107TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 107–693
Part 2

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

SEPTEMBER 25, 2002.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 4600]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4600) to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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81–872

AMENDMENT

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

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

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 3. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years 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 injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years 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.

SEC. 7. PUNITIVE DAMAGES.

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

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

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

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 9. DEFINITIONS.

In this Act:

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

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

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

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

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

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

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term "compensatory damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term "compensatory damages" includes economic damages and 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 statutory limit (whether enacted before, on, or after the date of the enactment of this Act) on the amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, whether or not such State limit permits the recovery of a specific dollar amount of damages that is greater or lesser than is provided for under this Act, notwithstanding section 4(a); or

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

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

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

SEC. 13. SENSE OF CONGRESS.

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

PURPOSE AND SUMMARY

H.R. 4600 seeks to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

BACKGROUND AND NEED FOR LEGISLATION

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

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

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

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

The mere threat of a health care lawsuit is so perverse that many doctors engage in defensive medicine. Stanford economists Daniel Kessler and Mark McClellan have conducted studies using national data on Medicare populations and concluded that patients from states that adopted medical care litigation reforms—such as limiting non-economic damage awards (pain and suffering)—incur significantly lower hospital costs while suffering no increase in adverse health outcomes associated with the illness for which they were treated. Based on these studies, the authors have quantified the cost of "defensive medicine," in which doctors perform tests and prescribe medicines that are not necessary to better the health of the patient, but rather serve as a precautionary step just in case the doctor is named in a lawsuit. Published in the Quarterly Journal of Economics, their study, "Do Doctors Practice Defensive Medicine," estimates that direct medical care litigation reforms could lead to reductions of well over $50 billion per year in health care expenditures, without serious adverse consequences for patients.

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

Overall, according to data of the National Association of Insurance Commissioners, the rate of increase in medical liability premiums in California since 1976 has been a very modest 167%, whereas the rest of the United States has experienced a 505% rate of increase. The price of some lines of medical liability insurance have even gone down significantly in California after MICRA was enacted. According to the Doctor's Company, in 1976, when California's MICRA law went into effect, the average medical malpractice premium was $23,698 in 2001 dollars. In 2001, the average premium was only $14,107.

On July 24, 2002, President Bush called on Congress to pass legislation that includes minimum standards to make the medical liability system more fair, predictable, and timely. Several of the provisions are similar to California's MICRA. H.R. 4600 includes many of the provisions outlined by President Bush.

HEARINGS

The Subcommittee on Health held a hearing on "Harming Patient Access to Care: The Impact of Excessive Litigation" on July 17, 2002. The Subcommittee received testimony from: Lisa Hollier, M.D., on behalf of the American College of Obstetricians and Gynecologists; Sam Roberts, M.D.; Mr. Stuart H. Fine, Chief Executive Officer, Grand View Hospital, on behalf of the American Hospital Association; Ms. Lauren Townsend, Coalition for Consumer Justice; Ms. Fran Visco, President, National Breast Cancer Coalition; Richard Anderson, M.D., CEO, The Doctor's Company, on behalf of the Physician Insurers Association of America; Mr. Jamie Court, on behalf of the Foundation for Taxpayer and Consumer Rights; Mr. Travis Plunkett, on behalf of the Consumer Federation of America; Victor E. Schwartz, Esq., Shook, Hardy & Bacon L.L.P.; and Mr. Jim Hurly, on behalf of the American Academy of Actuaries.

COMMITTEE CONSIDERATION

On September 18, 2002 the Full Committee met in open markup session and favorably ordered reported H.R. 4600, as amended, by a roll call vote of 27 yeas and 22 nays, a quorum being present.

COMMITTEE VOTES

Clause 3(b) of rule XII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion

to report legislation and amendments thereto. The following are the recorded votes taken on the motion by Mr. Tauzin to order H.R. 4600 reported to the House, and on the amendments offered to the measure, including the names of those members voting for and against.

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 63

BILL: H.R. 4600, Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002.

AMENDMENT: An amendment to the amendment in the nature of a substitute offered by Mr. Waxman, No 1a, to strike subsection (c) of section 7, which states that no civil monetary penalties may be awarded against the manufacturer or distributor for products that comply with the Food and Drug Administration standards.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 22 yeas to 27 nays.

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

9/18/2002

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 64

BILL: H.R. 4600, Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002.

AMENDMENT: An amendment to the amendment in the nature of a substitute offered by Mr. Green, No 1b, to strike all after the enacting clause and insert language expressing the sense of Congress concerning the role of States in medical liability.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas to 23 nays.

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

9/18/2002

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 65

BILL: H.R. 4600, Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002.

AMENDMENT: An amendment to the amendment in the nature of a substitute offered by Ms. Degette, No 1c, to strike subsections (b) and (c) of section 4 providing guidelines for the award of noneconomic damages.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 19 yeas to 33 nays.

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

9/18/2002

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 66

BILL: H.R. 4600, Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002.

AMENDMENT: An amendment to the amendment in the nature of a substitute offered by Mr. Markey, No 1d, to require health care liability insurance companies to pay an amount equal to savings realized by limits on the amount of damage awards in health care lawsuits to a trustee appointed by the court who is directed to redistribute the savings to reduce premiums for health care liability insurance.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 18 yeas to 31 nays.

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

9/18/2002

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 67

BILL: H.R. 4600, Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002.

