Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gillmor
Gingrey
Goode
Goodlatte
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Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
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Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
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Peterson (PA)
Petri
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Platts
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Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
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Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
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Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
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Stearns
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Sweeney
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Taylor (NC)
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Thornberry
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Turner (OH)
Upton
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Walden (OR)
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Weldon (PA)
Weller
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Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOES—201

Abercrombie
Ackerman
Alexander
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Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
Delahunt
DeLauro
Deutsch
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Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
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Eshoo
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Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
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Larsen (WA)
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Lynch
Majette
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Markey
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Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
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Obey
Olver
Ortiz
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Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—8

Combest
DeGette
Gephardt
Gilchrest
Hyde
Johnson (IL)
McIntyre
Snyder

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. (Mr. THORNBERRY) (during the vote). Members are advised 2 minutes remain in this vote.

□ 1207

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.

MESSAGE FROM THE PRESIDENT

A message in writing from the President of the United States was communicated to the House by Mr. Sherman Williams, one of his secretaries.

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

Mr. SENSENBRENNER. Mr. Speaker, pursuant to House Resolution 139, I call up the bill (H.R. 5) to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. SIMPSON). Pursuant to House Resolution 139, the bill is considered read for amendment.

The text of H.R. 5 is as follows:

H.R. 5

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 3. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

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

(1) Upon proof of fraud;

(2) Intentional concealment; or

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

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

SEC. 4. COMPENSATING PATIENT INJURY.

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

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

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

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

SEC. 5. MAXIMIZING PATIENT RECOVERY.

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

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

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

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

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

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

SEC. 6. ADDITIONAL HEALTH BENEFITS.

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

SEC. 7. PUNITIVE DAMAGES.

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

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

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

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

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

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

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

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

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

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

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

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

(1) PUNITIVE DAMAGES.—

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

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

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

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

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

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

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

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

SEC. 9. DEFINITIONS.

In this Act:

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

(2) CLAIMANT.—The term "claimant" means any person who brings a health care

lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

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

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

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

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

(D) any other publicly or privately funded program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 10. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

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

SEC. 13. SENSE OF CONGRESS.

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

The SPEAKER pro tempore. In lieu of the amendments recommended by the Committee on the Judiciary and the Committee on Energy and Commerce printed in the bill, an amendment in the nature of a substitute printed in House Report 108–34 is adopted.

The text of H.R. 5, as amended pursuant to House Resolution 139, is as follows:

H.R. 5

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—

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

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

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

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

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

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

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

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

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

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

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

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

(1) Upon proof of fraud;

(2) Intentional concealment; or

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

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

SEC. 4. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this Act shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

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

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

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

SEC. 5. MAXIMIZING PATIENT RECOVERY.

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

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

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

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

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

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

SEC. 6. ADDITIONAL HEALTH BENEFITS.

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

SEC. 7. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded

with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

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

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

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

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

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

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

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

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

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

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

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

(1) IN GENERAL.—

(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product, based on a claim that such product caused the claimant's harm where—

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

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

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

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

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a medical product approved, licensed, or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product. Nothing in this paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims against the manufacturer, distributor, or product seller of such medical product.

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

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

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

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or maintaining approval, clearance, or licensure 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 any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the 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 or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local

government; or which is grounded in antitrust.

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

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

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

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

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

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

(14) MEDICAL PRODUCT.—The term ''medical product'' means a drug, device, or biological product intended for humans, and the terms ''drug'', ''device'', and ''biological product'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

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

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

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

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the 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 AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this Act (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

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

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

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

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

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

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

SEC. 13. SENSE OF CONGRESS.

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

The SPEAKER pro tempore. The gentleman from Wisconsin (Mr. SENSENBRENNER) and the gentleman from Michigan (Mr. CONYERS) each will control 40 minutes and the gentleman from Louisiana (Mr. TAUZIN) and the gentleman from Michigan (Mr. DINGELL) each will control 20 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 include extraneous material on H.R. 5, the bill 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, our Nation is facing a health care crisis driven by uncontrolled litigation. Medical professional liability insurance rates have soared, causing major insurers to either drop coverage or to raise premiums to unaffordable levels. Doctors are being forced to abandon patients and practices or to retire early, particularly in high-risk specialties such as emergency medicine, brain surgery and obstetrics and gynecology. Women are being particularly hard hit, as are low income and rural neighborhoods.

H.R. 5, the HEALTH Act, is modeled after California's highly successful health care litigation reforms enacted in 1975 and known under the acronym MICRA. California's reforms, which are included in the HEALTH Act, include a $250,000 cap on noneconomic damages, limits on the contingency fees lawyers can charge, and authorization for defendants to introduce evidence to prevent double recoveries. The HEALTH Act also includes provisions creating a fair share rule by which damages are allocated fairly in direct proportion to fault, reasonable guidelines on the award of punitive damages, and a safe

harbor for punitive damages for products that meet applicable FDA safety requirements.

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

Still, the California reforms have been successful. Information provided by the National Association of Insurance Commissioners shows that since 1975, premiums paid in California increased by 167 percent while premiums paid in the rest of the country increased by 505 percent. As Cruz Reynoso, the Democratic Vice Chairman of the U.S. Civil Rights Commission wrote recently in the Los Angeles Times, ''What is obvious about MICRA is that it works and it works well. Our California doctors and hospitals pay significantly less for liability protection today than their counterparts in States without MICRA-type reforms.''

The Congressional Budget Office has concluded that ''under the HEALTH Act, premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law.'' If California's legal reforms were implemented nationwide, we could spend billions of dollars more annually on patient care. Reform at the Federal level is necessary because the current crisis is national in scope.

According to a report by the Department of Health and Human Services, ''The cost of these awards for noneconomic damages is paid by all other Americans through higher health care costs, higher health insurance premiums, higher taxes, reduced access to quality care, and threats to quality of care. The system permits a few plaintiffs and their lawyers to impose what is in effect a tax on the rest of the country to reward a very small number of patients.'' Congress must act to let doctors treat patients wherever they are and to reduce health care costs for all Americans.

H.R. 5 will also save the Federal taxpayers billions of dollars. Former Democratic Senator George McGovern has written in the Wall Street Journal, ''Legal fear drives doctors to prescribe medicines and order tests, even invasive procedures, that they feel are unnecessary. Reputable studies estimate that this 'defensive medicine' squanders $50 billion a year, enough to provide medical care to millions of uninsured Americans.''

According to the Department of Health and Human Services, ''If reasonable limits were placed on noneconomic damages to reduce defensive medicine, it would reduce the amount of taxpayers' money the Federal Government spends by $25.3–44.3 billion per year.''

Furthermore, despite accusations from the other side of the aisle, this is not a crisis caused by insurance companies. The President of the National Association of Insurance Commissioners wrote last month that ''To date, insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation. The preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices.''

We all recognize that injured victims should be adequately compensated for their injuries, but too often in this debate we lose sight of the larger health care picture. This country is blessed with the finest health care technology in the world. We are blessed with the finest doctors in the world. People are smuggled into this country for a chance at life and healing, the best chance they have in the world.

The Department of Health and Human Services issued a report recently that included the following amazing statistics. During the last half century, death rates of children and adults up to age 24 were cut in half and infant mortality rates have plummeted 75 percent.

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

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

As a Nation today, we have to choose. Do we want the abstract ability to sue a doctor for unlimited, unquantifiable damages when doing so means that there will be no doctors to treat ourselves and our loved ones in the first place? On behalf of all 287 million Americans, all of us who are patients, let us say yes to reasonable health care litigation management and pass the HEALTH Act.

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

Mr. CONYERS. Mr. Speaker, I am pleased to start the debate off on our side by yielding 3 minutes to the gentleman from North Carolina (Mr. WATT), the ranking member of the Subcommittee on Commercial and Administrative Law, where this bill would have gone had there been subcommittee hearings.

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

Let me say first of all that I do not argue with the right of California to do tort reform or North Carolina or New York or any of the States. There are crises in some States, situations vary from State to State, and State legislators have the prerogative to set whatever tort laws they think are desirable. But I think it is the ultimate act of arrogance on our part as Members of Congress to think that we should dictate to the States in an area that has historically and forever been the prerogative of the State and in a way that I think substantially adversely impacts our whole Federal form of government, and in a way that runs contrary to just about everything my Republican colleagues say they stand for, which is devolving things back to the States.

I talked to a doctor this morning and I said to him, I have never seen a malpractice take place across State lines. To the extent that you operate on a patient from North Carolina, you being a doctor in North Carolina and the patient is from South Carolina, that creates diversity of citizenship and gets you into the Federal court. I offered an amendment in the Committee on the Judiciary designed to restrict this legislation to suits that are brought properly in the Federal court. I think we have the prerogative as the Congress to define what the Federal tort standards should be. But when we start dictating to the States that you have got to follow this one-size-fits-all bill, I think we have just kind of lost sight of the whole thing.

This should not be about getting the result that we want in any particular lawsuit that is pending. It should be about setting a framework, a public policy framework that honors the parameters that our Founding Fathers set up. For the life of me, I cannot figure out what the Federal nexus is for having a bill this broad. We can argue that there is a crisis; I do not think that is really the issue. The issue is how should we respond to the crisis and what should be our role at the Federal level in this context.

Mr. SENSENBRENNER. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. SMITH).

Mr. SMITH of Texas. Mr. Speaker, I thank the chairman of the Committee on the Judiciary for yielding me this time.

Today, America faces a national insurance crisis that is destroying our

health care system. Medical liability insurance rates have soared, causing insurers either to drop their 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, brain surgery, and obstetrics and gynecology. This is an intolerable problem that cries out for a solution.

The American people understand the problem. A poll conducted in early February shows that 59 percent of all Americans believe the crisis should be solved either by reining in personal injury lawyers or by placing caps on the amounts juries can award. The obvious cause of skyrocketing medical professional liability premiums is escalating jury verdicts. The median medical malpractice jury award doubled between 1995 and 2000, from a half a million to $1 million. That does not reflect the huge costs of cases that do not result in jury awards. In fact, 70 percent of all medical malpractice claims result in no payments because claims are either dismissed or withdrawn.

The CEO of Methodist Children's Hospital in my hometown of San Antonio has seen his premiums increase from less than $20,000 to $85,000 in less than 10 years. He has been sued three times. In one case, his only interaction with the person suing was that he stopped by her child's hospital room and asked how the child was doing. Each jury cleared him of any wrongdoing, and the total amount of time all three juries spent deliberating was less than 1 hour. Of course, the doctor's insurance company did spend a great deal of time, effort and money in his defense.

Mr. Speaker, Congress can solve the current health care crisis, but it can solve it only by passing the HEALTH Act.

Mr. CONYERS. Mr. Speaker, I am delighted to yield 3 minutes to the gentleman from New York (Mr. WEINER), a distinguished member of the committee.

Mr. WEINER. Mr. Speaker, first of all, as the debate begins, let us put some myths to rest. We are going to hear a great deal of references to the California law that put in a cap. Since 1998, premiums have gone up 37 percent in California. Nationally they have gone up about 6 percent. So you keep talking about how great that has worked, but frankly it has not. In Florida where they also have a cap, and there are plenty of places around the country that do, they have a $450,000 cap that was put in the last time that suddenly we had an insurance crisis in this country in 1985, 1986. What happened then? Oh, yeah, insurance companies lost a lot of money in the stock market then, too, so that was the last crisis that we had. At the time Florida, they were smart, they asked insurance companies to report back to them the effect of the law. Aetna Casualty reported back. St. Paul, then the largest malpractice insurer, reported back; and in the words of St. Paul they said, quote, ''The new limits will produce little or no savings to the tort system as it pertains to medical malpractice.''

So feel free to keep talking about the examples that we have, but I think that you will find that when push comes to shove, the precedent is that these caps do not lower premiums. They do not lower premiums.

We are also going to hear a great deal of assertion today about out-of-control juries, out-of-control awards, judges who are completely out of their mind when they make decisions. Frankly, Duke Law School studied this notion not so long ago, as a matter of fact, in December of 2002. Here is what they said, and this is a quote: ''The assertion that jurors decide cases out of sympathy for injuries to plaintiffs rather than the legal merits of the case have been made about malpractice juries since at least the 19th century, yet no research shows support for these claims.''

But this is part of what I think is an underlying theme on the other side. American citizens cannot be trusted on juries to decide for themselves. They are not smart enough. Apparently my colleagues believe that juries that are made up of nine or 12 American citizens from your districts cannot be trusted to make these decisions. They simply are not trustworthy. But who are they? They are the same people that voted for you. Why is it you trust them to make a decision about who their Congressman would be and you will not trust them to make a decision about whether or not some medical malpractice case occurred and someone should be held accountable for that?

But there is another current here that I think is even more pernicious. Here we are. We sit in the Committee on the Judiciary. Let us take a look at what we have been doing recently. First, we are coming out after victims of this. This law only applies to you if you have been a victim of medical malpractice. You are a victim, but still we in the House want to take away your rights. Next we are going to take up bankruptcy reform. If you are really poor or you have fallen on hard times, we are coming after you next. But do not get too comfortable, because soon I hear that if you are an asbestos victim, we are going to come after your rights, too. This is who the Republican Party is standing up for in this House.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Pennsylvania (Ms. HART).

Ms. HART. Mr. Speaker, I rise in support of H.R. 5, the HEALTH Act. The practice of medicine in the United States is in real crisis. According to the American Medical Association, Pennsylvania's OB–GYN medical malpractice insurance rates increased from $25,000 to $64,000 over the last few years. That is an increase of over 125 percent. That is, if the doctor can get insurance.

Excessive lawsuits have gotten so out of control that many doctors are closing their practices, leaving many patients with long waits to see physicians who are farther and farther away from them. Just this past Monday, I met with a dozen physicians in my district. Of the dozen, nearly all of them raised their hands when I asked them if they have children. Of those, all but a few said that they would advise their children not even to consider studying medicine; and one doctor said his wife forbade their kids to even entertain such notions, all because of the unreasonable burden of out-of-hand insurance costs and the consistent fear of lawsuits.

The Pennsylvania Medical Association reports that 80 percent of physicians have difficulties in recruiting new doctors and 89 percent of doctors practice defensive medicine, which increases health costs and drives doctors away from the highly specialized fields.

This bill sets time-tested limits on liability so that we can end this crisis. The proposal provides commonsense reforms. It limits the number of years to file a health care liability action so claims are brought while evidence and witnesses are available. It allocates damage in proportion to a party's degree of fault. It allows patients to recover full economic damages, such as future medical expenses and loss of future earnings while establishing a cap on noneconomic damages of $250,000. It places reasonable limits on punitive damages as well.

The criteria in this bill assure patients who are injured by a doctor that they will recover. But it also ensures that more of the money goes to the injured patient, not the attorney. Essentially, the lawyer is limited to 40 percent of the first $50,000 of the award, one-third of the second $50,000 and 15 percent of amounts over $600,000. The bill will protect victims of real malpractice, but it will also help reduce lawsuits.

Our Nation has the best health care system in the world, but it is in peril. H.R. 5 will put us back on track.

Mr. CONYERS. Mr. Speaker, I yield myself 30 seconds for the benefit of my distinguished colleague, the gentlewoman from Pennsylvania, on the Committee on the Judiciary. She does not know, as she leaves the floor, that a census conducted by the Pennsylvania Medical Professional Liability Catastrophe Loss Fund found that between 1990 and 2000, the number of doctors in Pennsylvania increased by 13.5 percent, while the population increased by only 3.4 percent.

Mr. Speaker, I include the following citation for the RECORD:

In Pennsylvania a census conducted by the Pennsylvania Medical Professional Liability Catastrophe Loss Fund found that between 1990 and 2000, the number of doctors increased by 13.5 percent, while the population increased by only 3.4 percent. Not only is Pennsylvania not losing doctors, it had more doctors in 2001 than it did in the preceding

five to ten years. Furthermore, the Philadelphia Inquirer notes that in 2000, ''Pennsylvania ranked ninth-highest nationally for physician concentration, a top-10 position it has held since 1992. There were 318 doctors for every 100,000 residents in 2000, according to the American Medical Association.

□ 1230

Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. WEXLER), a distinguished member on the Committee on the Judiciary.

Mr. WEXLER. Mr. Speaker, I rise in opposition to H.R. 5. I do so because the proponents of this bill would have the country believe that the issue before this Congress is whether or not there is a medical malpractice crisis in America.

There is a medical malpractice crisis, but the issue before this Congress is how do we resolve that crisis? How do we minimize the premiums that doctors have to pay in order to participate in our medical society?

The reason we are in this position, according to a recently released report, particularly as it relates to my State, the State of Florida, by the group Public Citizen, is that a small number of negligent doctors and the cyclical nature of the insurance industry are largely to blame.

The Public Citizen report found that 6 percent of all doctors are responsible for one-half, 50 percent, of all medical malpractice cases. Six percent of doctors are responsible for 50 percent of malpractice cases. Yet the bill before this Congress does not at all address peer review of physicians, nor does it address the insurance aspect of the medical malpractice crisis, nor, most importantly, does it require insurance companies to pass on the savings from the alleged cap that would occur, pass that money on to doctors in the form of lower premiums.

In the State of Florida, which amounts to about 16 million people, in the last reported year there were 230 cases of awards in excess of $250,000, yet the proponents of this bill would argue that we will resolve this problem by limiting the excessive number of lawsuits that amount to excessive damages. They do not exist, these lawsuits, in the excessive number that they claim.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. GINGREY).

Mr. GINGREY. Mr. Speaker, I thank the distinguished chairman of Committee on the Judiciary for granting me time to speak on H.R. 5, the Medical Justice Act, HEALTH ACT of 2003. As an OB/GYN Member of the body, I think I have a unique perspective on this issue, not only as a physician who has delivered more than 5,000 babies and seen many of my colleagues giving up their practice because of fear of runaway lawsuits, but also as a grandparent. Let me explain that to you, because this issue is all about access to care for our patients, the citizens this country.

My identical twin granddaughters were born 5 years ago at 26 weeks. They each weighed 1 pound 12 ounces. Thank God we were in a community where we had access to care. There was an OB/GYN physician willing to take care of my daughter in that high risk situation. There was a skilled neonatologist. We did have a hospital that still had an intensive care nursery.

Had we not been in that situation, had we been in a more rural part of my State or in some of the other States that are in a crisis mode, like the testimony that we heard from the mother yesterday from the State of Mississippi, my daughters would not have received that care, and instead of being healthy, vibrant 5-year-olds today, I am sure that both of them would have cerebral palsy, our family would be devastated and society would probably bear the brunt of the cost of their care for the rest of their lives.

So this bill is all about access to care. It is not taking away a person's right to a redress of grievances in a situation where they have been injured by a practice below the standard of care. It is not taking away from a trial attorney that works in the area of personal injury their right to do business, and most do in a very equitable manner and with integrity. No, it is not about that at all. It is about access to care.

I am proud to stand here today and enthusiastically support H.R. 5, and I hope the rest of my colleagues in this Chamber will do the same.

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

Mr. Speaker, only for the benefit of the gentleman from Georgia, who asserts that this bill does not take away anybody's rights, the gentleman must be aware, sir, as a Member of Congress and a doctor, that there is a $250,000 cap on noneconomic damages, unless he thinks that is not taking away anybody's rights.

Mr. GINGREY. Mr. Speaker, will the gentleman yield?

Mr. CONYERS. I yield to the gentleman from Georgia.

Mr. GINGREY. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, as we know, this bill, of course, is applicable to those States that have not addressed this issue. Certainly the State of West Virginia and others who have finally tackled this issue, as they did in California in 1978, I believe, they can set their own caps. This law, H.R. 5, will be applicable to those States who, for one reason or another, have not.

Mr. CONYERS. Mr. Speaker, reclaiming my time, what about the States that have no caps?

Mr. GINGREY. Mr. Speaker, if the gentleman will continue to yield, the States that have no caps, of course, for noneconomic damages, this cap of $250,000 would be applicable.

Mr. CONYERS. In other words, the gentleman is sticking to his statement that this takes away nobody's economic rights, is that correct?

Mr. GINGREY. If the gentleman will allow me to respond?

Mr. CONYERS. If the gentleman will just answer yes or no.

Mr. GINGREY. The answer is no, it takes away no one's economic rights.

What in H.R. 5 is the gentleman pointing out to me or suggesting that takes away a person's right to economic recovery?

Mr. CONYERS. Mr. Speaker, if may I kindly and politely reclaim my time, and I would ask the gentleman to seek his own time from this point on.

Mr. Speaker, I yield 3½ minutes to the gentleman from Massachusetts (Mr. DELAHUNT), who has really worked hard on two committees and covered a lot of territory as a Member of Congress.

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

Mr. Speaker, next week we will be considering most likely on the floor of the House a bill dealing with bankruptcy. Today we are considering a bill that is bankrupt, because it is an act of special cruelty that is being perpetrated on the most vulnerable of victims of malpractice, stay-at-home mothers and children, children like Steven Olson, who was left blind and brain damaged after an HMO refused to give him a $800 CAT scan when he was 2 years old. He is going to need round-the-clock care for the rest of his life. A jury, a jury, awarded him more than $7 million for his pain and suffering. But California has a cap on noneconomic damages, so the judge was forced to reduce the award to $250,000. That is $12 a day for the rest of his normal life expectancy.

Is that all he is owed for the irreversible damage that was done to him? Is that fairness? Is that justice? I think we know the answer.

Mr. Speaker, the sponsors of this bill have assured the physicians of America that this bill will lower their insurance premiums. The doctors are being deceived, for it includes none of the provisions that would be necessary to bring about such a result.

The bill does nothing to reduce the staggering number of medical errors that kill so many thousands of Americans each year, according to some estimates, up to 98,000 deaths per year. That is a real crisis. It does nothing to weed out the 5 percent of the medical profession who are responsible for 54 percent of the medical claims. So what is going to happen is good doctors will continue to subsidize those that ought to be out of the profession.

It does nothing to regulate the rates that insurance companies charge their policyholders. That did prove effective in California when it was passed in 1988.

Instead of adopting any of these measures, the Republican majority has chosen to blame the victims, capping injury awards at artificially low levels that are insufficient to meet their needs and making it difficult for them

to even find a qualified attorney who is willing to take their case.

It is unconscionable, Mr. Speaker, for Congress to deprive these victims of the right to have a jury of their peers decide what their pain and suffering is worth. It is rather ironic that rather than regulating insurance rates, the apostles of the free markets opt to impose a system of wage and price controls. What irony.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2⅔ minutes to the gentleman from Virginia (Mr. FORBES).

Mr. FORBES. Mr. Speaker, I first would like to thank the distinguished chairman for his hard work on bringing this bill forward.

Mr. Speaker, we have heard a number of things today, including from my good friend from North Carolina who mentioned that he had failed to see a situation where a malpractice case crossed State lines. Yet the case law in his own State contains many cases just like that.

As a matter of fact, the Supreme Court in North Carolina has actually ruled that if a patient leaves North Carolina, where they have no cap, travels to Virginia and are treated by a doctor there who thinks he has the protection of a malpractice cap, they can actually be sued in North Carolina, and the Supreme Court there said no cap applies.

Mr. Speaker, I have worked on this crisis, which I believe is indeed a crisis in health care and access to health care, for over a decade now, and every single time this issue is debated I see the opponents of this type of legislation coming in and they try to paint these faces.

On the one hand, they will show a victim of the most egregious scenario, and certainly those victims do exist. On the other side, they will show a portrait, mental, if no other way, of a doctor who is the most egregious kind of doctor.

Mr. Speaker, that is not the true face of this legislation, not the true face of this problem. Let me give you three of those faces.

One is the young internist who tries to save the life of a patient who can no longer breathe, and is actually getting on a helicopter and traveling to a hospital with that patient. At the end, even though they have committed no malpractice, they end up in litigation for almost 4 years. At the end of the process, the doctor looks at you and says, I did nothing wrong, but for 4 years I had a cloud of litigation over me, worried about whether I was going to lose my home and everything I had.

It has the face of the emergency room physician who has been working for 8 hours, and all of a sudden responds to a code outside of the department with a dying patient that he cannot pull one more miracle out of the hat on, and that patient dies. He is brought into that litigation just as a shotgun approach, and, after 3½ years, even though he has no award against him, his malpractice premium has gone up 70 percent.

Mr. Speaker, it also has the face of a family practitioner, an African American practitioner who I met with just a few months ago, who 2 years ago his premium was $30,000. Last year it went up to $100,000. This past year it went up to $230,000. Mr. Speaker, he closed his doors. The difficulty is not that he is no longer in that office; the difficulty is when all of the patients he serves knock on that door, he is not there to open it again.

Mr. Speaker, the difficulty with not passing this bill is the fact that all of those patients would no longer have access to health care. That is why it is important we get it passed.

□ 1245

Ms. JACKSON-LEE of Texas. Mr. Speaker, I ask unanimous consent to control the time of the gentleman from Michigan (Mr. CONYERS).

The SPEAKER pro tempore (Mr. SIMPSON). Is there objection to the request of the gentlewoman from Texas?

There was no objection.

Ms. JACKSON-LEE of Texas. Mr. Speaker, it is my pleasure to yield 3 minutes to the distinguished gentlewoman from California (Ms. WATERS), a member of the Committee on the Judiciary and a ranking member on the Committee on Financial Services.

Ms. WATERS. Mr. Speaker, today we are here to debate a bill, H.R. 5, written for us by the insurance industry. Supporters of restricting jury awards and malpractice lawyers' fees say excessive billion-dollar damage awards in medical liability suits is the reason medical malpractice insurance premiums have risen so sharply and that nearly half the States are experiencing an insurance crisis. However, others say, and I agree, that rising malpractice rates are part of the cyclical nature of the insurance business, and insurers are raising premiums now to recoup recent stock market losses. In addition, I believe any crisis that exists is specific to certain medical specialties and regions of the country.

Let us, Mr. Speaker, say it like it is: the insurance industry wants this bill because it will increase their profits. Well, forgive me if I do not support the insurance industry over injured patients. I do not represent insurance industry profiteers. I represent the people in my district, the people who will be severely disadvantaged if this bill passes in its current form.

We have gone back and forth on this issue for a long time now. The medical malpractice insurers tell us again there is a crisis, there is a shortage, there is a stoppage, or whatever else they think will bully Congress into doing their bidding. It is truly terrible that good doctors are paying the price for the insurance industry's bad business decisions. It is truly terrible that the insurance industry has fooled doctors into believing that injured patients are to blame for high premiums, and it is truly terrible that the insurance industry has this control over the health care system.

I would say to my colleagues, it is time for us to put an end to the misrepresentations of the insurance industry. It is time for us to stand up for our constituents and for people who have been injured, who have been maimed, and even killed, who deserve to be protected.

I say vote ''no'' on this bad bill. Our citizens deserve to be compensated for medical malpractice.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. KING).

Mr. KING of Iowa. Mr. Speaker, I thank my distinguished chairman, the gentleman from Wisconsin (Mr. SENSENBRENNER), for yielding me this time and also for his work on this important bill.

Mr. Speaker, I would like to rise in support of H.R. 5. Many of the people I represent in Iowa have to drive a long ways to see a doctor and even further to see a specialist. Thankfully, the health care access prices in Iowa may not be as severe as they are in some of the other States, and we have heard some of that this afternoon. However, I know that rural States like Iowa need to do everything they can do to improve access to health care.

Rising medical liability premiums due to lawsuits make it harder for doctors to stay in business and continue to see patients. As I said before, sometimes it is easier to sue a doctor than it is to see one. The health care access crisis hits rural Iowa hard because we have to drive further to seek medical attention. The people in my district cannot afford to lose a single OB-GYN or ER doctor to the rising medical insurance premiums; and if we do, our families will suffer.

Expectant mothers will have to drive further to see their obstetricians, accident victims will spend critical minutes and hours in transportation, seniors will have to drive further and sometimes will not receive the care that they need. Access is critical. The people I represent should not have to spend more time on the road than in a doctor's office.

The health care access crisis is further exaggerated in my district because we have the lowest reimbursement rate of the 50 States for Medicare reimbursement rates, and that means we have a thinner margin to play with.

I would point out also that, if the folks that are seriously opposing this bill were defending just the interests of the patients, we would have seen an amendment that would have waived contingency fees on noneconomic damages.

Ms. JACKSON-LEE of Texas. Mr. Speaker, it gives me great pleasure to yield 3 minutes to the distinguished gentlewoman from California (Ms. LOFGREN), a senior member of the House Committee on the Judiciary and Committee on Science.

Ms. LOFGREN. Mr. Speaker, I am probably one of the few Members who have actually operated under MICRA in California. In the 14 years that I served on the board of supervisors, we bought malpractice insurance for the doctors at the county hospital; we settled lawsuits pursuant to MICRA related to the county medical professionals. People have argued the pros and cons of MICRA. The point that needs to be made is that H.R. 5 is not MICRA.

MICRA's cap on noneconomic damages applies to medical malpractice cases only. H.R. 5 extends liability relief to insurance companies, HMOs, nursing homes, medical device manufacturers, and pharmaceutical companies. In some cases, injured persons, for example, an elderly person abused in a nursing home, will only be able to look to their noneconomic damages for relief because they do not have any earnings to recover.

MICRA in California does not limit punitive damages in personal injury cases, but H.R. 5 caps punitive damages at two times economic loss, or $250,000, whichever is greater.

H.R. 5 would actually preempt California law by precluding tort recovery against nursing homes, HMOs who wrongly make medical decisions, and insurance companies. It would undercut California's elder abuse statutes, as well as undercut new measures that we have fought hard for in California that allow HMOs to be held accountable for their decision-making when that decision-making disrupts the doctor-patient relationship.

So whatever one thinks about MICRA in California, examine carefully H.R. 5, because it is not MICRA; it is putting the doctors in front of the insurance companies. But the big beneficiaries are the HMOs, the pharmaceutical companies, and the insurance companies and nursing homes.

I think this is not what our country should be doing to preempt California's elder abuse statutes and our new effort to hold HMOs accountable for the practice of medicine through insurance.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2 minutes to the gentleman from Indiana (Mr. CHOCOLA).

