses and the like by one penny for anybody. The economic damages that are suffered are unlimited under this legislation. What it does limit is noneconomic damages that cannot be quantified.

What the gentleman from Michigan says is that we all should pay more in doctors' fees and the taxpayers should pay more in Medicare expenses simply because we do not want to limit noneconomic damages for maybe one plaintiff or a couple of plaintiffs.

So here is something where the interests of a few completely wipe away the interests of the greater good, particularly those people in rural areas that are looking for OB–GYNs.

Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. GEKAS).

(Mr. GEKAS asked and was given permission to revise and extend his remarks.)

Mr. GEKAS. Mr. Speaker, I thank the gentleman for yielding me time.

We on the Committee on the Judiciary have been wrestling with this issue for many years and have had many different proposals cross our desks on this very same theme. What brings us to the floor now is that when we were first considering it the problems were terrible. Now the problems are more than terrible, almost unbearable.

Every day in Pennsylvania, just like in your home States, you hear anecdotes about the giving up of a practice by a physician or the constriction of services to be rendered at a hospital or actually the closing of a hospital, all due to the rising cost of insurance premiums and the awards granted on behalf of plaintiffs across the board.

What is so good about the plan we have in front of us is, as the gentleman from Wisconsin was able to articulate, that this puts no caps at all on the economic damages. As a matter of fact, the testimony that we had from the Californians who testified as to the system that is extant in their State was that even though health care costs are rising and that they must consider that in the awards that are granted in California, the rising health care costs, even though they go up, are going up incrementally, and the cap on the noneconomic damages remains the same, thus preserving the very root of this kind of legislation. It is to allow physicians and hospitals to remain in place across the spectrum of medical services. Why? Because their economic damages of their own, caused by the high insurance premiums and high awards visited against them, would be retarded by this legislation. It would not cure the matter, but it would retard their financial difficulties.

If we can retard their financial difficulties, we give them reason to stay in place, to leave their practice thriving in a particular sector in my State and in yours. It would allow hospitals to be able to budget in such a way, with the shrinking cost of insurance that we hope that this brings about, to be able to extend services or remain in place over a long period of time, where otherwise, with the high costs now seen across the Nation, they are incapable of maintaining their own level of services. So this is the time to bring about a great reform.

I remember in 1995 we were on the floor with a different version of this bill and many of us thought we had a great chance of passing it. But, for one reason or another, it did not occur. All I do now is repeat that that was then when the situation was very bad; today it is much worse, and we have a chance to strike a blow at this emergency right now.

Mr. CONYERS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, before I yield to my friend from Massachusetts, I think we ought to make sure we are all talking about the same bill.

On page 5 of this bill we eliminate the doctrine of joint and several liability, meaning that if one person does not have enough money, then nobody else is responsible for them paying for the damages.

Number two, the statute of limitations is reduced to 3 years, and that is on page 3. What that means then is if a person with AIDS discovers it in 6 years, they just missed out, because the statute of limitations would now be 3 years.

For my friend from Pennsylvania's information, this bill does cap noneconomic and punitive damages.

Mr. Speaker, I am pleased to yield 2 minutes to the distinguished gentleman from Massachusetts (Mr. MARKEY), from the Committee on Energy and Commerce.

Mr. MARKEY. Mr. Speaker, I thank the gentleman for yielding me time.

So the Republicans say that they have identified a big problem: Insurance premiums for physicians are skyrocketing, and we have to do something about it.

What is their solution? Just what the insurance companies ordered for a solution: A cap on noneconomic damages at $250,000; pain and suffering, all that, $250,000. The juries are not even told that the limit is $250,000, so they could come back with a $1 million verdict, but only $250,000 to the victim.

But their bill does not say that the savings goes to physicians. No. They have all the money go to the insurance company executives.

Now, last night I made a request to the Republicans that I be allowed to make an amendment that says that any amount of money that a jury renders above $250,000, let us say $1 million, that the court would then give that money over to a court-appointed trustee and the court-appointed trustee would then ensure that the insurance premiums for the physicians inside that area would be lowered.

The Republicans prohibited that from coming out here because that would guarantee that the physicians would be the beneficiaries, not the insurance industry. And what is the problem? Well, the insurance company executives have a fiduciary relationship to their shareholders, to their wives, to their children, to maximize profits for themselves. That is a legal responsibility.

If we are going to pass this bill and limit the ability for victims to recover, then the only justification should be that physicians' premiums go down, and that is the one big missing link in the Republican bill. There is no requirement that the insurance companies lower the premiums for doctors, and that is what the Democrats are trying to do, to help the patients, to help the doctors. And what is the Republican Party doing once again? They are bringing out the agenda of the insurance industry.

If we have learned anything from the accounting practices across this country, it is that it is impossible to know where those savings would have gone.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. ISAKSON). The Chair would appreciate it if Members would recognize the gavel.

□ 1345

Mr. SENSENBRENNER. Mr. Speaker, I yield myself 2 minutes.

The gentleman from Massachusetts (Mr. MARKEY) thunders away about the Republican solution to the problem of escalating medical liability insurance premiums. He is entitled to his opinion. But the Democrats have no solution at all. They would like to continue the present system. They would like to see these rates skyrocket. They would like to see physicians close their practices or go into other specialties. They would like to see OB-GYNs be priced out of the market. They would like to see clinics in rural areas closed, and they would like to see the affordability and the accessibility of health care to poor people shrink.

I figured out how much the patient ends up having to pay. In the State of Mississippi, an OB-GYN can be charged as much as $110,000 a year this year for professional liability insurance, based upon 2,000 billable hours per year. Based upon 2,000 billable hours per year, a half an hour visit to that OB-GYN, the first $27.50 of whatever that doctor charges the patient goes for that patient's share of the doctor's professional liability insurance premium, and everything else that the doctor charges ends up being used to pay the doctor's other expenses as well as to allow the doctor to take some money home to support himself or herself and their families. So all of these costs end up getting passed on to the patients, and if you want to complain about the high cost of health insurance, the way to start doing something about it is to pass this bill so that doctors do not have to pay through the nose for professional liability insurance.

Mr. Speaker, I yield 3 minutes to the gentlewoman from Pennsylvania (Ms. HART).

(Ms. HART asked and was given permission to revise and extend her remarks.)

Ms. HART. Mr. Speaker, I rise in support of the legislation. Many of my colleagues today have made claims that this bill is bad, as we just heard, that this is just what the insurance companies order. Actually, if my colleagues will look at this map, they will see it is actually just what the doctors ordered.

The States in red, my home State of Pennsylvania, are the States where we are in a crisis. Doctors are leaving my State in droves, leaving patients with nowhere to go for health care. Those in opposition say they dislike caps on damages and limits on lawyers' contingency fees. Let us start with that cap on damages. It is a $250,000 cap, and it is on punitive damages. It has nothing to do with the actual recovery that the injured plaintiff is due. It is the additional damages that are being limited.

Let us talk about the limit on lawyer contingency fees. The lawyer who actually suffered no injury at all is being limited on how much in fees he can take from that plaintiff's award. That is the award that is due to the plaintiff because of the actual injury. The bill helps the injured person retain more of the award that she is due. The lawyer would be limited to, listen, 40 percent of the first $50,000; one-third of the second $50,000; one-fourth of the next $500,000; and 15 percent of any amount over $600,000. Do the math. The lawyer gets plenty of money under this plan. I do not believe we will have a shortage of lawyers taking on cases as a result of this; but if we do not get this, we will continue to have a shortage of doctors who are willing to take on patients. Without this rule, we will continue the mass exodus in these States in red, and the States that are not in red are soon to follow.

This past weekend I visited with a physician friend of mine. Both she and her husband are practicing medicine in my home State of Pennsylvania. She gave me the bad news of her firsthand experience and how she and her husband are interviewing out of State to practice medicine out of State because they can no longer afford the insurance that they need to be able to continue to practice to provide good service to their patients.

In Pennsylvania over the last 4 years, rates have increased 125 percent, according to the ''Medical Liability Monitor.'' The American Medical Association has statistics that are similar. If we do not pass this HEALTH act, we are saying to the people of America we are not concerned about their health. I believe that we are, and I believe that the majority of us will support the HEALTH act, a wonderful bill by the gentleman from Pennsylvania (Mr. GREENWOOD) and a bill that we should all support to make sure that our constituents get the health care they need.

Mr. CONYERS. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Massachusetts (Mr. MARKEY).

Mr. MARKEY. Mr. Speaker, I thank the gentleman for yielding me this time.

We are going to see many crocodile tears shed this afternoon on behalf of physicians and their high premiums. But the Republicans refuse to allow the Democrats to make an amendment that ensures that all of the savings that come from the limits on how much a patient can recover goes to lower insurance premiums. They refuse to allow us to even make the amendment because they are going to allow the insurance industry to pocket this money. That is what this time is all about. It is about the insurance companies, not about the physicians. We support the physicians.

Mr. CONYERS. Mr. Speaker, I am sorry I corrected the other side in connection with their understanding of their bill which may have brought about an overreaction about what Democrats do not want to happen to the health system in America. I apologize for that.

Mr. Speaker, I yield 2 minutes to our very distinguished colleague, the gentleman from North Carolina (Mr. WATT), on the Committee on the Judiciary.

Mr. WATT of North Carolina. Mr. Speaker, I have to say with respect to all my colleagues that I think we have lost sight of what this is all about. When we start debating the merits or demerits of this bill, we miss the point. The point is that in North Carolina if I walk into a physician's office, all of that treatment takes place right there in North Carolina, and historically the tort law and medical negligence law has been determined State by State; and were I in the State legislature of North Carolina, all of this discussion that we are having would probably be a very appropriate debate.

But for people who came to Congress saying that they believed in States' rights and the federalist form of government that we have, this debate is totally misplaced. It would be like us saying, well, we are very dissatisfied with schools all across the country; therefore, we are going to federalize the whole education system in America. That is what this debate reminds me of.

My Republican colleagues, in 1995, told me that they believed in States' rights. And ever since then, they have been trying to federalize the standards on everything that has traditionally been done at the State level, and this is just another one of those examples.

When I raise this point, nobody seems to care. Well, my Constitution says that unless there is some interstate commerce connection, and I have not seen any medical practice take place across State lines since I have been going to doctors; unless there is some kind of Federal nexus here, why are we debating tort reform here, rather than having the gentlewoman from Pennsylvania (Ms. HART) go back and tell her State legislators that they need to address this problem? If they are losing doctors in Pennsylvania, then they ought to address the problem in Pennsylvania and solve the problem there, not federalize the issue.

Mr. CONYERS. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Maine (Mr. ALLEN).

Mr. ALLEN. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, I rise in opposition to H.R. 4600, a bill to protect doctors, other health care providers, drug companies, and manufacturers of medical devices from the consequences of their own negligence. It reduces compensation for severely injured people in order to save money for negligent providers and their insurers.

This is a congressional power grab to take over tort law from the States. Many States, including Maine, have

held down malpractice premiums without stripping compensation from severely injured plaintiffs. Maine requires a review of malpractice claims by an independent panel within 90 days of the plaintiff's filing a claim. I served on two of those panels before I left the practice of law, and the result is more cases are settled early without an arbitrary cap on damages.

I believe that we here in the Congress should deal with our issues and leave the State law issues to the States. We do not need to take over State legislative responsibility.

We are now in the fourth week since the August recess, and not one single appropriations bill that we ought to be dealing with has come to the floor of this House; instead, we are spending our time dealing with matters more appropriate for State legislators.

Mr. CONYERS. Mr. Speaker, I yield 1 minute to the gentleman from Washington (Mr. INSLEE).

(Mr. INSLEE asked and was given permission to revise and extend his remarks.)

Mr. INSLEE. Mr. Speaker, I would just like to tell my colleagues about a woman, I will call her Jane, and she is a citizen of the State of Washington. She went in for a routine test, a mammography, a biopsy was done, she was diagnosed as having breast cancer. She had a double radical mastectomy because of that diagnosis. She then developed a blood clot that went into her bowel and she required her bowel to be removed. She then developed another blood clot that caused gangrene in her leg, and they had to cut off her leg.

Some time later, a subsequent review, a quality control assurance review, found that the diagnosis was inaccurate. The pathology report was flat dead wrong. She never had cancer, she never had anything that required significant surgery. She is a woman without breasts, without a bowel, and without a leg due to a failure, either of a physician or of a medical device, both of which would be affected by this legislation.

Now, I do not know what is just to do in Jane's situation, but I do know this: the first people that should be making that decision are 12 of her peer citizens sitting in a jury box looking at the evidence, the second should be the State legislature, and the last should be the U.S. Congress. We should reject this legislation.

Mr. CONYERS. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. NADLER), one of our ranking members of the Committee on the Judiciary.

Mr. NADLER. Mr. Speaker, this bill is a cruel attempt to protect insurance companies by trampling the rights of consumers.

We are told today the bill is necessary to drive down insurance rates because juries award too much money to plaintiffs. But that is a diversion from the real problem, which is very simple: mismanagement by the insurance companies. Insurance companies make their money by investing the premiums they collect in the stock market. When the market is strong, they keep premiums artificially low, because they can make plenty of money in the markets. When the market turns sour, they must dramatically increase premiums to cover their costs. It is a predictable cycle, and that is why once about every 10 years when the market goes south, we hear of a great crisis which is then blamed on out-of-control lawsuits and the consumer has to get it in the neck.

Mr. Speaker, lawsuits account for the same minuscule fraction of health care costs as they always have. Studies have shown the average jury award has not changed at all in the last decade, so why the sudden crisis? Because the market is in a tailspin and the insurance companies need to recoup their losses because they kept the rates too low during the good years. But why should injured patients pay to bail out the failed management of these companies? And who seriously believes that premiums will go down if this bill is passed?

As Debora Ballen, executive vice president of the American Insurance Association said, ''Insurers never promised that tort reform would achieve specific premium savings,'' just savings to their bottom line, I guess. And, of course, the Republican Committee on Rules refused to allow an amendment on the floor that would say that they have to pass on the savings to the doctors, to the consumers.

□ 1400

In pursuit of this giant bailout, what we have here is a breathtaking assault on the rights of consumers and patients. Take the $250,000 cap on noneconomic damages, a figure that might have been reasonable in 1975 when the MICRA law was passed in California; it is woefully inadequate today. The equivalent today would be $1.5 million.

Again, the Republican Committee on Rules refused to allow an amendment to even say, okay, $250,000, we will put in an inflation amount to adjust it, so it does not decrease to nothing with inflation. If we maintain this cap now, it will be impossible for consumers to hold doctors accountable for malpractice in the future.

Not content merely to cap malpractice suits, this bill also guts, guts State HMO laws, protects big drug companies and medical product manufacturers, makes punitive damages almost impossible to assess, and places an unreasonable statute of limitations on injured patients.