AMENDMENT: An amendment to the amendment in the nature of a substitute offered by Ms. Eshoo, No 1e, to strike subsection (c) of section 7, which states that no civil monetary penalties may be awarded against the manufacturer or distributor for products that comply with the Food and Drug Administration standards, and to insert language to section 9 defining the terms "health care lawsuit," "health care liability action," and "health care liability claim."

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas to 29 nays.

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

9/18/2002

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 68

BILL: H.R. 4600, Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002.

AMENDMENT: An amendment to the amendment in the nature of a substitute offered by Ms. Eshoo, No 1h, to strike paragraph (2) of section 7(b), which limits the maximum punitive damages awarded to two times the amount of economic damages awarded or $250,000, whichever is greater.

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

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

9/18/2002

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 69

BILL: H.R. 4600, Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002.

AMENDMENT: An amendment to the amendment in the nature of a substitute offered by Mr. Stupak, No 1i, to change the statue of limitations.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas to 28 nays.

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

9/18/2002

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 70

BILL: H.R. 4600, Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002.

AMENDMENT: Motion by Mr. Tauzin to order H.R. 4600 reported to the House, amended.

DISPOSITION: **AGREED TO**, by a roll call vote of 27 yeas to 22 nays.

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

9/18/2002

COMMITTEE OVERSIGHT FINDINGS

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

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVE

To improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 4600, the Help, Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

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

CONGRESSIONAL BUDGET OFFICE ESTIMATE

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

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 25, 2002.

Hon. W.J. "BILLY" TAUZIN,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4600, the Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Alexis Ahlstrom (for federal revenues and spending), and Stuart Hagen (for the private-sector impact).

Sincerely,

STEVEN LIEBERMAN
(For Dan L. Crippen, Director).

Enclosure.

H.R. 4600—Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002

Summary: H.R. 4600 would impose limits on medical malpractice litigation in state and federal courts by capping awards and attorney fees, reducing the statute of limitations, eliminating joint and

several liability, and changing the way collateral-source benefits are treated.

Those changes would lower the cost of malpractice insurance for physicians, hospitals, and other health care providers and organizations. That reduction in insurance costs would, in turn, lead to lower charges for health care services and procedures, and ultimately, to a decrease in rates for health insurance premiums.

Because employers would pay less for health insurance for employees, more of their employees' compensation would be in the form of taxable wages and fringe benefits. As a result, CBO estimates that enacting H.R. 4600 would increase federal revenues by $40 million in 2003 and by $2.4 billion over the 2003–2012 period.

Enacting H.R. 4600 also would reduce federal direct spending for Medicare, Medicaid, the government's share of premiums for annuitants under the Federal Employees Health Benefits (FEHB) program, and other federal health benefits programs. CBO estimates that direct spending would decline by $11.3 billion over the 2004–2012 period. Because the bill would affect revenues and direct spending, pay-as-you-go procedures would apply.

Federal spending for active workers participating in the FEHB program is included in the appropriations for federal agencies, and therefore is discretionary. CBO estimates that enactment of H.R. 4600 would reduce discretionary spending for the FEHB program by about $400 million over the 2004–2012 period.

The bill would preempt state laws that provide less protection for health care providers and organizations from liability, loss, or damages (other than caps on awards for damages). That preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA). Such a preemption would limit the application of state law, but it would require no action by states that would result in additional spending or a loss of revenue. Thus, the threshold established by UMRA for intergovernmental mandates ($58 million in 2002, adjusted annually for inflation) would not be exceeded.

H.R. 4600 would impose a private-sector mandate on attorneys in malpractice cases by limiting the size of the awards they could receive. CBO estimates that the direct cost of that mandate would exceed the annual threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation) in each of the first five years the mandate would be effective.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 4600 is shown in the following table. The effects of this legislation on direct spending fall within budget functions 550 (health) and 570 (Medicare). The effects on spending subject to appropriation fall within multiple budget functions.

	By fiscal year, in millions of dollars—										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003–2012
CHANGES IN REVENUES											
Income and HI Payroll Taxes (on-budget) ...	30	80	130	160	170	180	190	210	240	260	1,650
Social Security Payroll Taxes (off-budget) ..	10	30	60	70	80	90	90	100	110	110	750
Total	40	110	190	230	250	270	280	310	350	370	2,400
CHANGES IN DIRECT SPENDING											
Estimated Budget Authority	0	−250	−390	−690	−1,220	−1,520	−1,660	−1,770	−1,880	−1,920	−11,300

	By fiscal year, in millions of dollars—										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003–2012
Estimated Outlays	0	−250	−390	−690	−1,220	−1,520	−1,660	−1,770	−1,880	−1,920	−11,300
CHANGES IN SPENDING SUBJECT TO APPROPRIATION											
Estimated Authorization Level	0	−20	−40	−40	−40	−50	−50	−50	−50	−60	−400
Estimated Outlays	0	−20	−40	−40	−40	−50	−50	−50	−50	−60	−400

Note.—HI = Medicare Hospital Insurance program.

Basis of estimate: This estimate assumes that H.R. 4600 will be enacted in October 2002. It would apply to lawsuits initiated on or after the date of enactment.