Mr. CHOCOLA. Mr. Speaker, I thank the chairman for yielding me this time.

Mr. Speaker, one of the biggest problems facing our health care system today does not start in the doctor's office or in the operating room; it starts in the courtroom. We have a problem in America. There are too many frivolous lawsuits against good doctors, and patients are paying the price. It costs money to fight a frivolous lawsuit and oftentimes, in order to avoid litigation, doctors and insurance companies settle cases, even though they have not committed a medical error.

So it pays to sue. One can file lawsuit after lawsuit and eventually the legal system begins to look like a lottery. With the trial lawyers taking as much as 40 percent, it is clear who is winning.

We want our legal system to benefit patients, not trial lawyers. Anyone who has been harmed at the hands of a doctor should have their day in court. They should be able to recover the full cost of their care, and they should be able to recover reasonable noneconomic damages.

But we know the insurance companies raise the cost of medical malpractice coverage when faced with the risk of unlimited noneconomic damages. Doctors cannot afford to pay their insurance premiums and end up raising rates or leaving their homes for States with reformed medical litigation systems. That means that the health care is no longer affordable and accessible to many of our citizens. When doctors cannot pay the premiums and stop practicing medicine, everyone loses.

Mr. Speaker, this culture of litigation has to end. No one has ever been cured by a frivolous lawsuit.

So I support the reasonable limits on noneconomic damages. I believe it is time to pass medical liability reform that benefits patients, not trial lawyers. I urge the House to pass H.R. 5, the HEALTH Act of 2003.

Ms. JACKSON-LEE of Texas. Mr. Speaker, it gives me great pleasure to yield 1 minute to the distinguished gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), a physician and an advocate for good health care for all Americans. We thank her very much for her leadership.

(Mrs. CHRISTENSEN asked and was given permission to revise and extend her remarks.)

Mrs. CHRISTENSEN. Mr. Speaker, H.R. 5 is but another wolf in lamb's clothing, pretending to help doctors and patients, but really only helping the large health care corporations and doing nothing to help lift the malpractice burdens from doctors and other providers, or to ensure fair treatment to their patients. Health care professionals need to see through this sham.

I am a family physician. I see my classmates and other doctors, good ones, many who have never been sued, struggling to keep malpractice coverage and just to keep their offices open under the press of high premiums.

It is truly unfortunate that many of the organizations representing us are mistakenly supporting H.R. 5, because I think they think this is the best they can get. H.R. 5 is not. As a matter of fact, it is no help at all. Doctors are but pawns in what is clearly special interest legislation.

Mr. Speaker, H.R. 5 is an assault on the poor and minorities as well, because regardless of their injury and needs, the awards would be capped at low levels. For everyone, this bill sets values on human life and suffering that none of us can measure.

I say to my colleagues, defeat this bad bill that does a disservice to all of us, and join with our colleagues, the gentleman from Michigan (Mr. CONYERS) and the gentleman from Michigan (Mr. DINGELL) and others, to pass a far better bill, a bill that will bring relief to HMOs, health professionals, and the patients who depend on their services and who need to be made whole.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Tennessee (Mrs. BLACKBURN).

(Mrs. BLACKBURN asked and was given permission to revise and extend her remarks.)

Mrs. BLACKBURN. Mr. Speaker, I rise today to support the HEALTH Act of 2003, because I know what runaway health costs and a broken health care system look like.

In Tennessee we are battling to fix our own system, a statewide, nearly-universal health care service run by the government called Tenncare.

H.R. 5 means doctors in your neighborhood, not 50, 100, or 500 miles away in a metropolitan area. H.R. 5 means lower insurance premiums for working families and for small businesses.

This bill will not take away anyone's right to compensation. What it will do is prevent our community doctors, our community doctors from being targeted by profiteering lawyers.

I encourage all of my colleagues to join in supporting the HEALTH Act of 2003.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself 25 seconds.

I beg to differ with the gentlewoman from Tennessee. I wish her remarks were accurate, in noting from the American Insurance Association a comment that says, ''Insurers never promised that tort reform,'' which is what medical malpractice, what H.R. 5 is, ''would achieve specific premium savings.'' So in fact, the doctors will not be helped from this legislation, H.R. 5. The only persons that will be helped will be the insurance companies.

Mr. Speaker, it gives me great pleasure to yield 1 minute to the distinguished gentleman from Missouri (Mr. CLAY), a fighter for the rights of many and an advocate for good health care for all Americans.

Mr. CLAY. Mr. Speaker, I thank the gentlewoman for yielding me this time.

Mr. Speaker, I rise in opposition to H.R. 5. The bill does a disservice to the medical liability insurance problem. It fails to provide the necessary solutions which are needed to have a win/win situation for all concerned parties.

Proposed legislative relief in the form of damage caps such as H.R. 5 may be construed as only a small portion of the remedy. Caps alone will not result in an immediate decrease in premiums. Malpractice suits take 3 to 8 years to come to trial. Current pending or filed suits will not be resolved for years. New caps on damages may not retroactively cover current suits. Therefore, premiums will not go down.

This bill is silent on the issue of the insurance industry and the failed investments policies of that industry's

past. The choice is simple: enact H.R. 5 and have a system that has a tremendous overhead and continues to cause a disservice, or have a true reform plan that gives an immediate reduction in cost.

Mr. SENSENBRENNER. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. GERLACH).

Mr. GERLACH. Mr. Speaker, physicians in Pennsylvania face skyrocketing liability insurance rates. This is forcing them to leave their practices, retire early, or stop performing certain procedures.

□ 1300

That threatens access to care for patients in Pennsylvania and across this country. In my district alone, hospital services have been curtailed and advanced life support services have been terminated at an alarming rate. Without passage of medical liability reform at the Federal level, this situation will continue to worsen.

From 1977 to 2000 the number of practicing OB/GYNs in southeastern Pennsylvania has declined by 20 percent, and that is before the astronomical increase in doctors' medical liability, doctor insurance rates that took place last year. In Pennsylvania more than 75 hospital services have been closed or curtailed in the past year alone. The most severely affected specialty services are obstetrics, orthopedics, general surgery and neurosurgery.

Mr. Speaker, my constituents need real, meaningful medical liability reform and they need it now. We cannot allow the continuation of a system that is threatening and has in fact cut off patients' access to their doctor or hospital of choice. Let us put the patients above litigation and let us pass this bill.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself 15 seconds.

The playbook is being said over and over again. Victor Schwartz on tort reform says that many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I have never said that in 30 years.

Mr. Speaker, I will not vote for H.R. 5, because as it is, it does nothing to decrease the premiums our Nation's physicians are burdened with. It does nothing to decrease the number of frivolous lawsuits. It does nothing to decrease the amount of malpractice being inflicted upon the American people, by bad doctors who are jeopardizing the lives of their patients, and driving up the insurance costs of their colleagues. And it does nothing to protect the rights of those suffering in the wake of an act of medical negligence.

I have doctors in my district, who are struggling with high malpractice insurance premiums. In some regions, for some specialties, those premiums can be outrageous. If this bill becomes law, the caps on claims from injured patients will put a lot of money into the coffers of insurance companies. I offered an amendment yesterday in the Rules Committee that would have forced insurance companies to pass at least half of that money down to physicians in the form of reduced premiums. That just makes sense, if this bill is really intended to decrease premiums. But that amendment will not receive a vote today. That fact lays bare the claim that this bill is anything more than a gift to the insurance industry.

This bill has many troubling aspects and omissions. For example, noneconomic and punitive damages are capped at $250,000 and there is no provision to have this arbitrary number rise over time with inflation. So, we know that the value of the dollar will go down over time. Do we also feel the value of a human life, or of a child's pain and suffering will also go down over time? I surely do not. This could have easily been changed, but it was not.

Another aspect of this bill that I feel is morally repugnant, is in its valuing of rich people's lives more than poor people's, or children's, or stay-at-home mothers'. In the case of truly heinous acts of negligence, a judge and jury can award a damaged person with punitive damages. Punitive damages, as the name implies, are meant to punish egregious wrong-doers. This bill caps punitive damages at $250,000 or twice the economic damages, whichever is higher. So if a CEO with a high salary is injured and can't go back to work, his economic damages could be in the millions, and therefore through punitive damages—the perpetrator would be punished severely. On the other hand, if the injured is a child or a stay-at-home mother, the economic damages would be low, and the punitive damages would be capped at $250,000. Why would the U.S. Government, dedicated to the idea that every person should be treated as equal, say that doctors who hurt rich people should be punished more than those who hurt poor people—that the value of a poor person's life is less—that it is OK to take bigger risks in treating poor people? This is absolutely morally bankrupt.

And the bill does nothing to stem the tide of frivolous lawsuits. This bill, by definition, cuts awards to those people who a jury decided were not frivolous. This is short-circuiting our judicial process.

What in the name of God and country are we doing giving a gift to insurance companies, while people are suffering and access to medical care is threatened? I will vote against H.R. 5 and urge my colleagues to do the same.

Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. BERMAN), a distinguished senior member of the Committee on the Judiciary who knows about California medical malpractice law firsthand.

Mr. BERMAN. Mr. Speaker, I thank the gentlewoman for yielding me time.

Mr. Speaker, two points: In California we had much of the same issue that the country is now facing, rapidly escalating medical malpractice premiums, concerns that the health care system was broken, and we weighed the two approaches we had. One is the accountability for bad medical practices through the tort system versus a compromise that used a combination of tort reform, enhanced regulation of the medical profession and hospitals in terms of ensuring that bad practice would not be allowed to go unpunished and to continue, and insurance industry regulation legislation.

Now, we have this crisis in many other States of the Nation. Without getting into the issue to the extent to which tort reform played a role in reducing medical malpractice premiums and without getting into the debate about why we would need to federalize the entire system rather than letting the States work this through the same way California did, I just wanted to draw the attention of the body to the fact that what you are being told is not true. This is not an effort to take the California law as passed in 1975, known as MICRA, and to pass it and federalize it and to have it apply to the country as a whole.

This is a bald faced effort to cherry-pick certain provisions of that law, add many different people to the coverage of that law that were never included in that law, add additional tort reform provisions to that law that were not included in that law and then claim that we are doing MICRA.

In MICRA we enacted a series of very serious tort reforms, including the cap of $250,000, which I opposed vociferously then and do now. But we also massively enhanced both the level of insurance industry regulation and the authority of the boards of medical quality assurance, the disciplinary boards, to discipline those few physicians who were truly bad doctors, whose record of malpractice was astounding. If there was not going to be the full accountability from the tort system for the conduct of those physicians, then their status, their licenses would be in jeopardy.

We provided immunity to other physicians so that they would testify about the bad practices of those few doctors. We set up peer review committees in every area of this State. We significantly enhanced the powers of the boards of medical quality assurance. None of that, absolutely none of that appears here. This is a one-sided effort appealed to by certain interests, decrying other interests, to pretend they are taking the balanced approach of California when they are cherry-picking it to only limit its impact on one issue, the ability of injured patients to recover because of the negligence of another.

Mr. SENSENBRENNER. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. BURGESS).

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

Mr. Speaker, I rise today in support of H.R. 5, the HEALTH Act. Before coming to Congress I served as a doctor in north Texas for over 25 years. Over that time I delivered over 3,000 babies and handled my fair share of high-risk births. Because of the nature of my profession, I was not immune to being named in a lawsuit. Even though these claims were eventually dropped, my patients could not get back my time or the benefit of the care that they lost because I was away from my practice defending my livelihood.

The current legal environment reduced the access my patients had to my services, and that is a situation

that I find unconscionable. Thousands of doctors share a similar story and millions of patients are affected in the same way by the current system.

The legal environment in which doctors must work is lopsided to favor a very narrow special interest group, that of the plaintiffs' bar. Because of this patients are losing access to specialized care they need because doctors are being driven out of business or taking time away from their practices to defend against frivolous claims. I urge passage of H.R. 5.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Jersey (Mr. PASCRELL), one who has been a fighter for physicians and first responders.

Mr. PASCRELL. Mr. Speaker, I thank the gentlewoman for yielding me time.

Mr. Speaker, I read section 12 of this legislation and it says that this is going to go into effect on the enactment of this bill, it becomes law. There is no grant program to help health care professionals. There is no end of frivolous lawsuits that has been discussed anywhere in this legislation. There is no attempt to pass on the savings to the very doctors who you have conned into believing that their rates are going to go down.

The insurance industry has said time and time again, not to the doctors, that there is no guarantee that the premiums will go down if this is enacted. And what you are going to do to us in New Jersey and 10 other States where we have strong legislation dealing with HMOs that rule the roost, you are going to let them all off the hook and you are going to protect bad doctors, bad hospitals and you are certainly going to protect bad insurance companies. And I say to you, you have created a great injustice here by putting forth this legislation without even allowing us to consider trying to solve the problem. Our bill does that.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. KIRK).

Mr. KIRK. Mr. Speaker, I thank the distinguished chairman for yielding me time and will answer my colleague that you cannot con doctors into anything. Doctors are not only trained professionals who can diagnosis what is wrong with you, they can diagnose what is wrong with our country.

I rise in support of H.R. 5. Without this bill health care in my State of Illinois will change for the worse. I am standing here representing Dr. Gina Wehrmann, who after paying her malpractice bill made less than the office manager in her practice and is now a pharmacist at Walgreens. I also stand with Dr. Scott Hansfield, head of obstetrics at Highland Park Hospital, who recently notified 2,500 of my constituents that he is leaving the practice of medicine and moving to a tort reform State.

The AMA has just put Illinois on the crisis list of liability watch for their practice. And in testimony before the Committee on Small Business, we learned that 85 percent of neurosurgeons have been sued in my State. Asked if this is too many, the plaintiffs' association said, no, 85 percent of neurosurgeons in Illinois were bad doctors.

I am worried about the plaintiffs' bar and its unintended war on women, forcing OB/GYNs out of my State of Illinois.

This is needed legislation. We need to pass it now. I commend the chairman.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield the gentleman from New Jersey (Mr. PASCRELL) 10 seconds to respond.

Mr. PASCRELL. Mr. Speaker, is this gentleman letting us know today that he is guaranteeing a reduction in the premiums if this bill is passed? Is that what the gentleman is saying? I would like him to say for the record.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield 3 minutes to myself.

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I want to answer and I thank the distinguished speaker.

Mr. Speaker, I am going to ask the young lady just to come closer. We have the personal touch here this afternoon.

I want to answer the question that has been raised. This is over and over again about whose problems we are solving. Can I give my friends the real facts?

Sixty-one percent of the cases are dropped. That means as you go into the courthouse, and those of you who have been injured, you have your cases dismissed 61 percent. Plaintiffs only get 1 percent of the verdicts across the Nation. Defense verdicts. That means they rule on behalf of the HMOs, the doctors, the hospitals, 6 percent, and settlements are 32 percent.

H.R. 5 is a bill that does not harm the doctors and the physicians, which we do not want to harm, but it literally destroys the victims. What it does is when the verdicts come it injures the victims because you tell them that they cannot get a recovery.

There is no crisis in medical malpractice insurance. What the crisis is is the insurance companies who refuse to reduce the payments.

So let me show you who will be hurt by H.R. 5. Nathaniel will be hurt by H.R. 5. This is the face of H.R. 5. Why? Because Nathaniel was 6 weeks old when Nathaniel became brain damaged because he was not diagnosed with jaundice. In the Democratic substitute we eliminate cutting off Nathaniel's damages. We take the caps off the noneconomic damages. Is it not interesting that physicians who want to have their rates reduced do not get any relief directly from the insurance payoff because this is not access to medical care. This is insurance payoff day.

What we do for Nathaniel in the Democratic substitute is we say to the doctors, if you are good doctors, we want the savings that have been given to those to be reduced. I had an amendment that said reduce it by 50 percent. Put 50 percent of the savings and reduce the premiums of the doctors. This is real medical malpractice response. This puts the doctors in the rural communities in New Jersey, in Mississippi, in Texas and New York in the innercity. This helps the babies like Nathaniel.

And then to my dear friends, what about the States rights? What about the States that want to make their own determinations to protect their own citizens, to ensure that Nathaniel does not lay languishing with brain damage, and because he was only 6 weeks old, the noneconomic damages that would provide for him for the rest of his life were cut off, the pain and suffering damages were cut off at $250,000 in today's time? So besides cutting us off from having amendments, besides denying us a substitute—a legitimate way to discuss a reasonable response—this is what we have today: A false bill that addresses a false issue and Nathaniel languishing in brain damage. Our bill would have provided Nathaniel for getting his day in court, providing for his mother and father the pain and suffering they are experiencing while he languishes without hope.

Payoff day for insurance companies. I stand against it. Vote against H.R. 5.

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

Mr. Speaker, the gentlewoman from Texas (Ms. JACKSON-LEE) displayed a chart that indicated that 61 percent of the malpractice cases were either settled or dropped, and she insinuated that that was for free. It is not for free. It costs money to defend those suits, to go to court, to file answers, to do whatever discovery is necessary in order to convince the plaintiff that they do not have a case, and those costs get folded into the liability premiums that the physicians have to pay.

Who gets off free? It is the plaintiff that gets off free because the plaintiff is on a contingency fee and if there is no recovery then the plaintiff does not have any lawyer fees at all.

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

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself 25 seconds to respond.

The Republicans have represented that H.R. 5 is to reduce the premiums of physicians. Let it be perfectly clear, and I stand by my document, 61 percent are dismissed, but let it be perfectly clear that nowhere will the physicians have premiums reduced and more doctors be able to practice because we pass H.R. 5, which is a payout to the insurance companies. I maintain that position and it is accurate.

Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Pennsylvania (Mr. HOEFFEL), who experiences firsthand what happens with a

crisis in his State. He is a leader on these issues.

□ 1315

Mr. HOEFFEL. Mr. Speaker, I thank the gentlewoman for yielding me the time.

I agree with her concern because Pennsylvania doctors have a tremendous problem with medical malpractice premiums doubling and tripling, but they have been sold a bill of goods. This bill will not bring down their premiums. We should try to help those doctors, but not by punishing the most severely injured victims of medical malpractice.

We need insurance reform. The law in California did not work to bring down premiums. When they put a $250,000 cap on damages, the premiums continued to rise until they passed insurance reform in 1988 and mandated a reduction in premiums. That is what we need to be doing here.

At a minimum, we have got to put flexibility into these hard and inflexible caps. We ought to allow the trial judge at a minimum to allow something above the caps if circumstances on a case-by-case basis require that, but this House will not allow that to happen.

Let us look at the sad case of Linda McDougal, who was diagnosed with breast cancer and had both breasts removed because of the lab report. It turned out the lab was wrong. The good news for Linda McDougal is that she does not have breast cancer. The bad news is she does not have breasts anymore.

What is that worth? The proponents of this legislation would say that a woman's breasts are worth no more than $250,000. I do not want my colleagues to make that decision. I want a jury to make that decision. I want to defeat this bill.

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

We have heard an awful lot about the impact on insurance premiums, and I just want to read from the CBO estimate, the cost of this bill. The CBO estimates that under this bill premiums for medical malpractice insurance ultimately would be an average of 25 to 30 percent lower than what they would be under the current law. However, other factors noted above may affect future premiums, possibly obscuring the anticipated effect of the legislation.

The effect of H.R. 5 would vary substantially across States, depending upon the extent to which a State already limits malpractice litigation. There would be almost no effect in malpractice premiums at about one-fifth of the States, while reductions in premiums would be substantially larger than the overall average at about one-third of the States.

What this means is that the reduction in premiums will be much greater in the States where there is a crisis, and what this bill does is that it provides access to medical care in States where high risk specialists are closing their practices because they cannot make enough money to support themselves and to pay their liability insurance premiums.

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

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself 10 seconds.

The real point is that the insurance companies have specifically said they will not reduce premiums with the passage of H.R. 5.

Mr. Speaker, I yield 1 minute to the distinguished gentleman from Illinois (Mr. DAVIS), who knows hospitals because they are in his district, an advocate for good health care for all Americans.

(Mr. DAVIS of Illinois asked and was given permission to revise and extend his remarks.)

Mr. DAVIS of Illinois. Mr. Speaker, in Chicago, an electrocardiogram is misread and the patient dies of a heart attack. A rare heart disorder is mistaken for a back strain and kidney stone. The patient dies. Both of these cases are about real people and real pain. In both cases, the families were awarded decent sums of money by juries, but I can tell my colleagues, no sum of money will ever replace the loss and suffering of people's lives. Yes, there is a crisis in health care, but this one-size-fits-all $250,000 cap on medical malpractice payoffs will not solve the problem.

I have a profound respect for doctors, nurses, hospitals and other health care professionals who provide services, some 25 of them in my Congressional district, five medical schools, but I am not prepared to leave to chance a $250,000 cap on consumers.

Mr. SENSENBRENNER. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. STENHOLM).

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

Mr. STENHOLM. Mr. Speaker, I rise in support of H.R. 5, of which I am an original cosponsor. I cosponsored this bill because I believe that it will help ensure the availability of vital health services for patients in this country.

Listening to the debate today, the average citizen would assume that it is necessary to choose sides. Either one is for the docs and other health care providers or they are for the patients. I simply reject that premise and assert another, which is this. We must have a system where good doctors can practice good medicine if we are going to have healthy patients.

Does creating a good system mean that no doctor will ever fail again? No patient will ever again be injured through negligence or poor practice patterns? Of course not. But when those injuries occur through clearly bad behavior on the part of a health care team, I want the health care professionals to be responsible for their action.

I sympathize with the case examples brought to the floor by my colleagues on my own side of the aisle. There are a great many tragedies which occur when health care is poorly delivered. I have no interest in removing appropriate avenues of redress for those injured people and their families, but I do not believe these cases have much, if anything, to do with the bill before us today because it retains a great deal of legal redress for plaintiffs.

No one can claim that the system we have now is good for the doctors or the patients when doctors must pursue expensive defensive medicine rather than doing what they think is right. No one can think it is good for places to have doctors leaving the profession in droves because of the financial and physiological strains of caring for people under current malpractice realities.

The bottom line is that the failure of the medical liability system is compromising patient access to care. More than half of Texas physicians say that they are considering early retirement due to skyrocketing insurance premium, and nearly one-third are reducing the kind of services they provide.

Spiraling medical liability insurance premiums are forcing many hospitals to consider difficult decisions from cutting services to closing clinics. Some hospitals find it difficult to appropriately staff emergency departments, recruit and retain physicians in high-risk specialties. Where is the victory for patients in that scenario?

This situation is further magnified in rural communities where there are fewer hospitals and health care professionals. These hospitals and clinics already operate on narrow profit margins, and skyrocketing medical liability insurance push them closer to the brink of closure.

Ignoring the litigation problems we have now is a recipe for disaster. Many States, like my own, are already on the precipice of disaster, especially in fields like obstetrics.

It is for these reasons I join my fellow colleagues as original cosponsor of the HEALTH Act of 2003. The bill is not perfect. It can be improved but it will not be improved if it is defeated today.

I urge my colleagues, especially those who represent rural America, to support H.R. 5, which will have a chance of stabilizing our Nation's shaky medical liability system.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Rhode Island (Mr. LANGEVIN), who has faced many issues that deal with the needs of hospitals and his own constituents and good health care, and I thank him for his leadership.

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

Mr. LANGEVIN. Mr. Speaker, I thank the gentlewoman for yielding me the time.

Today, I rise in strong opposition to H.R. 5, the HEALTH Act, because this unhealthy act would severely limit the ability of patients to bring suits and

seek appropriate damage awards while failing to require insurers to lower their rates once the so-called reforms are in place. This misguided measure would unfairly impact women, low income families and children or have absolutely no impact on the affordability of malpractice insurance coverage.

Proponents of this legislation claim that it contains the right cure for the medical malpractice liability crisis. This elixir is nothing more than a placebo that will not lead to safer medicine, but rather protect egregious medical malpractice behavior.

Though not a victim of medical malpractice, the $250,000 cap in this legislation could never compensate me for what I lost when I became paralyzed.

For these reasons, I would strongly urge my colleagues to oppose the underlying bill and to support the Democratic alternative, which would allow patients to seek redress while providing relief to physicians and hospitals in need while holding insurance companies more accountable.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Georgia (Mr. SCOTT).

Mr. SCOTT of Georgia. Mr. Speaker, I thank the gentleman very much for yielding that time.

I am very delighted to stand before a distinguished House of Representatives to make this plea.

I support this measure. I come from Georgia and represent a new Congressional district that represents one of the fastest growing areas in this country. It is the 13th Congressional District. I am here because of that growth, and I am also here to tell my colleagues that there is no greater pressing issue facing my district and the people of Georgia than this health care crisis that we are faced with today in medical liability insurance.

Our doctors are suffering immensely, not only in terms of having to cut back on the quality of services that they have to offer but also in our medical schools, where they are preparing our doctors for the future. Many of the medical schools in my State are saying now that many of the students are having second thoughts about even coming into the medical profession; 17.8 of the 2,800 physicians in Georgia are already reporting that they are contemplating, contemplating cutting back in their critical services for at-risk procedures, and nearly 2 percent have even indicated that if things do not change they are moving out of the State of Georgia.

I think we all know that Georgia is one of 18 States that has the highest, most significant medical malpractice insurance premium costs, and it is costing our State dearly. I am here to speak for those doctors and the dentists and the hospitals in that 11-county area that I represent around the City of Atlanta that is faced with this crisis, and I hope that this Congress will hear us as we cry out in Georgia on behalf of our physicians, our dentists, all of our health care providers, give us some relief.

I know this H.R. 5 before us is not a perfect bill. Nothing is perfect. Who amongst us or what amongst us is perfect? But it is a start. It is a beginning, and it is not incumbent upon us to complete the task, but neither are we free to desist from doing all we possibly can. That is what the American people are expecting of us.

Take this first step. Let us move this process forward. When it gets to the Senate we can work to perfect it even better. I urge my colleagues' vote on this very important matter, and let us bring better health care to our people of Georgia and the Nation.

I am here representing the patients, doctors, hospitals, and health care providers in the 13th Congressional District in Georgia. This is a new district, which encompasses parts of eleven counties due to the tremendous growth in this part of the state. It is also a diverse district, including county, regional, and private hospitals, several health care facilities, and hundreds, if not thousands of physicians and dentists, and other health care professionals. Georgia has been designated as one of 18 states facing a medical liability crisis and since Georgia's health care industry is being threatened by this crisis, I have decided to support the patients . . . and the doctors . . . and the hospitals . . . by supporting H.R. 5.

Earlier this year, the Georgia Board for Physician Workforce, the state agency responsible for advising the Governor and the Georgia General Assembly on physician workforce and medical education policy and issues, released a study showing the effects of the medical liability crisis on access to health care for Georgia's patients. For example, the study shows that 17.8 percent of physicians, more than 2,800 physicians in Georgia, are expected to limit the scope of their practices which is by far the largest effect of the medical liability insurance crisis on access to medical care. These physicians are expected to stop providing high risk procedures in their practices during the next year in order to limit their liability risk. Nearly 1 in 3 obstetrician/gynecologists and 1 in 5 family practitioners reported plans to stop providing high-risk procedures, indicating that access to obstetrical care may be significantly reduce during the next year as a result of the medical liability insurance crisis.

In addition, nearly 11 percent or 1,750 physicians reported that they have stopped or plan to stop providing emergency room services. 630 physicians plan to stop practicing medicine altogether or leave the state because of high medical malpractice insurance rates. About 13 percent of doctors reported that they had difficulty finding malpractice insurance coverage. In fact, at one particular Georgia hospital, the hospital could not give credentials to a surgeon and add that physician to its staff because the surgeon could not afford to buy medical malpractice insurance. In another instance, an obstetrician-gynecologist had to close his Georgia practice and work for a health care agency because he could not afford to buy medical malpractice insurance. What happens to the patients that his hospital could have treated but now it cannot because it does not have the surgeons that it needs? What happens to the mothers who need a doctor to provide pre- and post-natal health care but cannot find one because doctors are leaving the profession due to the high cost of medical malpractice care?

I support H.R. 5 because doctors, hospitals, and the health care industry are caught in the middle between insurance companies and lawyers. Doctors are being squeezed by their medical malpractice insurance premiums and by the high amounts being awarded to injured patients. Doctors need to see results; they need to know that if this bill becomes law that their insurance premiums will go down. The message must reach the insurance companies that premiums have to go down so that the medical profession can survive and access to health care is improved. The health care industry must have relief and this bill, although not the final answer is the first step in addressing the problems that affect doctors and the health care industry.

We have to address the issue of medical malpractice insurance and the extremely high cost of health care. We have to do something. This bill is not the complete answer. It is not the final answer. It is not the best answer but it is a start. We do have to do something and we have to do it now. In 2000, Georgia physicians paid more than $92 million to cover jury awards. That amount was the 11th highest in the nation despite the fact that Georgia ranks 38th in total number of physicians in the United States. Forty percent of the state's hospitals faced premium increases of 50% or more in 2002. St. Paul, the state's second largest insurance carrier, stopped selling medical liability insurance last year. Remaining insurers have reportedly raised rates for some specialties by 70 percent or greater. Some emergency room physicians, OB–GYNs and radiologists have not yet found a new carrier.

In addition, Georgia is heavily dependent on other states to train physicians. Approximately 70% of participating physicians in Georgia completed training in another state. High costs of medical malpractice liability insurance may reduce the attractiveness of Georgia as a location for medical practice. High professional liability insurance costs are a significant financial problem for teaching hospitals, reducing the already limited funding available for faculty, residents, and other medical education costs. The high cost of medical malpractice insurance for doctors and hospitals harms mostly those communities who serve minorities and low income patients. The physicians and hospitals who depend on Medicare reimbursements and who serve the 44 million uninsured Americans everyday cannot afford to pay higher insurance premiums. We need to ensure that these communities have access to quality health care and the best physicians or the health disparity that currently exists will continue to deepen and create a 2 tier health care system. We must do something now. We must support the patients who cannot speak for themselves. We must support our doctors and hospitals and we must pass relief for them today.

It is important for the House to pass a bill that can go to the Senate for consideration. I hope to perfect the bill even more as it moves through the legislative process. It would be a mistaken not to do anything. In fact, I have never seen a problem solved by doing nothing.