Mr. Speaker, we should not be misled by the bill's supporters. Do not believe for a second that insurance rates will go down as a result of this bill. This cruel bill should be seen for what it is: another gift from the Republican majority to the big insurance companies at the expense of patients, consumers, and, I might add, doctors.

This irresponsible bill should be disapproved.

Mr. SENSENBRENNER. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. COX).

Mr. COX. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, we are here because of patients. Patients are not getting care. Trauma centers are closing. Emergency rooms are closing. OB–GYNs are leaving their practice. Women are without health care. That is why we are here.

On June 30 of this year, Methodist Hospital in south Philadelphia, which had been delivering babies since 1892, closed its doors. They closed their maternity ward and they stopped delivering babies. This is going on all over the country.

In Nevada, in all of southern Nevada, now, there is no trauma center. Southern Nevada's only trauma center closed its doors in July. Las Vegas is now the only city of its size without any care for such people in these circumstances. Our intention is to ensure that no more patients are denied the care they deserve.

We have heard there was a Democratic amendment that should have been made in order that would have ensured that savings from this bill, which the Congressional Budget Office estimates at $14 billion, $14 billion more available to go into health care, into hospitals, into Medicare givebacks, into quality of care, that we should have had this amendment that guaranteed that savings went to doctors.

Somebody should ask whether the doctors supported that amendment, because they did not. The way this amendment was written, the premiums would still have been high because the awards still would have had to be paid, this time to a trustee instead of to the trial lawyers, but the premiums would not have come down. That is why doctors did not support the amendment.

Somebody made the claim that the Dalkon shield case, bringing up the old horribles of the past, that damages would not have been awarded in that case had this bill been law. That is completely false. In 1976 Congress changed the law, post-Dalkon shield, to require pre-market approval for devices. The House and Senate reports on that legislation specifically mentioned Dalkon shield as something that would have been kept off the market if we had had pre-market approval in the law.

What this bill says is if a device has been approved by the FDA, then there will not be punitive damages; in other words, if people comply with the pre-market approval requirements, why should the lawyers be able to claim that there was some kind of willful, egregious, and so on kind of injury committed.

In California, we have had this system a long time. I have heard some people say that California's premiums have gone up faster than inflation. Of

course they have, they have gone up 150 percent since this law has gone on the books. But at the same time, we have to tell the whole story, malpractice premiums in the rest of the country have gone up 500 percent. This has saved a great deal of money for us in California.

Medical liability insurance premiums in constant dollars have actually fallen in California by more than 40 percent, and injured patients are receiving compensation more quickly in California than in the United States as a whole. Injured patients receive a larger share of the awards.

This is all about patients; it is all about making sure that their doctors can serve them. That is why doctors support this bill. That is why patients support this bill. It is why it is high time that we pass this bill.

Mr. CONYERS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, to my friend, the gentleman from California (Mr. COX), I say, please check the punitive damages that the Dalkon shield Cooper 7 IUD, the hundreds of millions that they would have not had to pay had this bill been in effect.

Mr. Speaker, I yield 2 minutes to my friend, the distinguished gentleman from Texas (Mr. SANDLIN).

Mr. SANDLIN. Mr. Speaker, someone needs to stand up for American physicians. Somebody needs to stand up for the American health care system.

What is the problem? Malpractice premiums have skyrocketed. What is the answer proposed by our friends on the other side? It is H.R. 4600. Let us make no mistake about it, H.R. 4600 is a hoax, it is a sham, and our friends know it. It is a sham on the American medical establishment by the insurance carriers, who want to limit their exposure but will not commit to reducing premiums.

Please read the bill. H.R. 4600 limits the amount that carriers pay for legitimate claims, but it has absolutely no provision requiring reducing premiums; none, zero, zilch, nada, nothing, and they know it. It is a scam.

In fact, Mr. Speaker, in States that have enacted caps, in States that have enacted caps, the malpractice premiums are higher than in States that have no caps. But the carriers do not want to tell us that. Why? That is because their interests are in conflict with the medical community.

I want to ask a question: Do the words ''Patients' Bill of Rights'' ring a familiar note? What causes the problems? It is not physicians, it is not patients, it is not even the lawyers they are talking about; the problem is the market. St. Paul recently, in announcing it was exiting the market, said they paid too much in claims; but, oh, yes, they forgot to mention they lost $108 million in Enron. Every time the market goes down, they claim a medical liability crisis. How convenient is that?

The truth is that the carriers are asking doctors, hospitals, and patients to pay for their bad investment decisions. It is as simple as that. They know it. We have asked the insurance carriers to put in this bill a requirement to reduce premiums. They will not do it. They will not talk about it. That is because they know they are going to raise the premiums. It is a scam on the entire system.

There are a lot of other problems. At least 31 States have found portions of this bill to be unconstitutional. It does limit economic damages because it gets rid of joint and several liability. They know that. They know it limits economic damages.

Let us just get right back to it. It boils down to this point: It helps the insurance carriers; it does nothing for the physicians and nothing for the patients, and they know it.

Mr. CONYERS. Mr. Speaker, I yield the balance of my time to the distinguished gentlewoman from Texas (Ms. JACKSON-LEE) to concluded the debate on our side of the aisle.

The SPEAKER pro tempore (Mr. GUTKNECHT). The gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 2 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the distinguished gentleman from Michigan (Mr. CONYERS), the ranking member, for yielding time to me.

Mr. Speaker, time is short for an important step for America, and that is, of course, something that probably we have not debated on this floor. We do not make light of the horrific tragedy of 9/11, but what it caused Americans to do is to reinforce their commitment to our values. Part of that is the judiciary system, which allows Americans to go into a courthouse and address their grievances, away from violence and intimidation.

It is interesting that we would come in that backdrop to begin to tell Americans that they cannot go into the courthouse when they have been injured and begin to find relief. Why we are promoting this kind of bill that denies and equalizes justice for all Americans I cannot give an answer.

Many people criticize lawyers. I remember Shakespeare saying, the first thing you should do is to kill all the lawyers. I am one, but I serve the American people as a Representative for the 18th Congressional District in Texas.

Mr. Speaker, let me tell the Members, I supported reform in the State of Texas. I believe the President of the United States supported it. But can Members imagine that the legislation that we have on the floor today goes overboard, goes way beyond the idea of allowing poor people to get into the courthouse and lawyers to represent them when tragedy has befallen them.

For example, a 50-year-old woman who earned about $12,500 annually settled her malpractice claim during trial for $12 million because her surgeon had impaired her spine; a spear, if you will, went through her spine. With this particular health act, she would be severely limited by the $250,000 cap, a woman who makes $12,500.

Let me tell the Members why this is bogus, Mr. Speaker, with respect to the idea that this bill will help prevent hospitals from closing and doctors' offices from closing.

I am their friend. We cannot survive without a medical profession. Doctors will tell us that they are being shut down because of these premiums. They are not angry at lawyers, they are being made to be angry at lawyers.

When we had this bill in Texas, the premium went up from $26,000 to $45,000. This is a bogus bill and we should vote it down because it denies the American people the opportunity to get into the courthouse. This is a bill against poor people.

Mr. Speaker, I oppose H.R. 4600, the so-called "HEALTH" Act of 2002. I do this with somewhat mixed emotions, because I agree with the bill's stated purpose: to Help get Efficient Accessible Low Cost Timely Health care to all Americans. I agree that one of the obstacles to accessible low cost health care is the outrageous liability insurance premiums charged to health care providers. I also feel that some approaches to litigation contribute to the cost of our Nation's health care by encouraging professionals to use tests, procedures, and treatments that may not be necessary. I agree with supporters of this bill that high malpractice insurance premiums charged by insurance companies have led some physicians to abandon high-risk specialties and patients.

Unfortunately, H.R. 4600 does not address any of these problems. The bill does not discourage lawsuits. This bill does not decrease liability insurance premiums, the real problem. The bill does place a cap on noneconomic damage awards, but there is no reason to think that limiting awards to suffering people with legitimate claims will translate into decreased premiums for providers.

In California, where tort reform has been the strictest and has had almost three decades to work, premiums are still 8 percent higher than premiums in States without noneconomic damage caps. Medical malpractice insurers in California pay out less than 50 cents in claims on every dollar they bring in through premiums. Obviously tort reform is lining the coffers of insurance companies and not getting to doctors or their patients.

It is surprising that supporters of this bill are presenting it as a means to decrease premiums, when those in the know, such as the executive vice president of the American Insurance Association, and American Tort Reform Association president, both have stated that limitations like those in this bill will not necessarily decrease premiums.

I am also confused about where this arbitrary cutoff of $250,000 for noneconomic damages comes from. It happens to be the same number used in similar legislation passed 27 years ago in California, with no adjustment for inflation or changes in costs of living. Due to skyrocketing health care costs, $250,000 will only get an injured person about $40,000 worth of care.

The bill does not cap economic damages—which is good news for those with high incomes. Rich people will be able to stay rich

and perhaps that is appropriate. But what about mothers who work at home raising their children, or the elderly on fixed incomes? They will not be able to claim large economic damages due to losses in income. If they are crippled or blinded by a negligent HMO, or pharmaceuticals company, they may get their $250,000—but maybe they will receive 8 or 9 thousand dollars per year. That is a pittance for someone working through the tough times after a catastrophic injury.

Perhaps that would be a fair sacrifice if the funds would go to our hospitals or public health clinics, but to increase revenues of insurance companies? I say no.

Furthermore, since we do not have a bill before us today that would limit liability insurance, or would decrease the number of frivolous lawsuits, perhaps we should leave it to the States to decide how to address these issues. California is not the only State in the Union that is working to tackle these problems; Texas has worked to solve this problem and has put forward a better solution. H.R. 4600 would override such local efforts and compromise the rights of States, and probably not help improve the health of a single American, except maybe a few insurance company CEOs.

I encourage my colleagues to vote against H.R. 4600.

Mr. SENSENBRENNER. Mr. Speaker, I yield myself the balance of my time.

The SPEAKER pro tempore. The gentleman from Wisconsin is recognized for 1 minute.

Mr. SENSENBRENNER. Mr. Speaker, the gentlewoman from Texas (Ms. JACKSON-LEE) is dead wrong. This bill will not close the courthouse to anybody who has a legitimate claim. It does not restrict anybody's right to sue. What it does do is it puts some sense in the compensation. It puts some sense in the compensation in a manner that allows affordable and accessible health care to be available nationwide. We will not be pricing doctors out of their practice by high professional liability insurance premiums. We will not force maternity wards and trauma centers to close their doors for the same reason.

The time has come to put some sense in this system. California did that. They do not have a crisis there because their State legislature did that. We now have to step up to the plate and work for the patients, particularly in the States that are listed in red and in yellow on the map that was referred to by the gentlewoman from Pennsylvania (Ms. HART).

Pass the bill.

The SPEAKER pro tempore. All time for the Committee on the Judiciary has expired.

The gentleman from Pennsylvania (Mr. GREENWOOD) and the gentleman from Ohio (Mr. BROWN) each will control 10 minutes.

The Chair recognizes the gentleman from Pennsylvania (Mr. GREENWOOD).

Mr. GREENWOOD. Mr. Speaker, I yield myself 2¼ minutes.

Mr. Speaker, as usually happens at this time in the debate, the rhetoric gets hotter and we tend to find ourselves at our most cynical attitudes. But let us see if we can do a little better than that in the next 20 minutes.

The fact of the matter is that we do not accuse the Democratic Party of being the lackeys of the trial lawyers, and they should not accuse us of being the lackeys of the health care industry. But what we all should care about is our constituents. We should care about the pregnant woman, we should care about an individual harmed in an automobile accident, we should care about their access to health care.

Also, we should care about them if they cannot find a doctor. We should care about them if the trauma center is closed and cannot save their lives. We should care about them if they are injured by a doctor. It is not either/or.

We have a crisis in this country right now. It is nearly countrywide. The crisis is that the cost of medical malpractice insurance has skyrocketed to the point where obstetricians cannot deliver babies anymore, where neurosurgeons are leaving trauma centers, where trauma centers are closing their doors. We are very close, if we are not there already, to Americans dying because they cannot get emergency care and the quality of our health care system deteriorating across-the-board.

There is a solution. There is a solution here that enables us to care about our constituents when they are struggling to find care or emergency care, and care about them when they are hurt by a physician and they have a legitimate claim. That has been modeled in California.

I have heard my constituents argue erroneously that capping noneconomic damages will not affect premium rates. That is dead wrong. Let us settle that. There is the chart. The source here is the National Association of Insurance Commissioners.

This chart tells the whole story. While California's rates have stayed flat for the last 25 years, the rest of the country's rates have soared. This is the solution. We all ought to work on it together, get it over to the Senate, and save America's health care system.

Mr. Speaker, I reserve the balance of my time.

□ 1415

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, I support medical malpractice reform but I oppose this bill. H.R. 4600 lays the blame for rising medical malpractice premiums solely on individuals whom a court and jury determine have been injured by medical malpractice. Apparently Congress knows better than judges, juries and patients; but we do not know better than insurers.

This bill does not have a single provision acknowledging the insurance industry's accountability for skyrocketing premiums. Insurers have tripled their investment in the stock market over the past 10 years. Of course, now they are trying to recoup their losses.

Democrats have tried to negotiate with the majority to even look at this issue. But the majority rejected every attempt to force the insurance industry to assume any responsibility for its dramatic premium increases. There are avenues we could take to stabilize medical malpractice premiums, loss ratio requirements, reinsurance pools, transparency to help us see exactly why insurers are raising their rates. But no, in this billing the insurance industry is held harmless. It is the patients' fault.

California has the most stringent liability caps in the country. Premiums are higher in California than the average for the rest of the country. Premiums have grown faster in California than the average for the rest of the country. Still somehow the solution to the medical malpractice crisis is to cap jury awards. And by the way, to cap them in a way that promises wealthier patients larger rewards than other patients. This bill apparently says those who are more wealthy suffer more than those who are not.

H.R. 4600 will also shield HMOs that fail to provide the needed care. It would shield drug companies whose medicine has toxic side effects. It would shield manufacturers of defective medical equipment. In this bill, businesses are never at fault. Patients are greedy. Jurors are misguided. It is the patients' fault. That is the problem.

At a time when the public is calling for greater corporate accountability, this bill turns on the public itself and holds injured patients, not the insurance industry, accountable. I ask for a ''no'' vote.

Mr. GREENWOOD. Mr. Speaker, I yield 1 minute to the gentleman from Louisiana (Mr. TAUZIN), the chairman of the Committee on Energy and Commerce.

Mr. TAUZIN. Mr. Speaker, I rise in strong support of the bill and on behalf of the Committee on Energy and Commerce recommend it to my colleagues in the House.

When injured patients in this country have to wait on average 5 years before a medical injury case is complete, our system is failing. When an injured patient loses up to 58 percent of the awards to attorneys and the courts, something is wrong. And when 60 percent of malpractice claims against doctors are dropped or dismissed, you can imagine the unnecessary costs to the system that all of us pay into.