Major provisions of the bill

H.R. 4600 would place caps on awards by limiting non-economic damages, such as pain and suffering, to $250,000, and punitive damages to twice the amount of economic damages or $250,000, whichever is greater. Punitive damages would be further constrained by limiting the circumstances under which they may be sought. Economic, or compensatory, damages would not be limited. Attorney fees would be restricted as follows: 40 percent of the first $50,000 of the award, 33.3 percent of the next $50,000 of the award, 25 percent of the next $500,000, and 15 percent of that portion of the award in excess of $600,000. The caps on attorney fees would apply regardless of whether the award was determined in the courts or settled privately, and could be reduced further at the discretion of the court. (The court could not, however, increase attorney fees beyond the caps.) For awards of future damages equal to or exceeding $50,000, any party to the lawsuit could request that future damages be paid by periodic payments.

The bill would impose a statute of limitations requiring that lawsuits begin within three years after the injury alleged to have happened as a result of malpractice occurs or one year after the claimant discovers, or should have discovered, the injury, whichever occurs first. Under the joint and several liability provisions of current law, defendants found negligent in a lawsuit are each liable for the full amount of damages, regardless of their proportionate share of responsibility for the injury. H.R. 4600 would limit the liability of each defendant to the share of damages attributable to his or her responsibility.

Collateral-source benefits are other sources of compensation a claimant may have access to in the event of an injury. A common source of such benefits is the claimant's health insurance, which would likely pay for a portion of the medical costs arising from the injury. Other sources include disability insurance payments, workers' compensation, and life insurance payments. The bill would allow evidence of such benefits to be introduced at trial by either claimants or defendants. In addition, providers of collateral-source benefits would not be allowed to place a lien on the claimant's award or recover any amount from the claimant, whether or not the case goes to trial.

Impact on medical malpractice insurance premiums

CBO's estimate of the impact of this bill is based on a statistical analysis of historical premiums for medical malpractice insurance coverage in states that have and have not enacted medical mal-

practice tort limitations. We conducted another analysis using medical malpractice claims data provided by the Physician Insurers Association of America. CBO also considered the impact of factors not directly related to trends in malpractice claim payments that may have contributed to recent increases in medical malpractice premiums. Those factors include reduced investment income of insurers, the need of insurers to replenish depleted reserves, and recent increases in reinsurance costs for all types of insurance.

CBO's analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 4600 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law. That effect would increase somewhat over the ten-year time horizon of this estimate because caps on awards would not be indexed to increase with inflation. As a result, the caps on awards would become more constraining in later years.

CBO estimates that, under this bill, premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law. However, other factors discussed above may exert upward pressure on future premiums, possibly obscuring at least some of the anticipated effect of the legislation. The effect of H.R. 4600 would vary substantially across states, depending on the extent to which a state already limits its malpractice litigation. There would be almost no effect on malpractice premiums in about one-quarter of the states, while reductions in premiums would be substantially larger than the overall average in about one-third of the states.

Impact on health insurance premiums

The percentage effect of H.R. 4600 on overall health insurance premiums would be far smaller than the percentage impact on medical malpractice insurance premiums. Malpractice cost account for a very small fraction of total health care spending; even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums. In addition, some of the savings leading to lower medical malpractice rpemiums—those savings arising from changes in the treatment of collateral-source benefits—would represent a shift in costs from medical malpractice insurance to health insurance. Because providers of collateral-source benefits would be prevented from recovering their costs arising from the malpractice injury, some of the costs that would be borne by malpractice insurance under current law would instead be borne by the providers of collateral-source benefits. Most such providers are health insurers.

CBO's estimate does not include savings from reductions in the practice of defensive medicine—services and procedures that are provided largely or entirely to avoid potential liability. Estimating the amount of health care spending attributable to defense medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty

about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.

A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments that are disproportionately likely to experience malpractice claims. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending. Although the provisions of H.R. 4600 could result in the initiation of fewer lawsuits, the economic incentives for individual physicians or hospitals to practice defensive medicine would appear to be little changed.

Nonetheless, while there is insufficient evidence to justify including a defensive medicine adjustment in the estimate, the promising nature of the studies' results merits further analysis. CBO has obtained a person-based longitudinal database that contains detailed claims information on Medicare spending for covered services used by a random sample of fee-for-service beneficiaries between 1989 and 1997. Using these data, CBO hopes to expand the analysis of earlier researchers to include broader measures of spending (including hospital services, physician care, post-acute care, and ancillary services) and a larger number of conditions, to help determine the extent to which the results of the earlier studies may apply to overall health care spending.

Federal revenues

CBO estimates that, over a three-year period, enacting H.R. 4600 would lower the price employers, state and local governments, and individuals pay for health insurance by about 0.4 percent, before accounting for the responses of health plans, employers, and workers to the lower premiums. Those responses would include an increase in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered, and increases in the scope or generosity of health insurance benefits. CBO assumes that these behavioral responses would offset 60 percent of the potential impact of the bill on the total costs of health plans.

The remaining 40 percent of the potential reduction in premium costs, or about 0.2 percent of group health insurance premiums, would occur in the form of lower spending for health insurance. Those savings would be passed through to workers, increasing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumes that all of that savings would ultimately be passed through to workers. We assume that state, local, and tribal governments would absorb 75 percent of the decrease and would increase their workers' taxable income and other fringe benefits to offset the remaining one-quarter of the decrease. CBO estimates that the resulting increase in taxable income would grow from $126 million in calendar year 2003 to $1.1 billion in 2012.

Those increases in workers' taxable compensation would lead to more federal tax revenues. The estimate assumes an average marginal rate of about 20 percent for income taxes and the current-law rates for the Hospital Insurance and Social Security payroll taxes (2.9 percent and 12.4 percent, respectively). CBO further assumes that 15 percent of the change in taxable compensation would not be subject to the Social Security payroll tax. As a result, we estimate that federal tax revenues would increase by $40 million in 2003 and by a total of $2.4 billion over the 2003–2012 period if H.R. 4600 were enacted. Social Security payroll taxes, which are off-budget, account for about 30 percent of those totals.

