115TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 115–55
Part 1

PROTECTING ACCESS TO CARE ACT OF 2017

MARCH 22, 2017.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. GOODLATTE, from the Committee on the Judiciary, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 1215]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 1215) 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.

CONTENTS

69–006

The Amendment

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Protecting Access to Care Act of 2017".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) STATUTE OF LIMITATIONS.—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 after the date of injury unless tolled for any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

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

Actions by a minor shall be commenced within 3 years from the date of the injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of injury, or 1 year after the injury is discovered, or through the use of reasonable diligence should have been discovered, 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 have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(b) STATE FLEXIBILITY.—No provision of subsection (a) shall be construed to preempt any state law (whether effective before, on, or after the date of the enactment of this Act) that—

(1) specifies a time period of less than 3 years after the date of injury or less than 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, for the filing of a health care lawsuit;

(2) that specifies a different time period for the filing of lawsuits by a minor;

(3) that triggers the time period based on the date of the alleged negligence; or

(4) establishes a statute of repose for the filing of health care lawsuit.

SEC. 3. COMPENSATING PATIENT INJURY.

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

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, shall not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

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

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a

judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

(e) STATE FLEXIBILITY.—No provision of this section shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of economic or noneconomic damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this section.

SEC. 4. MAXIMIZING PATIENT RECOVERY.

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

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

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

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

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

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

(c) STATE FLEXIBILITY.—No provision of this section shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a lesser percentage or lesser total value of damages which may be claimed by an attorney representing a claimant in a health care lawsuit.

SEC. 5. 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.

(c) STATE FLEXIBILITY.—No provision of this section shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies periodic payments for future damages at any amount other than $50,000 or that mandates such payments absent the request of either party.

SEC. 6. PRODUCT LIABILITY FOR HEALTH CARE PROVIDERS.

A health care provider who prescribes, or who dispenses pursuant to a prescription, a medical product approved, licensed, or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product.

SEC. 7. 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 liabil-

ity 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) 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.

(5) ECONOMIC DAMAGES.—The term "economic damages" means objectively verifiable monetary losses incurred as a result of the provision or use of (or failure to provide or use) 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, unless otherwise defined under applicable state law. In no circumstances shall damages for health care services or medical products exceed the amount actually paid or incurred by or on behalf of the claimant.

(6) FUTURE DAMAGES.—The term "future damages" means any damages that are incurred after the date of judgment, settlement, or other resolution (including mediation, or any other form of alternative dispute resolution).

(7) HEALTH CARE LAWSUIT.—The term "health care lawsuit" means any health care liability claim concerning the provision of goods or services for which coverage was provided in whole or in part via a Federal program, subsidy or tax benefit, or any health care liability action concerning the provision of goods or services for which coverage was provided in whole or in part via a Federal program, subsidy or tax benefit, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term "health care liability action" means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider 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, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision or use of (or the failure to provide or use) 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 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, as well as any other individual or entity defined as a health care provider, health care professional, or health care institution under state law.

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

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

(13) 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 incurred as a result of the provision or use of (or failure to provide or use) health care services or medical products, unless otherwise defined under applicable state law.

(14) 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.

(15) REPRESENTATIVE.—The term "representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a medical power of attorney, or any person recognized in law or custom as a patient's agent.

(16) 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. 8. 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. 9. RULES OF CONSTRUCTION.

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

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

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

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—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

(c) STATE FLEXIBILITY.—No provision of this Act shall be construed to preempt any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 10. 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 cause of action accrued.

Purpose and Summary

The Protecting Access to Care Act's reforms are premised on the need to provide checks and balances on otherwise unlimited lawsuits that increase the cost of health care and limit the availability of doctors nationwide. The Protecting Access to Care Act also contains an explicit Federal nexus: the bill's reforms only apply to lawsuits "concerning the provision of [health care] goods or services for which coverage was provided in whole or in part via a Federal program, subsidy or tax benefit." Wherever Federal policy affects the distribution of health care, there is a clear Federal interest in reducing the costs of such Federal policies.

The bill also includes provisions in each section that allow states to opt-out of each provision provided they have their own limits on non-economic damages in place (either higher or lower than that set out in the bill), or they have other limits that provide the same or greater protections as those provided for in the bill.