Now, I want to do something we do not do around here enough. I want to admit to being wrong once in my life. I was in the legislature of Louisiana. I voted wrong. I voted against these reforms as a young State legislator. They were passed over my objections and they worked.

Doctors and hospitals in Mississippi are streaming into Louisiana because they do not have those protections in

Mississippi and people in Mississippi are losing access to quality health care. Let me tell you, I do not care whether you have insurance or not. You can have all the insurance in the world; if there is no doctor to serve you, if there is no emergency room to go to, if there is no hospital to take care of you, you are in trouble. This bill makes sure we have doctors and hospitals and emergency rooms in America.

Mr. Speaker, I rise in strong support of H.R. 4600, legislation to ensure that patients have access to high quality health care.

When injured patients have to wait, on average, 5 years before a medical injury case is complete, our judicial system has failed. When injured patients lose 58 percent of their compensation to attorneys and the courts, our judicial system has failed. When 60 percent of malpractice claims against doctors are dropped or dismissed, but the fear of litigation still forces doctors with 25 years or more of experience to retire early, our judicial system has failed.

What my home State has in place and what California have benefited from for over 27 years are commonsense guidelines for health care lawsuits. These guidelines ensure that injured patients receive greater compensation and that frivolous lawsuits—that extort health care professionals and drive doctors from the practice of medicine—are limited.

The reforms in this bill will work. According to the Congressional Budget Office, "H.R. 4600 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." Even better, "CBO estimates that, under this bill, premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."

That means that Congress really has an opportunity to pass legislation that will have a direct impact on patient access to care. With these reforms, patients will have greater access to health insurance. With these reforms, doctors will stay in business and not be forced to move to another State, or even worse, drop a specialty practice altogether. With these reforms, patients will have greater access to providers so they will actually receive "health care."

The issue at hand today is fundamental to all of the deliberations we make with regard to health care policy. We all recognize that health care costs money, and that high health care costs are a barrier to health care. But, even if a patient has health insurance, what is that insurance coverage worth if there are few doctors available to treat you?

This bill before us will have a tremendous impact on patients' lives. I encourage all of my colleagues, on both sides of the aisle, to support the legislation.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to my colleague, the gentlewoman from northeast Ohio (Mrs. JONES).

Mrs. JONES of Ohio. Mr. Speaker, I would like to thank my colleague for yielding me time.

You know what, I am really tired of people not telling the truth on the floor of the House. Hospitals are not going to stay open any longer because of this bill. People are not going to get any better health care because of this bill.

What is going to give them better health care is if this Congress will go ahead and give people universal health care. The fact is that H.R. 4600 introduced under the guise of fixing the problem of rising costs of malpractice insurance does not say anywhere that insurance companies will be required to reduce premiums. Nowhere does it assure that any savings that the insurance companies get will be passed along to the doctors.

The shame of it all is it is taking away the ability of judges who served, like me, the ability to determine when punitive damages ought to be awarded. It is taking away the ability of people who are injured to have the ability to bring their claim in court. The reality is that this bill does none of the things that have been claimed by the other side.

Now, the hospitals are going to be open in Cleveland, Detroit, New York as a result of this; and nobody is going to get better health care. I say to my colleagues vote against this legislation. It does nothing to help our patients.

Mr. GREENWOOD. Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, unlimited liability is an unacceptable drain on our health care system today. It is about access to care. It is about unruly costs from defensive medicine. We have got to make a change before it begins to truly affect our patients any more than it already has.

Now, I understand that people who have been injured by medical malpractice deserve redress. I also know people on the other side of the issue believe you can never match a value to a human life. But when is it enough? Is it enough when a sick patient cannot find a doctor because too many doctors have closed down their practices over rising malpractice premiums? Is it enough when an emergency trauma center closes its doors? Is it enough when nurses and support personnel in that trauma center are put out of work, Mr. Speaker?

There has got to be a figure out there somewhere that is enough. Saying that no figure is enough and that we can never place a limit, some reasonable limits on noneconomic awards, is to condemn the American patients to lesser care as this reckless liability system takes its toll on our health care system today.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. WAXMAN), my friend on the committee.

Mr. WAXMAN. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, 1 minute. There is not a lot I can say in 1 minute, but let me say the following: the Republicans seem to think that Washington has all the answers right here, and we ought to take it away from the States to make their own decisions, and I think that is a wrong approach.

They would impose a bill to be in place for all of this country when there are a lot of differences and a lot of different approaches to issues like tort liabilities, licensures of professionals and how to handle those matters. But supporters of this bill claim it is modeled after the California Medical Injury Compensation Reform Act, but the liability limits in this bill go far beyond medical malpractice. They extend to any lawsuits relating to any health care or medical product including the manufacturers and distributors of drugs and medical devices. This is far beyond the liability limits adopted in California or, as far as I am aware, any other State. So I oppose this bill.

I know that they are trying to do something about the medical malpractice problem, but I do not think it answers the problem; and I think it makes it one-size-fits-all, and it is not the best approach.

Mr. GREENWOOD. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health of the Committee on Energy and Commerce.

(Mr. BILIRAKIS asked and was given permission to revise and extend his remarks.)

Mr. BILIRAKIS. Mr. Speaker, today I rise in strong support of H.R. 4600, the HEALTH act. Since other speakers, Mr. Speaker, have effectively described the extent of our problem and the need for a solution, I want to emphasize one feature of the bill that is very important to me, and this is actually somewhat in response to what the gentleman from California (Mr. WAXMAN) has just shared with us.

While H.R. 4600 does cap noneconomic damages, which I believe will help bring stability and predictability to the medical liability insurance market, it also does protect States' rights, since any State cap on noneconomic punitive damages, up or down, will supersede the Federal limits. And that is why I feel this bill strikes the right balance between the need for Federal action and the States' traditional role of the primary regulator of insurance markets.

Mr. Speaker, I believe I can stabilize our out-of-control medical liability system without harming the ability of patients to recover adequate compensation when they have been harmed. We can do this by passing H.R. 4600 today.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to my friend, the gentleman from Pennsylvania (Mr. DOYLE).

(Mr. DOYLE asked and was given permission to revise and extend his remarks.)

Mr. DOYLE. Mr. Speaker, I rise in opposition to H.R. 4600. We do have a problem with physicians and hospitals paying too much for malpractice insurance, but H.R. 4600 is not the answer. The cap on H.R. 4600 is based on a 1975 California law that when adjusted for inflation would have a value of slightly more than $40,000 today. This 1975 base cap penalizes the most vulnerable victims of medical malpractice: children, homemakers, the elderly and minorities, society members who have limited incomes and thus will benefit less from future economic earnings.

Nearly 12 percent of Americans currently live in poverty and would depend on noneconomic damages to live on if injured.

In my home State of Pennsylvania the people have decided against caps by including a prohibition on caps in our State constitution. Like them, I do not believe a cap on damages will do anything to reduce insurance premiums or ensure the quality of health care. But I realize the issue of a cap is a good starting point for discussion. Members like myself want to compromise and work on real solutions for the problems. Let us vote against this bill and start to work on a compromise that truly will reduce premiums.

Mr. GREENWOOD. Mr. Speaker, I yield 1 minute to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Speaker, I am pleased to announce that the chairman of the Senate Finance Committee has just endorsed the Medicare provision for low-reimbursement States like Iowa that we passed in our House prescription drug bill.

What does that have to do with this bill? Well, Iowa ranks dead last on Medicare reimbursements. When we have increased premiums for malpractice and our physicians and other practitioners are already dead last in terms of Medicare reimbursements, the increase in the malpractice premiums means that many patients may not have a doctor in the State of Iowa. What is the situation in Iowa? Well, when St. Paul went out of business, some physicians in Iowa were able to pick up coverage from Wisconsin; but it would be my prediction that in the next 12 to 18 months, unless there is some fix in terms of the malpractice premium situation, Iowa is going to be facing the same type of crisis that many of the States that have been talked about already today will be facing. So these are two inter-related issues. I am very pleased to support this bill.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. GUTKNECHT). The Chair would admonish all Members that references to legislative positions of Senators must be confined to their factual sponsorship of bills, resolutions or amendments.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I rise in strong opposition to H.R. 4600. At first blush this bill sounds great. That is why some medical groups are supporting it. We definitely need to do something about skyrocketing malpractice costs that are driving good doctors out of their offices and away from their patients, but this is not the way.

As a physician myself, I have thought about this bill until I realized it exempted manufacturers of drugs, products and HMOs from liability. Once again, the doctors are the only ones liable. Everyone else, those who put the products in our hands, those who dictate what we do, would be off the hook.

This bill does nothing to guarantee that medical malpractice premiums will actually be reduced. In California, which the Republicans cite, doctors' premiums have grown 3.5 percent from 1991 to 2000 compared with the national increase of 1.9 percent. This is not the kind of tort reform we need. This is a terrible bill, and I urge my colleagues to oppose it.

The SPEAKER pro tempore. The Chair would advise that the gentleman from Pennsylvania (Mr. GREENWOOD) has 3–3/4 minutes remaining. The gentleman from Ohio (Mr. BROWN) has 4 minutes remaining.

Mr. GREENWOOD. Mr. Speaker, I yield 1 minute to the gentleman from Indiana (Mr. BUYER).

Mr. BUYER. Mr. Speaker, I rise in support of H.R. 4600 because it strikes an appropriate balance between the needs of patients who have been harmed to seek redress and the needs of all patients to have access to health care.

I note my colleague from the Committee on Energy and Commerce, the gentleman from Massachusetts (Mr. MARKEY), was concerned about whether premiums would go down or not. I would welcome him to read the Congressional Budget Office's report that was ordered by the Committee on the Judiciary. CBO estimates that under this bill premiums for medical malpractice ultimately would go down on an average of 25 to 30 percent. So I would welcome the gentleman to read that.

I also particularly support section 11 that provides flexibility to the States. I think that is smart to do that. Indiana has a very good law that has been in place for over 3 decades. It is comprehensive medical malpractice reform. The system works well. It has a medical review panel.

□ 1430

It also limits recovery from lawyers. The total recovery is capped. Attorney's fees are capped. We have a compensation fund managed by the State, and injured patients receive compensation in a timely fashion. I would like to thank the chairman for permitting this flexibility in the bill.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. ANDREWS).

(Mr. ANDREWS asked and was given permission to revise and extend his remarks.)

Mr. ANDREWS. Mr. Speaker, I thank the chairman and ranking member, soon to be chairman, my friend, for yielding me the time.

There is a malpractice insurance crisis in our country. The woman who delivered my two daughters no longer delivers babies these days because of that crisis, and I understand it. I also understand the way to end that problem is not to enact the greatest transfer of income in history from victims of medical malpractice to insurance companies, and that is what this underlying legislation does.

What it says is that people who have been the victims of medical mistake, medical malpractice and medical error will see an arbitrary ceiling on what they can recover when something has happened to them. What the bill does not say is that the savings that would no doubt accrue to the benefit of insurance companies must accrue to the benefit of the physicians who paid in malpractice premiums.

The iron rule of insurance law in America is when insurance companies get the money they keep it. They do not share it with the doctors. They do not share it with the patients. They keep it. This is an insurance company relief act at a time when our physicians and patients need relief.

Mr. GREENWOOD. Mr. Speaker, I yield 1 minute to the gentleman from Mississippi (Mr. PICKERING).

Mr. PICKERING. Mr. Speaker, I rise in support of this act. In my home State we now have a crisis. Our legislature cannot reach agreement. It cannot enforce or enact any type of boundary or set of limits that will give us some protection and stability and predictability and certainty for our medical community. We have acute shortages of nurses, of OB/GYNs, of neurosurgeons. Our trauma care, if there is a car accident, this is becoming a matter of life and death in Mississippi.

We needed to do something here so that we can help in Medicare and Medicaid and for our veterans so that we can help have the nursing and the physician professions stay in business and stay in a very noble calling to heal the sick and to make well those who are hurt and injured.

If we do not do this, we will see health care in places like Mississippi diminish. It will not be affordable. It will not be accessible. I know from personal experience.

My mother just had open heart surgery. My sister just had her eighth child. On one day we had new life in our family. On the next day my mother got a new heart. We must have the medical care and we need this act to contain the costs and to keep those who heal in business.

Mr. BROWN of Ohio. Mr. Speaker, how much time is remaining and who actually is going to close?

The SPEAKER pro tempore (Mr. GUTKNECHT). The gentleman from Ohio (Mr. BROWN) has 3 minutes remaining and the gentleman from Pennsylvania (Mr. GREENWOOD) has 1–3/4 minutes remaining. The gentleman from Pennsylvania will close.

Mr. GREENWOOD. Mr. Speaker, I yield 1 minute to the gentleman from Kentucky (Mr. FLETCHER).

Mr. FLETCHER. Mr. Speaker, I thank the gentleman from Pennsylvania (Mr. GREENWOOD) for the work he has done on this. What this bill is really about, it is about affordable, accessible, available and quality health care. Whatever else is said really makes very little difference if we cannot have health care access in all of America.

Some are saying this may limit the particular damages individuals injured may get, but in fact, the truth of this bill, the damages that a patient incurs are not limited in this bill, and it has proved very effective. The economic damages are unlimited. The punitive damages are up to twice the economic damages, which makes those unlimited virtually.

Let me say this. I do not begrudge personal lawyers having seven digit incomes. That is not the issue here. The issue is the siphoning of money out of the health care system that goes somewhere else, money that could be used to deliver health care.

The other issue is accessibility. There are some in rural America, if we do not pass legislation like this, either on the Federal level in many States, that are going to have to drive an extra mile to get looked at. That means that a patient is going to be injured, a child is going to be lost or another individual will not receive the health care.

I think it is imperative that we pass this legislation. I want to thank the leadership on this.

Mr. BROWN of Ohio. Mr. Speaker, I yield our final 3 minutes to the gentlewoman from Colorado (Ms. DEGETTE), who has been a leader for patient's rights.

Ms. DEGETTE. Mr. Speaker, as a former State legislator, I am continually amazed how this Congress seems to think that we are the 'super' State legislature and that we should solve all the problems that we in our cynicism do not think the States can solve. The truth is regulation of medicine is a State issue and regulation of medical malpractice is a State issue. Every State has a malpractice statute, and right now the majority of the States are reviewing those statutes to see if they are adequately addressing this issue. I think we should leave it up to the States, and that is one reason I oppose this bad, bad bill.

I know there is a malpractice insurance crisis in this country. I talk to my doctors just like everybody else, but I want to ask my colleagues this, why should the patients suffer twice because we want to reward the insurance companies? The patients are being asked to sacrifice their rights under this legislation. The doctors are still going to have to pay high insurance premiums because nothing in this legislation stops the insurance companies from continuing to rack up the rates, and the ones that are going to suffer are the patients.