We must help doctors, physicians and dentists, hospitals, other health care providers,

and American patients who are suffering in untold ways. Immeasurable damage is occurring in our nation's health care delivery system because of the high cost of medical malpractice insurance. With the passage of this bill, we are sending a clear and salient message to the insurance industry, which sets the premium rates for medical malpractice insurance and that message is: Bring Down the Cost of Medical Malpractice Insurance for Physicians and Hospitals.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Massachusetts (Mr. TIERNEY), an individual who has stood firm on the rights of patients, the rights of victims.

Mr. TIERNEY. Mr. Speaker, I thank the gentlewoman for the time, and with due respect to our colleagues that have spoken on the other side of this issue, I want to say that we all understand the issues that are here and we understand the impact that premiums have on doctors, but it is a shame that we have to choose a vehicle in this bill that pits doctors against victims of malpractice.

The doctors that come into my office understand that if there is an error made they want the patient to be compensated. There is no offer in this bill to give us a system better than the jury system. There is an arbitrary amount set that even doctors, when they look at it, understand that there is not nearly enough to fully compensate people.

This is simply an insurance company bill, an HMO bill, a prescription drug manufacturing bill that will limit their liability, and in order to try to push it through, pits doctors, well-intended doctors, against patients, victims.

The fact of the matter is this legislation should be looking at ways to weed out undeserving suits so that doctors are not exposed to them, while making sure that we preserve a way for people that are injured to get their full compensation in a fair manner. We have to also add into that premium control because the insurance companies simply are not a well-run organization, and that is where the answer is for doctors, improve that with insurance reform.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2 minutes to the gentleman from Indiana (Mr. PENCE).

Mr. PENCE. Mr. Speaker, I rise in strong support of the Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2003.

As I rise today, in the midst of a contentious debate, Mr. Speaker, I think of my family and my parents. I think of the good health that God has so mercifully given our family over the years. I think about this great country of ours and the cutting-edge research of universities and our hospitals, like those in Muncie and Anderson and Richmond, Indiana, that I serve here in Washington.

□ 1330

We undoubtedly have the best health care system in the world, the envy of other nations. Yet, Mr. Speaker, the costs of health care are rising so much so, to the point where constituents of mine, like Gary Miller of Portland, Indiana, are in fear of losing access to health care due to its affordability. Gary Miller just called my office this morning as we began the debate on this bill to register his concern about the rising cost of health care in America. Well, I am here today, Mr. Speaker, to tell people like Gary Miller that help is on the way.

Physicians in this country are some of the finest people you will ever meet. It takes a special heart of compassion to help people that are hurting physically day in and day out. And no well-meaning compassionate physician, Mr. Speaker, should be forced to close the door of his or her practice just because they cannot afford to pay health care premiums caused by frivolous litigation. Even the most well-meaning trial lawyers in the country are filing litigation that is driving health care premiums through the roof.

The Good Book tells us: ''You shall not muzzle the ox while it treads out the grain.'' And today I say to my colleagues, it is time to take the muzzle off physicians in this country and allow them to practice medicine and continue to heal our land. It is time to free doctors from the fear of bankruptcy and potential limitless litigation that currently hurts patients by causing doctors to engage in defensive medicine.

Mr. Speaker, I urge my colleagues to vote ''yes'' on this bill so people like Gary Miller do not have to live in fear of losing access to health care again. I urge a ''yes'' vote so we can get this country back on the road to affordable and available health care for all Americans.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Washington (Mr. INSLEE), who knows what it is like to have victims denied economic damages under this legislation.

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

Mr. INSLEE. Mr. Speaker, I think it is fair to say that this bill itself is a case of legislative malpractice. It is legislative malpractice because it will not deliver the goods to doctors in a reduction of their premiums because there is an outright total and utter failure to deal with insurance reform, which the evidence has shown is necessary to get a reduction in premiums.

We ought to listen to the story of a 23-year-old lady named Jennifer, a newlywed in Washington, who went in for a simple medical test and was told she had a rare form of cancer. She had an extended period of chemotherapy, she had a hysterectomy, and they then took out part of her lungs. She went through years of medical procedures and the test was faulty. She never had cancer.

Now, I do not know what the right dollar figure is for a woman's loss of the ability to bear children, but I know it is not $250,000. I know it is not what Ken Lay earned in about 2½ weeks, and I know that that decision should be made by 12 citizens sitting in a jury box rather than people answering to special interests in the United States Congress.

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

Mr. Speaker, I think there is a little bit of confusion around about the non-economic damage limit. There is a specific provision in H.R. 5 that says no provision of this act shall be construed to preempt any State law whether effective before, on, or after the date of enactment of this act that specifies a particular amount of compensatory or punitive damages or the total amount of damages in a health care lawsuit, regardless of whether or not such monetary amount is greater or lesser than that that is provided under this act.

Now, every one of the 50 States is free to adjust the $250,000 limit on non-economic damages upwards or downwards by enactment of the State legislature. My State limits it at $350,000. This is not touched by the HEALTH Act whatsoever. So if anybody thinks that this act is a straitjacket, the legislature is free to change it.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Mrs. JOHNSON).

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman for yielding me this time, and I rise in strong support of this legislation.

Yesterday, on this House floor, we passed legislation that will reduce medical errors by enabling hospitals and other providers to develop systems that identify and present errors. In addition, it will enable us to build an interoperable system of technology that will, for example, eliminate mistakes in filling prescriptions. So yesterday we took a giant step forward toward reforming the very systems that will improve the quality of care we deliver to the people of America and, at the same time, reduce costs of health care.

Today, we need to pass this malpractice reform bill because, again, it will reduce costs by eliminating millions of defensive practices that have developed in our system simply for the purpose of enabling a physician to defend himself in court. By eliminating those defensive actions, we not only reduce costs but we will improve the quality of care patients have available to them.

It is ironic that when we are in a period of rapid change in medicine, where medical science is moving us toward ever-more sophisticated ways of diagnosing and treating illness, we are also reducing access to care through a liability system that cannot distinguish between error in a complex era and malpractice. So we are at the same time improving the quality of health people can get and denying them access to that care.

Ask any woman who has a high-risk pregnancy how hard it is to find an obstetrician who will take a woman with a high-risk pregnancy because of the cost of malpractice insurance. Talk to those doctors who are leaving practice or who are choosing to no longer do certain high-risk operations and procedures in order to keep their malpractice costs within some kind of reasonable bounds. Talk to those people out there in the real world who cannot see enough new patients to pay their gigantic malpractice preimum increases, and you cannot help but conclude that malpractice costs have gotten so out of control, they are now denying access to people in America to advanced health care.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I wish this bill would help cure that problem.

Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. LINDA T. SÁNCHEZ), one of our newest Members, and a new member on the Committee on the Judiciary, who we are very proud to have because she has been a real fighter for patients' rights.

Mr. Speaker, I ask unanimous consent that the gentleman from Massachusetts (Mr. DELAHUNT) be allowed to manage the balance of the time on the minority size.

The SPEAKER pro tempore (Mr. SIMPSON). Is there objection to the request of the gentlewoman from Texas?

There was no objection.

Ms. LINDA T. SÁNCHEZ of California. Mr. Speaker, I thank the gentlewoman from Texas for yielding me this time, and today I rise in opposition to H.R. 5.

There is no doubt that most Americans have real problems accessing affordable health care in this country, and we need to find a solution. However, H.R. 5 is a deplorable bill. It is the most simplistic method for addressing problems that we are experiencing with our medical community. It is akin to trying to put out a forest fire with a squirt gun.

Placing a cap on a victim's recovery will not magically keep medical malpractice insurance rates from rising. It will not keep trauma centers from closing. It will not keep specialists from practicing in their areas. H.R. 5 simply restricts injured patients' access to justice. It is modeled after a California law affectionately known as MICRA.

As a representative from California, I happen to know a lot about MICRA. MICRA's caps on pain and suffering damages have not reduced insurance rates for doctors in my State, but rather it took Prop 103, an insurance reform initiative, to stabilize the rates there.

H.R. 5 without insurance reform is meaningless, and I urge a ''no'' vote.

Mr. DELAHUNT. Mr. Speaker, would the Chair indicate how much time is remaining?

The SPEAKER pro tempore. The gentleman from Massachusetts (Mr. DELAHUNT) has 3 minutes remaining, and the gentleman from Wisconsin (Mr. SENSENBRENNER) has 2 minutes remaining.

Mr. DELAHUNT. Mr. Speaker, it pleases me to yield 1 minute to the gentleman from Ohio (Mr. RYAN), a new Member and someone we are particularly proud of.

Mr. RYAN of Ohio. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, we know that the premiums are high, and we know the doctors are suffering; but this bill is not going to address the problem. And I would like to just take a minute, Mr. Speaker, to point out some of the inconsistencies from the majority party, the party that says we need to give all the power to the States. In this bill they are taking power away from the States. This is the party that says we are for individual responsibility, unless that individual is in the jury box, then we do not want to give it to them. This is the party that is for less government and less regulation, but at the same time they are putting price controls on attorneys. That is not free market.

Like a leading malpractice insurer in California said, I do not like to hear insurance company executives say it is the tort system. It is self-inflicted. That, in this bill, is not going to address that problem.

Mr. Speaker, I am afraid that all the faces and the names have turned to numbers in Washington, DC. This is not the answer. Real people are going to get hurt. We would like to welcome everybody back to the era of caveat emptor, or buyer beware.

Mr. DELAHUNT. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. SANDLIN), the chief deputy whip of the Democratic Caucus.

Mr. SANDLIN. Mr. Speaker, somebody in this Chamber needs to stand up for the doctors and somebody needs to stand up for the hospitals. Malpractice premiums are choking America's physicians, and H.R. 5 is nothing but a sham because H.R. 5 does not mention one time, from front to back, soup to nuts, does not ever even mention malpractice premiums. We need to do something about those premiums for the doctors. We need to do it now. We need to do it today. H.R. 5 will not do it.

And how about frivolous lawsuits? Frivolous lawsuits need to be ended. If a suit is filed with no basis in law or in fact, it should be dismissed at the cost of the plaintiff and the plaintiff should be sanctioned. But what does H.R. 5 says about frivolous lawsuits? It does not say one thing. That is a shame. That is outrageous.

We are only talking about benefits for insurance companies. We are talking about caps. The only people protected are insurance carriers. The only people celebrating today are executives in tall buildings owned by insurance companies.

This is not good for doctors, it is not good for hospitals, it is not good for patients. Let us stand up for them. Let us do the right thing.

Mr. DELAHUNT. Mr. Speaker, I yield 1 minute, the balance of my time, to the gentleman from New York (Mr. NADLER), who serves admirably on the Committee on the Judiciary.

Mr. NADLER. Mr. Speaker, one thing that has not been remarked upon is that the cap of $250,000 for pain and suffering, whether a baby is killed, a person is paralyzed for life, an old person is killed, regardless, aside from economic damages, they can only get $250,000. But that cap is not inflated. When that was first written in 1975 in California, $250,000 was worth what today is worth $1.6 million. The $250,000 now is worth what was then worth less than $39,000.

If there is no inflater put into this bill, and the Republicans in committee voted against it, except a couple of them, and they would not let me bring it onto the floor, then what we are really saying is people should get no recovery at all for pain and suffering and lifelong anguish and death and dismemberment. None. Only for lost wages, if they are workers, or for medical bills. Because eventually that is what this $250,000 will be worth, next to nothing.

Finally, on frivolous lawsuits. On contingency fees you cannot bring frivolous lawsuits, which is why this bill does not mention it and why talking about it is so dishonest.

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

Mr. Speaker, I have been listening intently to this debate. Many of my friends on the other side of the aisle apparently have not been listening at all to the debate, and I just want to rebut a couple of their points.

First, they say this will not reduce insurance premiums. They were right in that it will not reduce insurance premiums by law, but the CBO says that overall insurance premiums will be reduced by 25 to 30 percent and more in States where there is a greater problem. That is the market working. That is the economics working on it. But those premiums are not going to be reduced if the current law stays where it is.

Then we have heard time and time again about $250,000 in noneconomic damages. This bill gives each State the right to adjust that amount to a greater or a lesser amount. So the State legislatures can make a determination on whether $250,000 is proper or not. If they fail to do so, then the $250,000 in the HEALTH Act is the law for that State.

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Finally, we have heard ''Physician, heal thyself,'' and that a small number of physicians are responsible for the vast majority of malpractice claims. Let me say that the current tort liability system provides a huge disincentive for doctors to talk about problems

amongst themselves and to get the collective benefit of a number of doctors' opinions on how to treat a patient.

There has been a study that asked, "Generally speaking, how much do you think the fear of liability discourages medical professionals from openly discussing and thinking about ways to reduce medical errors?" Mr. Speaker, 59 percent of the physicians replied, "A lot."

If we pass this law, we will be seeing more collectively doctors' brains put together to deal with difficult cases, to talk about mistakes and make sure they do not happen again. This bill should be passed. I urge an aye vote on the bill.

The SPEAKER pro tempore (Mr. SIMPSON). Without objection, the gentleman from Ohio (Mr. BROWN) will control the time for the gentleman from Michigan (Mr. DINGELL).

There was no objection.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Louisiana (Mr. TAUZIN).

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

Mr. Speaker, I rise today in strong support of H.R. 5. I am joined by every major medical association representing the doctors of America across this country and across the very specialty organizations that are so deeply affected by the rising cost of medical malpractice insurance that many of them are leaving the practice that they were trained to do.

I thank the gentleman from Pennsylvania (Mr. GREENWOOD) and the gentleman from California (Mr. COX) for drafting this legislation. I certainly thank the gentleman from Wisconsin (Mr. SENSENBRENNER) and the staff of the Committee on the Judiciary for working so closely with the staff of the Committee on Energy and Commerce to advance the cause of this very important bill.

We will hear many stories today about the victims and how they are harmed in the health care system. And, of course, we cannot dispute the fact that many doctors make human errors. In fact, yesterday we indicated that the To Err Is Human report encouraged us to pass a medical errors bill, which we passed yesterday on the floor, which is designed to begin sharing information to reduce the number of those errors and to make sure that doctors are not hauled into court every time they help one another when trying to reduce the number of errors in the system.

We know there are victims of medical errors, but we do not often hear about the victims of the medical malpractice system gone awry. They are the victims who get denied access to health care in very critical moments because some doctor could not get his insurance renewed because premiums were too high, some doctor left the practice, some medical clinic, some institute closed down in the community, the stories we heard from victims yesterday here in Washington, D.C.

One wife and children were here talking about how the husband and father was in a horrible automobile accident and went to the hospital, only to find out the neurosurgeon who should have been there to help him had lost coverage 4 days earlier and was no longer at the hospital to service them. That gentleman suffers massive brain disabilities as a result of not having someone there to serve him.

Many pregnant women look forward to a natural childbirth, only to find out that doctors are increasingly recommending C-sections, and doctors who deliver babies are getting out of the business because they cannot afford the skyrocketing liability coverage policies that they need.

60 Minutes did a piece on one of those doctors who gave his whole life, his career to delivering babies. He cannot do it any more. He is doing prenatal work now because he cannot afford the awful cost of liability coverage.

So not only are these doctors harmed because they cannot practice the professions they love and worked so hard to learn, but the patients that come to them are increasingly being harmed. Doctors are moving from one community to another, moving to States that have liability protection because they have learned that they cannot afford the liability coverage in the community they were raised and educated in. They have to move from Mississippi to Louisiana, for example, and Mississippi loses the availability of those good physicians.

Those hidden victims, patients who cannot get care, who suffer from a lack of access to health care, are just as real, just as injured as any victim who has been injured by medical error or malpractice in this country. We have to do something about this. It is a broken system. When the health care system breaks down, it is our responsibility to make sure that we fix it, and we fix it so it does not just work in California or Louisiana, it works across America.

Our families are spread all over. My children are living in all kinds of States. I want them to be able to walk into a hospital and find somebody ready to serve them. I do not want them to walk into a hospital in Mississippi and find out a needed doctor is not there. That is the task we have before us today. As we move this legislation forward, we will complete the task we started yesterday, on the one hand beginning to cure that awful problem of medical errors within the system, errors which produce injury, and recovery is possible under our legal laws; and, secondly, to make sure that the legal liability system is fixed.

What are we doing here? We are recommending to the Congress and to the Nation nothing more, nothing less than the experience of the great State of California, which in 1975 adopted the law upon which H.R. 5 is based, a law which has kept liability premiums in California at one-third the increase level which has been experienced across the country. The other side of the aisle have been debating whether this will reduce insurance premiums. I tell them, go to CBO. CBO has estimated a 25 to 30 percent reduction in insurance costs across America if we pass H.R. 5.

Mr. Speaker, guess what, my State will not get that benefit. We already have the benefit of lower premiums because of reforms like this. Those premium reductions will go to States that do not have the benefit of a State law like California and Louisiana. Therefore, the reductions in premiums are likely to be higher in those States where there are no caps on liabilities.

One final thought. For those Members that are arguing that we are somehow capping the entire liability award, we are doing what California did with a Democratic governor and a Democratic legislature: We are only capping the noneconomic damages. That is the only thing we are capping. We are capping it at $250,000, but we are telling California and Massachusetts and Louisiana, or any other State in the Nation, if they do not like that cap, they can adopt their own cap. They can adopt a higher or lower cap. This legislation preserves for the States the right to adopt the cap that works for them.

But this legislation for the first time will say to everyone in this country, we are all entitled to have a health care professional available to us when we need it who otherwise would not be here because of a liability system that is so broken that it drives decent health care workers out of business and out of their professions at our loss.

Mr. Speaker, this legislation has to get passed and has to get passed soon. I urge Members to adopt this legislation today.

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

Mr. BROWN of Ohio. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, I want Members on both sides of the aisle to be aware of three unanswered questions about H.R. 5. First, if the authors of this bill are sure that it will reduce and stabilize medical malpractice premiums, why are insurers accountable for producing that result?

During the medical malpractice debate in Ohio, insurers said they do not know whether premiums would come down. During a recent hearing in Pennsylvania, the actuary witness said he could not say whether premiums would come down. Even Sherman Joyce, President of the American Tort Reform Association said, "We cannot tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."

We are voting on a bill that overrides State law and undercuts compensation for victims of medical malpractice, yet we do not know whether medical malpractice premiums will come down. California passed tort reform in 1975. Medical malpractice premiums continued to go up. Not until California 13

years later demanded a reduction in premiums with insurance reform did the situation improve. Yet insurers have zero, no obligation under this bill.

We are supposed to take it on faith and trust the insurance companies that they will pass along the savings. Apparently we cannot trust patients, cannot trust juries, cannot trust lawyers, but we can trust the insurance industry.

My second question is: Why is there no single insurance reform in this bill? The authors of H.R. 5 refer again and again to MICRA. The gentleman from Louisiana (Mr. TAUZIN) did, other Members will. MICRA is the California law that sets a quarter-million-dollar liability cap. Members know it was not MICRA that brought down premiums in California, it was insurance reforms 13 years later. Malpractice insurance premiums rose 450 percent after MICRA went into effect, and only when California established a prereview of rate increases and automatic rollback of excessive premiums did the doctors get any relief, yet this bill has no insurance reforms, no premium rollback. Why? The insurance industry does not like it.

The third question is if H.R. 5 is a response to spiking medical malpractice insurance premiums, something we want to do something about and our substitute bill does, why does this bill shield HMOs, shield drug companies, shield medical device manufacturers, and shield insurance companies from liability? It might have something to do with the fact that those industries have given tens and tens and tens of millions of dollars to Republican candidates. The majority bristles at the notion that the curious omissions from this bill have something to do with helping their friends, the drug companies, the insurance industry, the HMOs and the medical device industry.

Mr. Speaker, if the majority wants Democrats and the American public to stop accusing them of catering to their corporate friends, then maybe the majority should stop catering to their corporate friends. Then we could write a bill that will help doctors, then we could write a bill that will help patients. This bill simply is not it.

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

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, we would not help this debate by arguing that the other side is catering to trial lawyers. That is not going to help this debate. Let us argue on the facts for a change.

The gentleman from Ohio (Mr. BROWN) may not agree with what happened in California, but this is what Senator FEINSTEIN said. ''I believe MICRA is the reason rates have gone down.'' That is a California Senator talking about her State.

Mr. Speaker, I yield 2 minutes to the gentleman from Missouri (Mr. BLUNT).

Mr. BLUNT. Mr. Speaker, I am pleased to see this bill on the floor today. We will hear many reasons today why this is a problem that needs to be dealt with but some reason about why is not the time. Now is the time to deal with this issue. Now is the time to put patients first, to see that our delivery system begins to function again. There are a dozen States that are in crisis mode and a dozen others that are about to get there.

The gentleman from Louisiana (Mr. TAUZIN) mentioned the people we had in town yesterday to talk about the importance of this bill, the two families that were here talking about what had happened to their families, not because they were in some isolated spot where one would assume care would not be available, but care was not available because we do not have this situation under control.

We had one family, a mother, a wife, two teenage children whose husband and father is no longer able to care for that family because instead of care being available, as it would have been just months ago minutes from the accident, care was now available 6 hours later because that person had to be moved.

We had one person talk about her dad in Las Vegas, Nevada, one of the fastest growing communities in the country, was in a car accident and could not get care because the trauma center had just closed because of this problem. That family's father is gone.

Mr. Speaker, any of us who vote on this legislation today could find ourselves, no matter how urban and concentrated the area we are traveling to in the next few days would be, in the situation of those families.

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Or we can see those we love and care about, no matter how we think they would be in imminent contact with health care, find that health care was not available because we have not dealt with this problem. Today we have a chance to do that. Chairman GREENWOOD and Chairman TAUZIN and our friends on the Committee on the Judiciary brought this bill to the floor. It is a bill we need to pass today. I am pleased we have this opportunity.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1½ minutes to the gentleman from Michigan (Mr. STUPAK), who cares about patients and physicians.

Mr. STUPAK. Mr. Speaker, I thank the gentleman for yielding me this time. The majority of our doctors are hardworking and professional and serve their patients with the utmost ability. Only a few doctors are bad actors who act in negligent or irresponsible ways. But the reality is that this bill will do nothing to help doctors. It does not address the high insurance rates or the plight of doctors. H.R. 5 is totally misguided. It does not address insurance costs for doctors. Instead, it caps meritorious lawsuits where a judge or jury has found for the victim.

H.R. 5 puts a cap of $250,000 on noneconomic damages. Many dismiss noneconomic damages as pain and suffering and imply that they are less important than economic damages. The true definition of noneconomic damages are those damages that are real, permanent harms that cannot easily be quantified or measured in terms of money, such as blindness, physical disfigurement, loss of fertility, loss of a limb, loss of mobility, loss of life, or loss of a child. These are horrific losses; and under this bill, they are capped at $250,000.

I offered an amendment to remove the antitrust exemption for insurance companies. If this bill is truly designed to address the insurance crisis in this country, how is it that it does not contain a single provision about insurance? The insurance industry is the last industry left in the United States that is not subject to antitrust laws. If we really want to bring insurance rates down well, we must make insurance companies subject to government regulation and competition and subject to our antitrust laws.

Everyone in this House of Representatives believes that something needs to be done about the skyrocketing costs of medical malpractice insurance.

The majority of our Nation's doctors are hard working and professional, and serve their patients to the utmost of their ability. Only a few—a small minority—of doctors are bad actors, who act in negligent or irresponsible ways.

But the reality is that this bill will not help our nation's responsible and hard-working doctors. It does not address the high insurance rates or the plight of our doctors. Only the Conyers-Dingell motion to recommit will accomplish these goals. I believe that the Conyers-Dingell bill is a targeted and positive measure to address malpractice insurance in this country.

H.R. 5, on the other hand, is a boon to HMOs, to drug companies, and to medical device manufacturers, who receive the bill's protection from damages without any justification. I cannot understand why a bill that is supposedly designed to help our Nation's doctors would include these other groups—except to provide them with an unjustified windfall.

H.R. 5 is totally misguided—it does not address insurance costs for doctors—instead it caps those meritorious lawsuits where a judge or a jury has found for the victim.

H.R. 5 puts a cap of $250,000 on noneconomic damages. Many dismiss noneconomic damages as being pain and suffering, and imply that these are less important than economic damages.

The true definition of noneconomic damages are those real, permanent harms that cannot be easily quantified or measured in terms of money.

Noneconomic damages include blindness, physical disfigurement, loss of fertility, loss of a limb, loss of mobility and the loss of a child. These are horrific losses—and under this bill they are capped at $250,000.

And not only are they capped at this amount, but because this bill does not even allow an annual adjustment for inflation, each year that $250,000 will lose more and more of its value, and be worth less and less.

I offered an amendment at the Rules Committee to allow an adjustment for the rate of

inflation, but my amendment was not made in order. I cannot believe that even this small and reasonable adjustment to help victims was denied.

I also offered an amendment to remove the antitrust exemption for insurance companies—that too was denied. If this bill is truly designed to address the insurance crisis in this country, how is it that it does not contain one single provision about insurance rates for doctors?

Democrats offered an amendment to require that insurance companies should pass on 50 percent of the amounts that they save as a result of this bill to doctors in the form of lower premiums. This would be a true way to ensure relief to doctors. Of course, this amendment was denied.

Medical insurers are the only industry left in America that is not barred from getting together and setting rates. If we really want to bring insurance rates down, we must make insurance companies subject to government regulation, to competition, and to antitrust law.

This bill will do nothing to help our doctors. Statistics have shown that even where caps exist, premiums are still inflated.

For example, my own state of Michigan has a cap in medical malpractice cases of $280,000 on noneconomic damages, with some limited exceptions.

Neighboring Illinois has no cap on noneconomic damages in these cases. Yet, the average liability premium in internal medicine is ⅓ higher in Michigan than the premium is in Illinois.

I support our Nation's doctors and I want to help them in the crisis they are facing. But voting for H.R. 5 and its misdirected caps will not provide that help, and I cannot support this bill.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 1½ minutes to the gentleman from Florida (Mr. STEARNS), chairman of the Subcommittee on Commerce, Trade and Consumer Protection of the Committee on Energy and Commerce.

Mr. STEARNS. Mr. Speaker, I am here to give a clear example from my home congressional district, a Dr. Joseph Hildner, a board-certified family-practice specialist in Belleview, Florida. He had a patient that was overweight and smoked too much. He never followed the doctor's advice, missed many appointments all the time, and failed to take blood pressure prescriptions. Suddenly the patient gets a heart attack, right? Then he sues because he was not cared for. The trial attorney simply identified anything that could have been done, declaring that no standard care was done for this patient by Dr. Hildner.

Obviously, Dr. Hildner tried to settle this thing because the doctor felt that he would go through long litigation. As it turns out, the lawyer was suing well above the amount of money that the insurance company had for his patient. This is just an example. So what happens to Dr. Hildner? His premiums go from $30,000 to $70,000. How does he pay? How do the doctors in this country pay? They start to hustle through more patients and more patients. They practice what is called defensive medicine; they have all these tests, just simply to protect themselves. He admits he is hustling through all these patients like cattle. He cannot give them the attention they need. So now he is giving unnecessary tests.

In the end, we need this bill. That is why I am an original cosponsor of H.R. 5.

I rise as an original cosponsor of, and in support of H.R. 5. This bill would help curb some of explosive noneconomic damage awards in medical liability cases, and resultant soaring malpractice insurance rates that lawsuits have been spurring.

Physicians in my home state of Florida, among other states, are already in a state of crisis, as evidenced by the ''walk-out'' earlier this year.

Dr. W. Herman Sessions of the Family Practice Associates in Orange Park, FL, wrote to me recently that his practice is considering exiting. He wrote,

I am telling my female patients to get their mammograms this year because I feel that we are not going to be having mammograms read in the state of Florida next year. A radiology friend told me that it was at the last minute that they were able to obtain insurance to read mammograms. He told me that he is not certain that when their policy expires in one year that they will be reading mammograms without some sort of resolution to the liability crisis.

We have had difficulty recruiting physicians to our hospital because nobody wants to practice in the state of Florida with our liability problem. These physicians are surgeons and surgical subspecialists. Our local neurosurgeon obtained liability insurance on the very last day of the year and he is able to practice for the calendar year of 2003. I asked him what his plans are for 2004. He told me that he will either retire, do strictly office consultation and no surgery, or move to another state.

And my constituent Johnny Beach from Bell, Florida, a young, married University of Florida senior worries about his wife's access to OB/GYNs.

Importantly, this legislation rightly does not cap economic damages, so that the tort system can continue to protect patients from malpractice as intended. I am pleased to cosponsor this bill, and urge its passage.

Joseph Hildner, M.D., a board-certified Family Practice specialist in Belleview, FL, writes: ''We had a patient who is an obese smoker. Never followed our advice, missed many appointments, failed to fill blood pressure prescriptions. Patients suffered a heart attack, then sued for failure to arrange a stress test.'' The trial attorney simply identified anything that might have been done, declared that to be the ''standard of care'', threatened to sue for higher than the doctor's coverage limits, then settled for less. Even with a 90 percent chance of winning, a physician can't take the chance of going to trial and losing: the ''excess verdict'' would allow for seizure of his own personal assets. So the doctor settles. Actual negligence need not occur; an attorney only has to do is allege negligence.

But citizens of Belleview lose. Dr. Hildner is known for excellent clinical outcomes at controlled costs. He says,

I've always enjoyed the art of medicine in which I get to practice clinical judgment. As a primary care physician, I am a shepherd, getting those who need it expensive high tech care, and protecting those who don't from unnecessary interventions. I'm also known for taking time to listen and explain. I don't have my hand on the doorknob while a patient is trying to talk.

Last year his insurance premium increased from $30,000 to $70,000. How does he pay? Now has to see more patients, and spend less time. ''I'm now having to talk patients into ''defensive medicine'' tests they don't need, just so I can protect myself. I am beginning to hustle my patients through like cattle, to see enough to pay the bills. So this friendly country doctor known for using clinical judgment, and providing efficient, cost-contained, appropriate care, and known for taking time, is now talking patients into unnecessary tests (which is running up costs), and hustling them through.''