Federal spending

CBO estimates that H.R. 4600 would reduce direct spending for federal health insurance programs by $11.3 billion over the 2004–2012 period. Those totals reflect reductions in spending resulting from the effect of lower premiums for malpractice insurance, partially offset by increases in direct spending because federal programs could no longer collect collateral-source benefits.

CBO estimates that premiums for the Federal Employees Health Benefits (FEHB) program would decline by the same 0.4 percent as the estimated average change in premiums for private health insurance. (That estimate includes the effects of H.R. 4600 on both premiums for malpractice insurance and the collection of collateral-source benefits.) We assume that participants in the FEHB program would offset 60 percent of that reduction by choosing more expensive plans, so that spending for the FEHB program would decline by about 0.2 percent. The 2003 premiums for FEHB plans have already been announced, so there would be no effect on FEHB spending in 2003. Federal spending for annuitants in the FEHB program is considered direct spending. CBO estimates that H.R. 4600 would reduce direct spending for annuitants in FEHB by $270 million over the 2004–2012 period. Federal spending for active workers participating in the FEHB program is included in the appropriations for federal agencies, and therefore is discretionary. CBO estimates that enactment of H.R. 4600 would reduce discretionary spending for FEHB by about $400 million over the 2004–2012 period. Spending for postal workers and postal annuitants participating in the FEHB program is off-budget. CBO estimates that changes in spending for Postal Service participants would be offset by changes in the prices of postal services, and therefore would net to zero.

Each year, the Centers for Medicare & Medicaid Services sets Medicare payment rates for physician services and hospital services that include explicit adjustments for changes in the cost of malpractice premiums. CBO estimates that H.R. 4600 would have no effect on Medicare spending in 2003, because payment rates have already been set for hospital services and will be set for physician services before the effects of the bill could be incorporated in the rate-setting process. CBO estimates that incorporating lower malpractice premiums in Medicare payment rates would reduce Medicare spending by $10.8 billion over the 2004–2012 period.

CBO assumes that the rates that state Medicaid programs pay for hospital and physician services would change in proportion to the changes in Medicare payments. In addition, lower Medicare

payment rates would result in lower payments by beneficiaries for cost sharing and premiums. Therefore, H.R. 4600 would reduce spending by federal programs that pay premiums and cost sharing for certain Medicare beneficiaries—Medicaid and the Tricare for Life program of the Department of Defense (DoD). CBO estimates that H.R. 4600 would reduce direct spending for Medicaid and DoD by $3.6 billion over the 2004–2012 period.

Under current law, Medicare and Medicaid pay the medical costs arising from medical malpractice injuries. In the event that a patient wins a settlement, the programs require reimbursement for the costs they incurred. H.R. 4600 would prohibit Medicare and Medicaid from making any future collections. CBO estimates that implementing this provision would increase outlays by $3.4 billion over the 2004–2012 period.

Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects through 2006 are counted.

	By fiscal year, in millions of dollars—										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Changes in receipts	0	30	80	130	160	170	180	190	210	240	260
Changes in outlays	0	0	−250	−390	−690	−1,220	−1,520	−1,660	−1,770	−1,880	−1,920

Intergovernmental and private-sector impacts: The Unfunded Mandates Reform Act defines a mandate as legislation that "would impose an enforceable duty" upon the private sector or a state, local, or tribal government. CBO believes that UMRA's definition of a mandate does not include legislation that would, for example, impose requirements or limitations on recoveries, address burdens of proof, or modify evidentiary rules because such changes would be methods of enforcing existing duties, rather than new duties themselves as contemplated by UMRA. The provisions of H.R. 4600 would not impose or change the underlying enforceable duties or standards of care applicable to those providing medical items and services under current law. Rather, they would address the enforcement of existing standards of professional behavior through tort litigation procedures.

Clearly, a cap on recoveries of damages from medical malpractice would lower recoveries by future plaintiffs while reducing the costs borne by potential defendants. This cost effect, however, would not itself establish a new mandate. It would be more reasonably viewed as part of the process for enforcing the professional duties of medical providers, rather than an enforceable duty as defined by UMRA.

Intergovernmental mandates and other public-sector impacts

Intergovernmental mandates. The bill would preempt state laws that would prevent the application of any provisions of the bill, but it would not preempt any state law that provides greater protections for health care providers and organizations from liability, loss, or damages. Those that provide a lesser degree of protection would be preempted. (State laws governing damage awards would not be preempted, regardless of whether they were higher or lower than the caps provided for in the bill.) These preemptions would limit the application of state law, but they would require no action by states that would result in additional spending or a loss of revenue. Thus, the threshold established by UMRA for intergovernmental mandates ($58 million in 2002, adjusted annually for inflation) would not be exceeded.

Other Public-Sector Impacts. State, local, and tribal governments would realize net savings as a result of provisions of H.R. 4600. State, local, and tribal governments that assess income taxes also would realize increased tax revenues as a result of increases in workers' taxable income. CBO has not estimated the magnitude of those increased revenues.