In California, they have had a statute for many, many years. The malpractice insurance rates are higher than the States that do not have these kind of caps, and why? We are putting no limitations on these out-of-control insurance rates. In the meantime, here is what this terrible bill does to the patients, to people who are actually injured by medical malpractice.

The first one is the $250,000 cap on noneconomic damages. As I said in committee, I think people misunderstand what noneconomic damages are. They are not punitive damages. They are very real damages that patients suffer. They are things like loss of a leg, disfigurement, pain and suffering and the loss of fertility. Under common law, noneconomic damages would not be capped, but when we cap them at $250,000, victims who do not work outside the home like women, children, others with very low economic damages will not be able to be adequately compensated.

There is a case in Colorado where a child fell on a stick and his doctor did not adequately diagnose it, and that child, if he were limited to $250,000, his mother had to quit her job. He has been limited to a wheelchair. His chance to succeed as a citizen in our society is gone, and we are not going to adequately compensate him for that all because the insurance companies want to charge excessive rates. That is wrong. That is wrong for that kid, that is wrong for his family, and that is wrong for every single patient who suffers at the hands of malpractice.

The second problem with this bill, well, there are many problems, but the second I want to talk about is the elimination of joint and several liability. Under common law, defendants are jointly and severally liable. When we eliminate it, victims will not receive compensation.

Please defeat this bad bill.

Mr. GREENWOOD. Mr. Speaker, the previous speaker and most of the opponents of this bill have acknowledged that we have a crisis, a crisis that has to be resolved, and unfortunately, they have not articulated an alternative to our proposal, only their criticisms of it.

The fact of the matter is that this bill tips the scales back so that they are in balance. This bill allows 100 percent of economic damages, millions and millions of dollars of damages available to plaintiffs for their health care and their lost wages and many, many other economic damages. It puts a cap as a floor of $250,000 for noneconomic, noncalculable economic damages and allows every State in the union that wants to raise that to wherever they see fit.

This is the opportunity now to decide whether this House will stand up to the crisis and solve it or turn its head and let it fester for another 20 years.

Mr. CHAMBLISS. Mr. Speaker, the American Medical Association has declared Georgia one of twelve states with a medical malpractice crisis. About four in every ten hospitals in Georgia are now facing liability insurance premiums that have increased by more than 50 percent, and one of every four of those facilities has been hit hard with increases that exceed 200 percent. The St. Paul Company was the second largest health care underwriter in Georgia. When it ceased writing medical malpractice insurance policies last December, around 42,000 physicians nationwide had to scramble for coverage and protection. Some still have not found new insurance. Radiologists, OB/GYN specialists, and surgeons are among the groups hardest hit by these rising rates.

Many of Georgia's 178 hospitals already are struggling financially from staffing shortages and financial pressures. Some hospitals in Georgia will either have to look at closing or offer fewer services to patients who are in desperate need of care. The problems in Georgia highlight a national challenge for both hospitals and physicians. Physicians are threatening to relocate or retire in the wake of dramatic increases in malpractice insurance premiums. Patients cannot afford to lose care because doctors cannot afford premiums. This is outrageous and a sad commentary on the state of our health care system.

Litigation costs have premiums which are forcing doctors to scale back services, retire early, and reduce care to the poor. Like physicians, hospitals are having a difficult time finding medical malpractice insurance because with the skyrocketing cost of litigation several providers have ceased writing coverage altogether.

I would like to share some examples to demonstrate the severity of this problem in Georgia:

There is an 80 bed hospital in Alma, Georgia, which is in the 8th Congressional district, that was forced to take out a bank loan to cover a medical malpractice insurance premium that more than tripled in one year (rising from $118,000 to $396,000). Memorial Hospital and Manor in Bainbridge, Georgia was faced with a staggering 600 percent increase on its existing policy (increasing from $140,000 to $970,000).

According to WebMD Medical News, Dr. Sand Reed in Thomasville, Georgia, an OB/GYN, said her medical malpractice insurance increased 30 percent just this year. She is considering giving up delivering babies. She should not be forced to make these choices and her patients will suffer when they lose her expertise and experience in this area.

According to the Atlanta Journal Constitution, Ty Cobb Health, a consortium of three rural Northeast Georgia Hospitals and nursing homes, received a bill by fax this summer just 24 hours before a check was due. Not only did the insurance company increase his deductible ten fold, but the premium jumped from $553,000 to $3.15 million—a 469 percent increase. They eventually got an extension but can no longer plan for expansions or renovations of their emergency room.

In Fitzgerald, Georgia, Dr. Jim Luckie, has quit delivering babies because his premium

was so high. His liability insurance expired in April and it took him six weeks to get a new policy. When his insurance premium more than doubled, the family practitioner decided to discontinue the OB portion of his medical practice.

Dr. Edmund Wright, also of Fitzgerald, is a family practitioner who performed Caesarean sections and has had to give up that part of his practice. His premiums quadrupled to $80,000 this year and would have been $110,000 had he continued the surgical delivery procedure, which insurance companies consider ''high risk.''

In 2000, Georgia physicians paid more than $92 million to cover injury awards. That amount was 11th highest in the nation despite Georgia ranking 38th in total number of physicians in the U.S. It's clear Georgia is in a medical malpractice crisis.

Substantial medical malpractice reform is critical. The current system is destroying the doctor-patient relationship. I have talked extensively with the members and leadership of the Medical Association of Georgia, and have met with hospital and physician groups, as well as with patients and it is clear that we need to reform our current system for the sake of our patients, physicians, and hospitals. We need a system that allows any patient the right to pursue any cause where injury is the result of negligence. At the same time, we need a system that provides reasonable protection to hospitals and physicians.

Without the important reforms included in H.R. 4600, physicians and hospitals will continue to struggle to keep their doors open. I urge my colleagues to fight for all who deserve and need quality, affordable healthcare and to vote for this important legislation.

Mr. PAUL. Mr. Speaker, as an OB–GYN with over 30 years in private practice, I understand better than perhaps any other member of Congress the burden imposed on both medical practitioners and patients by excessive malpractice judgments and the corresponding explosion in malpractice insurance premiums. Malpractice insurance has skyrocketed to the point where doctors are unable to practice in some areas or see certain types of patients because they cannot afford the insurance premiums. This crisis has particularly hit my area of practice, leaving some pregnant woman unable to find a qualified obstetrician in their city. Therefore, I am pleased to see Congress address this problem.

However this bill raises several question of constitutionality, as well as whether it treats those victimized by large corporations and medical devices fairly. In addition, it places de facto price controls on the amounts injured parties can receive in a lawsuit and rewrites every contingency fee contract in the country. Yet, among all the new assumptions of federal power, this bill does nothing to address the power of insurance companies over the medical profession. Thus, even if the reforms of H.R. 4600 become law, there will be nothing to stop the insurance companies from continuing to charge exorbitant rates.

Of course, I am not suggesting Congress place price controls on the insurance industry. Instead, Congress should reexamine those federal laws such as ERISA and the HMO Act of 1973, which have allowed insurers to achieve such a prominent role in the medical profession. As I will detail below, Congress should also take steps to encourage contractual means of resolving malpractice disputes. Such an approach may not be beneficial to the insurance companies or the trial lawyers, but will certainly benefit the patients and physicians which both sides in this debate claim to represent.

H.R. 4600 does contain some positive elements. For example, the language limiting joint and several liability to the percentage of damage someone actually caused, is a reform I have long championed. However, Mr. Speaker, H.R. 4600 exceeds Congress' constitutional authority by preempting state law. Congressional dissatisfaction with the malpractice laws in some states provides no justification for Congress to impose uniform standards on all 50 states. The 10th amendment does not authorize federal action in areas otherwise reserved to the states simply because some members of Congress are unhappy with the way the states have handled the problem. Furthermore, Mr. Speaker, by imposing uniform laws on the states, Congress is preventing the states from creating innovative solutions to the malpractice problems.

The current governor of my own state of Texas has introduced a far reaching medical litigation reform plan that the Texas state legislature will consider in January. However, if H.R. 4600 becomes law, Texans will be deprived of the opportunity to address the malpractice crisis in the way that meets their needs. Ironically, H.R. 4600 actually increases the risk of frivolous litigation in Texas by lengthening the statute of limitations and changing the definition of comparative negligence.

I am also disturbed by the language that limits liability for those harmed by FDA-approved products. This language, in effect, establishes FDA approval as the gold standard for measuring the safety and soundness of medical devices. However, if FDA approval guaranteed safety, then the FDA would not regularly issue recalls of approved products later found to endanger human health and/or safety.

Mr. Speaker, H.R. 4600 also punishes victims of government mandates by limiting the ability of those who have suffered adverse reactions from vaccines to collect damages. Many of those affected by these provisions are children forced by federal mandates to receive vaccines. Oftentimes, parents reluctantly submit to these mandates in order to ensure their children can attend public school. H.R. 4600 rubs salt in the wounds of those parents whose children may have been harmed by government policies forcing children to receive unsafe vaccines.

Rather than further expanding unconstitutional mandates and harming those with a legitimate claim to collect compensation, Congress should be looking for ways to encourage physicians and patients to resolve questions of liability via private, binding contracts. The root cause of the malpractice crisis (and all of the problems with the health care system) is the shift away from treating the doctor-patient relationship as a contractual one to viewing it as one governed by regulations imposed by insurance company functionaries, politicians, government bureaucrats, and trial lawyers. There is not reason who questions of the assessment of liability and compensation cannot be determined by a private contractual agreement between physicians and patients.

I am working on legislation to provide tax incentives to individuals who agree to purchase malpractice insurance, which will automatically provide coverage for any injuries sustained in treatment. This will insure that those harmed by spiraling medical errors receive timely and full compensation. My plan spares both patients and doctors the costs of a lengthy, drawn-out trial and respects Congress' constitutional limitations.

Congress could also help physicians lower insurance rates by passing legislation that removes the antitrust restrictions preventing physicians from forming professional organizations for the purpose of negotiating contracts with insurance companies and HMOs. These laws give insurance companies and HMOs, who are often protected from excessive malpractice claims by ERISA, the ability to force doctors to sign contracts exposing them to excessive insurance premiums and limiting their exercise of professional judgment. The lack of a level playing field also enables insurance companies to raise premiums at will. In fact, it seems odd that malpractice premiums have skyrocketed at a time when insurance companies need to find other sources of revenue to compensate for their recent losses in the stock market.

In conclusion, Mr. Speaker, while I support the efforts of the sponsors of H.R. 4600 to address the crisis in health care caused by excessive malpractice litigation and insurance premiums, I cannot support this bill. H.R. 4600 exceeds Congress' constitutional limitations and denies full compensation to those harmed by the unintentional effects of federal vaccine mandates. Instead of furthering unconstitutional authority, my colleagues should focus on addressing the root causes of the malpractice crisis by supporting efforts to restore the primacy of contract to the doctor-patient relationships.

Mr. DELAY. Mr. Speaker, we're facing a growing crisis in our health care system.

In a number of states, there's a continuing exodus of doctors and talented specialists that's drawing down the quality of health care available to many Americans.

The reason for it is simple. The plaintiff's bar has been working for years and years to undermine, weaken, and strip-away the legal protections for practicing physicians.

Their reckless pursuit of ever-growing legal judgments is placing affordable insurance coverage out of reach for doctors in far too many states.

The raw greed motivating plaintiff's lawyers is driving good doctors out of states like Florida, Illinois, New York, North Carolina, Ohio, Pennsylvania, Texas, and West Virginia, to pick only a few.

These states are in crisis. And if anyone doubts if, they can test my assertion by trying to schedule an appointment with a neurosurgeon in one of these states. You'd better not need help in a hurry.

Doctors are confronting an awful choice: Abandon the communities and patients they trained to heal or be broken over the unacceptable costs of rising medical insurance premiums.

All of this raises a dangerous question. The medical liability insurance crisis creates liabilities for us beyond the practical problems of routine care.

What happens in states with over-burdened medical systems if there's a terror attack that produces mass casualties? What happens to the people when doctors have been driven across the border to neighboring states?

Mr. Speaker, we need real common-sense reforms and we need them today. The HEALTH Act delivers that relief and I ask Members to support it.

Mr. KNOLLENBERG. Mr. Speaker, we must act now to address the malpractice insurance crisis facing our nation. Medical providers across the country are turning away new patients or simply closing their doors because they can no longer afford the skyrocketing malpractice insurance premiums. This is particularly true in high-risk specialties such as obstetrics/gynecology and emergency medicine.

An American Hospital Association survey released this June found that more than 1,300 health care institutions have been affected by increasing malpractice costs. It further reported that 20 percent of the association's 5,000 member hospitals and other health care organizations had cut back on services and 6 percent had eliminated some units.

And the AMA today designated 19 states as "Medical Liability Crisis State." Fortunately, my home state of Michigan is not on that list, but if things continue as they are, all of our home states will be on that list.

This is unacceptable. Patients do not have time to wait for care or travel long distances to find a provider when they are in emergency situations. We cannot allow people to die because emergency rooms cannot afford to insure the necessary specialists. Women should also be able to receive prenatal care without worrying that their doctors might not be able to continue providing care throughout their entire pregnancy.

Moreover, fear of litigation leads many doctors to prescribe medicines and order tests that they feel are unnecessary. Studies estimate that this defensive medicine costs billions of dollars a year, enough to provide medical care to millions of uninsured Americans.

I believe we must work to eliminate medical errors and patients should be able to seek redress when medical mistakes are made but our health care system should serve patients, not lawyers. I have strong concerns with any endless, frivolous, and costly personal injury-like litigation. Today's system is skewed toward enterprising plaintiff's attorneys but the focus should be toward expanding health care access.

The causes of the liability crisis are complex but legislation we are considering today is a significant step in ensuring health care providers will be able to continue serving patients. The HEALTH Act would help stabilize liability premiums as well as help patients get awards and settlements faster and ensure that patients, not lawyers, receive the majority of the awards.

This is common-sense legislation modeled after California's twenty-five year-old, highly successful litigation reforms. I encourage my colleagues to support this bill because Americans do not have the time to wait for assurance that health care practitioners can maintain their practices and continue to serve patients.

Mr. BLUMENAUER. Mr. Speaker, it is clear that a crisis exists relating to the costs of medical malpractice liability insurance premiums. This bill is no a solution, and I will not vote for it. The problem deserves an effective solution based on a real causal evaluation, which this bill lacks. Even insurers and their lobbyists reject the notion that tort reform would achieve any specific premium reduction.

I am particularly concerned that the model for this bill, California's Medical Injury Compensation Reform Act (MICRA), does not appear to have made any improvement at all in the battle against high malpractice insurance premiums. MICRA included a $250,000 cap on non-economic damages as well as arbitration and attorney fee provisions, yet doctors still pay premiums that are higher than the national average.

Furthermore, the caps on damages in this bill are arbitrary, and based on a scale established in 1975. In Oregon, the Supreme Court has repeatedly ruled that even looser caps are a clear violation of state law, and Oregon voters have resisted efforts to change this. This bill would overturn their decisions, as well as patients' rights laws in 11 other states.