Pass H.R. 5.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1½ minutes to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I just want to explain how this bill helps HMOs and hurts those patients that are victims of HMOs. Many of us for the last 4 years on a bipartisan basis tried to push a patients' bill of rights that basically would say that if you are denied care by your HMO, you can go to an outside maybe administrative agency and then finally can go to court and sue because of the denial of care and what the consequences of that were and actually get damages from a jury or a judge. This bill would kill that.

In many States, as well as in some Federal courts right now, patients have been given the right to sue an HMO, which is exactly what we were trying to do here in Congress when we supported a patients' bill of rights. But this bill says, no, you are not going to be able to do that anymore because it limits your ability to recover noneconomic damages as well as punitive damages against an HMO or another private insurance company.

I think there is a great deal of hypocrisy here. There are Members on the Republican side of the aisle that have said for years that they want to expand victims rights if they have been denied care or hurt in some way by an HMO, but they turn around today and they pass this bill which they are going to pass which basically limits those victims and their ability to sue an HMO even though the State courts and even though a lot of the Federal courts are now expanding victims' rights to sue.

What we are doing here is preempting the State law. If a State says, as mine in New Jersey says, that you can sue an HMO, this bill comes in and says, well, you can do it only under very limited circumstances. You cannot come here and say that you care about the victims. You do not care about the victims not only because you are putting a cap on them of $250,000 but you are not even going to let them sue the HMO in a fair way.

Mr. TAUZIN. Mr. Speaker, I am delighted to yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), chairman of the Subcommittee on

Health of the Committee on Energy and Commerce, who has done such great work on this bill.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for yielding me this time. I, of course, rise in support of H.R. 5. I believe that the sensible reforms contained in this bill will go a long way toward alleviating the medical liability insurance crisis many States are facing and will also help prevent future crises from occurring.

On Tuesday of last week, the Energy and Commerce Subcommittee on Health, which I chair, approved H.R. 5, which was subsequently approved by the full committee on Thursday. In both cases, approval was by voice vote. The severity of the current crisis has necessitated that we act now. I would note that our committee has held numerous hearings over the past year to explore this issue and consider potential solutions.

That is why I continue to be disappointed with the rhetoric surrounding this debate. As chairman, I had wanted to focus a good deal of our last subcommittee hearing on how the insurance industry sets medical liability insurance premiums. In fact, the majority invited both the American Academy of Actuaries and the Physician Insurers Association of America to come testify at our hearing. Unfortunately, in spite of all the rhetoric on insurance, unfortunately the minority did not invite any insurance witnesses. Instead, they once again played politics, including inviting a witness to discuss something called Proposition 103, which he claimed is the real reason why California has been largely insulated from the current crisis. That struck me as somewhat odd, considering that the organizations working to defeat H.R. 5 never mentioned this ballot initiative during our debate on H.R. 4600 in the last Congress, even though this initiative passed in 1988.

What this tells me is that many people would rather play politics than work towards a real solution. I respect that some Members may feel that it is never appropriate to place any limit on subjective, unquantifiable, non-economic damages regardless of the cost to the health care system. However, I do not respect those who will do or say anything to derail this process. I am voting for this bill because by doing so I am moving us one step closer to a solution. The medical community and the patients they serve demand it.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1½ minutes to the gentleman from Pennsylvania (Mr. DOYLE), who has stood up for patients and doctors alike.

Mr. DOYLE. Mr. Speaker, I represent Pittsburgh, Pennsylvania; and in the great State of Pennsylvania, doctors are paying way, way too much for malpractice insurance. It is a crisis, and they need some immediate relief. Unfortunately, the bill we have before us today will do nothing to give any doctor in my State any immediate relief. It will not do a single thing to reduce frivolous lawsuits. There is nothing in this bill that will reduce frivolous lawsuits.

So, Mr. Speaker, what should we do to address this situation? In Pennsylvania, we have just recently last year passed three laws that I believe are going a long way to address the problem. Number one, Pennsylvania has prohibited venue shopping for oversympathetic jury pools. We have established tough sanctions against lawyers who filed frivolous suits. We have reformed joint and several liability provisions to ensure all liable parties are truly responsible for their fair share of the judgment. We have established strict new standards for expert witnesses. We have allowed courts to reduce verdict amounts if the award will adversely impact access to health care. We have imposed a 7-year statute of limitations on filing of claims, and we have required insurers to offer patients safety discounts to medical facilities with good track records.

These are the types of reforms that will help deal with the situation. Putting a $250,000 cap on noneconomic damages disproportionately hurts poor people. These damage awards, they are not the cause of the problem. Two-thirds of patients who file claims receive nothing. Only 7 percent of these cases go to court. Let us not cap damages on people who can least afford it. Let us let States like Pennsylvania enact meaningful reforms like we have already done.

Mr. TAUZIN. Mr. Speaker, I am delighted to yield 3 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD), chairman of the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce and the author of this legislation.

Mr. GREENWOOD. Mr. Speaker, I thank the gentleman for yielding me this time. I would like to respond to some of the arguments made by the opponents. First off, there has been this constant drumbeat of accusations that somehow this legislation does not provide the care and the coverage for those who are harmed. Let us say it for the 15th time: this bill allows anyone who is injured by a doctor or a hospital or any other health care entity the ability to recover every single penny of economic damages, all their medical care, all their lost wages, lifetimes of lost wages. There are cases over and over again in the State of California that has this legislation in place where there are awards of $50 million, $80 million, et cetera. Plenty of money for the victims to cover their needs.

Secondly, there is this drumbeat that this is really about the insurance industry. Why are we not regulating the insurance industry? Listen carefully. Sixty percent of the physicians in this country buy their medical liability insurance from physician-owned companies. Those companies exist for one purpose, and that is to keep the price of medical liability insurance low. They do not gouge their customers; they do not collude with one another, because they are the doctors. They are not doing anything to raise rates or to hold rates up high. They are doing everything to push rates down. Guess what? They cannot offer lower premium prices than commercial insurers. So if your whole thesis here is, oh, those insurance companies, they are overcharging, they are gouging, they are colluding, explain to me, I beg you, stand up and explain to me why it is that the physician-owned companies are in the same boat and are not able to provide affordable coverage?

The gentleman from New Jersey (Mr. PALLONE) talked about shielding pharmaceutical companies, shielding HMOs, device companies from lawsuits. This bill does nothing of the kind. If a pharmaceutical company is guilty of making bad medicine or overcharging medicine, they will be liable for millions of dollars, untold millions of dollars for economic damages. There is no shield whatsoever.

Then finally let me say this. We have heard over and over again from the opponents of this legislation, it does not really help doctors. Let us see who supports it: the American Medical Association, the American Association of Neurological Surgeons, the American Association of Nurse Anesthetists, the American Association of Orthopedic Surgeons, the American Association of Thoracic Surgery, the American Association for Vascular Surgery, the American College of Cardiology, the College of Chest Physicians, the College of Emergency Physicians, the College of Nurse Midwives, the College of Nurse Practitioners, the California Medical Association. Every doctors' group in America supports this legislation.

So do not stand up with a straight face, opponents of this legislation, and tell us that the doctors are not smart enough to figure out that this is exactly the prescription that they need.

Mr. BROWN of Ohio. Mr. Speaker, understand that physician-owned companies are still companies that practice business the way other businessmen and women do.

Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. DINGELL), the ranking Democrat on the full Committee on Energy and Commerce.

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

Mr. DINGELL. I thank the gentleman for yielding me this time.

Mr. Speaker, we are witnessing a sorry spectacle today. Not only are we denied opportunity to properly debate but also to properly amend. And the doctors are being herded along in front of the HMOs and the insurance companies, because those insurance companies and HMOs are the beneficiaries of this legislation, not the doctors.

The Republican bill does nothing to limit frivolous lawsuits. It does, however, limit responsible lawsuits. The

Republicans would restrict the rights of doctors by protecting HMOs, not by assuring that HMOs are subject to the discipline of the court.

□ 1415

Republicans limit awards for meritorious claims. Republicans impose hurdles on aggrieved patients.

This is an outrageous piece of legislation. It is brought to the floor under outrageous proceedings. Thirty-one Members have asked for opportunities to offer amendments. They were denied. We are not even given a chance to offer a substitute to this legislation.

I can understand how my Republican colleagues are all looking sheepish and why they are thoroughly embarrassed. I would be embarrassed if I were engaged in this kind of practice myself, because, quite honestly, it is shameful, and it is totally inconsistent with the practices, rules and traditions of the House of Representatives. It is, indeed, a blow to the heart of the legislative process and responsible legislating. It is also a bite on the throat of the right to free debate and the right to amend and perfect legislation.

One of the important responsibilities of this body is to be able to amend legislation, for the House to work its will, for us to represent our people, for them to hear not only responsible debate, but to know that their will is heard and that their concerns are met, not only by debate, but by proper use of the amendment process. That is denied to us today, and I say to my Republican colleagues, shame on you. You have brought shame upon the House of Representatives. You have embarrassed me. I hope you have embarrassed yourself.

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

Mr. Speaker, I only want to point out to the House that the substitute offered by the gentleman from Michigan (Mr. DINGELL) in subcommittee and full committee was defeated on a bipartisan vote in full committee of 30 noes to 20 yeas.

Mr. Speaker, I yield 2½ minutes to the gentleman from California (Mr. COX).

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

We are here today because patients are losing, many have lost, access to care. People are dying as a result of not being able to see doctors in emergency rooms. Doctors who have never been sued are quitting the practice of medicine, and talented young men and women are not seeking careers in medicine because of what is happening.

Today there are billionaire lawyers. There is no such thing as a billionaire doctor. All of these billionaire lawyers have made their money in health care lawsuits.

The opponents of this legislation would have us believe that the phenomenon of billionaire lawyers is a reflection of social justice, but it is not. This money is coming out of our health care system. It is taking doctors out of emergency rooms. It is preventing women who are trying to deliver babies from having OB/GYNs available. There are not enough neurosurgeons to provide emergency care.

In Florida, the Orlando Regional Medical Center, which serves 33 counties, is planning to close its Level 1 trauma unit this month. Patients with serious head and neck injuries will have to be diverted to other hospitals. But in Florida those other hospitals in Tampa and Jacksonville, those trauma units are already overcrowded. The reason patients, particularly poor patients in Medicaid and in emergency rooms, cannot get care is the liability crisis caused by runaway lawsuits.

Doctors and hospitals now spend more on liability insurance than on medical equipment. The Chicago Tribune reports that in Illinois liability insurance premiums are rising 100 percent or more for high risk specialties. Our intention is that no more patients are denied the care that they need because the doctors who wish to serve them cannot afford liability insurance.

The solution, H.R. 5, the HEALTH Act, which I have introduced in this Congress since 1993 and am now coauthoring with the gentleman from Pennsylvania (Mr. GREENWOOD), is based on California's law, written by a Democratic legislature and signed by Jerry Brown, a Democratic Governor.

We have these reforms in our State, and they work. California's medical liability insurance premiums in constant dollars have fallen by more than 40 percent, while the rest of the country is in crisis. Injured patients in my State of California receive compensation more quickly than in the U.S. as a whole. Injured patients receive a greater share of the recoveries in lawsuits. California no longer suffers from the flight of doctors and needed services that we have seen in so many other parts of the country.

By passing this legislation, we will bring these California reforms nationwide, making health care more accessible for patients who are today denied care. I urge this House to pass the HEALTH Act, H.R. 5.

Mr. BROWN of Ohio. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Missouri (Ms. MCCARTHY), a member of the committee and an advocate for patients.

(Ms. McCARTHY of Missouri asked and was given permission to revise and extend her remarks.)

Ms. MCCARTHY of Missouri. Mr. Speaker I rise in opposition to H.R. 5 and in favor of the motion to recommit.

Mr. Speaker, I rise today in opposition to H.R. 5, a measure which restricts the rights of legitimately injured patients harmed by medical malpractice, restricts the rights of doctors in favor of insurance companies and does nothing to curtail frivolous law suits nor restrains insurance rates.

In addition to trampling on patient rights, this bill tramples on state's rights. H.R. 5 takes the constitutional concept of federalism to the extreme by severely limiting the traditional rights of plaintiffs seeking damages, a matter that should not be decided by Congress because it proposes tort reforms that are traditionally, and possibly constitutionally, areas to be decided by state legislatures and state courts.

Twenty-five states including Missouri cap non-economic damages to victims. The average Missouri award is $81,000 well below the $250,000 cap presented in H.R. 5, as well as Missouri state law. Twenty states courts have ruled that caps on damages are unconstitutional. H.R. 5 enacts a statute of limitations which 18 state courts have ruled unconstitutional. It is inappropriate for Congress to limit the rights of individuals when state courts have ruled that their rights are protected under state constitutions.

Missourians Jay and Sue Stratman have a son, Daniel Lee Stratman, who is only 11 years old. In July of 1996 Daniel was checked into the hospital for "minor" outpatient hernia repair surgery. Daniel was set to be released that same evening. Daniel was not released until November 8 of that year and nothing has been the same for either Daniel or his family.

Daniel is permanently disabled due to severe brain damage, which was a result of multiple repeated anesthetic errors during the supposedly routine surgery for inguinal hernia repair. As a result of the medical errors, Daniel has suffered profound neurological damage including severe cognitive deficits, a decreased level of awareness, diminished bowel and bladder control, and severe gross and fine motor skill injury. He is cortically blind due to the lack of oxygen and perfusion to his brain during surgery. His comprehension level and communication capability have been severely diminished. Daniel requires 24-hour vigilance and this will be true for all of his remaining 70-year life expectancy.

The cap in H.R. 5 unjustly penalizes those individuals without income, like Daniel. Others that fall into that category include: stay-at-home moms and the elderly. When a stay-at-home mom dies, or a child dies, or a senior citizen suffers irreparable harm, there is no economic loss because it is impossible to prove damages from loss of income.

By capping punitive damages, H.R. 5 limits protection for injured patients like Daniel. Instead the bill before us protects HMOs and big insurance companies from legal responsibility. HMOs and big health insurers, who are also big campaign contributors, should not receive special treatment under the law.

Further, H.R. 5 does nothing to reduce insurance premiums for doctors—the very thing Congress needs to address. Currently, medical malpractice insurance rates are rising because insurance companies are squeezing doctors to make up for investment losses over the last few years, investment loses most citizens have also experienced. Instead of penalizing doctors, hospitals and patients Congress should make major reforms to the insurance industry.

I support the Conyers-Dingell motion to recommit because it rightly focuses on giving Americans quality healthcare and weeding out frivolous lawsuits while maintaining the rights of patients with legitimate claims, and respect for the humanitarian doctor's perform.

I urge my colleagues to oppose H.R. 5 and support the motion to recommit to include patient's rights and state's rights.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Maine (Mr. ALLEN), who has pointed out in USA Today that the malpractice premiums are only 3 percent of revenue, actually less than the rent that physicians pay.

Mr. ALLEN. Mr. Speaker, this bill will not reduce health care spending significantly. If you add up all the malpractice premiums in this country, they represent one-half of 1 percent of the $1.4 trillion we spent on health care last year.

Now, some States have problems. Maine does not impose caps on noneconomic damages, yet we have comparatively low insurance premiums. Maine has a mandatory pre-litigation screening panel for every medical malpractice case. The panel consists of one attorney, one doctor and one retired judge. This panel process weeds out the frivolous lawsuits and encourages legitimate cases to come to a fairly quick resolution. Sixteen other States have similar screening panels.

States with screening panels should be exempt from the cap on noneconomic damages. There is no reason to impose this law on States which have figured out how to deal with this problem on their own. But this bill imposes a one-size-fits-all Federal rule in a traditional area of State jurisdiction.

And this bill does something else. This bill sticks individual plaintiffs, particularly those who are children or unemployed or elderly, with perhaps a huge lifetime cost because of severe injuries, instead of sharing those costs through our insurance system. So, once again, the Republican majority is basically saying it is better to stick the loss on those who suffer it than to share that loss broadly through insurance.

A $250,000 cap does not mean $250,000 will ever go to a plaintiff, because they always have expenses and attorney's fees and all of that. It seems to me that this cap is unbelievably low, it is imposed arbitrarily on States which have figured out another way to deal with this problem, it is bad policy, and I urge my colleagues to vote down H.R. 5.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, if H.R. 5 passes, we will be committing legislative malpractice, in my view. Listen to my constituents. If you were on a jury, you just might feel they deserve more than $250,000 for the pain and suffering they have suffered and will suffer. H.R. 5 would take that right away from you and other citizens.

''On May 19, 2000,'' writes my constituent, ''I went for an outpatient surgery. During the surgery, the oxygen ignited, unbeknownst to the surgeon, the anesthesiologist and three to four other highly-trained medical personnel in the room. While the surgery continued, my entire face was burned.

''After a year of failed treatment to deal with the scarring, essentially I lost my entire upper lip, the front of my nose, the floor of the nose and immediate interior of my nose. I was referred to a specialist in Boston for reconstructive treatment. For these past three years I have been in a mask covering my face and I have nasal tubes to stent open my nose for 23 hours a day. With my mask on, I can only drink through a straw. My breathing was entirely cut off for almost 2 years, and is still not stable due to the scarring inside my nose. I have to travel to Boston monthly. I have been through eight surgeries and have two to four more pending, plus oral surgery and orthodontics.

''My claim is not frivolous, in spite of the rhetoric of the medical insurance and political spokespersons favoring legislation to cap awards for pain and suffering at $250,000.

''Legislation to cap damages fundamentally punishes again the victims of these horrendous medical mistakes. It is astonishing that federally proposed legislation would first target the victims of these errors before addressing the errors themselves.''

The other one is from a grieving father of Rabbi Josef Yitzchak Lefkowitz, 28-years-old, who went into the hospital for an adjustment to his bite. In the recovery, the breathing tube fell out of his nose, but his jaw was wired shut and they could not find wire cutters to open his mouth. He died an agonizing and painful death.

These are not lottery winners. These are not people who won the jackpot. They deserve better than H.R. 5.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1½ minutes to the gentlewoman from California (Ms. SOLIS).

Ms. SOLIS. Mr. Speaker, I believe we can all acknowledge that rising medical malpractice premiums are hurting doctors and patients. But I heard earlier from the other side that trauma centers are closing, and they are closing in Los Angeles. But it is not because of frivolous lawsuits, it is because we have not provided adequate reimbursement for Medicaid for those poor hospitals. That is why, and we are not even addressing that.

I have to say, with all due respect, that the bill will not lower insurance premiums. Caps in California did not lower premiums. Insurance reform did, Proposition 103, and only slightly, because we are still above many other States in the country.

We need to bring insurance providers to the table and we need to have that kind of discussion, not one that talks back and forth here on the floor.

Caps on noneconomic damages unfairly penalize children, retirees and stay-at-home moms. And you know why? Because they do not make an income.

Mr. Ed Whiddon, a retired lieutenant colonel in the Air Force, was a victim of malpractice at the hands of an anesthesiologist who left him a paraplegic. His compensation was almost entirely for pain and suffering damages because he was retired, no income, did not qualify for lost wages.

The bill would unfairly limit damages for retirees like this former member of our Armed Forces and others who earn no wages, like poor moms and children.

Let us protect patients' rights. Let us help those poor people. Let us open up those trauma centers by really addressing the issue adequately. This way is the wrong way. I urge my colleagues to oppose H.R. 5 and to support the Conyers-Dingell alternative.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1½ minutes to the gentleman from Houston (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, my Ohio colleague could not say Texas. He just wanted to say Houston.

Mr. Speaker, I rise in opposition to H.R. 5, and I am frustrated like a lot of Members, one because we do not have an opportunity to have additional amendments. I thank our chairman for allowing us to let democracy work its will in our committee. We had a long hearing all day. But here on the floor we do not have that option. The same thing happened last year on prescription drugs. It is frustrating.

We are fighting for democracy all over the world, but we do not get to have a voice here on the floor of the House with an alternative.

I have a district in Texas, and we have a medical malpractice crisis. Of course, we have gone in and out of this for the last 30 years, but it has been dealt with by our State legislature in Texas, and literally as we stand here today, there is legislation that is out of the committee on the floor of the House for consideration that will solve our problem in Texas where it should be dealt with.

Thirty-seven States, including my home State of Texas, are considering legislation that would address the malpractice situation. We do not need Congress to tell us what to do. We can deal with it.

If Congress makes a mistake with H.R. 5, and I consider it a mistake, it is one-size-fits-all, Washington-knows-best for all 50 States, instead of letting the States deal with it.

The California experience that my colleagues on the Republican side talk about so successful, it was California, as hard as it is for a Texan to say they did something good, but it works. We do not need to tell California or Texas or any other State what they can do. They can deal with it, instead of us dealing with it here.

But let me talk about H.R. 5 just a little bit. It does not deal with medical errors, we have separate legislation on that; it does not stem the tide of frivolous lawsuits; and it does not help us deal with physician shortages. That is why it should be voted down.

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

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

Mr. WAXMAN. Mr. Speaker, I am going to put a longer statement in the RECORD, but I want to say this, that this bill is a flawed approach. It has a one-size-fits-all approach to every State, and it ought to be up to the States to decide how to deal with these issues.

California has a law that California's legislature adopted. But California and other States have jurisdiction over liability laws and licensure of medical professionals and disciplining those who are conducting malpractice. We ought not to take this whole thing over here in Washington. States ought to be able to adopt their own laws.

Secondly, the tort laws are to serve two purposes. First, to make people whole who are injured. By putting a cap on damages, it denies individuals the ability to be made whole through the court system.

Secondly, the idea of the tort law is to deter future malpractice, and I am afraid we are not going to deter future malpractice by this legislation.

I want to lastly point out, this bill goes beyond California law. It gives special treatment to HMOs, to pharmaceutical manufacturers and medical device manufacturers in a way that is completely inappropriate through an FDA approval process that then insulates them from liability for punitive damages, which I think is way out of line and wrong.

Mr. Speaker, I rise in opposition to this bill because it is fundamentally flawed and will do far more harm than good. It imposes a one-size fits all solution on every state. It imposes arbitrary caps on liability that defeat the purpose of compensatory and punitive damages. It gives legal protections that go far beyond the legitimate needs of doctors, benefiting profitable pharmaceuticals, HMOs, and insurance companies. And to add insult to injury, all of this comes at the expense of the injured victims of medical malpractice.

States have traditionally handled every aspect of the medical malpractice insurance problem, and are better equipped than the federal government to respond to skyrocketing insurance premiums in some areas of the country. States establish the applicable standards of care for health care professionals and are responsible for their licensure. States are responsible for boards of discipline and criminal laws to deter and punish professional misconduct. States are responsible for the rules governing lawsuits and the functioning of their civil justice system. And states are responsible for the regulation of the insurance industry. Like the State of California, which the supporters of this legislation hold up as a model for the country, other states are perfectly capable of enacting appropriate liability and insurance reform.

This bill, however, establishes a one-size-fits-all solution on the entire country and overrides state laws. For example, if this bill is enacted, states cannot elect to have a longer statute of limitations. States cannot opt out of liability caps. States cannot choose to inform juries of caps on liability or impose the traditional rule of joint and several liability. States cannot allow punitive damages in cases involving drugs and medical devices approved by the FDA.

H.R. 5 also takes the wrong approach to tort damages, which are designed to make victims of medical malpractice whole and punish those who have engaged in egregious misconduct. H.R. 5 allows unlimited recovery for objectively quantifiable damages, such as lost wages or medical bills, but it caps non-economic damages at $250,000. Non-economic damages are difficult to quantify, but they nonetheless compensate victims for real injuries such pain and suffering, the loss of the child, the loss of a limb, or permanent disfigurement. This bill's cap of $250,000 is clearly not enough to make victims whole in every case. H.R. 5 also takes the wrong approach to punitive damages, which are capped at two times the amount of economic damages or $250,000. Many wrongdoers protected by this bill—including HMOs, insurance companies, and pharmaceuticals—could absorb such a penalty with absolutely no impact on their bottom line. This defeats the very purpose of punitive damages in our system of justice, which is to punish wrongdoers and deter future misconduct.

In addition to these problems, this bill is a blatant give-away to special interests. It conspicuously ignores the business practices of insurance companies, which are certainly a cause—if not the primary cause—of the medical malpractice insurance crisis. And the bill gives special liability protection to large, profitable corporations such as MHOs and the manufacturers, suppliers, and distributors of drugs and medical devices. While these corporations have been major contributors to the Republican party, they have done little else to make a case for the protections they've won in H.R. 5.

I urge my colleagues to oppose the bill.

□ 1430

The SPEAKER pro tempore (Mr. SIMPSON). The gentleman from Ohio (Mr. BROWN) has 2½ minutes remaining; the gentleman from Louisiana (Mr. TAUZIN) has 1½ minutes remaining.

Mr. TAUZIN. Mr. Speaker, I have only one additional speaker to close, so I would urge my friend to use up the balance of his time.

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman. We have two more speakers.

Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. ENGEL).

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

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

Mr. Speaker, let me say up front that I think we need to help doctors with unconscionable medical malpractice rates. I mean this most sincerely, and I pledge to do everything I can to help them; but this bill is not the way to go. It will adversely impact patients who are injured. These are people whose lives are irreparably harmed and this legislation, in my opinion, punishes them even further.

We can find a balance, but the majority is ramming this legislation through the House without regard to how it will hurt victims of negligent practices.

A $250,000 cap on economic damages disproportionately affects those who do not earn a lot of money. Someone with a minimum-wage job or a stay-at-home mom or dad cannot place a value on their work, but a corporate executive will walk away with millions in economic damages. This is not what we should be advocating in the House.

Further, the legislation limits the statute of limitations to 3 years from the day the injury occurred or 1 year from the day the injury is discovered. This is not fair. I had an amendment which I tried to put forward in the Committee on Rules in the hope that they would allow us an up-or-down vote on the floor. It was turned down. There are some injuries, for instance, HIV/AIDS or blood transfusions, where people do not find out about their injuries for more than 3 years.

So I believe this bill is not the way to go. It should be voted down, and I hope we can come back with good compromise legislation that helps doctors with malpractice rates.

Mr. BROWN of Ohio. Mr. Speaker, I would point out that we will have a motion to recommit, since the majority would not allow us any other amendments of the 31 requested.

Mr. Speaker, I yield 1½ minutes to the gentleman from Massachusetts (Mr. MARKEY).

Mr. MARKEY. Mr. Speaker, this bill has one huge flaw that even its proponents concede: that the benefits, if any, flow directly to the insurance companies, not to the doctors. Therefore, I tried to perfect this bill. During the Committee on Energy and Commerce markup, I offered an amendment to ensure that the savings from the bill's caps on damages for patients' pain and suffering would be passed along to the doctors in the form of reductions in their liability insurance premiums. Every Republican voted no. They each voted with the insurance industry.

This bill deserves to be defeated, as long as there is no effective guarantee that savings from the bill's caps on damage will go not to doctors, but to the insurance industry.

This bill claims to be a cure for the high cost of insurance premiums paid by doctors, but it is really just insurance for insurance companies. It is a public policy placebo that only offers the illusion of relief from sky-high insurance premiums, while pumping cash into the bottom line of insurance companies.

Capping damages may save insurance companies money when their policyholders are sued, but the bill does not require insurers to pass along one cent of savings to the doctors so that they can stay practicing in local communities across this country.

We can all agree that health care liability insurance is a critical issue that has significant impact on patients, on doctors, on insurance; but

this bill leaves out one critical link: the doctors who will not receive the benefits of the lower premiums that have been promised.

Vote ''no'' on this gag bill that does not allow for a full debate on the House floor.

Mr. TAUZIN. Mr. Speaker, I want to quickly point out, our own Congressional Budget Office estimates a 25 to 30 percent reduction in malpractice insurance costs and a savings to the U.S. Government alone of $18.1 billion if this bill passes.

Mr. Speaker, I yield the balance of our time for closing to the gentleman from New Jersey (Mr. FERGUSON).

Mr. FERGUSON. Mr. Speaker, congratulations to the chairman for all of his good work on this bill.

I rise in strong support of this legislation. I am proud to be a cosponsor, and I am pleased that today we finally move forward with meaningful, structural reforms that will have a tremendous impact on the medical liability crisis looming before our country.

Over the past few months I have seen health care providers, doctors, hospitals, nursing homes, all of our caregivers, curtail services to the community and to people in need. Why? They have done so because of the fear of frivolous lawsuits and these lawsuits which have caused insurance costs to skyrocket.

What amazes me is the misinformation that is out there on this issue and that has recklessly entered this debate. In fact, there is so much misinformation that some individuals in this body, I think, have forgotten what it is that we are trying to accomplish here.

Just the other day, I read an article claiming that medical liability reforms that we are going to pass with this bill will make it more difficult for patients to find lawyers. That is right. Is that the crisis that we are facing today? Not enough lawyers? Of course not. That is not what we are here for.

We are here because of patients, because we want to preserve patient access to care. All patients, whether a senior or a newborn baby, deserve the highest quality of care. But at the current rate, we cannot keep this promise.

My family has personally experienced the effects of this liability crisis in New Jersey with the recent birth of our third child. My wife's doctor lost her partner. The other OB whom she practices with had to leave the State because her insurance costs were too high. Our doctor was there for us, but I fear for other moms and dads, fathers and mothers, and loved ones in the future.

Frivolous lawsuits have never healed anyone. I have never met a trial lawyer who was developing a new treatment for AIDS. I have never seen a frivolous lawsuit treat someone with diabetes. I have never heard of a multimillion dollar jackpot reward that served a disabled veteran in a wheelchair. What they have done is driven patients away from their doctors.

Mr. Speaker, these are reasonable reforms. It is time that we ensure that our health care system serves patients and not trial lawyers. Vote ''yes'' on the HEALTH Act.

Ms. LEE. Mr. Speaker, for a nation that boasts about being the wealthiest in the world, claiming liberty and justice for all, the fact that there are over 40 million people without health insurance is a contradiction and a shame. And instead of addressing this crisis head on, this Administration and House Republican leadership continues to talk about health care and do nothing.