Background and Need for the Legislation

The Protecting Access to Care Act's reforms are necessary to help improve health care, make it more affordable, and save Federal taxpayer money while reducing the Federal debt. The Protecting Access to Care Act, modeled after California's decades-old and highly successful health care litigation reforms, would rein in unlimited lawsuits and thereby make health care delivery more accessible and cost-effective in the United States. California's Medical Injury Compensation Reform Act ("MICRA"), which was signed into law by Governor Jerry Brown in 1976, has proved immensely successful in increasing access to affordable medical care, and those proven reforms should be applied to contain costs in circumstances in which health care is provided through Federal programs and policies.

MICRA's reforms, which have been the law in California for over 40 years, include a $250,000 cap on noneconomic damages, limits on the contingency fees lawyers can charge to maximize victim recoveries; and authorization for courts to require periodic payments for future damages instead of lump sum awards to prevent bankruptcies in which plaintiff's would receive only pennies on the dollar. The Protecting Access to Care Act also includes provisions creating a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault. Finally, the Protecting Access to Care Act will accomplish reform without in any way limiting compensation for 100% of plaintiffs' economic losses (anything to which a receipt can be attached), including their medical costs, their lost wages, their future lost wages, rehabilitation costs, and any other economic out-of-pocket loss suffered as the result of a health care injury. And again, the Protecting Access to Care Act applies only to cases in which health care is provided through Federal programs and under Federal subsidies or tax benefits.

THE CONGRESSIONAL BUDGET OFFICE (CBO)

The Congressional Budget Office (CBO) has concluded that the legal reform package in the Protecting Access to Care Act would reduce the Federal budget deficit by billions of dollars over the next 10 years. CBO recognizes that civil justice reforms also have an impact on the practice of "defensive medicine." Defensive medicine occurs when doctors order more tests or procedures than are truly necessary just to protect themselves from lawsuits. Studies show that defensive medicine does not advance patient care or enhance a physician's diagnostic capabilities.

According to one CBO report, "CBO estimates that, under [these legal reforms], premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."[1] Lower health care lawsuit liability premiums would reduce health care costs for everyone and increase the supply of doctors. Further, CBO observed that an "analysis [of these legal reforms] indicated that certain tort limitations, primarily caps on awards . . . effectively reduce average premiums for medical malpractice insurance."[2]

By incorporating MICRA's time-tested reforms at the Federal level, the Protecting Access to Care Act will make medical malpractice insurance affordable again, encourage health care practitioners to maintain their practices, and reduce health care costs for patients. Its enactment will particularly help traditionally underserved rural and inner city communities, and women seeking obstetrics care.

THE GOVERNMENT ACCOUNTABILITY OFFICE (GAO)

The Government Accountability Office (GAO) found that rising litigation awards are responsible for skyrocketing medical professional liability premiums. The report stated that "GAO found that losses on medical malpractice claims—which make up the largest part of insurers' costs—*appear to be the primary driver of rate increases in the long run . . .*"[3] GAO also concluded that insurer profits "are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates" and that "in most states the insurance regulators have the authority to deny premium rate increases they deem excessive."[4]

REAGAN ADMINISTRATION

President Ronald Reagan established a special task force to study the need for tort reform. That task force, called the Tort Policy Working Group, consisted of representatives of ten Reagan administration agencies and the White House. The final report of that task force concluded as follows: "In sum, tort law appears to be a major cause of the insurance availability/affordability crisis which the Federal Government can and should address in a variety of sensible and appropriate ways." Indeed, the Reagan task force spe-

[1] Congressional Budget Office Cost Estimate of H.R. 4600 (the HEALTH Act) (September 24, 2002).
[2] *Id.*
[3] General Accounting Office, "Medical Malpractice Insurance," GAO–03–702 (June 2003) at "Highlights," 4, and 25 (emphasis added).
[4] *Id.* at 32.

cifically recommended "eliminate joint and several liability,"[5] "provide for periodic payments of future economic damages," [6] "schedule [limit] contingency fees" [7] of attorneys, and "limit non-economic damages to a fair and reasonable amount."[8] Indeed, regarding the limit on non-economic damages, the report concluded:

> *Recommendation No. 4: Limit non-economic damages to a fair and reasonable amount.*
>
> Non-economic damages such as pain and suffering, mental anguish and punitive damages are inherently open-ended. They are entirely subjective, and often defy quantification . . . Moreover, because such damages are essentially subjective, awards for similar injuries can vary immensely from case to case, leading to highly inequitable, lottery-like results. Accordingly, such damages are particularly suitable for a specific limitation."[9]

All of these recommended reforms are part of the Protecting Access to Care Act.