State, local, and tribal government would save money as a result of lower health insurance premiums precipitated by the bill. Based on information from the Bureau of the Census and the Joint Committee on Taxation and on our estimates of the effect of the bill on health care premiums, CBO estimated that state and local governments would save about $5 billion over the 2003–2012 period as a result of lower premiums for health care benefits they provide to their employees. That figure is based on estimates of state and local spending for health care growing from about $95 billion in 2003 to $189 billion in 2012 and an expectation that savings would phase in over a three-year period. The estimate accounts for some loss in receipts because state health, sickness, income-disability, ac-

cident, and workers' compensation programs would no longer be able to recover a share of malpractice damage awards.

State and local governments also would save Medicaid costs as a result of lower health care spending, CBO estimates that state Medicaid spending would decrease by about $2 billion over the 2003–2012 period.

Private-sector mandates and other impacts

The bill would impose a private-sector mandate on attorneys in malpractice cases by limiting the size of the awards they could receive. CBO estimates that the direct cost of that mandate to affected attorneys would amount to about $140 million in 2003, rising to about $320 million in 2007. Those costs would exceed the annual threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation) in each of the first five years the mandate would be effective.

Previous CBO estimate: On September 24, 2002, CBO produced a cost estimate for H.R. 4600 as ordered reported by the House Committee on the Judiciary on September 10, 2002. The two bills are identical with the exception of a minor difference in the set of exceptions to the statute of limitations. That difference does not effect CBO's estimate of the impact of the bill in premiums for health insurance, on federal revenues and spending, on state, local, or tribal governments, or on the private sector.

Estimate prepared by: Federal Revenues: Alexis Ahlstrom. Federal Outlays: Medicaid—Jeanne De Sa and Eric Rollins; Medicare—Julia Christensen and Alexis Ahlstrom; and FEHB—Alexis Ahlstrom. Impact on State Local, and Tribal Governments: Leo Lex. Impact on the Private Sector: Stuart Hagen.

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

FEDERAL MANDATES STATEMENT

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

ADVISORY COMMITTEE STATEMENT

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

CONSTITUTIONAL AUTHORITY STATEMENT

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

APPLICABILITY TO LEGISLATIVE BRANCH

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

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 establishes the short title of the bill as the "Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002".

Section 2. Findings and purpose

Section 2 states the findings and purpose of the bill.

Section 3. Encouraging speedy resolution of claims

Section 3 states that a health care lawsuit shall be commenced 3 years after the date of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. A health care lawsuit is defined in the legislation as meaning "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 good 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, marketers, 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." In no event shall the time for commencement of a health care lawsuit exceed 3 years unless tolled for any of the following: (1) upon proof of fraud; (2) intentional concealment; or, (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person. There is an exception for alleged injuries sustained by a minor before the age of 6, in which case a health care lawsuit may be commenced by or on behalf of the minor until the later of 3 years from the date of injury, or the date on which the minor attains the age of 8. This time period is tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

Section 4. Compensating patient injury

Section 4 provides that a claimant's economic loss may be fully recovered, without limitation. Economic loss includes, for example, objectively verifiable monetary losses, 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. In addition to unlimited recovery of economic loss, a claimant may recover up to $250,000 in non-economic damages. Non-economic 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, hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. In any healthcare lawsuit, an award for future noneconomic damages can not be discounted to present value. Juries are not to 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 the judgment, or by amendment of the judgment after entry. This section also establishes a fair share rule, thereby abolishing joint and several liability, that apportions damages in proportion to a defendant's degree of fault.

Section 5. Maximizing patient recovery

Section 5 requires that courts 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. This section establishes a sliding fee schedule for the payment of contingency fees from a claimant's damage recovery as follows: 40 percent of the first $50,000 recovered by the claimant; 33 ⅓ percent of the next $50,000 recovered by the claimant; 25 percent of the next $500,000 recovered by the claimant; and 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

Section 6. Additional health benefits

Section 6 clarifies that in any health care lawsuit, any party may introduce evidence of collateral source benefits received or reasonably likely to be received from other parties (and which benefits would cover the same injuries).

Section 7. Punitive damages

Section 7 states that punitive damages may be awarded, if otherwise permitted by applicable state or federal law, against any person in a health care lawsuit. The amount of punitive damages awarded may be as much as two times the amount of economic damages awarded or $250,000, whichever is greater. Juries are not to be informed of the formula. Punitive damages may only be awarded if it is first proven by clear and convincing evidence that a defendant acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. This section states that no demand for punitive damages shall be included in a health care lawsuit as initially filed. Punitive damages in healthcare lawsuits may not be awarded if compensatory damages are not awarded. This section allows for bifurcation procedures, at either party's request, so that the proceedings on punitive damages would be separate from and subsequent to the proceedings on compensatory damages.

This section does not permit the award of punitive damages against the manufacturer or distributor of a medical product based on a claim that the product caused the harm where: the product was subject to premarket approval or clearance by the Food and Drug Administration (FDA) with respect to the safety of the formulation or performance of the product or the adequacy of the labeling of the product, and the product was approved and cleared by the FDA; or, the medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the FDA and applicable regulations. This section prohibits a health care provider from being named as a party in a product liability lawsuit for prescribing a drug or device that is approved by

the Food and Drug Administration. Punitive damages may be awarded against a manufacturer or distributor of a medical product, however, if a person, before or after premarket approval or clearance of the product knowingly misrepresented or withheld information from the FDA that is required to be submitted that is material and causally related to the harm which the claimant allegedly suffered. Punitive damages may also be awarded if a person made an illegal payment to an FDA official for the purpose of either securing or maintaining approval or clearance.