The bulk of the uninsured are low-income and minorities. These are the Americans who too often are ignored. The uninsured have lived a campaign of survival, and deserve a voice today and every day on this floor.

As I stand before you on this floor, I would like to introduce you to these voiceless constituents. They are the men and women who have jobs in our stagnant economy. Most Americans receive health insurance through their employers, but millions lack coverage because their employers do not offer insurance or simply cannot afford to pay for it.

Many of these working Americans qualify for Medicaid. Medicaid covers 40 million low-income people and their families, but millions more do not meet its limiting income and eligibility requirements because of savage welfare reform restrictions crafted by the Republicans, leaving the most vulnerable uninsured.

The numbers speak volumes. Fifty-six percent of the uninsured population are low-income and nearly one in five of the uninsured are low-income children. Although minorities comprise only 34 percent of the population, over half of the nation's uninsured are minorities. Twenty percent of these uninsured are African American and 34 percent are Hispanic.

Minorities and the underserved bear a disproportionate burden of mortality and morbidity across a wide range of health conditions. Mortality is a crude indicator of health status and demonstrates how critical these disparities are for minorities. For African Americans and Latinos, these disparities begin early in life and persist. African American infant mortality rates are more than double those of whites, 14 percent vs 16 percent, and the rate for Latinos is 9 percent compared to 6 percent for whites. The death rate for African Americans is 55 percent higher than for whites, with AIDS being the 6th leading cause of death for African American males. I could go on with a multitude of statistics that clearly illustrate the stark disparities in health care that exist for minorities. Yet the point remains that these disparities are a result of lack of insurance and lack of access to health care.

Health insurance is important because it impacts health outcomes. Nearly 40 percent of the uninsured have no regular source of health care and use emergency care more due to avoiding high cost regular visits. This situation creates an ongoing cycle of adults and children skipping routine check-ups for common conditions, recommended tests, and treatments because of the financial burden, resulting in serious illnesses that are more costly. The uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided.

The message we must send is that universal health care that provides high quality health care should be provided without discrimination. That is why today I am introducing H.R. 3000, the U.S. Universal Health Service Act (U.S. UHSA). This proposal challenges us as Americans to take another look at the fundamental role government will have to play if we are ever to achieve an equitable and rational health care system.

Universal health care is the only way we can provide equal access and fairness to our health care system. The uninsured are suffering; if we don't acknowledge health care as a basic human right soon, it will be too late for some, and our society's most vulnerable will continue to suffer. Our nation is the only industrialized nation that does not have a health insurance program for everyone, and our health care system is failing. Make health care accessible! Make health care affordable! Make health care a guarantee! I encourage all of my colleagues to cosponsor H.R. 3000 and support health care for all.

Mr. UDALL of New Mexico. Mr. Speaker, I rise today in strong opposition to H.R. 5, the ''Medical Malpractice and Insurance Reform Act of 2003.'' Furthermore, I fervently object to the House Rules Committee's prohibition of amendments to this controversial measure, a decision that does not allow for open objective debate or consideration of any worthy alternatives. The rule governing this measure smacks of partisan politics, favors the corporate insurance industry over the health and well-being of the American population, and effectively subverts our great nation's democratic process. Denying us the opportunity to discuss this openly is absolutely unacceptable and exposes what this legislation is all about.

H.R. 5 is purportedly designed to lower the high costs of physicians' medical malpractice insurance rates. We all agree that skyrocketing insurance premiums for medical malpractice are spiraling out of control and demand immediate attention. This bill, however, will not guarantee lower rates for doctors. Instead, it will severely limit victims' ability to recover compensation for damages caused by medical negligence, defective products and irresponsible insurance providers. In other words, H.R. 5 does not fix the problems plaguing the nation's health care system: it rewards insurance companies for bad investment decisions, offers minimal deterrence to doctors practicing bad medicine, and seriously restricts the rights of injured patients to be compensated for their injuries caused by such practices.

It is clear that the House leadership is not really trying to help doctors, but rather their friends in the insurance industry. H.R. 5 would usurp the role of the jury by empowering the Congress to determine the rate of compensation due to malpractice victims. The insurance industry often ridicules the rare million-dollar ''windfall'' jury awards given, asserting that the victim must feel like they have won the lottery. Do you suppose the parents of the 17-year-old transplant patient who died after being given the wrong blood type, or the Wisconsin woman who had a double mastectomy, only to discover after the operation that the lab had made a mistake and she did not have cancer after all, feel as if the jury-awarded compensation has enriched their lives? I think not. It is doubtful that any person or family that loses a loved one, or suffers years of pain and suffering because of a medicinal mistake or oversight, feels like celebrating, especially after fighting their way through the court system and finally receiving compensation.

The insurance industry continually asserts that recent hikes in malpractice premiums are caused by excessive jury awards, and that the only remedy is to cap damage awards in malpractice lawsuits at $250,000—no matter how egregious or irresponsible the case. Capping damage awards will not lower insurance rates nor address the real problems in the medical liability system primarily for two reasons—First, the cyclical nature of the insurance industry, that is, raising premiums to recoup losses due to bad investments in the stock market, and second, the number of medical errors made by the medical profession.

Instead of enabling insurers, we should reject the one-size-fits-all cap that will restrict the ability of those most severely affected by a medical mistake—Americans who struggle daily to make ends meet—to be properly compensated.

I am sympathetic to those good doctors and care givers who must pay soaring insurance bills or be forced to shut down their practices because of the exorbitant cost of liability insurance. Currently, malpractice premiums in my state of New Mexico are relatively low in comparison to those in some other states. However, due to increased concern over other economic and health related issues, we are already feeling the effect of our best physicians leaving the area to work elsewhere. Accordingly, I am extremely sensitive to the impact that increased premiums would present to this already delicate situation.

The vast majority of doctors serve the public well. Instead of a real solution for these reputable doctors, the Leadership's plan punishes the innocent victims of medical malpractice, and does not reduce the premiums for good doctors. To reduce the malpractice premiums physicians pay, reforming the insurance industry and implementing programs to reduce medical errors and cracking down on negligent doctors would be a better solution than the liability caps and tort reform initiatives the Leadership supports today, legislation that directly and adversely affects the victims of medical malpractice and their loved ones.

As our nation's lawmakers, I firmly believe that we must pledge to continue to work with doctors and patients to find equitable solutions for the numerous problems that plague access to quality health care in this country. We must act now to ensure that our good doctors are not unjustly punished for the malfeasance of others, and that everyone who deserves just compensation for wrongful acts or omissions receives adequate remedy.

Regrettably, the Leadership denies us today the opportunity to openly debate the issue or offer alternatives to H.R. 5 on the House floor. Accordingly, I reiterate my opposition to H.R. 5, and state my intent to support a motion to recommit the issue for further consideration.

Mr. FLAKE. Mr. Speaker, today I voted ''no'' on final passage of H.R. 5, the Help Efficient, Accessible, Low-cost, and Timely Healthcare (HEALTH) Act. My vote was a difficult one, but I am not convinced that the federal government should preempt state law in this area.

Those supporting this bill have made some compelling arguments as to why Congress should step in and institute these reforms. They cite the national nature of insurance plans, whereby a doctor in Arizona might have to pay more for malpractice insurance due to an over-the-top jury award in Texas. They also note that, as doctors close up shop or stop providing high-risk care in specialties such as emergency medicine and obstetrics and gynecology, patients are forced to cross state lines in order to seek out treatment. We have all watched with dismay as hospitals have been forced to shut their doors and doctors have opted to treat patients without malpractice insurance due to the high costs of premiums. Certainly, the trial attorneys who line their pockets with egregious fees aren't suffering as a result of the mess they've made with unscrupulous lawsuits. These arguments only underscore an already evident need for the states to pursue medical malpractice reforms. However, as one who believes firmly in federalism, I am unwilling to support legislation that would, in effect, preempt the constitution of the state of Arizona,which prohibits caps on damages.

The natural evolution of health care delivery suggests that a federal solution such as H.R. 5 may one day be necessary. Even today, we need tort reform badly. It's up to the states to begin that process, and I plan to be part of those efforts. The states should follow California's example, which has been an undeniable success over the past 25 years.

Mr. CUMMINGS. Mr. Speaker, I rise today in opposition to the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act.

Each year tens of thousands of people die or suffer needless pain and deformity from preventable medical errors. I believe, as I am sure many of my colleagues believe that these Americans, whose families suffer tremendously as a result of these injuries and deaths are entitled to compensation. This compensation should not be decided by Congress but rather by a jury or judge in the prevailing jurisdiction which has made a decision based on the merits and facts of those cases.

Mr. Speaker, I think we need to focus on what's at stake here. We are talking about limiting meritorious claims. Claims of those like the little girl in North Carolina who received the improper blood type during her transplant and died shortly thereafter. Claims from innocent victims in my district and districts around the country who have received improper treatment or care and will suffer immeasurably as a result.

Mr. Speaker, for every $100 spent on health care in America, only $.66 has been spent on malpractice insurance. As patients are most often victimized by repeat offending doctors, this bill does nothing to reduce negligence by doctors and hospitals, but decreases incentive to improve patient safety.

Mr. Speaker, we are not talking about frivolous claims as the Republicans would have us believe. In fact, this bill will not limit any frivolous claims nor will it lower insurance premiums. Instead it is a band-aid approach to a huge problem. The Conyers-Dingell bill would have implemented the type of reform necessary to lower medical liability premiums for doctors through imposing anti-trust regulations on the insurance industry, but unfortunately the American people will not ever hear of this comprehensive plan. Again, the Republican-led House Rules Committee has muzzled the voice of the people.

Mr. Speaker, I have heard many members speak of the California plan—also known as MICRA plan. However, the results of California are mixed at best. It is reported that in fact after passing MICRA, the actual premiums of California doctors are 8 percent higher than in states without caps and health care costs continue to rise. In fact the state of California subsequent to MICRA had to pass insurance reform to stop skyrocketing premiums that helped only fatten the pockets of the insurance companies. That is exactly what H.R. 5 will do, fatten the pockets of the insurance companies, who are trying to compensate for the investment losses made in the stock market.

Finally Mr. Speaker, H.R. 5 will also preempt state law—which sets its caps or sets no caps based on the input of its people. I would like to point out that in my own State of Maryland which as a cap on non-economic damages, over three times higher than that in H.R. 5 I might add, that the medical insurance premiums are still higher than those in the adjacent District of Columbia which has no caps. This is the shell game that the insurance companies are playing—and the American people are the losers.

It is for these reasons that I will vote against H.R. 5, and I urge my colleagues to vote against H.R. 5.

Ms. HARMAN. Mr. Speaker, I support California's MICRA, but H.R. 5 is not MICRA and I rise with some reluctance to oppose it.

As the daughter and sister of medical doctors, I understand better than most the chilling effect unlimited medical liability awards have on the practice of medicine.

Indeed, my father, who had a practice in Culver City, California, retired from practicing medicine in the mid-1970s because of the alarming increase in premiums. Only after his retirement did California enact its Medical Injury Compensation Reform Act—or MICRA.

MICRA is an experiment in limiting non-economic and punitive medical liability damage awards—and it has succeeded. For medical doctors, MICRA has provided stability in insurance premiums. For patients, it reduced meritless claims and accelerated the time in which settlements can be reached.

I strongly support MICRA, although before extending it to the entire nation, I would proposed adjusting the $250,000 cap on punitive and non-economic awards, first enacted in 1975, to reflect its current value.

Though H.R. 5 adopts the structure of MICRA, it is weighted down by dubious procedural and substantive roadblocks for a variety of causes of action against HMO's, nursing homes, and insurance companies—areas where the California legislature has enacted significant protections for patients. California's medical professionals oppose the inclusion of these provisions under H.R. 5's MICRA-like caps and procedures.

Last year, I voted for H.R. 5—with the hope and expectation that improvements would be made in conference with the Senate to narrow its egregious provisions. This did not happen, and constructive amendments offered in the Energy and Commerce Committee were opposed on near-party line votes.

The closed process by which we are considering this important bill today belies any desire by the majority to make the improvements I believe are necessary.

I cannot support the bill again in its present form. Hopefully, changes will be made in the Senate to align it more closely with California's MICRA, with the modification of the caps I noted earlier. If this happens, I will support the conference report.

Medical professionals should be able to practice in a climate of certainty, and patients

should be charged reasonable rates for quality care. This is what I support for every community in the country. This is not what H.R. 5, in its present form, delivers.

Mr. OXLEY. Mr. Speaker, medical malpractice lawsuits are increasingly being used to enrich lawyers at the expense of patients and doctors. We would never close the doors of our legal system to people who have legitimately suffered. But the abuse of the system is threatening the quality of care delivered by our doctors and hospitals. According to the Ohio State Medical Association, 76 percent of Ohio doctors say insurance costs have affected their willingness to perform high-risk procedures. I've met with doctors in my district who say these high costs might force them to retire. My rural district cannot afford to lose quality physicians.

This is clearly an issue of tort reform, not insurance regulation. State insurance commissioners strictly regulate liability insurers. Companies are not permitted to raise their premiums to make up for past losses. Malpractice insurance premiums are skyrocketing because over the last decade there has been an explosion in the number of lawsuits and particularly large awards, some reaching lottery proportions. That's something the market will reflect.

Reasonable limits on non-economic damages are a sensible way to make sure that malpractice lawsuit awards address actual damages. They work, without compromising legal rights or physician vigilance. Ohio is a case in point. When my state placed caps on these awards in 1975, insurance premiums dropped. When this cap was overturned, lawsuits . . . and therefore, costs . . . went up almost immediately. What changed was the behavior of lawyers, not doctors.

H.R. 5, the HEALTH Act, is a surgical solution to a crisis that spans from the operating room to the court room. I urge its adoption.

Mrs. BIGGERT. Mr. Speaker, I rise in support of H.R. 5, the HEALTH Act.

Frivolous 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, procedures and treatments out of fear.

Those were the primary issues a panel of experts highlighted at a medical malpractice forum I hosted last summer in my congressional district.

At this forum, the doctors, hospital administrators, and other medical personnel that deal with these issues on a daily basis said these cracks in our medical system are driving physicians and hospitals out of business. They simply cannot afford the exorbitant malpractice insurance rates that result from these frivolous lawsuits. As a result, they are forced to close their doors, limiting patients' access to care.

Even if doctors can afford to stay in business, they cannot make decisions based solely on their patient's best interest. With the threat of malpractice suits constantly hanging over their heads, they must act in ways to protect themselves from being sued.

Take for example, the case of a five-year-old boy in my district who was hit by a car and sustained a broken leg, along with a minor skull fracture. Usually, in these sorts of cases, a neurosurgeon would monitor the patient, to make sure his brain injury remained stable. Because of malpractice concerns and excessive insurance premiums, no neurosurgeons at that hospital or in the area could afford to treat patients under the age of 18. In Illinois, a staggering 85 percent of neurosurgeons are sued for malpractice at least once in their careers.

Without a neurosurgeon to follow the patient, the child had to be transferred to another hospital and undergo an ambulance ride with a broken leg. Once he reached the other hospital, there was no pediatric neurosurgeon available, so the orthodpedic trauma surgeon had the child placed in traction. This involved inserting a pin into the patient's leg just above his knee to hang the weights that pulled on the leg, and keeping him in traction for a few weeks.

After two days, his parents wanted their child to be transferred back to the original hospital closer to home. This meant that the child had to endure another ambulance ride in vulnerable condition.

My point here is not that frivolous lawsuits hurt doctors; it's that they end up hurting patients—in this case, a five-year-old.

Are some malpractice lawsuits necessary? Absolutely. Patients must have access to justice and restitution. But it is wrong when trial lawyers can exploit the system through frivolous or unlimited suits. And it is wrong to jeopardize patients' access to healthcare.

Mr. Speaker, Congress has twice before had the opportunity to fix the malpractice system and I have supported these attempts. The good news is that we have another chance today to take a big step toward preserving the long-term viability of the medical system in Illinois and around the country.

I urge my colleagues to join me in supporting H.R. 5. It is time for Congress to enact common sense liability reforms that safeguard patients' access to care.

Mr. STARK. Mr. Speaker, I rise in strong opposition to H.R. 5, 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 designed to protect bad doctors, HMOs, and other health care providers from being held accountable for their actions. Either way, this bill is harmful to consumers and should be defeated.

The Republican Leadership has once again brought forth a bill that favors their special interests at the expense of patients and 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. Unfortunately, this bill attempts to achieve that goal solely on the backs of American's patients. I said, "attempts to achieve that goal" intentionally.

Despite the rhetoric from the other side, there is absolutely nothing in H.R. 5 that guarantees a reduction in medical malpractice premiums. There is not one line to require that the medical malpractice insurance industry—in exchange for capping their liability—return those savings to doctors and other providers they insure through lower malpractice premiums. To quote one of many economists on this matter, Frank A. Sloan, an economics professor from Duke, recently said, "If anyone thinks caps on pain and suffering are going to work miracles overnight, they're wrong." In fact, the outcome of this bill could have zero impact on lowering malpractice premiums and instead go into the pocketbooks of the for-profit medical malpractice industry. Of course, the bill's proponents avoid mentioning that very real possibility.

Proponents of this bill like to say that they are taking California's successful medical malpractice laws and putting them into effect for the nation. This is also hyperbole. California did not simply institute a $250,000 cap on medical malpractice awards. The much more important thing that California did was to institute unprecedented regulation of the medical malpractice insurance industry. This regulation limits annual increases in premiums and provides the Insurance Commissioner with the power and the tools to disapprove increases proposed by the insurance industry. It is this insurance regulation that has maintained lower medical malpractice premiums. Yet the bill before us does absolutely nothing to regulate the insurance industry at all.

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 can be attributed to medical malpractice costs—that's one half of one percent. So, supporters are spreading false hope that capping medical malpractice awards will reduce the cost of health care in our country by any measurable amount. It won't.

What supporters of this bill really 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 reasonably compensate victims for the harm that has been done to them.

H.R. 5 caps non-economic damages. By setting an arbitrary $250,000 cap on this portion of an award, the table is titled 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 artificially and arbitrarily lower awards for those without tremendous earning potential. This means that a housewife or a senior would get less than 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.

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.

This Congress has been unable to pass a Patients' Bill of Rights to protect the rights of patients enrolled in managed care plans. Thankfully states have not been similarly immobile. They have moved ahead and enacted numerous laws to hold HMOs and other health plans accountable for the care they provide to patients—and any harm they may cause in that process. My home state of California has enacted strong legislation in this regard. If H.R. 5 becomes law, those laws will be overridden. It is not just consumer advocates who

are concerned about this. Steven Thompson, lobbyist for the California Medical Association, was recently quoted in the Sacramento Bee as saying, ''The California law we supported was intended to protect doctors and hospitals—people who deliver care, but the health plans would benefit from the way the House bill is laid out.'' In other words, this bill is anti-Patients' Bill of Rights. Despite years of fighting in Congress to hold health plans accountable for their abuses, this bill actually protects them! I will not support any bill that precludes states from moving ahead to protect consumers—especially when Congress has proved incapable of addressing their needs.

The issue of rising malpractice insurance costs is a real concern. I support efforts by Congress to address that problem. That's why I would have voted for the Democratic alternative legislation that Representatives CONYERS and DINGELL brought to the Rules Committee last night. Unlike H.R. 5, the Dingell-Conyers alternative would not benefit the malpractice insurance industry at the expense of America's patients. Instead, it addresses the need for medical malpractice insurance reform—learning from the experience of California—to rein in increasing medical malpractice premiums. Rather than enforcing an arbitrary $250,000 cap, the bill makes reasonable tort reforms that address the problems in the malpractice arena—penalties for frivolous lawsuits and enacting mandatory mediation to attempt to resolve cases before they go to court. It also requires the insurance industry to project the savings from these reforms and to dedicate these savings to reduced medical malpractice premiums for providers. The Dingell-Conyers bill (H.R. 1219) is a real medical malpractice reform bill that works for doctors and patients alike.

The Democratic alternative bill is such a good bill that the Republican leadership refused to let it be considered on the House floor today. They were afraid that if Members were given a choice between these two bills, they would have voted for the Democratic bill. Once again the House Republican leadership has used their power to control the rules to stymie democratic debate.

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 provides vital patient 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. LANGEVIN. Mr. Speaker, I rise today in strong opposition to H.R. 5, the Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act, because this unhealthy act would severely limit patients' rights to sue for medical injuries while having virtually no impact on the affordability of malpractice insurance coverage. Because there is no provision in this measure requiring insurers to lower their rates once these so-called reforms are in place, it would leave countless patients deprived of relief while failing completely to help our struggling health providers.

Like many of my colleagues, I am deeply troubled by the rising cost of malpractice insurance. Doctors across the country are being adversely affected by an increase in medical liability insurance premiums. These increases are making it more costly for physicians to practice, and rising insurance rates could eventually mean that patients no longer will have easy access to medical care. Doctors completing residencies in expensive areas are seeking better rates elsewhere, and physicians already in the market are leaving.

There is wide agreement that something must be done to ensure reasonable rates and protect access to health care. Unfortunately, nothing in this legislation would decrease premium costs or increase the availability of medical malpractice insurance. Instead, it would make detrimental changes to the health care liability system that would extend beyond malpractice and compromise the ability of patients and other health care consumers to hold pharmaceutical companies, HMO's and health care and medical products providers accountable.

For example, the three-year statute of limitations on malpractice suits contained in this legislation is more restrictive than most state laws, and could cut off legitimate claims involving diseases with long incubation periods. Thus, a person who contracted HIV through a negligent transfusion but learned of the disease more than three years after the procedure would be barred from filing a claim.

In addition, H.R. 5 would arbitrarily limit non-economic damages to $250,000 in the aggregate, regardless of the number of parties against whom the action is brought. This cap would hurt patients like Linda McDougal, whose breasts were needlessly amputated due to a doctor's carelessness, and Jesica Santillan, who died after her doctor transplanted organs with an incorrect blood type into her body. It would disproportionately impact women, children, elderly and disabled individuals and others who may not have significant economic losses from lost wages or other factors but are still suffering very real injuries, such as the loss of a limb, pain and disfigurement, the loss of hearing or sight, or the loss of mobility or fertility. Surely, the impact of these injuries on their lives cannot be quantified at less than $250,000.

As an individual who was paralyzed at the age of sixteen when a police officer's gun accidentally discharged and severed my spine, I find this provision particularly offensive and callous. After my accident, my medical expenses were outrageously high, and amounted to more than most people make in a year. Although there is no amount of money that can ever return what was taken from me, I was awarded non-economic damages in the lawsuit my family filed shortly after my accident. Granted, my condition was not the result of medical malpractice, but had the non-economic damages in my case been capped, my life would have been profoundly affected because I would not have been fully compensated for my future health care needs. Likewise, I would not have been afforded the opportunity to attend college or had the hope of beginning a new life. While our civil justice system has determined that it is the injured party who deserves the greatest measure of protection, I find it a great disappointment that attempts to limit remuneration to victims of malpractice still persist.

In 1976, California enacted the Medical Injury Compensation Reform Act, MICRA, which limits non-economic damages to $250,000, and is similar to the cap being proposed in this legislation. However, in the twelve years following the enactment of MICRA, California's medical malpractice liability premiums actually increased by 190 percent. It took enactment of insurance reform in 1988 that mandated a 20 percent rate rollback to finally lower and stabilize malpractice premium rates. It is important to note, however, that California's rates are no lower than the national average. Moreover, California's 1976 cap on non-economic damages is now worth only $40,389, in 2002 dollars. As a result, a patient would need to recover $1,547,461 in 2002 for the equivalent medical purchasing power of $250,000 in 1976.

Further, H.R. 5 would completely eliminate joint liability for economic and non-economic loss, preventing many injured patients from being compensated fully. Joint liability enables an individual to bring one lawsuit against multiple entities responsible for practicing unsafe medicine or manufacturing a dangerous, defective product and have the defendants apportion fault among them, if the jury finds for the plaintiff.

Rather, our top priority in reforming America's health-care system should be reducing the shameful number of preventable medical errors that kill nearly 100,000 hospital patients a year—the equivalent of three fatal plane crashes every two days. In fact, only five percent of doctors account for 54 percent of malpractice payments. Earlier this year, the New England Journal of Medicine reported that surgical teams leave clamps, sponges and other tools inside about 1,500 patients nationwide each year. Making it more difficult for these victims to seek compensation will not lead to safer medicine; it will only protect egregious medical malpractice behavior.

Moreover, there is no evidence that the tort reforms proposed in H.R. 5 would guarantee a decrease in insurance rates. In fact, the average liability premium for both internal medicine and general surgery in 2001 was actually higher in states with caps on damages than in states without caps. The proponents of this measure claim that limiting ''frivolous lawsuits'' will lower premiums. However, a study that appeared in the New England Journal of Medicine in 1991 concluded that only about 2 percent of those injured by physicians' negligence ever seek compensation through a lawsuit. Recent studies show that this figure remains unchanged. That means that even completely eliminating medical liability would have virtually no impact on the cost of health care. Do we need to find a way to lower insurance and health care costs? Absolutely. Is H.R. 5 the way to do it? Absolutely not.

Instead, I plan to support the Democratic motion to recommit, which would allow patients to seek redress and provide assistance to physicians and hospitals in need. Specifically, this alternative would end frivolous lawsuits by requiring affidavits to be filed by qualified specialists certifying that the case is meritorious. It would also establish an independent advisory commission to explore the impact of malpractice insurance rates, particularly in areas where health care providers are lacking. Again, I would urge my colleagues to oppose the underlying bill, and to support the Democratic alternative.

Mr. EVANS. Mr. Speaker, in my tenure in Congress, I have been dedicated to reforming many aspects of the health care system to

promote the highest quality health care benefiting the greatest number of Americans. Mr. Speaker, I do not believe that the HEALTH Act would contribute to this goal.

This legislation blatantly advances the political agenda of the insurance companies. It does nothing to address the looming health care crisis we face where over 40 million Americans are without health insurance, access to quality care, or an ability to afford even basic screenings and medicines. This legislation would place a $250,000 limit on non-economic damages in malpractice suites brought against medical professionals. I cannot support limiting non-economic damages awards because I do not believe we have the authority to place an arbitrary dollar amount on the value of a person's health or life.

These payments compensate patients for very egregious injuries, such as the loss of a limb, vision impairment, and infertility. The loss of a child or spouse can also fall under the limiting category of non-economic damages. These damages are so wide and varying that a one-size-fits-all approach just will not suffice. Further, limiting payments would disproportionately affect women, children, the elderly, the disabled and others that may have endured indescribable suffering, yet cannot claim a loss of wages or salary. To limit payments on meritorious cases involving legitimately injured patients is a step in the wrong direction for both the best interests of patients and for the discussion on truly lowering malpractice insurance costs.

I do not believe that this legislation is particularly effective. These severe limitations would do little to lower insurance rates. For example, California, which has an equivalent cap on non-economic damages, has medical malpractice rates that are 19 percent higher than the countrywide average. It is crucial that a number of factors must be addressed to find an acceptable, working solution to this problem.

I support the alternative bill on which the Republican Congress refused to allow us to deliberate. That we are not allowed to debate on the Democratic alternative erodes the democratic process of which our government was founded and of which rules this House.

The Conyers-Dingell substitute would repeal the federal anti-trust exemption for medical malpractice insurance. This would increase competition and lower premium costs. The bill I support reduces the amount of frivolous lawsuits filed by providing severe penalties to lawyers who submit cases either without certification of merit or with a false certification of merit. I find the mandatory mediation provision in the Democratic substitute to be especially pertinent and of tantamount importance in approaching a viable solution to this complex problem. Mediation and the establishment of an alternative dispute resolution system will allow both defendants to reduce their litigation costs and victims to gain fair compensation.

I urge my colleagues to vote down H.R. 5 and demonstrate their support for a Democratic alternative which will truly begin to curtail ghastly expensive medical malpractice insurance costs.

Mrs. CHRISTENSEN. Mr. Speaker, H.R. 5 is but another wolf in lamb's clothing pretending to help doctors and patients, but really only helping the large healthcare corporations while doing nothing to help lift the malpractice burden from doctors and other providers or to ensure fair treatment to their patients. Health care professionals need to see through this sham.

I am a family physician. I see my classmates and other doctors, excellent ones, many who have never been sued, struggling to keep their offices open under the pressure of outrageously high malpractice insurance premiums. Physicians are desperate for relief from their premiums. Unfortunately, the organizations representing physicians have been strongly supporting H.R. 5 possibly thinking that it is the best they can get, but it is not.

It is truly a disservice to all of us that the Conyers-Dingell bill was not allowed consideration and debate. H.R. 5 does not even compare and is a poor attempt at a solution to this complicated problem.

In fact, H.R. 5 is not of any help at all as has been proven in several states. This is politics and special interest legislation pure and simple, and our patients and us should not be the pawns in this game.

This bill is another assault on the poor and minorities as well because regardless of their needs their awards will be capped at low levels. The cornerstone of H.R. 5 is a $250,000 cap on non-economic damages modeled after the arbitrary $250,000 cap instituted in MICRA. Compensation for economic damages for minorities is often much less than those awarded to white males, and $250,000 in 1975 is the equivalent of $855,018 in 2003. H.R. 5 puts values on human life and suffering that none of us can measure. H.R. 5's severely restricted the statute of limitations would further hurt minorities because they often have less exposure or access to medical care which causes them to often discover their injuries later.

What my physician colleagues and all health providers need is real reform. We need to address all of the factors that cause the rise in premiums. We need to create legislation that includes the measures which have worked in the states that have successfully addressed this issue and brought relief to their health providers. H.R. 5 doesn't do any of this.

I call on my colleagues to defeat this bill, and then join with our colleagues JOHN CONYERS and JOHN DINGELL to pass a bill that incorporates the measures that will most effectively reduce premiums, and bring relief not to HMO's, but to those who really need it, the health professionals and the patients who depend on their services.