SUPPORT FOR THE PROTECTING ACCESS TO CARE ACT BY THE NATIONAL COMMISSION ON FISCAL RESPONSIBILITY AND REFORM

The National Commission on Fiscal Responsibility and Reform supports health care litigation reform in its final December 2010 report. As the Commission states in a report that was endorsed by 61% of its members (by a vote of 11–7):

> Most experts agree that the current tort system in the United States leads to an increase in health care costs. This is true both because of direct costs—higher malpractice insurance premiums—and indirect costs in the form of over-utilization of diagnostic and related services (sometimes referred to as "defensive medicine"). The Commission recommends an aggressive set of reforms to the tort system.
>
> Among the policies pursued, the following should be included: . . . Imposing a statute of limitations—perhaps one to 3 years—on medical malpractice lawsuits . . . Replacing joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury . . .
>
> Many members of the Commission also believe that we should impose statutory caps on . . . non-economic damages, and we recommend that Congress consider this approach and evaluate its impact.[10]

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[5] Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability (February 1986), at 64.
[6] *Id.* at 69.
[7] *Id.* at 72.
[8] *Id.* at 66.
[9] *Id.* at 66.
[10] The National Commission on Fiscal Responsibility and Reform, "The Moment of Truth" (December 2010) at 34–35.

All these recommended reforms are included in the Protecting Access to Care Act.

SUPPORT FOR HEALTH CARE LAWSUIT REFORM BY *USA TODAY*

The *USA Today* editorial board came out supporting these Federal reforms, stating:

> A study . . . by the Massachusetts Medical Society found that 83% of its doctors practice defensive medicine at a cost of at least $1.4 billion a year. Nationally, the cost is $60 billion-plus, according to the Health and Human Services Department . . . The liability system is too often a lottery. Excessive compensation is awarded to some patients and little or none to others. As much as 60% of awards are spent on attorneys, expert witnesses and administrative expenses . . . The current system is arbitrary, inefficient and results in years of delay.[11]

The editors of *USA Today* also concluded that "one glaring omission [from Federal law] was significant tort reform, which was opposed by trial lawyers and their Democratic allies. CBO estimates that restricting malpractice suits would save $54 billion over 10 years by curbing tests and procedures that patients don't really need. So why not add it?"[12]

Enactment of the Protecting Access to Care Act will not result in more medical malpractice cases being brought in Federal court than would be brought in Federal court otherwise. The Supreme Court has held that a "federal standard" does not confer Federal question jurisdiction in the absence of Congressional creation of a Federal cause of action.[13]

Finally, many State supreme courts have judicially nullified reasonable litigation management provisions enacted by State legislatures, many of which sought to address the crisis in medical professional liability that reduces patients' access to health care. Consequently, in such States, passage of Federal legislation by Congress may be the only means of addressing the States' medical professional liability regime and restoring patients' access to health care. Laws passed by States that have already provided for, or may in the future provide for, different limits on damages in health care lawsuits will be preserved under the Protecting Access to Care Act.

THE HUGE COSTS OF DEFENSIVE MEDICINE ARE PASSED ON TO FEDERAL TAXPAYERS

As reported in *The Washington Post*, "U.S. health-care spending . . . is projected to accelerate over the next decade . . . [A] study, by the Centers for Medicare and Medicaid Services, projects that the average growth in health spending will be even faster between

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[11] *USA Today* editorial, "Our View on 'Defensive' Medicine: Lawyers' Bills Pile High, Driving Up Health Care Costs," *USA Today* (December 29, 2008).

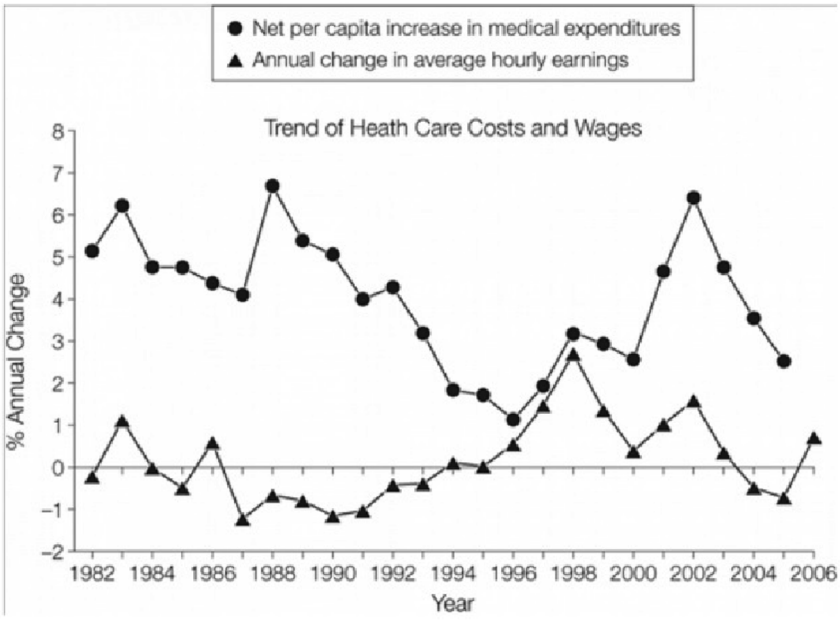
[12] *USA Today* editorial, "Don't try to repeal the new health care law—improve it" (November 18, 2010) at 9A.