Since Congress is very unlikely to enact this tort reform, we ought to look into the effect that poor investments, the legislative framework, and other insurance industry-side elements might have in this crisis. Until we achieve a greater level of transparency in the accounting practices of insurers who hold the strings to these premiums, we will be unable to truly provide the relief that the medical system needs. I am committed to working with all parties to solve the malpractice premium crisis.

Ms. GRANGER. Mr. Speaker, today in my district, doctors are being forced out of practice because of the skyrocketing cost of medical malpractice insurance. In fact, a very close friend of mine who his a practicing in physician in Fort Worth, doctor Susan Blue, has recently been notified that her insurance carrier will terminate her policy on December first of this year. Since 1990, doctor Blue has had nine malpractice claims filed against her. However, most of the claims were frivolous and without merit, and her insurance company only paid out on one of these claims. And in that instance, $5,000 was paid to simply avoid spending tens of thousands of dollars in defense.

Unfortunately, because doctor Blue has been unable to find malpractice insurance, she may be forced to retire in December—after 29 years of practicing quality medicine.

I wish I could say that doctor Blue's story is an isolated incident. But we all know it's not. Every Member of Congress here today has a doctor Blue in their district. Every Mmember of Congress has experienced doctors that are, right now, deciding whether or not to retire because of the high cost of malpractice insurance. As a nation, we cannot afford to lose one more doctor.

With one less doctor, patients wait longer, diseases progress further, and health insurance costs continue to spin out of control.

Let's hold on to the skilled community physicians and ensure patients have the doctor choice that they deserve and desire.

Today I will be voting for doctors like Susan Blue, and I will support common sense malpractice reform. I will be supporting H.R. 4600.

Mr. EHRLICH. Mr. Speaker, I am pleased that the House today is debating public policy options to help contain the growth of medical care costs in our nation. Patients across the country continue to see increases in their insurance premiums and health costs, and it is critical for Congress to find solutions to make health care more affordable for physicians to practice and patients to access.

Proponents of H.R. 4600, The Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act, argue that this bill, which would create national tort reform, would contain or lower medical malpractice insurance costs for physicians and by extension lower health costs for consumers. I understand the many arguments in favor of this legislation, including the need to limit excessive medical insurance costs which physicians face in many states and often pass on to their patients. Also, like my fellow House members, I too feel a need to help my constituents back home.

I agree that our society has become excessively litigious and that reasonable tort reform can be enacted to reduce medical malpractice insurance premiums, keep doctors in areas of medical need, and help patients. Supporters of this legislation argue that many states are incapable of enacting tort reform because of the restrictions of their state constitutions or other barriers. Supporters also argue that a federal remedy is reasonable because this bill allows for state limits on damages to supersede the federal caps. I understand that the majority of my party, our leadership, and the President support this bill.

I believe, however, the proper venue for this debate should not be the U.S. Congress but rather the many state legislatures whose constitutions forbid tort reform or where there is no political will to limit damages from medical malpractice. This is a state matter—not a federal one.

States can and do enact reasonable, successful tort reform. In Maryland, for example, our tort reform law has generally worked well. As a state delegate who served on the Judiciary Committee in Annapolis and as a Member of Congress, I strongly support Maryland's tort law, which differs significantly from H.R. 4600 on a number of important matters, including caps on noneconomic damages, attorneys' fees caps, statutes of limitation on claims, and joint and several liability. One of the notable features of the Maryland law is the cap on noneconomic damages at $620,000 this year, with a built-in adjuster for inflation of $15,000 annually. I believe this cap allows for working-class victims of medical malpractice to reap reasonable damages. Creating an inflation adjuster allows for the removal of politics from tort laws which would otherwise call for frequent political intervention to update damage caps or risk the erosion of their value to compensated victims.

Mr. Speaker, I opposed similar caps on damages during the Patients Bill of Rights debate on the floor of the House in 2001 because I have come to the conclusion that states can regulate tort reform best—if they only choose to do so. I understand that many states have experienced problems with increasing costs of medical liability insurance for physicians. I respectfully believe, however, that the proper area for that debate is not in

Washington, DC but in state capitals where tort systems clearly need to be addressed and regulated as they have been in the past.

Accordingly, I oppose H.R. 4600.

Mr. HAYES. Mr. Speaker, I rise today in strong support of H.R. 4600, the Health Act.

Skyrocketing insurance premiums are debilitating our nation's health care delivery system.

In April I visited hospitals in the 8th District of North Carolina to talk about workforce issues such as the nursing shortage. At every stop, the number one concern of these talented health professionals was resoundingly the dramatically escalating cost of liability insurance.

Last year, NorthEast Medical in Concord, North Carolina paid approximately $600,000 for professional liability/general liability insurance for the hospital. This year they will pay approximately $1.7–1.9 million for the same coverage. They have one of the best loss rates in North Carolina. Other hospitals that aren't so fortunate are paying even more.

Scoltland Memorial, a rural hospital with only 124 acute beds, 50 bed nursing home, and minimal claims history, has seen an increase of over $545,000 this year with most of their insurance quotes over $1 million. Many of the potential insurers left in the industry are not willing to cover nursing homes or only at an even greater premium.

First Health Richmond, another rural hospital, paid $836,810 in 2001 for liability premiums. But this past year, they paid over $2 million! This hospital submitted 14 requests for bids, and only one company was even able to offer a quote. Lack of competitive insurers means even higher costs for our hospitals.

However, the problem is not isolated to hospitals.

Many obstetricians/gynecologists have stopped delivering babies. Physicians are retiring or moving because they no longer can afford to serve their communities or are simply unable to even purchase insurance. Annual increases in malpractice insurance for doctors of 30–70 percent are common today.

Just this month, three sub-specialist groups have informed Union Regional Medical Center in Union County, North Carolina that they will have to discontinue serving the hospital's patients because of huge increases in liability coverage, or threats from their carrier of such.

Smaller community hospitals, like most of those in my district need these sub-specialists from our larger cities such as Charlotte and Fayetteville. Their availability adds to the quality of health services available in our communities.

In 1994, the average medical malpractice jury award was $1.14 million. In 2000, just 6 short years, the average award rose to $3.4 million.

We must reign in run-away jury verdicts and the greed of trial lawyers who search for deep pockets. Taxpayers and seniors are the leading victims of a systemic trial lawyer-driven litigation explosion that siphons federal dollars out of the nation's healthcare system, threatens seniors' access to quality health care, and costs taxpayers billions of dollars. The system is broken, and we need to fix it.

Without federal legislation, the exodus of providers from the practice of medicine will continue, and patients will find it increasingly difficult to obtain needed health care.

This crisis is a threat for all Americans. We must safeguard patients' access to care through common sense reforms. Vote "yes" on H.R. 4600.

Mr. STARK. Mr. Speaker, I rise in strong opposition to H.R. 4600, legislation that would undermine the right of patients and their families to seek appropriate compensation and penalties when they, or a loved one, are harmed or even killed by an incompetent health care provider.

At best, this bill is a wrong-headed approach to the problem of rising malpractice health insurance costs. At worst, it is a bill designed to protect bad doctors and other health care providers from being held accountable for their actions. Under any scenario, the bill is harmful to consumers and should be defeated.

The Republican Leadership has once again brought us a bill that favors their special interests at the expense of quality health care. Doctors, hospitals, HMOs, health insurance companies, nursing homes, and other health care providers would all love to see their liability risk reduced. This bill meets that need. Unfortunately, it does so solely on the backs of America's patients.

Supporters of this bill would have you believe that medical malpractice lawsuits are driving health care costs through the roof. In fact, for every $100 spent on medical care in 2000, only 56 cents could be attributed to medical malpractice costs—that's one half of one percent. So, supporters are spreading false hope that reducing the cost of medical malpractice would reduce the cost of health care in our country by any measurable amount. It won't.

What supporters of this bill do not want you to understand is how bad this bill would be for consumers. The provisions of this bill would prohibit juries and courts from providing awards they believe are appropriate relative to the harm done.

H.R. 4600 caps non-economic damages. By setting an arbitrary cap on this portion of an award, the table is tilted against seniors, women, children, and people with disabilities. Medical malpractice awards break down into several categories. Economic damages are awarded based on how one's future income is impacted by the harm caused by medical malpractice. There are no caps on this part of the award. But by capping non-economic damages, this bill would result in someone, without tremendous earning potential—a housewife or a senior for example—finding their award much lower than that of a young, successful businessman for identical injuries. Is that fair? I don't think so.

The limits on punitive damages are severe. Punitive damages are seldom awarded in malpractice cases, but their threat is an important deterrent. And, in cases of reckless conduct that cause severe harm, it is irresponsible to forbid such awards.

The bill prohibits the requirement of a lump sum payment to an injured party which allows the defendants to continue to reap interest benefits while holding the award. And, this prohibition on lump sum awards could mean that injured victims who can no longer work do not have the funds available to meet their needs. Why should the decision of how to award the penalty be taken from the court which is in the best position to make that determination since they know the details of the particular case?

Republicans claim to be advocates for states rights. Yet, this bill directly overrides the abilities of states to create and enforce medical malpractice laws that meet the needs of their residents.

The issue of rising malpractice insurance costs is a very legitimate concern for America's health care providers. I would happily work with colleagues to develop legislation to help change that. For example, we could look at better ways of spreading the risk of medical malpractice insurance across a wider spectrum of doctors. Another option that has been discussed is to experience rate malpractice insurance so that providers' premiums better reflect their own professional experience. These are just a few examples of steps that could be taken. But, the important difference between those proposals and the one before us today is that those changes don't harm patients.

Medical malpractice costs are an easy target. My Republican colleagues like to simplify it as a fight between America's doctors and our nation's trial lawyers. That is a false portrayal. Our medical malpractice system is a vital consumer protection. The bill before us drastically weakens the effectiveness of our nation's medical malpractice laws. I urge my colleagues to join me in voting against this wrong-headed and harmful approach to reducing the cost of malpractice premiums. It's the wrong solution for America's patients and their families.

Mr. SMITH of Michigan. Mr. Speaker, a national insurance crisis is ravaging the nation's essential health care system Medical professional liability insurance rates have skyrocketed, causing major insurers to drop coverage or raise premiums to unaffordable levels.

Doctors and other health care providers have been forced to abandon patients and practices, particularly in high-risk specialties such as emergency medicine, neurology, and obstetrics and gynecology. Low-income neighborhoods and rural areas are being particularly hard hit.

H.R. 4600 is, modeled after California's quarter-century old and highly successful health care litigation reforms (MICRA). MICRA was signed into law by Governor Jerry Brown, and has proved immensely successful in increasing access to affordable medical care. Overall, according to data of the National Association of Insurance Commissioners, the rate of increase in medical professional liability premiums in California since MICRA was enacted in 1976 has been a very modest 167 percent, whereas the rest of the United States have experienced a 505 percent rate of increase.

Economists have concluded that direct medical care litigation reforms—including caps on non-economic damage awards—generally reduce the growth of malpractice claims rates and insurance premiums, and reduce other stresses on doctors that may impair the quality of medical care.

By incorporating MICRA's time-tested reforms at the Federal level, the HEALTH Act will make medical malpractice insurance affordable again, encourage health care practitioners to maintain their practices, and reduce health care costs for patients. MICRA remains the only proven legislative solution to the current crisis, yet many state courts in states other than California have nullified legislative reforms. Congressional action is required.

The current, unregulated medical tort system can force doctors to practice defensive

medicine. It also discourages improvements in the delivery of medical care by deterring doctors from freely discussing errors or potential errors due to a fear of litigation. The HEALTH Act will also save billions of dollars a year in taxpayer dollars by significantly reducing the incidence of wasteful defensive medicine in federally-funded programs.

Mr. MORAN of Virginia. Mr. Speaker, I rise today in support of H.R. 4600 which safeguards patients' access to medical care by implementing common sense reforms.

Skyrocketing liability insurance has forced some physicians, hospitals, and other health care providers to cut back or end practicing medicine. Our best and brightest doctors are curtailing their medical practice or leaving the profession altogether because of the ballooning cost of medical malpractice insurance caused by an onslaught of frivolous, yet damaging, lawsuits.

At the most basic level, this is an access to care issue. As the former ranking member of the D.C. Appropriations Subcommittee, I saw first-hand the lack of access to decent health care for the disadvantaged and under-served population.

The District of Columbia is the only state or territory that has not made any changes to its civil liability system resulting in D.C. ranking number one in the country in terms of the average size of payments that juries award in malpractice suits.

One of the nation's premier pediatric hospitals located in the District of Columbia, Children's Hospital, over the last two years has had the total cost for malpractice insurance increase by 200 percent for less coverage. That is an additional $3 million a year going to insurance costs instead of going to treat sick patients. Howard University Hospital has been its malpractice insurance increase by 300 percent this year alone.

An Anacostia, OB–GYNs are terminating their practice because of the astronomical cost of medical malpractice insurance. Women are being denied access to critical prenatal care, gynecological services, and preventative treatment.

Congress must pass this common-sense legislation and put a stop to the costs of the runaway litigation system paid by all Americans, I urge my colleagues to vote in favor of this legislation.

Mr. PITTS. Mr. Speaker, in the Commonwealth of Pennsylvania, we have a crisis on our hands. Last year, there were more than $1.2 billion in medical malpractice suit payouts. That's a thousand dollars for every man, woman, and child in the Keystone State. That's a huge drain on our economy. Worse than that, it's hurting patients.

In my Congressional district, one hospital recently closed its trauma center and another canceled plans to build a center city clinic to serve the poor. A third hospital is about to close its maternity ward and fourth hospital nearby is on the verge of cutting back on emergency room services.

Why? Because they can't find medical malpractice insurance.

Insurance companies literally can't charge enough for their policies to stay in business, so they're leaving the Commonwealth. And that means doctors and hospitals can't get insurance. Doctors are leaving the profession or leaving the state.

One doctor in my district says there were thirty companies offering malpractice policies when he started his practice 30 years ago. Now there is only one, and he's not sure they'll give him a policy.

This is a crisis, Mr. Speaker. And Pennsylvania is not the only state in the Union that's in trouble.

It's time for Congress to act. And we need to act now.

I urge my colleagues to pass this bill.

Mr. DINGELL. Mr. Speaker, like many of my colleagues here today, I am concerned about the rising cost of malpractice insurance. It is a very real problem for doctors and patients and something we should address. But, I have serious reservations about this bill, H.R. 4600. And the closed rule under which it is being considered is an outrage—confirming that this bill is a political ploy that will not help doctors and patients.

High insurance rates have left doctors with few options. Those who can afford it will pay the increased costs, but those who cannot will either be forced to assume significant personal liability, leave high risk specialities, or leave the profession altogether. But, this legislation doesn't guarantee any reduction or abatement in increases that doctors are facing for their malpractice premiums. Instead, it focuses on drastic reforms of the judicial system that extend beyond malpractice, hurt injured consumers' access to redress, and provide a windfall to insurance companies.