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

Section 8 requires the court, at the request of any party, to order that the award of future damages equaling or exceeding $50,000 be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

Section 9. Definitions

Section 9 defines the terms included in the legislation.

Section 10. Effect on other laws

Section 10 states that this legislation does not apply to civil actions brought for a vaccine-related injury or death which is covered under provisions of the Public Health Service Act. It also states that nothing in the Act should affect any defense available to a defendant in a health care lawsuit or action under any other provision of federal law.

Section 11. State flexibility and protection of State's rights

Section 11 states that the provisions governing health care lawsuits outlined in the legislation preempt State law to the extent that State law prevents the application of these provisions. The legislation also supersedes the Federal Tort Claims Act (FTCA) to the extent that the FTCA provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced application of periodic payments of future damages. The FTCA is also superseded if it prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

Section 11 states that any issue that is not governed by any provision of law established by the legislation is governed by otherwise applicable state or federal law. The legislation does not preempt or supersede any law that imposes greater protections for health care providers and health care organizations from liability, loss, or damages.

Section 11 also states that this legislation does not preempt any state statutory limit (enacted before, on, or after the date of enactment of H.R. 4600) on the amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit.

Section 12. Applicability; effective date

Section 12 states that the provisions of the legislation apply to any health care lawsuit brought in federal or state court, or subject

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

DISSENTING VIEWS

We are concerned that many health care providers face difficulty obtaining reasonably priced medical malpractice insurance; this is a serious problem that merits attention. But this legislation was rushed through in a partisan fashion, and does not reflect a deliberative effort to craft a comprehensive and workable legislative solution in Committee.

The Subcommittee on Health held only one hearing on this matter in July. Despite testimony about the detrimental effect of this legislation on injured patients and about the need to more fully understand factors contributing to the insurance premium increases, not a single substantive change was made to the legislation. And a subcommittee markup was bypassed altogether. Instead, Members were given less than two days notice of a Full Committee markup. Every one of over a dozen amendments offered by the Minority was defeated on a partisan basis. Debate was limited after it was announced that the Republican leadership in the House had required the legislation to be reported after only just one afternoon's consideration. Clearly, this was not a process of bipartisan collaboration or one that would lend itself to addressing the problem thoroughly. The legislation is now being rushed to the Floor just one week after being reported, at the end of the session. Much less severe legislation against injured victims has already been defeated in the Senate, and with multiple necessary appropriations bills awaiting consideration on the Floor, the timing of this action is most curious.

The bill offers a "solution" prior to having discovered the root of the problem. Merely attacking injured patients' right of redress under the judicial system, as this bill does, is short-sighted, meanspirited, and ultimately will do little to address providers' concerns with malpractice insurance.

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

But while the rising cost of malpractice insurance is a very real concern for doctors and patients alike, we have serious reservations about this proposed "solution" for two primary reasons. *First,* what has caused the increase in malpractice insurance premiums is not easily identified. Moreover, it is not clear that this legislation will reduce the medical malpractice premiums that providers must pay

to insurance companies. *Second,* the scope and severity of the provisions in H.R. 4600 impose unreasonable restrictions on an injured patient's ability to hold wrongdoers accountable. The legislation provides nothing more than a shield for bad actors rather than meaningful reforms for overburdened doctors and providers.

To find an effective solution, we must closely examine the insurance industry and how its conduct affects medical malpractice premiums, an activity not undertaken by this Committee. Are medical malpractice insurers properly pricing their product? Are they accounting for their income and expenses while planning for expected downturns in the economy? Or, are they raising rates on doctors to compensate for questionable business judgments and accounting practices?

We know that many factors completely unrelated to jury verdicts and the civil justice system affect insurance rates: changes in state law and regulatory requirements; competitiveness of the insurance market; the types of policies issued within the industry; interest rates; and national economic trends. Moreover, there is scant evidence to date that various state tort reforms have realized appreciable premium savings. In a comparison of states that enacted severe tort restrictions during the mid-1980's and those that resisted enacting tort reform, a recent study found no correlation between tort reform and insurance rates.[1] Inflation adjusted premiums per doctor have actually declined over the past decade.[2] In California, which has one of the most restrictive malpractice laws in the country, the Medical Injury Compensation Reform Act (MICRA), premiums are 8% higher than premiums in states without non-economic damage caps.[3] At the same time, medical malpractice insurers in California are paying out in claims less than 50 cents on every dollar they have taken in through premiums.[4]

Insurance markets are subject to cycles, periods of underpricing of premiums to increase market share and book premium dollars, followed by a hardening of the market. Once the market hardens, competition intensifies, underwriting results deteriorate, and investment incomes fall. Insurance companies then need to raise premiums to cover losses. For example, as a result of the underpricing of insurance policies over the past decade, it would take a 50% hike in rates to increase inflation- adjusted rates to the same level as existed ten years ago.[5] We are now in the midst of a 'hard' phase of the insurance cycle and increases in malpractice premiums are consistent with overall market trends. This problem is not unique to malpractice insurance. While medical malpractice insurance premiums for the three riskiest specialties increased 10% from 2000 to 2001, auto insurance premiums saw similar increases of 8.4% during that same period.[6]

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[1] Center for Justice and Democracy, Premium Deceit—the Failure of Tort Reform to Cut Insurance Rates.

[2] Testimony of Travis Plunkett, before the Subcommittee on Health of the Committee on Energy and Commerce, July 17, 2001.