Mr. BLUMENAUER. Mr. Speaker, I am convinced action is needed to stabilize the delivery of health care, particularly for small communities and for medical specialties plagued by extraordinarily high premium rates. It is unacceptable to have prices spiraling so out of control that care is prohibitive for many doctors and patients. I am open to a range of alternatives to provide a long-term solution. This bill focuses only on capping damages to lower premiums, siting California's MICRA legislation as its model. Unfortunately, it ignores the other methods used in California, which may have had more impact over the long-term. The cap is eroding patients' rights by failing to provide for inflation and H.R. 5 suffers the same flaw.

The Republican alternative is simply an attempt to provide a partisan political response, rather than a serious effort at bipartisan legislative action. This bill is being rushed through the legislative process without an opportunity for amendment and with little relationship to the proposal that is likely to emerge from the Senate. Last fall, I voted against the same bill when it came to the floor. Unfortunately, the Republican proposal is still just a bargaining position, not a legislative solution.

It's very unlikely that this bill will be enacted into law, and if it was, it would be highly unfair to the people that I represent. I will continue to work with physicians and others in the health care community, and those who are involved and interested in patients' rights. We've missed an opportunity to advance more carefully crafted bipartisan solutions at this juncture, but there will be a time to do so in the future, and I look forward to participating in that fashion.

Mrs. BONO. Mr. Speaker, I rise today in support of H.R. 5 and the physicians that work tirelessly to care for the sick and injured.

I have witnessed first-hand the crux of the issue about which we debate today. My father worked as an ENT surgeon for 19 years in Southern California, both before and after California's MICRA law was enacted. He has also helped me to better understand the issues that those in private practice face and we both have an appreciation for the problems our doctors face. Living in Southern California my entire life has also allowed me to witness the changes that have taken place with regard to medical liability reform.

Numerous doctors from Southern California have contacted me about the benefit that they have seen from the liability laws that exist in our state and realize how much it has affected their ability to treat more patients effectively. Still, other states are witnessing a serious reduction in care, particularly in vital specialities including those that affect expectant mothers.

We face a vote today on an issue that centers on the ability of our doctors to practice the science that saves lives daily in our country. Currently physicians in many states face the reality of not being able to keep their practice running. Our problems cannot be solved by the trend of defensive medicine, as they can only lead to higher costs to the patient, the insurer, and the doctor. The ultimate price is paid when a defensive procedure costs not only money but the life of a patient.

It is unfortunate that many frame this debate in terms of political ideology. How can we continue to demoralize our doctors from working in the field that they love and providing care for those who are suffering? H.R. 5 is about tempering skyrocketing insurance premiums across the country. H.R. 5 is about providing real access to care and the continued ability for our health care system to run effectively in times of state and national budget deficits.

But, most importantly, Mr. Speaker, H.R. 5 is about allowing our doctors to help millions of people every year in the practice that they know better than any trial lawyer or bureaucrat in Washington, DC.

Mr. Speaker, I encourage my colleagues to support H.R. 5.

Mr. TOM DAVIS of Virginia. Mr. Speaker, I rise in strong support of H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act. I would also like to thank Chairman TAUZIN for his excellent work on this vital subject.

Mr. Speaker, it is unfortunate that we have to take this action today. I am a firm believer that everyone should have their day in court if they feel they have been wronged. However,

inherent in this right is the assumption, if not the obligation, that this course of action will be used judiciously. However, that is not what has occurred. Medical malpractice litigation has become an industry in and of itself, with trial lawyers seeking out sympathetic courtrooms and juries where frivolous claims will be given undue credence. The courts should be forums to redress wrongs, not lotteries.

We are now reaping the results of this litigious behavior, and the main result is that patients no longer have access to the healthcare they always assumed would be there. Doctors are leaving the communities they have served for decades. Try to get pre-natal care in Las Vegas. Try to see a neurosurgeon in Mississippi. They aren't there anymore. We have seen the doctors in West Virginia and New Jersey actually go on strike to protest the absurd rise in malpractice premiums due to frivolous lawsuits. I have spoken to doctors in my district that simply cannot afford their malpractice premiums anymore, and they are looking to us for help. We can have it one way or the other—we can continue on the current path, where every visit to the doctor is seen as a potential windfall, or we can take these necessary actions to return an element of sanity to the malpractice equation.

I support H.R. 5 because I believe it will ultimately allow many doctors to continue practicing medicine, and thus ensure our constituents continue to have access to the care they need. This legislation does not let anybody off the hook—bad doctors will still be held accountable for their actions and patients injured through negligence will still have fair recourse. It simply prevents the trial bar from completely ruining our health care system. I urge my colleagues to give H.R. 5 their support.

Mr. BACHUS, Mr. Speaker, under Alabama law, punitive damages are the only damages available in wrongful death actions. Therefore, under H.R. 5, absence action by the Alabama Legislature, the maximum recovery for wrongful death (of, say, a 30-year-old father of three) resulting from medical malpractice would be limited to (no more than) $250,000. In good faith, I could not support such a result.

Mrs. JONES of Ohio. Mr. Speaker, this past December in West Virginia, doctors at four hospitals went on a 30-day strike to protest climbing malpractice insurance rates. Following, in January 2003, Pennsylvania narrowly averted a strike only after a last-minute deal was made between the doctors and then governor-elect Ed Rendell. Similar occurrences in other states have made me shudder about the possibilities of similar events occurring in Northeast Ohio. The Cleveland Clinic, University Hospitals, and their affiliates serve as Ohio's premier medical facilities and I recognize the value that professionals working at those institutions provide to the Greater Cleveland community. Recent editorials in newspapers across the country have highlighted the frustrations experienced by medical professionals. These serve as a sounding call to Congress to readdress tort reform and medical malpractice.

Although I am greatly concerned about the rising costs of insurance premiums, especially for certain high-risk medical procedures, and the subsequent decline in the availability of health care that results from doctors retiring or moving their practices, I am not convinced that tort reform is the panacea to the spiraling increase in medical malpractice premiums. Studies and anecdotal evidence clearly show an absence of correlation.

In 1995, Texas passed a series of tort law restrictions that advocates claimed would lower the cost of insurance in Texas by $864 million a year. Legislation was also passed mandating that any savings from such tort law restrictions be passed on to consumers. Despite claims made by proponents of the legislation, overall insurance premium savings in Texas, including any that might be attributed to changes in tort law, have been minimal. Yet since that legislation was passed, insurance company profits have skyrocketed in Texas. This pattern has been evident in several other states that have initiated tort reform legislation.

In March 2002, the American Insurance Association (AIA) commented that lawmakers who enact tort reform should not expect insurance rates to drop further. The AIA is a major trade group of the insurance industry and their comment strengthens my belief that tort reform is not the solution to higher insurance premiums. Furthermore, in a response to a study by the Center for Justice & Democracy, the AIA stated, ''the insurance industry never promised that tort reform would achieve specific premium savings.''

Although I am troubled by the possibility of insurers not issuing policies to medical practitioners in Ohio, it would be a mistake to simply credit lack of tort reform as the reason. For example, Missouri found itself in a similar situation several years ago and instituted tort reform legislation in the form of caps on non-economic damages for medical malpractice suits. Yet Missouri continues to have fewer insurers offering services to doctors. In addition, insurance companies that issue policies have not lowered premiums and have continued to enjoy hefty profits.

Differences in the price of identical policies between different states can be attributed to factors other than whether that state has enacted tort reform measures. For example, comparable premiums in Ohio are lower in California primarily due to the fact that California has one of the strictest sets of insurance regulations in the nation as a result of Proposition 103.

Tort reform advocates often call for caps on punitive damages and pain and suffering awards as one of their top priorities. These calls are usually accompanied by citing some of the outrageously high verdicts awarded to plaintiffs. But they neglect to cite the fact that judges often exercise their authority to reduce these verdicts or that they are reduced in the appeals process. Further, calls for tort reform are often just a form of scorn toward trial lawyers who may receive fees of between 30 and 40 percent of verdict amounts. But those advocates fail to note that trial lawyers typically take cases knowing that they could lose—and not receive any compensation for their work.

Finally, the tort reform argument often neglects to mention an important party in any malpractice suit—the injured plaintiffs or their families. A recent report by the Institute of Medicine estimates that as many as 98,000 hospitalized Americans die each year as a result of medical errors. This is more than the number of deaths attributable to breast cancer or car accidents. Tort reform advocates, in their zeal to denounce trial lawyers and boost insurance company premiums, are tacitly saying that grievously injured victims of medical errors or their families deserve only minimal compensation for their injuries. Passage HR 5 will have an arbitrary and cruel effect on legitimate victims of medical malpractice.

Since 1994, the House of Representatives have passed bills limiting malpractice awards. Some of these bills take the further step of removing state malpractice claims into the Federal courts. Each time, however, these bills have failed to get the 60 Senate votes necessary for passage. As expected this issue has arisen with full force in the 108th Congress. Yet the facts remain the same: This legislation neglects plaintiffs' rights, limits state trial court judges' discretion, and fails to show any tangible net benefit to doctors who purchase premiums while simultaneously result in higher profits for insurance companies.

Rather than focusing on implementing malpractice caps legislation that will not solve the problem of rising premium rates, Congress (and doctors and their regulatory boards) should be more vigilant in enforcing laws that cap the numbers of hours worked by residents (fatigue is often cited as a major contributor to medical errors), adopting a uniform system for reporting and analyzing errors nationwide, and coordinating patients records (while taking care to protect privacy) so that doctors can easily gain access to a patient's complete medical history.

But while I cast my vote against H.R. 5, I remain committed to ensuring that the medical practitioners and facilities in this country remain a viable part of their communities' health care system. My alarm at the possibility of a medical practitioner talent drain caused by ever increasing medical malpractice premiums is real but I am committed to the conclusion that federal tort reform is not the solution.

Ms. LINDA SÁCHEZ of California. Mr. Speaker, I rise in opposition to H.R. 5 and to the rule that cut off any debate on a highly controversial bill with far-reaching consequences. The Majority has refused to permit consideration of any amendments whatsoever, going so far as to deny Democrats the opportunity to offer a substitute to the underlying bill.

There is no doubt that most Americans have a real problem accessing affordable health care. And it is true that we have some serious problems keeping specialists in practice and keeping trauma centers open. However, in seeking to address these problems, my Republican colleagues have come up with H.R. 5, a bill that caps a medical malpractice victim's recovery.

H.R. 5 is a deplorable bill. It is the most simplistic and useless method for addressing very real problems with our medical community. It is a ridiculous piece of legislation that is akin to trying to put out a forest fire with a squirt gun.

Supposedly, the goal of H.R. 5 is to stabilize medical malpractice insurance rates. But contrary to my colleagues' assertions, placing a cap on victim's recovery will not magically keep medical malpractice insurance rates from rising. It will not keep trauma centers from closing. It will keep specialists practicing medicine.

H.R. 5 only focuses on restricting injured patients' access to justice. H.R. 5 is modeled after California's Medical Injury Compensation Reform Act, known as ''MICRA''. My Republican colleagues love to sing the praises of MICRA.

However, as a Representative from California, I happen to know a lot about MICRA.

MICRA's caps on pain and suffering damages have not reduced insurance rates for doctors in my state. MICRA was signed into law in 1975, but stability in medical malpractice insurance rates did not occur after MICRA was passed. Between 1975 and 1993, in fact, health care costs in California rose 343 percent, nearly twice the rate of inflation. Not only that, but the California costs exceeded the national average each year during that period by an average of 9 percent per year.

Any rate stabilization that has occurred in California is not due to caps, but to Proposition 103, which went into effect in 1990. Proposition 103 was an insurance reform initiative that changed California's insurance laws from a so-called ''open competition'' to a ''prior approval'' regulatory system. Prop. 103 requires insurers to obtain approval of rate increases. But even with enactment of Proposition 103, rates in California have stayed close to national premium trends.

Medical malpractice insurance rate hikes are cyclical. They tend to be at their highest when insurance companies' investment income is at its lowest. Tort caps have not and do not eliminate this cyclical pattern.

I'm not the only one who has said that tort caps alone will not lower insurance rates. I would like to quote just a few other individuals who have made similar statements:

> ''Insurers never promised that tort reform would achieve specific savings.''—American Insurance Association
>
> ''We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.''—Sherman Joyce, president of the American Tort Reform Association
>
> ''Many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years.''—Victor Schwartz, general counsel to the American Tort Reform Association

Insurance companies are reluctant to look at any role they may play in the increasing liability insurance rates. Yet, their investment practices have made it nearly impossible for them to balance paid claims with premiums. Capping damages for plaintiffs is only one part of the stabilization equation. In order to bring about true stabilization, we must reform the insurance industry.

H.R. 5, without insurance reform is meaningless. H.R. 5 simply re-injures the legitimate victims of medical malpractice.

Had we been given the opportunity, Democrats would have offered a substitute crafted by Representative DINGELL and CONYERS. That substitute takes concrete steps to eliminating frivolous lawsuits. It requires insurance companies to share their savings with doctors and patients. It evaluates the causes of insurance rate increases and proposes solutions. In short, it seeks to deal with the problem of rising medical malpractice insurance rates by addressing all aspects of the problem—insurance companies, doctors, patients, and the tort system. It would have been the comprehensive and fair way of fighting the real problem. This legislation would have prevented the forest fire before it began.

The Members of this House—and the general American public—deserve the opportunity to consider a real proposal to address the medical malpractice insurance rate crisis. I urge a no vote on this rule.

Mr. UDALL of Colorado. Mr. Speaker, I regret that I cannot support this legislation.

I do think that high premiums for malpractice insurance are a serious problem for doctors in many states. And I agree with the bill's supporters that this is a problem for those who need medical services, because it tends to make health care less available.

I would like to do something about that problem—but I think that if Congress is going to act, it should do so in a way that is both better balanced and better focused than the bill the House is debating today.

The need for balance and focus is all the greater when Congress considers legislation that would apply everywhere and would override a number of different State laws, including laws related to the relations between Health Maintenance Organizations (HMOs) and individual patients.

Over the years, many of our colleagues—particularly those on the other side of the aisle—have been outspoken about the problems associated with that kind of top-down, one-size fits-all approach to a problem that can be addressed by State legislators who are in a better position to respond to the particular circumstances of their constituents.

I haven't always agreed with those criticisms, but in this case I think they are appropriate.

For example, Colorado law places limits on the amounts that can be awarded in some lawsuits against doctors. I do not think the Colorado law is perfect, but I do think that our legislature is in a better position to judge such matters than the Congress—especially when we are forced to act under the kind of restrictive rules the one that applies to this bill.

I hoped the Republican leadership would let the House consider amendments that could have made this bill more effective and better balanced. However, that did not happen, and now we are forced with a take-it-or-leave it choice—a ''my way or the highway'' approach to legislating that is unworthy of this House.

Under those circumstances, and after careful consideration, I have decided I cannot support the bill. I am not persuaded that it will have a significant effect on the premiums doctors have to pay for malpractice insurance—or at least an effect great enough to warrant the reduction in the ability of injured people to win redress of their damages.

We have heard much about ''frivolous'' lawsuits—and I think there really are some. But not every lawsuit is frivolous—some are well-founded, because sometimes people really are hurt by negligence or other improper conduct. If I were persuaded that this bill struck the right balance, reducing the risks of frivolous lawsuits without unduly affecting the others—and if I were persuaded that as a result escalating insurance premiums would be effectively restrained—I would support it.

But as it is, I am not persuaded of those things and so, given the sole choice of a yes or no vote, I must regretfully vote no.

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 women unable to find a qualified obstetrician in their city. Therefore, I am pleased to see Congress address this problem.

However this bill raises several questions 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. 5 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, buy will certainly benefit the patients and physicians, which both sides in this debate claim to represent.

H.R. 5 does contain some positive elements. For example, the language limiting joint and several liabilities to the percentage of damage someone actually caused, is a reform I have long championed. However, Mr. Speaker, H.R. 5 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. Ironically, H.R. 5 actually increases the risk of frivolous litigation in some states by lengthening the statue 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. 5 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. 5 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 no reason why questions of the assessment of liability and compensation cannot be determined by a private contractual agreement between physicians and patients.

I have introduced the Freedom from Unnecessary Litigation Act (H.R. 1249). H.R. 1249 provides 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, such as my Quality Health Care Coalition Act (H.R. 1247), 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 losses in the stock market.

In conclusion, Mr. Speaker, while I support the efforts of the sponsors of H.R. 5 to address the crisis in health care caused by excessive malpractice litigation and insurance premiums, I cannot support this bill. H.R. 5 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. STRICKLAND. Mr. Speaker, I speak on the floor today in opposition to H.R. 5 and in opposition to the closed rule under which we are debating the bill.

I have heard from doctors and hospitals throughout my district that they are struggling with high malpractice rates. I think we all recognize that this is a big problem in many regions of the country, and I believe we must take action to ensure patients can continue to access quality and timely health care. In my rural Ohio district, access to care is a constant problem for many of my constituents. I hear the voices of the family practice physicians who tell me they no longer may be able to afford to deliver babies. In some cases in Ohio, pregnant women must travel long distances for prenatal care and delivery services because there is only one doctor providing these services throughout a county. Something must be done, but I do not think H.R. 5 gets it done.

These are the reasons I have cosponsored H.R. 1124, which has been introduced by Rep. DINGELL. H.R. 1124 would address high malpractice rates through moderate tort reforms, requiring attorneys to submit a certificate of merit declaring a case to be meritorious, and requiring medical malpractice insurance companies to dedicate at least 50 percent of the savings from these tort reforms to reducing the insurance premiums paid by physicians and other health professionals. In addition, H.R. 1124 attempts to look at the broad issues that may have contributed to the high malpractice rates doctors across the country are facing by establishing an independent advisory commission on medical malpractice insurance. I wish Congress had acted quickly and in a bipartisan fashion last year—had we done so, we may already have more answers about why rates are now as high as they are. And finally, H.R. 1124 would create a grants program through the Department of Health and Human Services to ensure that areas affected by high malpractice rates do not suffer a shortage of providers. However, we will not even hear debate about these provisions or others because the Leadership passed a closed rule that limits debate to the base bill. This does a disservice to the American people, to the House, and to the health care providers we want to help.

I believe H.R. 5 will not address the high malpractice rates our doctors are confronting. H.R. 5 fails to address or even acknowledge the complicated nature of this problem: my colleagues who have introduced H.R. 5 haven't considered how the insurance industry may have contributed to the high rates or considered how individual states' systems have affected malpractice rates.

Throughout the Energy and Commerce Committee's consideration of H.R. 5, I spoke about two provisions in H.R. 5 that I strongly oppose.

First, H.R. 5 would limit the liability of HMO's, drug companies, and nursing homes. These companies have never come to me to explain why their liability should be limited; in fact, I strongly believe consumers should have the right to use every tool possible to collect damages if they are injured by a drug or device company whose product is defective. My constituents have access to prescription drugs—the drugs are there in the pharmacy, ready to be purchased, and the drug companies aren't going out of business. Unfortunately, many of my constituents, especially seniors, can't afford to pay the prices these companies are charging. Since the drug companies are doing quite well, I think it's safe to say that they don't need the further protections H.R. 5 would afford them.

Second, I cannot support H.R. 5 because of its $250,000 limit on noneconomic damages. Noneconomic damages are awarded by a jury to compensate a victim for intangible pain and suffering. These noneconomic damages compensate for real, permanent harms that are not easily measured in terms of money, including blindness, physical disfigurement, loss of fertility, loss of limb, loss of mobility, and the loss of a child.

Noneconomic damages are often very important to low income adults, women, and children who often would not recover a large economic damage award when they are injured. In addition, someone whose injury is purely cosmetic may not have economic damages because the injury doesn't directly affect his or her ability to work. For example, the facial disfiguration 17-year-old Heather Lewinski has had to live with for the past 9 years because when she was 8 years old a plastic surgeon committed clear malpractice and scarred her for life. The years of pain and suffering Heather has lived with and testified to before the Energy and Commerce Committee two weeks ago are real. Heather's lawsuit against the plastic surgeon who injured her resulted in zero economic damages, but she did receive compensation in the form of noneconomic damages. H.R. 5 would have limited her award to $250,000. I cannot vote for legislation that would arbitrarily limit the damages that might be so important to the average American who finds themselves injured through medical malpractice. Although proponents of H.R. 5 contend that the bill will limit frivolous lawsuits, I believe it will not do so; instead, this provision would arbitrarily cap meritorious claims of malpractice.

I ask my colleagues: if we trust our jury system to make decisions about life and death, I believe we must be able to trust that jury system to make decisions about money.

The increase in malpractice rates is a huge problem for doctors and hospitals, and that is why I wish this bill had been crafted with input from the leaders of both parties. At the least, I wish we had the benefit of an open rule that would allow real debate here on the floor. I will not support this bill because I think it fails to prevent frivolous lawsuits, fails to address the problems with the insurance industry, and fails to provide direct relief to communities that are struggling with access problems resulting from high malpractice rates.

Mr. SHAYS. Mr. Speaker, I rise in support of the medical malpractice reforms contained in H.R. 5, the HEALTH Act. This legislation will help prevent frivolous litigation and significantly limit the practice of ''defensive medicine,'' which has contributed to spiraling health care costs.

H.R. 5 caps noneconomic at $250,000, but doesn't place any limit on the economic damages which plaintiffs can recover. Excessive jury awards have driven the cost of health care up for everyone, so in my mind, there has to be a limit on how much juries can award victims in non-economic and punitive damages. The HEALTH Act is critical to retarding the explosion in health costs and making insurance more affordable to the 41 million Americans who lack it.

The dramatic increases in insurance rates which many physicians have experienced over the past year also prevent them from actually practicing medicine. Many physicians I have spoken to are at wits' end trying to figure out how to maintain their practice and pay these exorbitant costs.

On March 4, the American Medical Association added Connecticut to the list of states facing crises in their medical malpractice insurance rates. The organization also cited Connecticut as a state where a large number of physicians have ended their practices because of the high medical malpractice insurance rates.

These malpractice reforms, which are based on a proven California law, will make much-needed changes to the federal civil justice system without denying the legal rights of legitimate plaintiffs. It is imperative we move forward on this reform to discourage abuse of

our legal system and curb the unsustainable growth of medical costs in our country.

Mr. Speaker, I strongly support the HEALTH Act because it will bring meaningful reform to a flawed system. I urge my colleagues to vote for this legislation.

Ms. KILPATRICK. Mr. Speaker, H.R. 5 is the Republican's quick fix to the health care crisis across the nation. They address the problem of increased insurance cost for medical malpractice, but have proposed a contorted theory for fixing it. An in-depth look at H.R. 5 shows that it does absolutely nothing to implement ways to decrease insurance premium costs, and furthermore, it does initiate means to increase the availability of medical malpractice insurance. For the foregoing reasons, I voted ''no'' on this passage.

H.R. 5 will limit the amount of non-economic damages that a patient can recover in a malpractice suit and it sets a bar for punitive damage recovery that is nearly impossible to reach. Overall, this bill limits the amount of recovery for all patients by providing a one-size-fits-all solution. How can we limit what a jury can award to an individual who has lost her/his right to reproduce because of a doctor's or medical manufacturer's negligence? How can we limit damage awards to an individual who has been paralyzed as a result of their negligence? How can we set a standard that is so difficult to meet that it will reduce the opportunity that plaintiffs will have to punish these defendants for their malicious acts? H.R. 5 is moving away from fixing the crisis in our health care industry and leaning towards making it worse by essentially punishing the victims.

Mr. Speaker, we need a bill that acts fast to help doctors and the medical industry sustain themselves financially. Right now, as we debate H.R. 5, thousands of doctors are leaving their respective states because they cannot afford the high insurance premiums. Doctors are now taking on much heavier loads of patients, much more than some of them can handle. To such as extent, some say that their situation is ripe for potential negligence cases, as they are not able to devote the attention necessary for the patient. They need our help now, Mr. Speaker, and we cannot change their situation by selling unfounded limits on non-economic damages.

Additionally, we must work to curb rogues from bringing fraudulent malpractice claims that flood our courtrooms, which are factored into the issue of high insurance premiums. For example, we should not prohibit a justified victim from receiving $750,000 in non-economic damages, but rather, we should aim to deter those rogues from each bringing fraudulent claims for non-economic damages worth $250,000. H.R. 5 does not provide for any differentiation between legitimate claims and the many unwarranted claims that bring a halt to judicial economy every day.

The Democratic substitute is superior because it would have sought and punished rogues for bringing fraudulent cases. It would not have capped non-economic damages or punitive damages. The substitute commissioned a study to assess the medical malpractice issue and determine how we can better address and then eliminate the problem. As for the current crisis, the substitute would authorize the Department of Health and Human Services (HHS) to provide grants to geographic areas that experienced extreme shortages of health providers due to the high premiums.

Although the Democratic substitute was superior for this crisis situation, the Republicans used their control of the House to prevent the substitute from being brought to the floor for a debate, along with any amendments that Democrats would have offered. This is undemocratic and an irresponsible use of leadership. The House floor is where all members should have the opportunity to discuss various ideas, views or bills from both sides of the aisle. To preclude that possibility is undemocratic. Mr. Speaker, I do not agree with the Republicans regulation of this very important issue and I also vehemently disagree with H.R. 5.

Mr. COSTELLO. Mr. Speaker, I rise today in opposition to H.R. 5, the HEALTH Act. There is no question that medical liability insurance rates are out of control. These high insurance costs are threatening to put many doctors and other health care professionals out of business and limit access to health care. However, I cannot in good faith support legislation that limits the rights of patients, victims, and their families while protecting the health insurance industry. HMOs and big health insurers should not receive special treatment; they are not above the law and should not be exempt from responsibility through this legislation.

Under H.R. 5, insurance carriers can still raise rates any amount, at anytime. The Republican Leadership refused to allow free and fair debate by not allowing a substitute or any amendments to be debated and voted upon by the House of Representatives. The substitute would reform malpractice insurance carriers, which is essential in solving the medical liability crisis. It would also weed out frivolous lawsuits without restricting the rights of legitimate claims.

H.R. 5 is a one-size-fits-all approach that places caps on non-economic and punitive damages and does not address the issue of frivolous lawsuits. When a stay-at-home mother, child, or senior citizen dies or suffers irreversible harm, there is no economic loss because it is impossible to prove damages from loss of income. H.R. 5 takes away the rights of parents who lose children, husbands who lose wives, children who lose parents, and patients who have very real losses that are not easily measured in terms of money. These caps imposed in H.R. 5 unfairly take away the rights of victims of medical malpractice to receive compensation for their injuries.

H.R. 5 is modeled after the state of California's 1975 reform laws; however, my Republican colleagues give a false impression of the ramifications of that law. For more than a decade after California passed the 1975 law limiting damages in medical malpractice lawsuits, doctors' premiums continued to rise faster, overall, than the national rate of inflation. Once voters enacted Proposition 103, a measure to cap all insurance rates in California, premiums leveled off. The ballot initiative curbed the premiums, not the law implementing caps.

Physicians in Illinois and across the country are facing skyrocketing medical liability premiums, and for many providers, medical liability insurance is either unaffordable or completely unavailable. I believe something needs to be done to derail frivolous lawsuits and reform the insurance industry. Insurers' business practices for accounting and pricing have contributed sharply to the current problem. H.R. 5 does not reform the insurance industry, places unfair, restrictive caps on victims, and does not address frivolous lawsuits. For these reasons, I oppose H.R. 5.

Mr. GARRETT of New Jersey. Mr. Speaker, it's always easier to fix blame than to find a solution. That's certainly true when it comes to the health care accessibility crisis we have right now in America.

In state after state, including my home state of New Jersey, doctors are closing down or limiting their practices. Trauma centers are shutting their doors, and overall health care costs are rising dramatically because of medical liability problems. Who suffers? Thousands upon thousands of individual patients who need care—some who need critical care.

Rather than solve this problem, some people want to distort the facts and point fingers to serve a large political agenda. They'd sacrifice access to medical care as part of their effort to prevent tort reform of any kind.

Today, I have heard allegations that the real culprit is the lack of regulation over insurance company investment practices and pricing. As the former chairman of the New Jersey Assembly Insurance Committee, I can assure you that this is simply not the case. Insurance is a highly-regulated industry, where state insurance departments oversee nearly every aspect of the marketplace, including product pricing and insurer investment practices.

To be more specific, state insurance laws do not allow insurance companies to raise rates to make up for past investment losses. As Steve Roddenberry, a top Florida insurance official, said recently, and I quote, ''We cannot permit it.'' Furthermore, the stock market has very little influence on companies who write medical malpractice insurance. In 2001, stock market investments made up just 9 percent of the industry's portfolio. Just 9 percent.

So it's simply not true that the lack of insurance regulation is causing premium increases. But what is causing those increases?

In large part, it's because the insurers are paying out more than they're taking in. That's right—insurance is an income-and-expense business just like any other. And in today's medical malpractice marketplace, companies are being forced to spend more on claims than they can collect in premiums.

The bottom line? The average medical malpractice insurance company is paying out $1.50 for every dollar it collects. That's not a recipe for success in the business world.

And that's why we have this crisis.

As long as insurance companies, many of which, by the way, are owned directly by their insured doctors, are faced with these losing scenarios, pressures on rates will continue unless something is done about what causes those companies to lose money.

This leads me back to my original point. If the doctors and nurses and hospitals who care for our children, our seniors, and the neediest among us cannot afford to deliver that care, we have a much bigger problem than who's making some money in the stock market. And rather than point fingers, it's time we address the real issue of lawsuit abuse, so we can solve the problem and let the health care system start working again.

Mr. Speaker, patient access to care in jeopardized. Physicians are being forced to limit services and practice defensive medicine and patients are bearing the burden, often being

forced to travel hundreds of miles to the next available doctor in order to receive life-saving care.

I strongly encourage my follow members to pass the HEALTH Act, providing a much-needed, common sense solution toward reforming America's medical justice crisis. Together, let's ensure that patients get quality care first rather than gong to court.

Mr. DEFAZIO. Mr. Speaker, I attempted to offer three of the thirty-one amendments to H.R. 5, the HEALTH Act, last night. Inexplicably, these were disallowed out of hand.

This rule is an abuse of the process. Yes, it might be payback to the Democrats based on some revisionist history, but more importantly, it's a payoff to the Republicans' generous benefactors in the insurance industry, and through this bill, a payoff to the pharmaceutical industry.