What has caused the increase in malpractice premiums is not easily identified. Many factors completely unrelated to jury verdicts and the civil justice system affect insurance rates: pricing of malpractice insurance; practices of accounting for income and expenses while planning for downturns; investment choices. Yet, this legislation addresses none of these issues. In fact, neither of the two Committees of jurisdiction ever explored these issues and their relation to malpractice premiums. Instead, we are voting today on a bill that won't do anything to lower doctors' premiums but will disproportionately hurt women, low-income families, and seniors.

The legislation severely restricts non-economic damage awards. Yet, evidence shows no relation between caps and lower malpractice premiums. Four out of the top five most expensive states for medical malpractice premiums cap damages in medical malpractice cases. Michigan doctors pay far above the national average for medical malpractice insurance, in spite of Michigan's $280,000 cap on non-economic damages. Such limits sever only to enrich insurance companies at the expense of the most vulnerable, women, children, the elderly and low income families.

The legislation also sets a nearly impossible standard for awarding punitive damages and then limits such damages based on the level of economic loss, again unfairly penalizing those with lower earnings. An egregious act that severely injures or disfigures Ken Lay, former CEO of Enron, could be punished more severely than if that same act had hurt a child, a stay-at-home mother, or an elderly woman in a nursing home.

The legislation also goes well beyond the realm of medical malpractice and provides immunity from punitive damages to manufacturers of drugs and devices that are approved or cleared by the Food and Drug Administration (FDA) as well as those that are not FDA approved but are ''generally recognized as safe and effective.'' This is like arguing that because someone drives at the speed limit, they can not be negligent or reckless. It is clearly possible to obey the speed limit, yet still act in a negligent or reckless manner. The bill that was brought to the floor purports to address this criticism, but the change is mostly cosmetic. The FDA statue and regulations, like FDA approval, should not be a shield for liability from injury caused by egregious acts.

The legislation also sets a stringent federal statute of limitations on state tort cases. In no event shall the time for commencement of a lawsuit exceed three years. Here again, last minute changes were made to the bill that are cosmetic rather than meaningful. The time should toll from discovery, not manifestation. Such a definition only invites more, not less, litigation. This issue is a well settled one with plenty of examples in case law and statute, and would be quite easy to fix correctly. The majority chose otherwise, leaving many injured patients whose claims would fall subject to this bill shut off from recourse.

One more item I should mention is the sense of the Congress on holding insurance companies liable for damages when their medical decisions cause harm. This provision is all bark and no bite. Democrats and a handful of moderate Republicans have tried for more than five years to enact a Patients' Bill of Rights that would allow injured patients to hold HMOs accountable under state law. Time and time again, however, such legislation has been blocked by Republicans who ultimately wish to shield insurance companies from liability. This last minutes cosmetic change cannot hide that fact.

In sum, instead of help for doctors with their malpractice premiums and fair compensation for injured patients, this bill puts more money in the pockets of insurance companies, and combines broad liability protections for industry with restrictions on patients who are harmed. The rising cost of malpractice insurance is a real problem requiring careful, balanced, and targeted legislation. Sadly, efforts to address this problem have become the vehicle for all manner of anti-patient provisions. I urge my colleagues to reject H.R. 4600.

Mr. MOORE. Mr. Speaker, I rise in opposition to H.R. 4600.

Like my colleagues, I am concerned about medical malpractice premiums and their effect on the availability of physicians, especially obstetricians and specialty physicians to practice in certain states. I am not at this time convinced, however, that H.R. 4600 is the complete answer to the medical malpractice insurance premium problem. The concentration of excessively high premiums in certain states shows that this is a regional, not national problems.

I believe that Congress should address the medical malpractice insurance system as a whole. The pricing and accounting practices of medical malpractice insurers may have contributed to this problem. There are indications that imprecise accounting practices have inflated the bottom line of companies and price wars in the early 1990s led insurers to sell malpractice coverage at rates that were inadequate to cover anticipated claims. Recent stock market declines have further exacerbated the financial difficulties of these companies, which have raised premiums or gone out of business in response.

I believe that a solution to the problem of rapidly rising medical malpractice insurance

premiums must address all of the factors that contribute to premium cost. Earlier this year, I sent a letter with several of my colleagues asking that the General Accounting Office conduct a study on the effect of market conditions and insurance company practices on medical malpractice insurance premiums. I am introducing into the RECORD a copy of that letter as well as a July 3, 2002, article from the Wall Street Journal.

I expect to have preliminary results from the GAO in December. Once we know the full scope of the problem, I hope that we can work together to find a comprehensive solution to this problem.

WASHINGTON, DC,
July 2, 2002.

Hon. DAVID M. WALKER,
Comptroller General of the United States, General Accounting Office, Washington, DC.

DEAR MR. WALKER: We are writing to request your assistance in evaluating the extent to which current market conditions and insurance company practices are contributing to an increase in medical malpractice premiums.

It has been reported that insurance companies have been raising the medical malpractice premiums which doctors must pay in certain regions of the country. Congress has begun to investigate this issue, and many in Congress have already proposed legislation. However, thus far the focus of debate in Washington has been limited. As Congress attempts to balance the rights of patients with the interests of doctors and insurers, we believe that a thorough analysis of insurance industry practices is necessary. Medical malpractice is an important issue that must be examined thoroughly and deliberately from all perspectives.

In this regard, we ask that you examine the financial statements and information submitted to regulators by insurance companies that offer medical malpractice insurance, as well as any other information maintained by regulators that may be relevant to this issue. In particular, we would like to know how reductions in the investment income of insurers may be adversely affecting the financial outlook of these companies, thus increasing physician premiums to compensate for any declines. To the extent feasible, you should also analyze the underwriting history of medical malpractice insurance to determine whether premiums have historically experienced similar increases and also determine whether current market conditions are in some way unique.

We would also like you to examine the competitiveness of markets, particularly in those areas experiencing the sharpest premium increase. For example, has the lack of competition in the medical malpractice insurance market adversely affected physician premiums? In addition, we are interested in having a better understanding of how malpractice settlements and judgements compare to premiums earned for medical malpractice lines of insurance. In particular, we would like to know how incurred but not yet reported holdings have affected the reserve practices of medical malpractice insurers.

As your examination proceeds, please provide us with a status report no later than September 3, 2002. We thank you for your assistance and look forward to your ultimate findings on this important issue for patients and doctors.

Sincerely,

John Conyers, Jr., John J. LaFalce, Joseph M. Hoeffel, Nick J. Rahall II, Alan B. Mollohan, John D. Dingell, Max Sandlin, Ronnie Shows, Dennis Moore, Marion Berry.

[From the Wall Street Journal, June 24, 2002]

INSURERS' PRICE WARS CONTRIBUTED TO DOCTORS FACING SOARING COSTS

(By Rachel Zimmerman and Christopher Oster)

As medical-malpractice premiums skyrocket in about a dozen states across the country, obstetricians and doctors in other risky specialties, such as neurosurgery, are moving, quitting or retiring. Insurers and many doctors blame the problem on rising jury awards in liability lawsuits.

''The real sickness is people sue at the drop of a hat, judgments are going up and up and up, and the people getting rich out of this are the plaintiffs' attorneys,'' says David Golden of the National Association of Independent Insurers, a trade group. The American Medical Association says Florida, Nevada, New York, Pennsylvania and eight other states face a ''crisis'' because ''the legal system produces multimillion-dollar jury awards on a regular basis.''

But while malpractice litigation has a big effect on premiums, insurers' pricing and accounting practices have played an equally important role. Following a cycle that recurs in many parts of the business, a price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims.

PRICE SLASHING

Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of shortsighted price slashing led to industry losses of nearly $3 billion last year.

''I don't like to hear insurance-company executives say it's the tort [injury-law] system—it's self-inflicted,'' says Donald J. Zuk, chief executive of Sepie Holdings Inc., a leading malpractice insurer in California.

What's more, the litigation statistics most insurers trumpet are incomplete. The statistics come from Jury Verdict Research, a Horsham, Pa., information service, which reports that since 1994, jury awards for medical-malpractice cases have jumped 175%, to a median of $1 million in 2000. During that seven-year period, the median award for negligence in childbirth was $2,050,000—the highest for all types of medical-malpractice cases, Jury Verdict Research says. (In any group of figures, half fall above the median, and half fall below.)

GAPS IN DATABASE

But Jury Verdict Research says its 2,951-case malpractice database has large gaps. It collects award information unsystematically, and it can't say how many cases it misses. It says it can't calculate the percentage change in the median for childbirth-negligence cases. More important, the database excludes trial victories by doctors and hospitals—verdicts that are worth zero dollars. That's a lot to ignore. Doctors and hospitals win about 62% of the time, Jury Verdict Research says. A separate database on settlements is less comprehensive.

A spokesman for Jury Verdict Research, Gary Bagin, confirms these and other holes in its statistics. He says the numbers nevertheless accurately reflect trends. The company, which sells its data to all comers, has reported jury information this way since 1961. ''If we changed now, people looking back historically couldn't compare apples to apples,'' Mr. Bagin says.

Some doctors are beginning to acknowledge that the conventional focus on jury awards deflects attention from the insurance industry's behavior. The American College of Obstetricians and Gynecologists for the first time is conceding that carriers' business practices have contributed to the current problem, says Alice Kirkman, a spokeswoman for the professional group. ''We are admitting it's a much more complex problem than we have previously talked about,'' she says.

SCRAMBLING FOR DOCTORS

The upshot is beyond dispute: Pregnant women across the country are scrambling for medical attention. Kimberly Maugaoteg of Las Vegas is 13 weeks pregnant and hasn't seen an obstetrician. When she learned she was expecting, the 33-year old mother of two called the doctor who delivered her second child but was told he wasn't taking any new pregnant patients. Dr. Shelby Wilbourn plans to leave Nevada because of soaring medical-malpractice insurance rates there. Ms. Maugaotega says she called 28 obstetricians but couldn't find one who would take her.

Frustrated, she called the office of Nevada Gov. Kenny Guinn. A staff member gave her yet another name. She made an appointment to see that doctor today but says she is skeptical about the quality of care she will receive.

In the Las Vegas area, doctors say some 90 obstetricians have stopped accepting new patients since St. Paul Cos., formerly the country's leading provider of malpractice coverage, quit the business in December. St. Paul had insured more than half of Nevada's 240 obstetricians. Carriers still offering coverage in the state have raised rates by 100% to 400% physicians say.

Dr. Wilbourn says his annual malpractice premium was due to jump to $108,000 next month, from $33,000. The 41-year-old solo practitioner says the increase would come straight out of his take-home pay of between $150,000 and $200,000 a year. In response, he is moving to Maine this summer.

Dr. Wilbourn mourns having ''to pick up and leave the patients I cared for and the practice I built up over 12 year.'' But in Maine, he has found a $200,000-a-year position with an insurance premium of only $9,800 for the first year, although the rate rises significantly after that. Premiums in Maine are relatively low because a dominant doctor-owned insurance cooperative there hasn't pushed to maximize rates, the heavily rural population isn't notably litigious and its court system employs an expert panel to screen out some suits, says Insurance Commissioner Allessandro Iuppa.

Until the 1970s, few doctors faced big-dollar suits. Malpractice coverage was a small specialty. As courts expanded liability rules, malpractice suits became more common. Dozens of doctor-owned insurance cooperatives, or ''bedpan mutuals,'' formed in response. Most stuck to their home states.

St. Paul, a mid-sized national carrier named for its base in Minnesota, saw an opportunity. An insurer of Main Street businesses, St. Paul became the leader in the malpractice field. By 1985, it had a 20% share of the national market. Overall, the company had revenue of $8.9 billion last year, with about 10% of its premium dollars coming from malpractice coverage.

The frequency and size of doctors' malpractice claims rose steadily in the early 1980s, industry officials say. St. Paul and its competitors raised rates sharply during the 1980s.

Expecting malpractice awards to continue rising rapidly, St. Paul increased its reserves. But the company miscalculated, says Kevin Rehnberg, a senior vice president. Claim frequency and size leveled off in the late 1980s, as more than 30 states enacted curbs on malpractice awards, Mr. Rehnberg says. The combination of this so-called tort

reform and the industry's rate increases turned malpractice insurance into a very lucrative specialty.

A standard industry accounting device used by St. Paul and, on a smaller scale, by its rivals, made the field look even more attractive. Realizing that it had set aside too much money for malpractice claims, St. Paul ''released'' $1.1 billion in reserves between 1992 and 1997. The money flowed through its income statement and boosted its bottom line.

St. Paul stated clearly in its annual reports that excess reserves had enlarged its net income. But that part of the message didn't get through to some insurers—especially bedpan mutuals—dazzled by St. Paul's bottom line, according to industry officials.

In the 1990s, some bedpan mutuals began competing for business beyond their original territories. New Jersey's Medical Inter-Insurance Exchange, California's Southern California Physicians Insurance Exchange (now known as Scpie Holdings), and Pennsylvania Hospital Insurance Co., or Phico, fanned out across the country. Some publicly traded insurers also jumped into the business.

With St. Paul seeming to offer a model for big, quick profits, ''no one wanted to sit still in their own backyard,'' says Scpie's Mr. Zuk. ''The boards of directors said, 'We've got to grow.' '' Scpie expanded into Connecticut, Florida and Texas, among other states, starting in 1997.

As they entered new areas, smaller carriers often tried to attract customers by undercutting St. Paul. The price slashing became contagious, and premiums fell in many states. The mutuals ''went in and aggravated the situation by saying, 'Look at all the money St. Paul is making,' '' says Tom Gose, President of MAG Mutual Insurance Co., which operates mainly in Georgia. ''They came in late to the dance and undercut everyone.''

The newer competitors soon discovered, however, that ''the so-called profitability of the '90s was the result of those years in the mid-80s when the actuaries were predicting the terrible trends,'' says Donald J. Fager, president of Medical Liability Mutual Insurance Co., a bedpan mutual started in 1975 in New York. Except for two mergers in the past two years, his company mostly has held to its original single-state focus.

The competition intensified, even though some insurers ''knew rates were inadequate from 1995 to 2000'' to cover malpractice claims, says Bob Sanders, an actuary with Milliman USA, a Seattle consultancy serving insurance companies.

ALLEGED FRAUD

In at least one case, aggressive pricing allegedly crossed the line into fraud. Pennsylvania regulators last year filed a civil suit in state court in Harrisburg against certain executives and board members of Phico. The state alleges the defendants misled the company's board on the adequacy of Phico's premium rates and funds set aside to pay claims. On the way to becoming the nation's seventh-largest malpractice insurer, the company had suffered mounting losses on policies for medical offices and nursing homes as far away as Miami.