[3] Medical Liability Monitor, 2001.

[4] Testimony of Jamie Court, before the Subcommittee on Health of the Committee on Energy and Commerce, July 17, 2001.

[5] Testimony of Travis Plunkett, before the Subcommittee on Health of the Committee on Energy and Commerce, July 17, 2001.

[6] Public Citizen, Equal Opportunity Rate Hikes, July 2002.

A serious effort to provide relief to providers from high malpractice premiums would have looked at these and other issues. A number of Congressional Democrats have requested the General Accounting Office look into these questions so that we may make informed decisions about any federal action needed. The Committee, however, chose to take a one-sided approach.

In addition to the above mentioned concerns that H.R. 4600 is premature and may not remedy the current problem, draconian provisions in the legislation make it even more unpalatable. There are many flaws in the legislation, but our dissenting views will focus on four of the most egregious: the cap on non-economic damages; the cap on punitive damages; the "FDA defense"; and the overly restrictive statute of limitations.

Non-economic damages

H.R. 4600 limits non-economic damages to $250,000 for all claims against negligent hospitals and doctors, drug and device manufacturers, nursing homes, HMOs and other insurers. This cap is an aggregate cap; no matter how many defendants participated in causing the injury or the severity of the injury, the most an injured patient can recover is $250,000. Non-economic damages compensate patients for very real injuries such as the loss of a limb or eyesight, the loss of mobility, the loss of brain or organ function, the loss of fertility, severe disfigurement and excruciating, chronic pain Juries are not allowed to be told of this cap, presumably because proponents of this legislation do not want them to try to compensate for such a harsh limit in other areas.

The severity of this cap is astounding. The intent is to parallel the cap in California's MICRA law, which was enacted in 1975 and never indexed to inflation. The value of this cap has declined to a mere $40,389 in 2002 dollars. Using the Consumer Price Index for medical care, this cap today would be more than $1.5 million. In addition, the California law only applies to medical malpractice cases and not claims against drug and device manufacturers, HMOs, insurance companies, or nursing homes covered under H.R. 4600.

In addition, by capping non-economic damages, H.R. 4600 discriminates against women, children, the elderly, minorities, the unemployed and others who cannot show substantial economic loss (i.e., lost wages or salary). A child who suffers brain damage or other catastrophically debilitating injury would recoup little in economic damages, and would be left with a maximum of $250,000 for the remainder of his life, which could exceed 70 or 80 years.

Non-economic damages are also an important measure of compensatory damages for older persons, and in particular nursing facility residents. These individuals have neither long life expectancies nor large earning capacities, the traditional measures of economic damages. By so stringently limiting non-economic damages, H.R. 4600 would remove a strong financial incentive to nursing facilities to provide residents with decent care.

Punitive damages

The legislation sets a nearly impossible standard for awarding punitive damages and then limits such damages to twice economic

damages or $250,000, whichever is greater. By basing punitive damages on the level of economic losses, the bill discriminates against injured women, children, elderly and others who tend to have lower incomes. For example, if Ken Lay were injured while CEO of Enron, his economic damages would have been worth millions upon millions of dollars. If a stay-at-home mother were injured, she would have minimal economic damages awarded to her.

In order to assess punitive damages, H.R. 4600 imposes a federal standard of "clear and convincing" evidence that (1) the defendant acted with malicious intent to injure or (2) the defendant understood the plaintiff was substantially certain to suffer unnecessary injury yet deliberately failed to avoid such injury. This standard of "malicious intent" requires more than criminal misconduct; such a standard would likely protect a drunk doctor who kills a patient because a court would likely hold that the doctor was unable to form the necessary intent.

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

FDA defense

H.R. 4600 goes beyond protecting providers from malpractice awards; it also provides immunity from punitive damages to manufacturers of drugs and devices that are approved or cleared by the FDA as well as those that are not FDA-approved but are "generally recognized as safe and effective," and to products that comply with packaging regulations. This is akin to arguing that because someone drives at the speed limit, they cannot be negligent or reckless. It is clearly possible to obey the speed limit, yet still act in a negligent or reckless manner.

Approval of drugs and devices by the FDA provides no guarantee that a particular device is not defective, that the manufacturer has continued to maintain safety after approval, or that all problems are discovered before approval. This topic was the subject of considerable debate in Committee. Proponents of the provision argued that because the bill includes an exception for cases where information was knowingly misrepresented or withheld from the FDA and the FDA requires manufacturers to report certain items to the FDA, if a manufacturer did not report problems, such manufacturer would not be exempted from punitive damages.

Notwithstanding the fact that the exception referenced only applies to withholding or misrepresenting information to the FDA, and thus protecting a manufacturer from punitive damages if it blatantly misrepresented its product to the public, there are numerous other problems with this provision. Manufacturers are not required to report all problems with manufacturing or changes in their process to the FDA. Moreover, some of the reports are only filed annually. What of patients injured before the report is filed?

After approval, the FDA does not review individual drugs for manufacturing defects and the FDA does not have nearly enough

resources to continuously monitor the conditions in every facility here and abroad. And, in particular now that approvals have been accelerated, the FDA ends up withdrawing approved drugs from the market for safety problems discovered after the approval. Also, dozens of cleared devices are recalled from the market each year for safety or effectiveness problems not identified in the clearance process. In the meantime, patients have been injured. The FDA cannot be omnipresent, nor should it be.