The Republicans claim that the underlying bill, H.R. 5, will control insurance costs through so-called ''tort reform.'' This bill won't do that. In fact, in 1999, a senior executive at the American Tort Reform Association conceded that ''We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.''

This is the third crisis in medical malpractice in 25 years. Each of these ''crises'' happens to coincide with recessions, stock market downturns, and insurance industry investment losses.

The insurance industry is an equal opportunity market abuser. They legally can and regularly do collude to raise rates and limit availability of all lines of insurance. If this ''crisis'' in medical malpractice insurance is due to a malpractice crisis then why also is there a crisis in health insurance, homeowners' insurance, auto insurance, and general liability insurance? Health insurance costs are up 13 percent, homeowners insurance, 8 percent, and auto insurance, 8.5 percent. Maybe it's time the insurance industry was subject to the same laws as other industries.

Mr. Speaker, the solution that will bring relief and improve access to our nation's physicians will start with a repeal of the antitrust exemption of the insurance industry. Legislation like H.R. 5 simply allows the insurance industry to profit off the backs of both doctors and patients.

Mr. KIND. Mr. Speaker, I rise today in opposition to the HEALTH Act, H.R. 5. Although I support the concept of sensible medical malpractice laws, this bill goes too far in defending negligence and not far enough in protecting patients.

In my home state of Wisconsin, we have medical malpractice laws that work. The components of this successful law include a cap on non-economic damages of $442,000, which is indexed annually for inflation; a requirement that all providers carry malpractice insurance; and a victims' compensation fund.

The victims' compensation fund is a unique entity that has served both patients and health care providers well. The fund operates by collecting contributions from Wisconsin health care providers and paying the victims once an award has been determined. The physicians are liable only for the first $1 million in an award. If the award exceeds $1 million, the compensation fund will pay the remainder of the award.

A major problem with H.R. 5 is that it goes beyond medical malpractice law by including the provisions regarding pharmaceutical and medical devices. The bill completely exempts from liability medical device makers and distributors as well as pharmaceutical companies, as long as the product complies with FDA standards. These provisions would have no effect on medical malpractice insurance rates. Instead, they would leave victims with little recourse and render them unable to hold pharmaceutical companies and the makers of defective medical products accountable for faulty or unsafe products.

Another problem with H.R. 5 is that it overrides some state laws. While the bill would not override Wisconsin's own cap on non-economic damages, it would supersede our state laws regarding statute of limitations, attorneys' fees, and the criteria for punitive damages. This bill is a one-size fits all solution that is not right for Wisconsin.

Although I oppose H.R. 5, I agree that medical malpractice issues must be addressed. Unfortunately, H.R. 5 is modeled after California's law, not Wisconsin's statutes. The successful components of Wisconsin's medical malpractice laws could be the basis for a much better bill. I urge my colleagues to go back to the drawing board to craft a consensus piece of legislation that both protects patients and keeps physicians in business. In Wisconsin, we are proud to have laws that effectively accomplish both of these goals. These laws are threatened, however, by the current proposal. Therefore, I oppose H.R. 5.

Mr. SHAW. Mr. Speaker, I rise today in strong support of H.R. 5, the HEALTH Act. America's doctors are facing a full blown crisis. What's at stake is nothing less than the survival of the profession. What's to blame is astronomical medical liability insurance rates.

Patients have watched helplessly as physicians have had to limit services or close their doors altogether and flee the state in search of more business friendly environments. Even worse, many young people who dreamed of studying medicine are choosing not to, realizing they won't be able to reconcile their dream with the reality of making a living.

In my state of Florida, the situation is among the worst in the nation. The American Medical Association has labeled Florida as one of 19 ''in crisis'' regarding medical liability which can reach sums of over $200,000 annually. When it's easier to sue a doctor than to see a doctor, something has to be done.

We know that the reforms in the HEALTH Act will actually lower the overall cost of healthcare. Doctors, laboring under a constant fear of being sued, have a natural tendency to practice defensive medicine—ordering tests that may not be needed or refusing to perform more risky procedures. The direct cost of malpractice insurance and the indirect cost from defensive medicine raise the federal government's health care cost by at least $28 billion a year.

It is clear that the current system of dispute resolution is not working. The entire industry suffers for the few bad eggs out there. Only 5% of doctors account for more than half of all the money paid out in malpractice suits, but all doctors pay the costs in their premiums. I believe it will take reform on the federal level to get the country's health system back on course and out of the courtroom and I therefore, support the HEALTH Act. I urge a ''yes'' vote on H.R. 5.

Mr. BISHOP. Mr. Speaker, I rise today to oppose H.R. 5.

Mr. Speaker, this bill is dangerous because it proposes a one-size-fits-all limit, regardless of the circumstances. It supersedes the laws of all fifty states and will not solve the problem of high insurance costs.

The real culprit is the insurance industry. All insurance premiums—including medical malpractice, automobile and homeowner policies—have seen a drastic increase in the past few years. These increases are not unique to medical malpractice. When the stock market returns and interest rates are high, malpractice premiums go down. When investment income goes down insurance companies increase premiums and reduce coverage. This is a fabricated ''liability insurance crisis.'' What we actually have is an ''insurance malpractice crisis.''

Those who support restrictions on medical malpractice awards must explain these arbitrary limits to the parents of Jessica Santillan, the young girl who died after receiving the wrong organs from a heart and lung transplant operation at Duke University Hospital.

Because of cases like this, Congress must expand, not limit patient's rights.

This bill does not address the high cost of insurance. Instead it limits meritorious cases and valid judgments. An exhaustive study of the court system by the University of Georgia concluded that ''there is no evidence of an explosion in tort filings, and there are few signs of run-a-way juries.'' In contrast, this bill will hurt real people with real losses. I urge my colleagues to vote against this bill and defeat this fraud on the public.

Mr. CROWLEY. Mr. Speaker, a lot of people on the other side have one crucial fact wrong—capping medical malpractice awards does not mean insurance rates will fall.

I have charts here that compare the average insurance premium for states with damage caps versus the average insurance premium for states with no caps.

For OB/GYN doctors, supposedly a group especially hard hit by medical malpractice awards—we find that OB/GYNs in states without caps on damages pay $44,485 in insurance. OB/GYNs in states with caps on damages pay $43,010—a ''whopping'' 3.4 percent difference.

For general surgery doctors, they pay $26,144 in premiums if they are in a state with no caps on damages. They pay $602 more—not less—if their state caps malpractice awards.

Look, if we want to decrease medical malpractice insurance costs for doctors, then let's talk about that.

Let's talk about investigating insurance company pricing practices.

Or, if we want to cap something, then let's cap the actual problem, insurance rates.

But to put the blame for rising insurance costs on victims—that's not only cruel, it's completely false.

Mrs. MCCARTHY of New York. Mr. Speaker, I rise today in strong opposition to H.R. 5, the HEALTH Act. As a nurse, I understand all too well the high cost of malpractice insurance and I recognize the crisis this is creating in our healthcare system, particularly in areas of high-risk procedures. I want a solution to fix this problem, but H.R. 5 is not the solution to helping this crisis.

H.R. 5 will only make this crisis worse. H.R. 5 exempts HMOs, pharmaceutical companies, and the FDA from punitive damage awards.

This means that HMOs will continue to make medical decisions for patients based on what's best for their bottom line and not what is best medicine for the patients they serve. Under this legislation, a pharmaceutical company manufactures a drug or the FDA approves a product that proves to be harmful or deadly, a patient's family is limited in their recourse. After last year's Congressional debate, on the need to hold HMOs accountable for their actions I am shocked that anyone who supported the Patient's Bill of Rights can vote for this legislation.

In addition, by capping the punitive damages to $250,000, this bill unfairly penalizes children, the elderly, and mothers who stay at home since it is impossible to prove economic damages from lost wages. The only compensation these patients have is non-economic or punitive damages.

Mr. Speaker, I am appalled at the arrogance of the Republican leadership, for prohibiting Members from offering any amendments to improve this legislation in any way shape or form.

Mr. Speaker, had I been allowed to offer an amendment, I would have offered the following to improve this legislation:

Reducing frivolous lawsuits.—We need to limit the amount of time during which a patient can file a medical malpractice action to no later than three years from the date of injury, or three years from the date the patient discovers the injury. And require an affidavit by a qualified specialist before any medical malpractice action may be filed. This ''Qualified Specialist'' would be a health care professional with knowledge of the relevant facts of the case, expertise in the specific area of practice, and board certification in a specialty relating to the area of practice.

Reducing premiums.—We should require medical malpractice insurance companies to annually project the savings that will result from the anti-price fixing mechanisms required by the Democrat substitute. Insurance companies must also develop and implement a plan to annually dedicate at least 50 percent of those savings to reduce the insurance premiums that medical professionals pay.

Solving healthcare professionals shortage.—We need to provide grants or contracts through the Health Resources and Services Administration (HRSA) to geographic areas that have a shortage of one or more types of health providers as a result of dramatic increases in malpractice insurance premiums.

Mr. Speaker, I urge all my colleagues to vote against H.R. 5.

Mr. WYNN. Mr. Speaker, the issue of high premiums for medical malpractice insurance is an important issue to doctors and patients. It is important that we lower insurance premiums, giving patients greater access to care. However, I am opposed to H.R. 5, the HEALTH Act.

First, tort reform has historically been the province of the States. All but 14 States, have some form of caps on medical malpractice suits. Thus, there is no need for Federal intervention.

However, I am not convinced that medical malpractice litigation alone has caused the increase in medical malpractice premiums. There is convincing evidence that suggests that the rise in medical malpractice liability premiums stems from poor business practices by many insurance companies. Insurance carriers in several cases appear to have relied on the investments in the booming stock market of the 1990s to price premiums at levels below the market price. Today's premiums seem designed to offset losses suffered when the market soured.

Meanwhile, it is unclear that even capping noneconomic damages in medical malpractice cases would lower premiums. Since California passed MICRA and capped noneconomic damages in the 1970s, their premiums have risen at rates above inflation.

Lastly, it took the 1985 passage of Proposition 103, which imposed price controls on premiums, to control the rising costs of premiums in California. Even with caps, California premiums are eight percent higher than in States without caps.

When considering this issue, we should not just consider tort reform, but examine the business and accounting practices of medical malpractice insurance carriers.

In committee, I introduced a substitute amendment to the underlying bill. The amendment would have created a medical malpractice commission to study the rising costs of medical malpractice insurance.

Last year, the Health Subcommittee held a hearing on the rising premiums. However, the committee never adequately considered the impact of the business practices employed by carriers on the rising cost of medical malpractice insurance. That is the real issue.

To date, the government has not fully examined all of the possible root causes for the rise in medical malpractice insurance.

My amendment in committee would have stripped the underlying bill and created a Federal bipartisan commission of eight members to study the cause of rising medical malpractice premiums during the last 20 years.

Specfically, the commission would look at the investment, accounting, and pricing practices of carriers, as well as jury awards in medical malpractice cases to determine what is causing the rise in premiums.

We all deserve our day in court; the case for caps on noneconomic damages has not yet been made. Before placing an unreasonably low cap on noneconomic damages in medical malpractice suits, let's sufficiently study the issue and determine the root cause for the rising premiums.

Mr. PITTS. Mr. Speaker, I rise today in support of H.R. 5.

Medical liability reform is one issue on which we cannot afford to waste time. In my home State of Pennsylvania, medical liability is not just a problem; it's a crisis. Medical liability rates are up 81 percent in Pennsylvania, and higher for some specialties. Every year, $22 billion is sucked out of the American economy due to excessive medical liability claims. In Pennsylvania alone, there are $1.2 billion in payouts each year. That's $1,000 for every man, woman, and child in the Commonwealth. As a result, insurance companies are fleeing and many doctors cannot afford—financially nor professionally—to continue to practice medicine in the State.

Last year, Chester County Hospital, in my district, came very close to taking the drastic step of closing its maternity ward when insurance for the obstetricians skyrocketed. The doctors reported that they would have to discontinue offering care at that hospital. Thankfully, the hospital stepped in at the last minute with a temporary solution and actually put these independent physicians on their payroll in order to provide coverage for them through the hospital captive insurance company. Since Chester County Hospital does twenty-one hundred or so deliveries a year, this load was too big for other providers in the area to pick up. Women would have had to leave Chester County to have their babies.

Lancaster General Hospital, also in my district, had to abandon plans to open a new clinic to serve the poor in Lancaster City when it learned that it would have to pay $1.5 million more for malpractice insurance. This is unacceptable. We cannot wait any longer to address this crisis.

Pennsylvania is not alone. In fact, most States face this same crisis. Patient access to health care is on the decline. It is alarming. Unless we can reign in the costs of medical liability, men, women, and children across the country will suffer from lack of access to health care. Our health care system cannot support nor afford the big payouts of medical liability lawsuits.

H.R. 5 is not simply an important bill, but a critical one. It will inject predictability and fairness into the medical liability process.

The bottom line is this: If you care about patient access to health care and are concerned about the rampant increase in the cost of health care, vote for this bill that is before us today.

Vote for H.R. 5.

Mr. NEY. Mr. Speaker, I rise today to express my support for H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2003. Our healthcare system is currently in a crisis. Medical malpractice insurance rates have risen to epidemic levels in many areas of the country—so much so that it is a national problem, not just a state or local issue. For many physicians, their rates have risen at factors of over four times the level that they experienced when they began practicing medicine.

Mr. Speaker, imagine having to pay upwards of $130,000 to $150,000 out of your own pocket to do business. This is what our doctors are experiencing.

Statistics such as these have far reaching implications and effects on our Nation's healthcare system. As insurance rates rise, the costs to do business rise, and the costs to consumers and patients rise. The end result is that hardworking Americans are paying the tab for unwieldy lawsuits. The HEALTH Act will help to lessen the medical liability of healthcare professionals and will thus lower the costs of healthcare to all Americans. It will reduce these lottery style lawsuits and will improve the protections for victims of malpractice.

This bill allocates damages fairly by holding a party liable only for his or her degree of fault. It also requires that a jury be informed of any payments already made, allowing for consideration of payment by other tortfeasors. The act does provide for full compensation of economic damages, such as future medical expenses and loss of future earnings, and it does not limit damages recoverable for physical injuries resulting from a provider's care nor does it cap punitive damages.

Instead, it places reasonable limits on punitive damages. They would be limited to the greater of: Two times a patient's economic damages, or $250,000. The HEALTH Act does limit unquantifiable, noneconomic damages,

such as pain and suffering, to $250,000. Patients will also be ensured that there will be funds to cover future medical expenses, and that a damage award will not risk bankrupting the defendants. The bill achieves this by allowing payments for future medical expenses to be made periodically, rather than in a single lump sum.

In conclusion, Mr. Speaker, for the sake of America's patients and healthcare system, I urge my colleagues to put partisanship aside and to pass this important piece of legislation.

Mr. Baca. Mr. Speaker, I come to the floor today in opposition to H.R. 5. I oppose this legislation because it will do nothing to change the current liability rates for doctors and it will punish America's senior, children, and poor people.

People must realize that if this bill is passed, patients will be limited to actual damages only. That means a child or senior citizen who doesn't have income would receive only $250,000 for their injuries but a CEO with the same injury could be compensated millions simply because his income is higher.

I just don't see the difference. Under this bill if a homemaker or a waitress from my district who works just as hard as a CEO goes into the hospital and is permanently disabled, she would receive $250,000. But if Bill Gates or Donald Trump goes into the hospital and experiences the same injury, a jury can award them millions.

Why don't the Republicans believe that the waitress or the homemaker deserve just compensation? Why do Republican's believe that a CEO's injury is worth more than our daughter's, son's, parent's, or grandparent's? Once again, we are seeing legislation from the Republicans that benefits only the wealthy.

Insurances companies are currently gouging our Nation's doctors and it needs to stop. But, capping punitive damages at $250,000 will not help doctors—it will only hurt patients.

I am horrified that my colleagues on the other side of the aisle want to trump the decisions made by juries and tell an injured patient who has just lost their eyesight or a limb due to gross negligence that their injury is worth only $250,000.

The patient could be in pain for the rest of their life. The Republicans want to take the power to decide away from the jury and tell everyone that their pain and suffering is only worth a mere $250,000—no matter how painful the injury, no matter how permanent the damage.

And the Republicans think that once medical malpractice claims are capped at $250,000 that insurances rates will drop. I hate to break it to the Republicans, but we tried that system in California. Over a 12-year-period rates rose 190 percent. It wasn't until we passed sensible insurance reform that doctors experienced relief from staggering insurances rates.

We need to get a grip on insurance rates to help the doctors, but not at the expense of injured patients. H.R. 5 does not make sense, we need to stop further punishing injured patients and pass sensible legislation that really helps doctors.

Mr. MOORE of Kansas. Mr. Speaker, I rise in opposition to H.R. 5.

Last year, when the House approved legislation virtually identical to H.R. 5, I expressed my strong belief that Congress should address the medical malpractice insurance system as a whole. My calls went unheeded.

I believed last year, as I believe now, that a solution to the problem of rapidly rising medical malpractice insurance premiums must address all of the factors that contribute to premium cost. I have spoken with many physicians in my congressional district about this problem, and almost to a person, they agree with my assessment that Congress should look at the entire health care system for a solution to this very complex problem. Neither this legislation nor the hearings held in House committees addressed the pricing and accounting practices of medical malpractice insurance companies. The legislation before us addresses neither the responsibilities of the medical profession, through state medical boards, to police itself, nor the barriers that exist in some states to keep the profession from doing so. This legislation does not provide solutions to address the problem of medical errors nor does it provide one dollar to help hospitals and physicians purchase existing technology that could dramatically reduce those errors. It is also clear that Congress has not clearly thought through the consequences of preempting the traditionally state-regulated and state-monitored field of health care professions.

I truly share the concern of many of my colleagues and those in the medical profession about the rising rate of medial malpractice premiums. Last week, in my office, representatives of the Kansas Medical Society expressed their concern that this legislation is overreaching and a threat to state laws in states like Kansas, where they believe that a delicate balance has been achieved between the interests of injured patients and the medical profession. Notably, many States, including those considered to be in ''crisis,'' have acted or are now acting to get their own houses in order.

Mr. Speaker, I call on my colleagues to reject spurious, ill-conceived and overtly political solutions, and join with me in an effort to attain a comprehensive understanding of our Nation's health care system. Then we can truly find a solution to this very real crisis.

Mr. DELAHUNT. Mr. Speaker, the sponsors of this bill have assured the physicians of America that the bill will lower their insurance premiums. Yet it includes none of the provisions that would be necessary to bring about such a result.

The bill does nothing to reduce the staggering number of medical errors that kill so many thousands of Americans each year.

It does nothing to weed out the five percent of the medical profession who are responsible for 54 percent of the claims.

It does nothing to regulate the rates that insurance companies charge for their policies.

Instead of adopting any of these measures, the Republican majority has chosen to blame the victims—capping jury awards at artificially low levels that are insufficient to meet their needs, and that makes it difficult for them to find a qualified attorney who is willing to take their case.

The cap on non-economic damages is cruelest to the most vulnerable: children and mothers who stay at home. They have no econimic damages. No loss of employment. No loss of past and future earnings. No loss of business opportunities. Apart from their medical bills, all of their losses are non-economic—for pain and suffering. Physical impairment. Disfigurement.

It's unconscionable for Congress to deprive these victims of the right to have a jury decide what their pain and suffering is worth.

Stephen Olson was left blind and brain-damaged after an HMO refused to give him an $800 CAT scan when he was two years old. He'll need round-the-clock supervision for the rest of his life. The jury awarded him $7.1 million for his pain and suffering. But California has a cap of non-economic damages, so the judge was forced to reduce the award to $250,000. Is that really all he is owed for the irreversible damage that was done to him?

Linda McDougal receive an unnecessary double mastectomy after doctors mixed up her lab results and erroneously told her that she had breast cancer. Under this bill, would receive a maximum of $250,000 for her lifetime of pain and disfigurement. Is that really all she is owed? Is that really all the compensation we would wish for our own mothers, sisters, and wives?

The irony is that despite the claims of the bill's supporters, there is no reason to believe that the cap on non-economic damages will have a serious impact on insurance premiums. A report by the New Jersey Medical Society estimated that a state cap of $250,000 on non-economic damages might result in reductions of, at most, five-to-seven percent. Other studies suggest that insurance rates are affected less by the level of non-economic damages than by the amounts paid out for economic losses.

And in California, whose 1975 Medical Injury Compensation Reform Act, known as MICRA, was the model for many of the provisions of this bill, there is little persuasive evidence that the law has brought about any reduction in premiums. Indeed, a 1995 study concluded that premiums increased dramatically during the decade following enactment of MICRA, and only stabilized once the voters imposed rate regulation under a 1988 ballot measure known as Proposition 103.

The sponsors of the bill are unwilling to take that step. Far be it from them to impose regulation on the insurance industry! Yet when it comes to litigation, these apostles of free markets opt for wage and price controls. They are horrified at the though that Congress would cap the amount of assets that wealthy bankrupts can shelter from their creditors, but have no compunction about capping the amount that malpractice victims can recover from their injuries.

I suppose it's all a question of priorities. If medical care were really a priority for the majority, we'd be talking about increasing reimbursement rates. Improving the quality of medical training. Providing incentives for doctors to practice in underserved communities. Reducing the paperwork burden that drives dedicated physicians out of the profession. But we can't talk about any of these things. They cost money. And with new tax cuts promised and deficits mounting, investments in the health care system are simply not a priority.

That's why we're debating a bill like this one instead. A bill that does nothing to address the legitimate concerns of physicians, while inflicting further harm on patients who have suffered enough.

Mr. SHUSTER. Mr. Speaker, the rising costs of medical liability insurance in Pennsylvania are among the worst in the country. In fact, Pennsylvania physicians faced a 50 percent increase in insurance costs in 2002, with

an additional 50 percent hike expected this year. Physicians have moved from my district to other States to continue practicing medicine. Recently, one of the most efficient hospitals in my district was literally within an hour of closing its doors when its pathology department could not secure medical liability insurance the 11th hour. The threat of rising medical liability costs to quality patient care in central Pennsylvania is beyond a crisis situation. The time for the House to act is now.

H.R. 5 is common-sense legislation aimed at reducing the skyrocketing medical liability costs that are threatening the availability of quality patient care in Pennsylvania and throughout the country. In addition, H.R. 5 protects the rights of patients with legitimate claims to receive compensation for economic losses, medicals costs, and lost wages.

Mr. Speaker, the threat of frivolous medical liability litigation is endangering the ability of physicians in my district to provide quality patient care. Congress must do its part to ensure access to care is not jeopardized at the expense of lining the pockets of trial lawyers.

I urge my colleagues to vote in favor of H.R. 5.

Ms. MALONEY. Mr. Speaker, I rise today in opposition to H.R. 5, the Medical Liability Limitation Act.

I represent many of the nation's premier health care and biomedical research institutions in the nation. As such, I have worked diligently to represent the interests of my district on health matters.

On this issue in particular, I have met with numerous doctors and I agree, they need relief from the high cost of insurance premiums. Rising health costs are not just impacting doctors. High health costs are hurting consumers, hospitals, employers and the economy, in general.

But H.R. 5 is not the right prescription!

Because of the strict caps for pain and suffering, H.R. 5 will especially harm women, children, the elderly and disabled individuals who may not have significant economic losses to recover. Stay-at-home moms and caregivers for children or the elderly, in particular, will be denied the ability to seek adequate compensation for damages inflicted upon them. H.R. 5 also will be especially punitive to women because many kinds of injuries that happen mostly to females—like those that affect the reproductive system, that cause a loss of fertility, or that are inflicted through sexual assault—are largely compensated through pain-and-suffering awards and other non-economic loss damages.

I met recently with a constituent who was a victim both of medical malpractice and pharmaceutical negligence. When she was in her mother's womb, her mother was prescribed DES at a time when reports about its ineffectiveness and its potential harmful effects on the fetus had already been circulated. Almost two decades later, she developed an adenocarcinoma, an aggressive cancer affecting her reproductive organs. Not only was she then misdiagnosed, her doctor prescribed treatments that were contraindicated and that hastened the growth of her cancer. The misdiagnosis resulted in extensive surgery and reconstruction resulting in her infertility and a lifetime of intense emotional and physical suffering. The pharmaceutical negligence, which was not accurately diagnosed for years—long after the statute of limitations would have expired under the terms of H.R. 5—has resulted in a lifetime of pain and a mountain of bills for follow-up medical care. If H.R. 5 had been the law when her mother had been prescribed DES, she would never have been awarded enough even to pay her extensive medical bills, let alone compensate her for years of pain and suffering.

For several Congresses, we have worked to pass a patient's bill of rights, to make sure that doctors and patients make medical decisions, not bureaucrats. H.R. 5 is an anti-patient's bill of rights.

H.R. 5 is too broad. Beyond the issue of medical malpractice, H.R. 5 includes severe liability limitations for pharmaceutical companies, medical device manufacturers, nursing homes and assisted living facilities, and insurance companies.

Unlike the Conyers/Dingell alternative which I strongly support, H.R. 5 promises no relief from the high malpractice insurance rates paid by doctors and hospitals and serves as nothing more than a bailout for insurance companies who are passing on their investment losses to doctors.

Vote "no" on H.R. 5.

Ms. DEGETTE. Mr. Speaker, I think we all agree that there is a crisis in medical malpractice insurance rates. Unfortunately, this bill does not mention insurance rates or offer solutions for the doctors who are feeling the burden of high premiums.

H.R. 5 relies on the misconception that savings from malpractice litigation reforms will relieve high insurance premiums. However, litigation is not the cause of high malpractice insurance rates. There has been no increase in the rate of malpractice claims filed in recent years and the average payout has remained steady over the past decade. In fact, the one state that proponents of malpractice litigation reform continually cite as a success is California. What they don't say is that California's malpractice insurance rates only stabilized after the state reformed its insurance system.

Despite this evidence, proponents of H.R. 5 have continued to represent this bill as a relief for physicians, rather than what it really is—a bill that will add additional injury to patients who have suffered from medical malpractice.

H.R. 5 would cap non-economic damages at an arbitrary amount of $250,000 for people who have been injured by malpractice. Non-economic damages compensate people for injuries that are very real, like permanent disfigurement, loss of sight or a limb, loss of fertility, and wrongful death. The cap on non-economic damages is unfair and should not become law.

This bill tells people like Heather Lewinski, a 17 year old girl who suffered permanent facial disfigurement at the hands of a plastic surgeon who lied to her and her family, that the severe pain, trauma, and suffering that she went through is worth $250,000. The bill tells people like Linda McDougal, whose breasts were amputated after she had been misdiagnosed with cancer, that the loss of her breasts and dignity is only worth $250,000. And it tells the family of Jesica Santillan, the little girl who died because the hospital failed to ensure that the heart and lungs she was about to receive would be compatible with her blood type, that their little girl's life was only worth $250,000.

Some advocates of H.R. 5 say that the bill only caps non-economic damages, not economic damages and that a person can receive full economic compensation for their injuries. Yet, this is unfair to the millions of Americans who do not work—retirees, stay-at-home moms, children, and seniors because they do not have economic damages. For example, Heather Lewinski, who underwent surgery when she was only 8 years old, did not have any economic damages. Linda McDougal's medical bills were already paid for and her loss would not directly affect her future earning potential. Yet, she suffered emotional trauma and a loss of dignity. Is her loss worth an arbitrary amount that was determined by a group of politicians? I certainly don't think so.

By adopting strict monetary caps on damages, Congress is creating a solution for a problem that does not exist. Medical malpractice claims are not increasing and juries are not making outrageous awards. According to the National Center for State Courts, there was no increase in the volume of medical malpractice claims between 1997 and 2001. Additionally, of the 16,676 medical malpractice cases with awards in 2001, only 5 percent were for $1 million or more. Clearly, this represents an extraordinarily small number of cases. I do not believe we should be restricting the rights of patients to receive fair and adequate compensation for their losses because of this very small number of large awards.

If we truly want to fix the real crisis that is plaguing our nation's doctors, we need to take a good look at the insurance industry. According to a study using the insurance industry's own data and conducted by Americans for Insurance Reform, while the total amount paid out over the past decade by malpractice insurers directly tracks the rate of medical inflation, the premiums that insurance companies charge doctors increase or decrease depending on the economy. In my state of Colorado, which has certain caps on damages, insurance companies took in over $119 million in premiums in 2001. Yet, they only paid out $36 million.

We should be taking a comprehensive approach to this crisis instead of placing unfair burdens on patients. We should be looking at the insurance cycle, how insurers manage investments and reserves, and financial pressures that health care payers place on providers and how that affects the way care is delivered.

Instead, we are considering a bill that is akin to curing a headache by amputating an arm. Arbitrarily limiting patients' rights is not fair and it will not solve the problem.

Stand up for the rights of patients and oppose this bill.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise today in opposition to the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act. Tens of thousands of people die each year from preventable medical errors. But rather than reform the medical system to prevent needless deaths and injuries, doctors and big insurance companies are lobbying to limit the rights of injured patients to seek full recovery in the courts. This measure unfairly impacts women and low income patients.

The HEALTH Act (H.R. 5) attempts to address the problem of high insurance costs for doctors by limiting punitive damages in medical malpractice cases to $250,000 and caps attorneys' fees under the guise of addressing

the rising cost of medical malpractice insurance. H.R. 5 caps non-economic damages in the aggregate—regardless of the number of parties involved in the dispute.

Despite its claim, H.R. 5 does nothing to directly address the problem of rising medical malpractice insurance rates for doctors. Malpractice insurance companies can expect a huge windfall from this legislation because it limits how much they have to pay out in claims, but does not address how much these insurance companies charge in premiums to doctors. The insurance industry has said that there is no guarantee of any specific savings from passage of this type of legislation.

The major malpractice problem facing Texans is the unreliable quality of medical care being delivered, which is a result of frequent medical mistakes and a lack of doctor oversight by the state medical board.