Pennsylvania regulators took over Phico last August. The company filed for bankruptcy-court protection from is creditors in December. A trial date hasn't been set for the state fraud suit. Phico executives and directors have denied wrongdoing.

In the late 1990s, the size of payouts for malpractice awards increased, carriers say. By 2000, many companies were losing money on malpractice coverage. Industrywide, carriers paid out $1.36 in claims and expenses for every premium dollar they collected, says Mr. Golden, the trade-group official.

The losses were exacerbated by carriers' declining investment returns. Some insurers had come to expect that big gains in the 1990s from their bond and stock portfolios would continue, industry officials say. When the bull market stalled in 2000, investment gains that had patched over inadequate premium rates disappeared.

Some bedpan mutuals went home. Scpie stopped writing coverage in any state other than California. ''We lost money, and we retreated,'' says the company's Mr. Zuk.

New Jersey's Medical Inter-Insurance Exchange, now known as MIIX, had expanded into 24 states by the time it had a loss of $164 million in the fourth quarter of 2001. The company says it is now refusing to renew policies for 7,000 physicians outside of New Jersey. It plans to reformulate as a new company operating only in that state.

St. Paul's malpractice business sank into the red. Last December, newly hired Chief Executive Jay Fishman, a former Citigroup Inc. executive, announced the company would drop the coverage line. St. Paul reported a $980 million loss on the business for 2001.

As carriers retrench, competition has slumped and prices in some states have shot up. Lauren Kline, 6½ months pregnant, changed obstetricians when her long-time Philadelphia doctor moved out of state because of rate increases. Now, her new doctor, Robert Friedman, may have to give up delivering babies at his suburban Philadelphia practice. His insurance expires at the end of the month, and he says he is having difficulty finding a carrier that will sell him a policy at any price.

Last year, Dr. Friedman says he paid $50,000 for coverage. If he gets a policy for next year, it will cost $90,000, he predicts, based on his broker's estimate. ''I can't pass a single bit of that off to my patients,'' because managed-care companies don't allow it, he says.

Dr. Friedman says he is considering dropping the obstetrics part of his practice. Generally, delivering babies is seen as posing greater risks than most gynecological treatment. As a result insurers offer less-expensive policies to doctors who don't do deliveries.

Mr. Golden of the insurers' association argues that whatever role industry practices may play, the current turmoil stems from lawsuits. The association says that from 1995 through 2000, total industry payouts to cover losses and legal expenses jumped 52%, to $6.9 billion. ''That says there are more really huge verdicts,'' Mr. Golden says. Even in the majority of cases in which doctors and hospitals win—the zero-dollar verdicts—there are still legal expenses that insurers have to pick up, he adds.

Industry critics point to different sets of statistics. Bob Hunter, director for insurance at Consumer Federation of America, an advocacy group in Washington, prefers numbers generated by A.M. Best Co. The insurance-rating agency estimates that once all malpractice claims from 1991 through 2000 are resolved—which will take until about 2010—the average payout per claim will have risen 47%, to $42,473. That projection includes legal expenses and suits in which doctors or hospital prevail.

While the statistical debate rages, pregnant women adjust to new limits and inconveniences. Kelly Biesecker, 35, spent many extra hours on the highway this spring, driving from her home in Villanova, Pa., to Delran, N.J., so she could continue to use her obstetrician. Dr. Richard Krauss says he moved the obstetrics part of his practice from Philadelphia because malpractice rates had skyrocketed in Pennsylvania. Ms. Biesecker, who gave birth to a healthy boy on June 5, says Dr. Krauss was the doctor she trusted to guard her health and the health of her baby: ''You stick with that guy no matter what the distance.''

Dr. Krauss, 53, left Philadelphia last year only after his malpractice premium rose to $54,000, from $38,000, and then was canceled by a carrier getting out of the business, he says. After getting quotes of about $80,000 on a new policy, he moved. New Jersey hasn't been a panacea, however. His policy there expires July 1, and the carrier refuses to renew it. The doctor says he hopes to go to work for a hospital that will pay for his coverage.

Mr. BERMAN. Mr. Speaker, I've heard many arguments against H.R. 4600, but there is one that I've not heard mentioned yet today. I suspect that the drafters did not intend the bill to have this effect, but as drafted the HEALTH Act endangers the effectiveness of the most successful anti-fraud tool that the government has at its disposal—the False Claims Act.

In 1986, Congress passed and President Reagan signed legislation strengthening the False Claims Act, a law originally signed by President Lincoln in 1863. The amendments passed in 1986 have made it possible for the government to recover close to $9 billion that would otherwise have been lost to health care fraud and abuse.

The definitions of ''health care lawsuit'' and ''health care liability action'' in this bill are very broad. Broad enough to encompass fraud cases brought under the False Claims Act. If a False Claims Act case was determined to fall under the HEALTH Act, it would be devastating to the effectiveness of this anti-fraud tool. Under False Claims the government can recover up to treble damages. In a decision 2 years ago, the Supreme Court determined that these recoveries constitute punitive damages. The Health Act would cap punitive damages at $250,000 or twice the amount of economic damages, whichever is greater.

Let's use as an example the 1996 case against Laboratory Corporation of America, a fraud case based upon false claims for medically unnecessary ''add-on'' tests submitted to Medicare, Medicaid, and CHAMPUS. The government recovery in this case was $182 million. These are not small cases. The treble damages serve as a deterrent—a very effective deterrent. By some estimates the deterrent effect of the False Claims Act amendments was between 150 and 300 billion dollars during their first ten years of existence. By blocking punitive damages in these cases, the bill could make the False Claims Act useless to the government as a tool against fraud.

In a report released last year, Taxpayers Against Fraud estimated that using the False Claims Act, the government was recovering $8 for each tax dollar spent fighting health care fraud. There are very few government efforts that can claim this level of efficacy.

I encourage my colleagues to reject this bill and permit the government to continue to protect itself from health care fraud.

Mr. GOODLATTE. Mr. Speaker, I rise in strong support of H.R. 4600, which makes health care delivery more accessible and cost-effective in Virginia and throughout America by curbing medical malpractice abuse.

In recent years, Americans have witnessed a dramatic rise in the costs of malpractice insurance for doctors and hospitals. This cost is ultimately passed along to patients. Skyrocketing insurance premiums are debilitating

America's health care system. Liability insurers are either leaving the market or raising rates to astronomically high levels. This has led physicians, hospitals and other health care providers to severely limit their practices or to leave the practice of medicine all together. Women, low-income neighborhoods and rural areas are among the hardest hit.

Fearing bankruptcy or the possibility of endless litigation, some doctors have turned to "defensive medicine"—which consists of wasteful prescription of medically unnecessary medicine and the performance of unnecessary tests with the intent of limiting liability exposures. These "defensive medicine" practices ultimately cost taxpayers billions of dollars. In addition, fearing litigation, some doctors may hesitate to discuss a potential misdiagnosis or medical error, thereby compounding the harm done to patients. A recent survey released by the Department of Health and Human Services revealed that over 76 percent of physicians are concerned that malpractice litigation has hurt their ability to provide quality care to patients.

This bill safeguards patient's access to care by limiting the number of years a plaintiff has to file a healthcare liability action. This ensures that claims are brought while evidence and witnesses are available. The legislation allocates damages fairly in proportion to a party's degree of fault, allows patients to recover economic damages such as future medical expenses and loss of future earnings, while establishing a cap of $250,000 on non-economic damages, such as pain and suffering. The bill also places reasonable limits on punitive damages.

American health care is still the envy of the world, but unless we act now to curb rapidly rising health care costs, we threaten the future availability of high quality affordable health care. One way to cut costs and improve quality is by curbing excessive lawsuits. This bill is a big step in the right direction to improving patient safety and doctor accessibility.

Mr. SMITH of Texas. Mr. Speaker, the cost of malpractice insurance has steadily risen, which has caused many insurers to drop coverage or raise premiums. Doctors and others have been forced to abandon patients, particularly in high-risk specialties such as emergency medicine and obstetrics and gynecology.

H.R. 4600, the HEALTH Act, will cap non-economic damages at $250,000, and limit the contingency fees lawyers can charge. This will reduce the number of medical malpractice claims and make medical malpractice insurance affordable again. Patients will receive better and less expensive health care.

By improving the medical malpractice system, the HEALTH Act will enhance the quality of care for all patients.

I urge my colleagues to support this legislation.

Mr. STENHOLM. Mr. Speaker, I rise in strong support of the HEALTH Act of 2002 (H.R. 4600), which will improve health care quality and help ensure the availability of health care services and coverage.

The failure of the medical liability system is compromising patient access to care. Liability insurers are leaving the market or raising rates to astronomical levels. In turn, more physicians and other health care providers are severely limiting their practices or are simply unable to afford to practice medicine. Physicians in Texas as well as Florida, Mississippi, Nevada, New York, Ohio, Pennsylvania, Washington, West Virginia and other states are already in crisis.

Skyrocketing medical malpractice insurance premiums are debilitating the nation's health care delivery system in communities across the country. Physicians in Texas have experienced a 51 percent increase in malpractice claims between 1990 and 2000, and according to the Texas Medical Association, increases in physician malpractice insurance rates in 2002 ranged from 30 percent to 200 percent.

Increasing numbers of physicians, hospitals, and other providers are curtailing their services, relocating to other states, or simply ceasing to offer medical services altogether. For example, obstetricians/gynecologists and surgeons in these states routinely pay more than $100,000 a year for $1,000,000 coverage. Some are paying more than $200,000. A physician facing these premiums is more likely to practice defensive medicine, order extra tests and use only procedures that limit risk. For some, it goes to the heart of their practice. For instance, many OB/GYN physicians have stopped delivering babies. The problem also has spread to emergency rooms where the crisis takes on life-or-death proportions.

Especially in rural areas, health care services are likely to be unevenly distributed. Many rural residents do not even have access to a local doctor, primary care provider, or hospital. Increases in medical malpractice insurance have resulted in a further loss of patient access to health care. Without access to local health care professionals, rural residents are frequently forced to leave their communities to receive necessary treatments. Not only is this a burden to rural residents, who are often older or lack reliable transportation, but it drains vital health care dollars from the local economy—further straining the financial well-being of rural communities.

Without federal legislation, the exodus of physicians from the practice of medicine will continue, especially in high-risk specialities, and patients will find it increasingly difficult to obtain health care.

It is for these reasons that I joined my fellow colleagues as an original cosponsor of the HEALTH Act, which safeguards patients' access to care, promotes speedy resolution of claims, fairly allocates responsibility, compensates patient injury, maximizes patient recovery, and puts reasonable limits, not caps, on punitive damages. This bill alone will not resolve our health care costs or access challenges but it is one part of the solution.

I urge my colleagues, especially those who represent rural America, to support H.R. 4600, stabilizing the nation's shaky medical liability system.

Mr. SHUSTER. Mr. Speaker, I rise today in support of H.R. 4600, the Help Efficient, Accessible, Low-cost, and Timely Healthcare Act, and ask my colleagues to support this common sense measure.

This legislation, modeled after California's 25 year old reforms, contains a tested package of reforms that will help lower medical liability premiums across the country is important for both physicians and patients.

In my great state of Pennsylvania, five commercial carriers that insured more than half of the hospitals and health systems have left the market or are not renewing policies for this year. Pennsylvania hospitals and physicians continue to face skyrocketing premiums. The cost of primary coverage has increased as much as 450% for some hospitals, and on average by 70 percent for all hospitals.

Further, the medical liability crisis is hindering the ability of our academic medical schools to recruit and retain students. According to the American College of Obstetricians and Gynecologists, one in ten obstetricians have already stopped delivering babies due to skyrocketing premiums. A shortage in radiologists willing to read mammograms has increased the wait time for screening mammograms at most major hospitals from two to three months. The current system is forcing our doctors to quit, encouraging them to seek other employment and jeopardizing the health care of our women.

In rural Pennsylvania this issue hits home. Many doctors are relocating to big cities where they can be part of a larger practice, specifically because they can't afford the insurance premiums on their own. In rural areas we have to travel farther and farther for quality health care—this dramatically affects our quality of life. Who wants to move to an area where they can't get health care?

It becomes more worrisome when it is an emergency. it is common knowledge that the sooner you get to the doctor the better chance you have in surviving a serious medical emergency. In rural areas, emergency medical personnel have to travel to the patient, diagnose the problem and then transport them to the nearest facility that can treat them. The further they have to travel the less likely they will survive.

Mr. Speaker, by passing H.R. 4600, we will take significant steps toward stabilizing the medical liability system by both safeguarding patients' access to care while helping to address skyrocketing health care costs. Congress needs to work for the betterment of the whole nation and pass this common-sense well tested package of reforms.

Mr. CROWLEY. Mr. Speaker, I rise in opposition to H.R. 4600. This bill's proponents say the legislation helps curb the costs of healthcare and helps doctors stay in business by reducing their insurance rates. However, they are wrong. I would like to illustrate why they are wrong and why I will oppose this legislation.

First, the $250,000 cap on non-economic damages will impede the right of patients and victims of gross negligence. Under this legislation, victims would not be allowed to sue for pain and suffering. That is wrong. Consider the cases of the patient who has the wrong leg amputated or who finds surgeon's initials carved into her skin or the recent example in Massachusetts where a surgeon left in the middle of surgery to go cash a check at the bank. Who would dare look these victims in the eye and say they should not be allowed to sue for anything beyond what this cap allows. Under current law, the onus is on the victims to prove they are deserving of a particular award. If they succeed in making their case, then they deserve to be awarded the appropriate amount by a jury of their peers in accordance with the law. This legislation leaves victims isolated without assistance and without the tools to protect themselves and their families.

Second, the bill takes power away from jurors and judges. Our constitution provides for trial by jury to ensure fair trials for all. Now the

Republican majority believes that the Constitution is wrong and people are not trustworthy; that power should be in the hands of the insurance companies not the American public. This bill is a one-size-fits-all approach to ruling on legislation. It says that even if jurors, who have conscientiously listened to every fact presented by both sides, want to award a plaintiff an amount beyond the cap, they are unable to do so. This bill says that judges, who are trained to listen to the specifics of a case and to understand the specifics of the law, cannot award damages as they see fit. This bill ties the hands of those who are expected to know the most about the law and about individual cases.

Third, the bill, which was drafted under the auspices of trying to lower malpractice insurance costs, offers no guarantees that medical malpractice costs will fall. Proponents claim the bill's intent is to reduce malpractice insurance rates, yet malpractice insurers can easily choose to price gauge. A June 24, 2002 Wall Street Journal article discusses the direct impact of insurers' "pricing and accounting practices" on increased malpractice rates. If we want to limit the burden on doctors, we need to limit their insurance rates, not limit victims' rights.