If enacted this provision could have the perverse incentive of encouraging manufacturers to be disengaged in quality monitoring in their manufacturing process. If a manufacturer does not know about problems, they cannot be accused of failing to report the problems to the FDA. Basically, what they don't know can't hurt them, but could surely hurt consumers.

Ultimately, by shielding manufacturers of dangerous or defective drugs from exposure to punitive damages, this bill would remove incentives for manufacturers to make the safest products and to quickly withdraw dangerous products from the market. Congress should not reduce any incentives for the industry to police itself above and beyond government regulation.

Statute of limitations

H.R. 4600 also sets a stringent federal statute of limitations on state tort cases. The statute of limitations for bringing an action is the earlier of three years after the date of injury or one year after the date of discovery, but in no event shall the time for commencement of a lawsuit exceed three years. This provision also was subject to considerable debate in Committee, with particular focus of the effect of this absolute time limit. While some injuries are manifested immediately, many times malpractice or product defects are not manifested or diagnosed for some time, for example, a hemophiliac who contracts HIV from tainted blood may not learn of the disease until five years later. By establishing a absolute time limit for filing a case this legislation would completely preclude many injured patients from any recourse and would therefore shield negligent practitioners, facilities, and manufacturers from any liability whatsoever.

To conclude, the legislation before us today focuses on drastic reforms of the judicial system and extends those draconian reforms beyond the realm of medical malpractice rather than focusing on the underlying causes of the medical malpractice premium increases facing providers. While inefficiencies in our courts may be a contributing factor to the current crisis, they are by no means the only cause—or even the single largest cause—of the current crisis.

Moreover, even if we accepted the notion that verdicts and settlements benefitting injured patients have increased significantly, which is less than clear, it is our responsibility to examine why judgments favorable to victims are on the rise—a factor this legislation does not even touch upon. Are there fatal flaws with our health care delivery system and HMO's that cause more medical errors and patient injuries? Failure to examine all aspects of the problem is irresponsible, and in this instance will wind up disproportionately hurting women, children, elderly, and others who

are injured as a result of the few careless or even malicious health care providers

The rise in malpractice premiums is a real problem that calls for real reform. All aspects of this crisis should be examined thoroughly and responsibly. And above all, any legislative solution should strike a careful balance preserving an injured patient's right to just compensation and the delivery of health care without unreasonable costs of insurance.

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PETER DEUTSCH.
TOM SAWYER.

DISSENTING VIEWS

We believe that H.R. 4600 is a gross violation of the constitutional concept of federalism. H.R. 4600 would make many changes to the common law that severally limit the traditional rights of plaintiffs seeking damages from the malpractice of physicians and negligence from a variety of health related entities including Health Maintenance Organizations and pharmaceutical manufacturers and distributors. This bill is not a matter to be decided by Congress because it proposes tort reforms that are traditionally, and possibly constitutionally, areas for decisions by state legislatures.

Many of the supporters of H.R. 4600 have stated that the bill is similar to California's Medical Injury Compensation Reform Act (MICRA), and that MICRA has been successful for California. MICRA is a law that the California state legislature enacted based on the particular needs of California and its citizens. Even assuming that MICRA has been successful for California, Congress cannot determine that a blanket one-size-fits-all medical malpractice bill based on MICRA will be successful for any other state.

Yet another reason a federal one-size-fits-all approach to medical malpractice reform is not warranted is that all fifty states have already addressed medical malpractice to varying degrees. About half of all states are either reviewing their medical malpractice laws or are expected to review their laws this year. Not only are states dealing with medical malpractice on their own, many state courts have held various portions of state medical malpractice laws unconstitutional. In twenty states, courts have ruled that caps on damages are unconstitutional and eighteen state courts have ruled that their statutes of limitations are unconstitutional. Since the issue of medical malpractice reform is under consideration in the states, there is no rationale for federal action.

Furthermore, H.R. 4600 would make sweeping changes to common law traditions by eliminating joint and several liability, capping the amount of non-economic damages, limiting punitive damages, and severely restricting the time for recovery by victims of medical malpractice. Under common law, defendants are joint and severally liable for harm to plaintiffs to ensure that the victims can actually recover damages for their injuries. Yet, H.R. 4600 entirely eliminates joint and several liability for medical malpractice lawsuits, which means victims are less likely to receive compensation for their injuries and the defendants who caused harm are insulated from having to pay for their mistakes.

Additionally, H.R. 4600 caps non-economic damages at $250,000 in the aggregate. Non-economic damages compensate victims for injuries that are very real. These are injuries like the loss of a leg, disfigurement, pain and suffering, and the loss of fertility. Under common law, non-economic damages are not capped. By limiting

non-economic damages to $250,000, H.R. 4600 insures that victims receive arbitrary compensation for the horrendous and oftentimes permanent injuries they suffer, rather than allowing a jury to determine the appropriate level of compensation in each individual case.

H.R. 4600 also severely limits the awarding of punitive damages. According to common law, a plaintiff must prove "reckless indifference," in order to win punitive damages. Yet, H.R. 4600 would require plaintiffs to prove "malicious intent to injure," which is much more difficult to prove. This ensures that only in the most egregious cases will punitive damages be imposed. Additionally, the bill would protect manufacturers and distributors of medical products by shielding them from punitive damages if their products were approved by the Federal Drug Administration or, even more problematic, if their products were "generally recognized among qualified experts as safe and effective."

H.R. 4600 is an affront to states' rights. Congress should not become an uber-state legislature by passing a bill to significantly restructure what is most appropriately a matter for state governments.

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