Government data show that "repeat offender" doctors are responsible for the bulk of malpractice payments. Between September 1990 and September 2002, 6.5 percent of Texas' doctors made two or more malpractice payouts worth a total of more than $1 billion. These represented 51.3 percent of all payments, according to information obtained from the federal government's National Practitioner Data Bank. Just 2.2 percent of the doctors made three or more payments, representing about a quarter of all payouts.

For every $100 spent on health care in America, only $.66 has been spent on malpractice insurance. As patients are most often victimized by repeat offending doctors (a mere six percent of doctors in Texas are responsible for 46 percent of all malpractice), this bill does nothing to reduce negligence by doctors and hospitals, but decreases incentive to improve patient safety.

Medical errors cause 3,260 to 7,261 preventable deaths in Texas each year. These errors cost families and communities $1.3 billion to $2.2 billion annually in lost wages, lost productivity and increased health care costs. In contrast, medical malpractice insurance costs Texas's doctors less than $421.2 million annually.

One more time the patient (consumer) gets the lump for being victimized. Vote against this rule and this bill under consideration..

It is for these reasons that I will vote against the rule and the bill, H.R. 5, and I urge my Colleagues to vote against H.R. 5.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 139, the previous question is ordered.

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. I am, Mr. Speaker.

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. 5 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 amendments:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medical Malpractice and Insurance Reform Act of 2003".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—LIMITING FRIVOLOUS MEDICAL MALPRACTICE LAWSUITS

Sec. 101. Statute of limitations.
Sec. 102. Health care specialist affidavit.
Sec. 103. Sanctions for frivolous actions and pleadings.
Sec. 104. Mandatory mediation.
Sec. 105. Limitation on punitive damages.
Sec. 106. Use of savings to benefit providers through reduced premiums.
Sec. 107. Definitions.
Sec. 108. Applicability.

TITLE II—INDEPENDENT ADVISORY COMMISSION ON MEDICAL MALPRACTICE INSURANCE

Sec. 201. Establishment.
Sec. 202. Duties.
Sec. 203. Report.
Sec. 204. Membership.
Sec. 205. Director and staff; experts and consultants.
Sec. 206. Powers.
Sec. 207. Authorization of appropriations.

TITLE I—LIMITING FRIVOLOUS MEDICAL MALPRACTICE LAWSUITS

SEC. 101. STATUTE OF LIMITATIONS.

(a) IN GENERAL.—A medical malpractice action shall be barred unless the complaint is filed within 3 years after the right of action accrues.

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

(1) The date of the injury.

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

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

(c) APPLICABILITY.—This section shall apply to any injury occurring after the date of the enactment of this Act.

SEC. 102. HEALTH CARE SPECIALIST AFFIDAVIT.

(a) REQUIRING SUBMISSION WITH COMPLAINT.—No medical malpractice action may be brought by any individual unless, at the time the individual brings the action (except as provided in subsection (b)(1)), it is accompanied by the affidavit of a qualified specialist that includes the specialist's statement of belief that, based on a review of the available medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant.

(b) EXTENSION IN CERTAIN INSTANCES.—

(1) IN GENERAL.—Subject to paragraph (2), subsection (a) shall not apply with respect to an individual who brings a medical malpractice action without submitting an affidavit described in such subsection if, as of the time the individual brings the action, the individual has been unable to obtain adequate medical records or other information necessary to prepare the affidavit.

(2) DEADLINE FOR SUBMISSION WHERE EXTENSION APPLIES.—In the case of an individual who brings an action for which paragraph (1) applies, the action shall be dismissed unless the individual (or the individual's attorney) submits the affidavit described in subsection (a) not later than 90 days after obtaining the information described in such paragraph.

(c) QUALIFIED SPECIALIST DEFINED.—In subsection (a), a "qualified specialist" means, with respect to a medical malpractice action, a health care professional who is reasonably believed by the individual bringing the action (or the individual's attorney)—

(1) to be knowledgeable in the relevant issues involved in the action;

(2) to practice (or to have practiced) or to teach (or to have taught) in the same area of health care or medicine that is at issue in the action; and

(3) in the case of an action against a physician, to be board certified in a specialty relating to that area of medicine.

(d) CONFIDENTIALITY OF SPECIALIST.—Upon a showing of good cause by a defendant, the court may ascertain the identity of a specialist referred to in subsection (a) while preserving confidentiality.

SEC. 103. SANCTIONS FOR FRIVOLOUS ACTIONS AND PLEADINGS.

(a) SIGNATURE REQUIRED.—Every pleading, written motion, and other paper in any medical malpractice action shall be signed by at least 1 attorney of record in the attorney's individual name, or, if the party is not represented by an attorney, shall be signed by the party. Each paper shall state the signer's address and telephone number, if any. An unsigned paper shall be stricken unless omission of the signature is corrected promptly after being called to the attention of the attorney or party.

(b) CERTIFICATE OF MERIT.—(1) A medical malpractice action shall be dismissed unless the attorney or unrepresented party presenting the complaint certifies that, to the best of the person's knowledge, information, and belief, formed after an inquiry reasonable under the circumstances,—

(A) it is not being presented for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation;

(B) the claims and other legal contentions therein are warranted by existing law or by a nonfrivolous argument for the extension, modification, or reversal of existing law or the establishment of new law; and

(C) the allegations and other factual contentions have evidentiary support or, if specifically so identified, are likely to have evidentiary support after a reasonable opportunity for further investigation and discovery.

(2) By presenting to the court (whether by signing, filing, submitting, or later advocating) a pleading, written motion, or other paper, an attorney or unrepresented party is certifying that to the best of the person's knowledge, information and belief, formed after an inquiry reasonable under the circumstances—

(A) it is not being presented for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation;

(B) the claims, defenses, and other legal contentions therein are warranted by existing law or by a nonfrivolous argument for the extension, modification, or reversal of existing law or the establishment of new law; and

(C) the allegations and other factual contentions have evidentiary support or, if specifically so identified, are reasonable based on a lack of information or belief.

(c) MANDATORY SANCTIONS.—

(1) FIRST VIOLATION.—If, after notice and a reasonable opportunity to respond, a court, upon motion or upon its own initiative, determines that subsection (b) has been violated, the court shall find each attorney or party in violation in contempt of court and shall require the payment of costs and attorneys fees. The court may also impose additional appropriate sanctions, such as striking the pleadings, dismissing the suit, and sanctions plus interest, upon the person in

violation, or upon both such person and such person's attorney or client (as the case may be).

(2) SECOND VIOLATION.—If, after notice and a reasonable opportunity to respond, a court, upon motion or upon its own initiative, determines that subsection (b) has been violated and that the attorney or party with respect to which the determination was made has committed one previous violation of subsection (b) before this or any other court, the court shall find each such attorney or party in contempt of court and shall require the payment of costs and attorneys fees, and require such person in violation (or both such person and such person's attorney or client (as the case may be)) to pay a monetary fine. The court may also impose additional appropriate sanctions, such as striking the pleadings, dismissing the suit and sanctions plus interest, upon such person in violation, or upon both such person and such person's attorney or client (as the case may be).

(3) THIRD VIOLATION.—If, after notice and a reasonable opportunity to respond, a court, upon motion or upon its own initiative, determines that subsection (b) has been violated and that the attorney or party with respect to which the determination was made has committed more than one previous violation of subsection (b) before this or any other court, the court shall find each such attorney or party in contempt of court, refer each such attorney to one or more appropriate State bar associations for disciplinary proceedings, require the payment of costs and attorneys fees, and require such person in violation (or both such person and such person's attorney or client (as the case may be)) to pay a monetary fine. The court may also impose additional appropriate sanctions, such as striking the pleadings, dismissing the suit, and sanctions plus interest, upon such person in violation, or upon both such person and such person's attorney or client (as the case may be).

SEC. 104. MANDATORY MEDIATION.

(a) IN GENERAL.—In any medical malpractice action, before such action comes to trial, mediation shall be required. Such mediation shall be conducted by one or more mediators who are selected by agreement of the parties or, if the parties do not agree, who are qualified under applicable State law and selected by the court.

(b) REQUIREMENTS.—Mediation under subsection (a) shall be made available by a State subject to the following requirements:

(1) Participation in such mediation shall be in lieu of any alternative dispute resolution method required by any other law or by any contractual arrangement made by or on behalf of the parties before the commencement of the action.

(2) Each State shall disclose to residents of the State the availability and procedures for resolution of consumer grievances regarding the provision of (or failure to provide) health care services, including such mediation.

(3) Each State shall provide that such mediation may begin before or after, at the option of the claimant, the commencement of a medical malpractice action.

(4) The Attorney General, in consultation with the Secretary of Health and Human Services, shall, by regulation, develop requirements with respect to such mediation to ensure that it is carried out in a manner that—

(A) is affordable for the parties involved;

(B) encourages timely resolution of claims;

(C) encourages the consistent and fair resolution of claims; and

(D) provides for reasonably convenient access to dispute resolution.

(c) FURTHER REDRESS AND ADMISSIBILITY.—Any party dissatisfied with a determination reached with respect to a medical malpractice claim as a result of an alternative dispute resolution method applied under this section shall not be bound by such determination. The results of any alternative dispute resolution method applied under this section, and all statements, offers, and communications made during the application of such method, shall be inadmissible for purposes of adjudicating the claim.

SEC. 105. LIMITATION ON PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may not be awarded in a medical malpractice action, except upon proof of—

(1) gross negligence;

(2) reckless indifference to life; or

(3) an intentional act, such as voluntary intoxication or impairment by a physician, sexual abuse or misconduct, assault and battery, or falsification of records.

(b) ALLOCATION.—In such a case, the award of punitive damages shall be allocated 50 percent to the claimant and 50 percent to a trustee appointed by the court, to be used by such trustee in the manner specified in subsection (d). The court shall appoint the Secretary of Health and Human Services as such trustee.

(c) EXCEPTION.—This section shall not apply with respect to an action if the applicable State law provides (or has been construed to provide) for damages in such an action that are only punitive or exemplary in nature.

(d) TRUST FUND.—

(1) IN GENERAL.—This subsection applies to amounts allocated to the Secretary of Health and Human Services as trustee under subsection (b).

(2) AVAILABILITY.—Such amounts shall, to the extent provided in advance in appropriations Acts, be available for use by the Secretary of Health and Human Services under paragraph (3) and shall remain so available until expended.

(3) USE.—

(A) Subject to subparagraph (B), the Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, shall use the amounts to which this subsection applies for activities to reduce medical errors and improve patient safety.

(B) The Secretary of Health and Human Services may not use any part of such amounts to establish or maintain any system that requires mandatory reporting of medical errors.

(C) The Secretary of Health and Human Services shall promulgate regulations to establish programs and procedures for carrying out this paragraph.

(4) INVESTMENT.—

(A) The Secretary of Health and Human Services shall invest the amounts to which this subsection applies in such amounts as such Secretary determines are not required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

(B) Any obligation acquired by the Secretary in such Secretary's capacity as trustee of such amounts may be sold by the Secretary at the market price.

SEC. 106. USE OF SAVINGS TO BENEFIT PROVIDERS THROUGH REDUCED PREMIUMS.

(a) IN GENERAL.—Notwithstanding any other provision of this title, a provision of this title may be applied by a court to the benefit of a party insured by a medical malpractice liability insurance company only if the court—

(1) determines the amount of savings realized by the company as a result; and

(2) requires the company to pay an amount equal to the amount of such savings to a trustee appointed by the court, to be distributed by such trustee in a manner that has the effect of benefiting health care providers insured by the company through reduced premiums for medical malpractice liability insurance.

(b) DEFINITION.—For purposes of this section, the term ''medical malpractice liability insurance company'' means an entity in the business of providing an insurance policy under which the entity makes payment in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim.

SEC. 107. DEFINITIONS.

In this title, the following definitions apply:

(1) ALTERNATIVE DISPUTE RESOLUTION METHOD.—The term ''alternative dispute resolution method'' means a method that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(5) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice action or a medical malpractice claim.

(6) MANDATORY.—The term ''mandatory'' means required to be used by the parties to attempt to resolve a medical malpractice claim notwithstanding any other provision of an agreement, State law, or Federal law.

(7) MEDIATION.—The term ''mediation'' means a settlement process coordinated by a neutral third party and without the ultimate rendering of a formal opinion as to factual or legal findings.

(8) MEDICAL MALPRACTICE ACTION.—The term ''medical malpractice action'' means an action in any State or Federal court against a physician, or other health professional, who is licensed in accordance with the requirements of the State involved that—

(A) arises under the law of the State involved;

(B) alleges the failure of such physician or other health professional to adhere to the relevant professional standard of care for the service and specialty involved;

(C) alleges death or injury proximately caused by such failure; and

(D) seeks monetary damages, whether compensatory or punitive, as relief for such death or injury.

(9) MEDICAL MALPRACTICE CLAIM.—The term ''medical malpractice claim'' means a claim forming the basis of a medical malpractice action.

(10) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico,

American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Virgin Islands, and any other territory or possession of the United States.

SEC. 108. APPLICABILITY.

(a) IN GENERAL.—Except as provided in section 104, this title shall apply with respect to any medical malpractice action brought on or after the date of the enactment of this Act.

(b) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice actions on the basis of section 1331 or 1337 of title 28, United States Code.

TITLE II—INDEPENDENT ADVISORY COMMISSION ON MEDICAL MALPRACTICE INSURANCE

SEC. 201. ESTABLISHMENT.

(a) FINDINGS.—The Congress finds as follows:

(1) The sudden rise in medical malpractice premiums in regions of the United States can threaten patient access to doctors and other health providers.

(2) Improving patient access to doctors and other health providers is a national priority.

(b) ESTABLISHMENT.—There is established a national commission to be known as the ''Independent Advisory Commission on Medical Malpractice Insurance'' (in this title referred to as the ''Commission'').

SEC. 202. DUTIES.

(a) IN GENERAL.—(1) The Commission shall evaluate the effectiveness of health care liability reforms in achieving the purposes specified in paragraph (2) in comparison to the effectiveness of other legislative proposals to achieve the same purposes.

(2) The purposes referred to in paragraph (1) are to—

(A) improve the availability of health care services;

(B) reduce the incidence of ''defensive medicine'';

(C) lower the cost of health care liability insurance;

(D) ensure that persons with meritorious health care injury claims receive fair and adequate compensation; and

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

(b) CONSIDERATIONS.—In formulating proposals on the effectiveness of health care liability reform in comparison to these alternatives, the Commission shall, at a minimum, consider the following:

(1) Alternatives to the current medical malpractice tort system that would ensure adequate compensation for patients, preserve access to providers, and improve health care safety and quality.

(2) Modifications of, and alternatives to, the existing State and Federal regulations and oversight that affect, or could affect, medical malpractice lines of insurance.

(3) State and Federal reforms that would distribute the risk of medical malpractice more equitably among health care providers.

(4) State and Federal reforms that would more evenly distribute the risk of medical malpractice across various categories of providers.

(5) The effect of a Federal medical malpractice reinsurance program administered by the Department of Health and Human Services.

(6) The effect of a Federal medical malpractice insurance program, administered by the Department of Health and Human Services, to provide medical malpractice insurance based on customary coverage terms and liability amounts in States where such insurance is unavailable or is unavailable at reasonable and customary terms.

(7) Programs that would reduce medical errors and increase patient safety, including new innovations in technology and management.

(8) The effect of State policies under which—

(A) any health care professional licensed by the State has standing in any State administrative proceeding to challenge a proposed rate increase in medical malpractice insurance; and

(B) a provider of medical malpractice insurance in the State may not implement a rate increase in such insurance unless the provider, at minimum, first submits to the appropriate State agency a description of the rate increase and a substantial justification for the rate increase.

(9) The effect of reforming antitrust law to prohibit anticompetitive activities by medical malpractice insurers.

(10) Programs to facilitate price comparison of medical malpractice insurance by enabling any health care provider to obtain a quote from each medical malpractice insurer to write the type of coverage sought by the provider.

(11) The effect of providing Federal grants for geographic areas that have a shortage of one or more types of health providers as a result of the providers making the decision to cease or curtail providing health services in the geographic areas because of the costs of maintaining malpractice insurance.

SEC. 203. REPORT.

(a) IN GENERAL.—The Commission shall transmit to Congress—

(1) an initial report not later than 180 days after the date of the initial meeting of the Commission; and

(2) a report not less than each year thereafter until the Commission terminates.

(b) CONTENTS.—Each report transmitted under this section shall contain a detailed statement of the findings and conclusions of the Commission.

(c) VOTING AND REPORTING REQUIREMENTS.—With respect to each proposal or recommendation contained in the report submitted under subsection (a), each member of the Commission shall vote on the proposal or recommendation, and the Commission shall include, by member, the results of that vote in the report.

SEC. 204. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General of the United States.

(b) MEMBERSHIP.—

(1) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, medical malpractice insurance, insurance regulation, health care law, health care policy, health care access, allopathic and osteopathic physicians, other providers of health care services, patient advocacy, and other related fields, who provide a mix of different professionals, broad geographic representations, and a balance between urban and rural representatives.

(2) INCLUSION.—The membership of the Commission shall include the following:

(A) Two individuals with expertise in health finance and economics, including one with expertise in consumer protections in the area of health finance and economics.

(B) Two individuals with expertise in medical malpractice insurance, representing both commercial insurance carriers and physician-sponsored insurance carriers.

(C) An individual with expertise in State insurance regulation and State insurance markets.

(D) An individual representing physicians.

(E) An individual with expertise in issues affecting hospitals, nursing homes, nurses, and other providers.

(F) Two individuals representing patient interests.

(G) Two individuals with expertise in health care law or health care policy.

(H) An individual with expertise in representing patients in malpractice lawsuits.

(3) MAJORITY.—The total number of individuals who are directly involved with the provision or management of malpractice insurance, representing physicians or other providers, or representing physicians or other providers in malpractice lawsuits, shall not constitute a majority of the membership of the Commission.

(4) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of the Commission of financial or other potential conflicts of interest relating to such members.

(c) TERMS.—

(1) IN GENERAL.—The terms of the members of the Commission shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(2) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(3) COMPENSATION.—Members of the Commission shall be compensated in accordance with section 1805(c)(4) of the Social Security Act.

(4) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate at the time of appointment a member of the Commission as Chairman and a member as Vice Chairman. In the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

(5) MEETINGS.—

(A) IN GENERAL.—The Commission shall meet at the call of the Chairman.

(B) INITIAL MEETING.—The Commission shall hold an initial meeting not later than the date that is 1 year after the date of the enactment of this title, or the date that is 3 months after the appointment of all the members of the Commission, whichever occurs earlier.

SEC. 205. DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.

Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties;

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission;

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

SEC. 206. POWERS.

(a) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

(b) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

(1) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(2) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(3) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

(c) ACCESS OF GENERAL ACCOUNTING OFFICE TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

(d) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General of the United States.

SEC. 207. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this title for each of fiscal years 2004 through 2008.

(b) REQUESTS FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

Amend the title so as to read: ''A bill to limit frivolous medical malpractice lawsuits, to reform the medical malpractice insurance business in order to reduce the cost of medical malpractice insurance, to enhance patient access to medical care, and for other purposes.''.

Mr. CONYERS (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit 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 (Mr. CONYERS) is recognized for 5 minutes in support of his motion.

Mr. CONYERS. Mr. Speaker, this is the Conyers-Dingell motion to recommit. It started out originally as the Conyers-Dingell substitute motion which, in the wisdom of the Committee on Rules and the chair of the Committee on Energy and Commerce, was determined not to be necessary. We did not need to waste this much time worrying or going over the same matter twice. So let us just have a 5-minute discussion on each side about a multibillion-dollar measure that affects every man, woman, and child in the United States of America. So I will take a couple of minutes and ask the dean of the House to spend the rest of the time making sure that we all understand what it does.

First of all, we do something about the problem that has been complained of grievously by every Member that has taken to the floor today. We do something about it. That is, we limit frivolous lawsuits by requiring that there is mandatory mediation for every malpractice lawsuit filed in the United States of America and that we require that attorneys' certificates of merit and mandatory sanctions occur. We require that affidavits of merit be provided from qualified medical specialists. We attempt to, in short, weed out frivolous lawsuits that will not restrict the rights of those with legitimate claims. Of course, finally, it is very important to realize that we reexamine the antitrust exemption that has been enjoyed by the insurance industry all of these years.

Mr. Speaker, I am delighted now to yield the balance of the time to the dean of the House, the gentleman from Michigan (Mr. DINGELL).

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

Mr. DINGELL. Mr. Speaker, the bill before us is a bad bill. The motion to recommit is forced upon us by the recalcitrance of the Republican leadership which has not permitted us to offer a substitute. This is the package that we could go home and talk with pride of to our people and to our doctors. It weeds out frivolous lawsuits. It does not restrict the rights of legitimate claimants. It establishes an equitable, 3-year statute of limitation that protects children, the aged, the poor.

It requires affidavits of merit from qualified medical specialists and attorneys' certificates of merit with mandatory sanctions. It requires mandatory mediation. It also allows health care providers to challenge malpractice premium increases. It provides direct assistance to physicians in crisis areas through Federal grants, and it provides direct assistance to medical centers in danger of closing. It repeals the antitrust exemption for malpractice insurance, and it establishes Federal malpractice insurance and a reinsurance program. This is a program that will work.

Under a House in which we had a decent opportunity to debate and amend, Members of this body would understand that this is the package for which they want to vote. They would understand that this is a package which their people wish them to vote for, and I include in that the health care providers. It is a bill, or rather an amendment, which would assure that health care providers would receive the help that they need while, at the same time, not providing unnecessary shelters for HMOs and other undeserving persons who have contrived to leap aboard a vehicle which they think is going out and a situation which permits the doctors to be used as frontmen for a bunch of iniquitous rascals who do not deserve relief.

Mr. CONYERS. Mr. Speaker, we yield back any time that may be remaining.

The SPEAKER pro tempore. Does the gentleman from Louisiana (Mr. TAUZIN) seek time in opposition to the motion?

Mr. TAUZIN. I do, Mr. Speaker.

I first yield to the gentleman from Nevada (Mr. GIBBONS) for a colloquy.

Mr. GIBBONS. Mr. Speaker, I would like to ask the gentleman from Louisiana (Mr. TAUZIN) a question which concerns the relationship of Nevada law and H.R. 5.

In my State of Nevada, we have recently passed a law that sets forth a $350,000 cap for noneconomic damages, but it has some exceptions. I would like to know how this legislation applies in this circumstance.

Mr. TAUZIN. Mr. Speaker, I thank the gentleman. Subparagraph 11(c)(1) says: ''Any State law, whether effective before, on, or after the dates of the enactment of this Act that specifies a particular monetary amount of compensatory or punitive damages, or the total amount of damages, that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided under this Act.''

Nevada's $350,000 cap generally fits the terms of this subparagraph and would generally apply. The handling of the exceptions is not specifically stated in the legislation. I would be prepared to work with the gentleman to discuss these exceptions as we move further in the process of this legislation.

Mr. GIBBONS. Mr. Speaker, I thank the gentleman for his response, and I look forward to working with him on this matter.

Mr. TAUZIN. Mr. Speaker, the Dingell motion offers us a different solution than H.R. 5. Interestingly enough, not a single one of the 175 health care organizations and associations, doctors across America, endorses that solution.

□ 1445

But they have all endorsed H.R. 5. And let me explain to you why the doctors and the health care organizations have not endorsed the Dingell solution and have endorsed H.R. 5. By the way, the Committee on Energy and Commerce took a vote on the general substance of this motion to recommit and voted 30 to 20 against it and it was not a party line vote. Let me tell you why it was defeated, why so many organizations opposed it. Because what it generally offers is not insurance reform but a Federal commission, another bureaucracy to study the problem and to make recommendations one day to us.

We have studied this problem ad infinitum. We have held numerous hearings. The States have experienced this problem going back 25 years and they

have offered us a solution. We are following their lead after 25 years of experience. Do we really need another Federal commission? No insurance reform, just a commission? And then to solve the problem of high malpractice liability coverage, this is the Dingell motion to recommit solution, not a single limitation at all on recoveries, unlimited recoveries as in current law, not a single cap on any kind of damages. Instead we get an attorney's certificate of merit. An attorney's certificate of merit. We get the trial lawyer to say, I think I have got a good lawsuit, and that is the solution.

Mr. Speaker, when an attorney signs a petition, when he signs the most egregiously incorrect, horribly drafted, when he signs the most inappropriate false petition, when he signs his name on it he is attesting to the validity of that petition. It may be a bad petition. It may be the most horrible lawsuit ever filed. It may get dismissed on the first motion to have it dismissed, but when he signed his name on it, he said it was a good petition.

So what does the Democratic motion to recommit tell us? We are going to solve this problem in America by having the same attorney sign a certificate that he has got a good suit, that he has got a good petition. Wow, that will really solve the problem.

I think you see why now that solution has been rejected by 175 organizations representing the doctors, the nurses, all the organizations across America who are crying to us for relief, who are telling us we are tired of petitions signed by lawyers that have no merit, that drive up medical malpractice suits, that drive us out of business and deprive the citizens of our country needed medical care when their loved ones need it the most. They are crying to us for help and the victims that came to us in our committee room and said, for God's sake, it is horrible when somebody commits a medical error, but it is also terrible when the doctor is not there when my child is sick, when my husband has been horribly mutilated in an automobile accident, when my daughter is trying to deliver her first child and there is no doctor there willing to do it because the cost of liability insurance is too high. They are crying to us to do something today. The motion to recommit tells us, well, let us just trust the lawyers and create a Federal commission. Whoopie-ding.

What do we tell those victims when we said all we did was trust the lawyers and created another Federal commission? I did not come here to create new Federal commissions to tell us what the problems were and what the solutions were. I came here like the rest of you, to figure out what the problems were and to solve them. H.R. 5 solves this program and deserves to be passed. This motion to recommit needs to go down.

The SPEAKER pro tempore (Mr. SIMPSON). 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 191, nays 234, not voting 9, as follows:

[Roll No. 63]

YEAS—191

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Duncan
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Lee
Levin
Lewis (GA)
Lipinski
Lowey
Lynch
Majette
Maloney
Markey
Marshall
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NAYS—234

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Berkley
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis (FL)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Isakson
Issa
Janklow
Jenkins
John
Johnson (CT)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Larson (CT)
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lofgren
Lucas (KY)
Lucas (OK)
Manzullo
Matheson
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Murtha
Musgrave
Myrick
Nethercutt
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Scott (GA)
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Stenholm
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOT VOTING—9

Clyburn
Combest
DeGette
Doyle
Gilchrest
Hyde
Istook
Johnson (IL)
Snyder

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. REHBERG) (during the vote). There are 2 minutes left in this vote.

□ 1508

Messrs. MCHUGH, QUINN, BURGESS, HOUGHTON, TANCREDO, BRADY of Texas and SAXTON changed their vote from ''yea'' to ''nay.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore (Mr. SIMPSON). 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.

RECORDED VOTE

Mr. CONYERS. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 229, noes 196, answered ''present'' 1, not voting 8, as follows:

[Roll No. 64]

AYES—229

Aderholt
Akin
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Cardoza
Carter
Castle
Chabot
Chocola
Cole
Collins
Cox
Cramer
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, M.
Dooley (CA)
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gillmor
Gingrey
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Holden
Hostettler
Houghton
Hulshof
Hunter
Isakson
Issa
Janklow
Johnson (CT)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
Matheson
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Murtha
Musgrave
Myrick
Nethercutt
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Scott (GA)
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Stenholm
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOES—196

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Coble
Conyers
Cooper
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
Delahunt
DeLauro
Deutsch
Diaz-Balart, L.
Dicks
Dingell
Doggett
Doolittle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Flake
Ford
Frank (MA)
Frost
Gephardt
Gonzalez
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Istook
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Jenkins
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (NY)
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lynch
Majette
Maloney
Markey
Marshall
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Terry
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

ANSWERED ''PRESENT''—1

Bachus

NOT VOTING—8

Combest
DeGette
Doyle
Gilchrest
Hyde
Johnson (IL)
Shuster
Snyder

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1516

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed a bill of the following title in which the concurrence of the House is requested:

S. 3. An act to prohibit the procedure commonly known as partial-birth abortion.

The message also announced that pursuant to section 276d–276g of title 22, United States Code, as amended, the Chair, on behalf of the Vice President, appoints the Senator from Idaho (Mr. CRAPO) as Chairman of the Senate Delegation to the Canada-United States Interparliamentary Group conference during the One Hundred Eighth Congress.

The message also announced that in accordance with section 1928a–1928d of title 22, United States Code, as amended, the Chair, on behalf of the Vice President, appoints the Senator from Delaware (Mr. BIDEN) as Vice Chairman of the Senate Delegation to the North Atlantic Treaty Organization Parliamentary Assembly during the One Hundred Eighth Congress.

ANNOUNCEMENT BY COMMITTEE ON RULES REGARDING H.R. 975, BANKRUPTCY ABUSE PREVENTION AND CONSUMER PROTECTION ACT OF 2003

Mr. DREIER. Mr. Speaker, the Committee on Rules may meet the week of March 17 to grant a rule which could limit the amendment process for floor consideration of H.R. 975, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2003. Any Member wishing to offer an amendment should submit 55 copies of the amendment and one copy of a brief explanation to the Committee on Rules up in room H–312 of the Capitol by noon on Tuesday, March 18. Members should draft their amendments to the bill as reported by the Committee on the Judiciary on March 12, 2003. Members are advised that the text should be available for their review on the Web sites of the Committee on the Judiciary and the Committee on Rules by Friday, March 14.

Members should use the Office of Legislative Counsel to ensure that their amendments are properly drafted and should check with the Office of the Parliamentarian to be sure their amendments comply with the rules of the House.

ANNOUNCEMENT BY COMMITTEE ON RULES REGARDING CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2004

Mr. DREIER. Mr. Speaker, the Committee on Rules may meet the week of March 17 to grant a rule which could limit the amendment process for the concurrent resolution on the budget for fiscal year 2004. Any Member who wishes to offer an amendment should submit 55 copies of the amendment and one copy of a brief explanation of the