Finally, this bill places caps on suits due to negligent doctors who shouldn't be practicing, dangerous HMOs that should be shut down, and faulty pharmaceuticals and faulty devices that should be off the market. Unfortunately there are bad pharmaceuticals and bad devices in this country. Consider the Dalcon Shield, the inter-uterine device that used to be on the market. This device caused many women to develop serious uterine infections or worse, and the company knew it was faulty. Their negligence was punished by crushing lawsuits that caused the corporation to go bankrupt—and they should have gone bankrupt because they were killing women. This bill would allow manufacturers of devices like the Dalcon Shield to pay off small awards by their insurance company to their victims and continue to kill.

Additionally, this bill exempts all HMOs from litigation for denials of care. So many of my Congressional colleagues talk about wanting to protect Americans against HMOs, yet here we are discussing a bill that would do precisely the opposite. This bill is protection for HMOs. This bill saves HMOs from paying victims whatever amount the judicial systems finds is just. Patients need and deserve stronger protections against their HMOs than this bill permits.

This bill simply takes power away from judges, jurors, and victims while guaranteeing no relief for hospitals and physicians. My constituents have been waiting for Congress to pass a serious Patients Bill of Rights, protect patients and their families, and lower medical costs. This bill will accomplish none of these goals.

Therefore, I will be opposing this vote and urge all Members who care about their constituents and about health care costs to oppose this bill as well.

The SPEAKER pro tempore. Pursuant to House Resolution 553, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. CONYERS

Mr. CONYERS. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. CONYERS. Mr. Speaker, I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. CONYERS moves to recommit the bill H.R. 4600 to the Committee on the Judiciary and the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

In section 11—

(1) in the first sentence of subsection (a), strike "subsections (b) and (c)" and insert "subsections (b), (c), and (d)"; and

(2) add at the end the following new subsection:

(d) PATIENTS' BILL OF RIGHTS.—Notwithstanding any other provision of this Act, if a State has in effect a law that provides for the liability of health maintenance organizations (as defined in section 2791(b)(3) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(3))) with respect to patients, or sets forth circumstances under which actions may be brought with respect to such liability, this Act does not preempt or supersede such law or in any way affect such liability, circumstances, or actions.

Mr. CONYERS (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Michigan?

There was no objection.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Michigan is recognized for 5 minutes in support of his motion.

Mr. CONYERS. Mr. Speaker, I ask that the gentleman from New Jersey (Mr. ANDREWS) join me in the motion to recommit, and I offer this motion on behalf of myself and him.

As currently drafted, this bill guts HMO reform laws that States have already passed because it creates broad new caps on damages when HMOs deny coverage to patients, and so what we do is to add a safe harbor provision to specify that these State patient's bills of rights laws are not preempted by this bill. Nothing more.

It goes without saying that these limits are far less friendly to consumers injured by HMOs than the patient protection laws already enacted by the States, and I would love to refer to the former Governor of Texas George W. Bush, who had a similar view in mind. They enacted an HMO law in Texas, and that law, still on the books, has a higher cap on punitive damages than this bill and no caps on noneconomic damages for suits against HMOs.

Mr. Speaker, I yield to the gentleman from New Jersey (Mr. ANDREWS).

Mr. ANDREWS. Mr. Speaker, I thank the gentleman for yielding.

There is a serious disagreement about the underlying bill and whether or not it poses the right solution to the malpractice crisis. Aside from that, there should be no dispute over what this bill should and should not do with respect to State laws that many of our States have passed to protect patients against abuses by the managed care industry. This bill should have no effect on those underlying State laws.

If this motion to recommit is not adopted, I believe the best analysis is that this bill would have the effect of repealing or substantially neutralizing and weakening those State law protections. The purpose of the motion to recommit is to make it explicit in the statute that this bill, if enacted into law, would not preempt State patient protections laws.

So, for example, there are States that have laws that say that if a person went to their primary care provider and she suggested that a person needed a series of tests regarding possible malignancy and the managed care company refused to pay for the tests regarding the possible malignancy and they developed a malignancy, developed cancer, got sick as a result of it, under these State patient protection laws there are certain remedies that that patient and her family would now have, the ability to get a review before the decision was made by an external objective body and the ability, if the decision were not reversed, the ability to recover damages resulting from the arbitrary medical malpractice by the managed care company.

This has been a principle embraced by Republicans and Democrats in State legislatures around the country. In fact, as the gentleman from Michigan (Mr. CONYERS) mentioned, the President of the United States embraced such a bill when he was chief executive of the State of Texas.

□ 1445

The good work that the Texas legislature has done, and other legislatures have done around the country, would be imperiled and put at risk if this motion to recommit is not adopted.

Mr. Speaker, I disagree with the underlying bill; but even those who agree with the underlying bill, I believe, did not set out with the intention of repealing State patient protection statutes. I know that the majority has added a sense of Congress provision to the underlying bill that says it is not really our intention.

Frankly, there is a better way for us to express our intention than simply expressing the sense of Congress. It is to write a statute or to write a provision in the statute that says that State patient protection provisions are not repealed as a result of the adoption of this bill.

Mr. Speaker, I think Members should support the motion to recommit whether they are for the underlying bill, or whether they are joining those of us who oppose the underlying bill. If

Members respect and support the right of their State legislature to enact State laws that would protect Members' constituents against abuses by managed care companies and State laws, Members should vote for the motion to recommit. I would urge Republicans and Democrats to vote for the motion to recommit.

Mr. SENSENBRENNER. Mr. Speaker, I claim the time in opposition to the motion to recommit.

The SPEAKER pro tempore (Mr. GUTKNECHT). The gentleman from Wisconsin (Mr. SENSENBRENNER) is recognized for 5 minutes.

Mr. SENSENBRENNER. Mr. Speaker, this is a very craftily drafted motion. The effect of its adoption will be to increase health care costs and further restrict availability of health care to people all around the country.

First, it will increase health care costs in that patients of HMOs and the employers that sponsor the HMO-type coverage will not be able to benefit from what the Congressional Budget Office estimates will be a reduction of somewhere between 25–30 percent of professional liability insurance. So there will be higher professional liability insurance premiums paid by the doctors who practice in the HMOs which will be passed on to their patients and which will be passed on to their employers.

This is an incentive for doctors to leave practicing with HMOs. And as we know, HMOs generally save money. Every Member who gets these statements from our insurance company that says ''This is not a bill'' on it, there are negotiated savings that would not be there if the doctor left the HMO as a result of this motion to recommit passing, and thus qualifying for the lower insurance premiums available, or where the protections of this bill would be available to doctors practicing outside of HMOs.

By increasing the cost of HMOs, more and more employers will decide that it is too expensive for them to continue to provide health insurance coverage. So the protections to patients will go down as fewer and fewer employers can afford the coverage through the HMOs.

But I think also the availability of quality health care will go down whether one is in an HMO or not in an HMO because the market works. If health care becomes more expensive, then there will be less health care that will be available. I do not think anybody who supports this motion to recommit can ever come to the floor of this House of Representatives with a straight face and sincerely complain about increased health care costs because that is exactly what the motion to recommit will accomplish should it pass.

Mr. Speaker, I yield to the gentleman from Pennsylvania (Mr. GREENWOOD).

Mr. GREENWOOD. Mr. Speaker, this motion to recommit is, I fear, a wolf in sheep's clothing. The fact of the matter is while it purports to be a small carve-out for the Patient Bill of Rights as they apply to HMOs, the fact of the matter is it would insulate and take away the protections for all of the physicians who work for HMOs, and I believe for the hospitals that contract with HMOs. It is very much a gutting amendment.

The fact of the matter is that we in this House have to decide which side we are on here. We are either on the side of providing adequate care to our patients, to our constituents, making sure that our physicians can stay in practice, stop retiring early, keeping the trauma centers open; or we are on the side of doing nothing, which is about what this bill would do with a motion to recommit with instructions.

The Congressional Budget Office has said that this bill will reduce premiums by 25–30 percent. Despite all of the railings against it, the fact of the matter is when we limit liability, as California has seen and the statistics are crystal clear there, when we limit non-economic damages, the rates go down. The rates go down because there is competition in the system, and the insurance companies will have to lower their premiums in order to compete with others in the same market.

The fact of the matter is, until we do that, we will remain on this head-long path towards crisis, in which case the traumas centers will close, the obstetrician offices will close, and patients, our constituents, will have third world health care if we do not pass this bill today.

Mr. SENSENBRENNER. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. CONYERS. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for any electronic vote on the question of passage.

The vote was taken by electronic device, and there were—yeas 193, nays 225, not voting 14, as follows:

[Roll No. 420]

YEAS—193

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldacci
Baldwin
Barrett
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Borski
Boswell
Boucher
Brady (PA)
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Clay
Clayton
Clement
Clyburn
Coble
Condit
Conyers
Costello
Coyne
Crowley
Cummings
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley
Doyle
Duncan
Edwards
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank
Frost
Ganske
Gephardt
Gonzalez
Gordon
Graham
Green (TX)
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holt
Honda
Hooley
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson (IL)
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind (WI)
Kleczka
Kucinich
LaFalce
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Lynch
Maloney (CT)
Markey
Mascara
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Mollohan
Moore
Nadler
Napolitano
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Phelps
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Ross
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Schiff
Scott
Serrano
Sherman
Shows
Skelton
Smith (WA)
Snyder
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Thompson (MS)
Tierney
Towns
Turner
Udall (CO)
Udall (NM)
Velazquez
Waters
Watson (CA)
Watt (NC)
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NAYS—225

Aderholt
Akin
Armey
Baker
Ballenger
Barr
Bartlett
Barton
Bass
Bereuter
Biggert
Bilirakis
Blunt
Boehlert
Boehner
Bonilla
Bono
Boozman
Boyd
Brady (TX)
Brown (SC)
Bryant
Burr
Burton
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Castle
Chabot
Chambliss
Collins
Combest
Cooksey
Cox
Cramer
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal
DeLay
DeMint
Diaz-Balart
Doolittle
Dreier
Dunn
Ehlers
Ehrlich
Emerson
Everett
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Frelinghuysen
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Grucci
Gutknecht
Hall (TX)
Hansen
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hilleary
Hobson
Hoekstra
Holden
Horn
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
Kerns
King (NY)
Kingston
Kirk
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo

McCrery
McHugh
McInnis
McKeon
McKinney
Mica
Miller, Dan
Miller, Gary
Miller, Jeff
Moran (KS)
Moran (VA)
Morella
Murtha
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Reynolds
Riley
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schaffer
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Stenholm
Sullivan
Sununu
Sweeney
Tancredo
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Tiberi
Toomey
Upton
Visclosky
Vitter
Walden
Walsh
Wamp
Watkins (OK)
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOT VOTING—14

Bachus
Barcia
Bonior
Callahan
Hilliard
Israel
Maloney (NY)
McDermott
Mink
Roukema
Slaughter
Stump
Thompson (CA)
Thurman

□ 1513

Messrs. CAMP, KIRK, BAKER, HORN, CRAMER, EHLERS, SHAYS, TIBERI, ISTOOK, MORAN of Virginia, Ms. ROS-LEHTINEN, and Mrs. KELLY changed their vote from ''yea'' to ''nay.''

Mr. LIPINSKI, Mr. LAMPSON, Ms. WOOLSEY, and Mrs. CLAYTON changed their vote from ''nay'' to ''yea.''

So the motion was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. GUTKNECHT). The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. SENSENBRENNER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 217, nays 203, not voting 12, as follows:

[Roll No. 421]

YEAS—217

Aderholt
Akin
Armey
Baker
Ballenger
Barr
Bartlett
Barton
Bass
Bereuter
Biggert
Bilirakis
Blunt
Boehlert
Boehner
Bonilla
Bono
Boozman
Boyd
Brady (TX)
Brown (SC)
Bryant
Burr
Burton
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Castle
Chabot
Chambliss
Collins
Combest
Cooksey
Cox
Cramer
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal
DeLay
DeMint
Dooley
Dreier
Duncan
Dunn
Edwards
Ehlers
Emerson
English
Everett
Ferguson
Fletcher
Foley
Forbes
Fossella
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall (TX)
Hansen
Harman
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hilleary
Hobson
Hoekstra
Holden
Horn
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
Kerns
Kingston
Kirk
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
McCrery
McHugh
McInnis
McKeon
Mica
Miller, Dan
Miller, Gary
Miller, Jeff
Moran (KS)
Moran (VA)
Murtha
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Osborne
Ose
Otter
Oxley
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Reynolds
Riley
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schaffer
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Stenholm
Sullivan
Sununu
Sweeney
Tancredo
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Tiberi
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins (OK)
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wolf
Young (AK)
Young (FL)

NAYS—203

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldacci
Baldwin
Barrett
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Borski
Boswell
Boucher
Brady (PA)
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Clay
Clayton
Clement
Clyburn
Coble
Condit
Conyers
Costello
Coyne
Crowley
Cummings
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Diaz-Balart
Dicks
Dingell
Doggett
Doolittle
Doyle
Ehrlich
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Flake
Ford
Frank
Frost
Gephardt
Gilman
Gonzalez
Gordon
Graham
Green (TX)
Grucci
Gutierrez
Hastings (FL)
Hill
Hilliard
Hinchey
Hinojosa
Hoeffel
Holt
Honda
Hooley
Hoyer
Inslee
Istook
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson (IL)
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kleczka
Kucinich
LaFalce
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Lynch
Maloney (CT)
Markey
Mascara
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McGovern
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Mollohan
Moore
Morella
Nadler
Napolitano
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Phelps
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Ross
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Schiff
Scott
Serrano
Sherman
Shows
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Terry
Thompson (MS)
Tierney
Towns
Turner
Udall (CO)
Udall (NM)
Velazquez
Visclosky
Waters
Watson (CA)
Watt (NC)
Waxman
Weiner
Wexler
Wilson (SC)
Woolsey
Wu
Wynn

NOT VOTING—12

Bachus
Barcia
Bonior
Callahan
Israel
Maloney (NY)
McDermott
Mink
Roukema
Stump
Thompson (CA)
Thurman

□ 1528

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

CONFERENCE REPORT ON H.R. 2215, 21ST CENTURY DEPARTMENT OF JUSTICE APPROPRIATIONS AUTHORIZATION ACT

Mr. SENSENBRENNER. Mr. Speaker, pursuant to House Resolution 552, I call up the conference report on the bill (H.R. 2215) to authorize appropriations for the Department of Justice for fiscal year 2002, and for other purposes.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. GILLMOR). Pursuant to the rule, the conference report is considered as having been read.

(For conference report and statement, see proceedings of the House of September 25, 2002, at page H6586.)

□ 1530

The SPEAKER pro tempore (Mr. GILLMOR). The gentleman from Wisconsin (Mr. SENSENBRENNER) and the gentleman from Virginia (Mr. SCOTT) each will control 30 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. SENSENBRENNER).

GENERAL LEAVE

Mr. SENSENBRENNER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to include extraneous material on the conference report on H.R. 2215 currently under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. SENSENBRENNER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I have a lengthy statement which I plan on putting in the