[13] *See* Merrell Dow Pharm. Inc. *v.* Thompson, 478 U.S. 804, 813 (1986).

2016 and 2025 . . . The projections are based on an assumption that the legislative status quo will prevail." [14]

As Nate Silver has pointed out in *The New York Times:* "[A]ll of the major categories of [federal] government spending have been increasing relative to inflation. But essentially all of the increase in spending relative to economic growth, and the potential tax base, has come from entitlement programs, and *about half of that has come from health care entitlements specifically*." [15]

As health care costs rise, wages fall, and the more companies must pay in health care costs, the less they can pay in wages. Just look at this chart published in the *Journal of the American Medical Association.*



The top line shows the growth in health care costs. The bottom line shows the growth in wages. The chart shows that when health care cost growth slows, wages go up. But as health care cost growth increases, wages stagnate, and when health costs grew at a slower rate—as in the mid-2000's—wages rebounded again.

If you want to increase wages, vote for this bill, because one of the drivers of higher health care spending is so-called "defensive medicine," a very real phenomenon confirmed by countless studies, in which health care workers conduct many additional costly tests and procedures with no medical value—charged to Federal taxpayers—simply to avoid excessive litigation costs.

A survey published in the *Archives of Internal Medicine* found that 91% of the over one thousand doctors surveyed "reported believing that physicians order more tests and procedures than need-

[14] Carolyn Y. Johnson, "Why America's Health-Care Spending Is Projected To Soar Over the Next Decade," Wash. Post (Feb. 15, 2017).

[15] *See* https://fivethirtyeight.blogs.nytimes.com/2013/01/16/what-is-driving-growth-in-government-spending/?__r=2.

ed to protect themselves from malpractice suits." The survey also asked "Are protections against unwarranted malpractice lawsuits needed to decrease the unnecessary use of diagnostic tests?" Overall, 91 percent of doctors surveyed agreed.[16]

One *Newsweek* reporter described the personal experience of individual doctors this way:

> "[T]ypical was [one doctor], who had a list as long as my arm of procedures ER docs perform . . . for no patient benefit. They include following a bedside sonogram . . . with an "official" sonogram [because] it's easier to defend yourself to a jury if you've ordered the second one; a CT scan for every child who bumped his or her head (to rule out things that can be diagnosed just fine by observation); X-rays that do not guide treatment, such as for a simple broken arm; CTs for suspected appendicitis that has been perfectly well diagnosed without it . . . [A]lthough doctors may hate practicing defensive medicine, they do it so they don't get sued . . . Nationwide, physicians estimate that 35 percent of diagnostic tests they ordered were to avoid lawsuits, as were 19 percent of hospitalizations, 14 percent of prescriptions, and 8 percent of surgeries . . . All told, it adds up to *$650 billion in unnecessary care every year* . . . Another [ER doctor] said he ordered 52 CT scans in one 12-hour shift: "That's $104 thousand dollars in 1 day."[17]

The most recent study, published a few months ago in the *Journal of the American College of Radiology,* studied the effects of tort reform on just radiographic tests alone and found that there were "2.4 million to 2.7 million fewer radiographic tests annually attributed to tort reforms." Just imagine what savings would occur if such reforms were attached to all Federal health care programs, as this bill would do.

REDUCING UNLIMITED LAWSUITS WILL HELP *REDUCE* MEDICAL ERRORS

The best evidence about medical injuries comes from two large studies of hospital records, which both concluded that *under one percent* of hospital charts showed negligent medical injury.[18] Nevertheless, the litigation reforms in the Protecting Access to Care Act *will reduce* the incidence of medical malpractice because the threat of potentially infinite liability in an unregulated tort system prevents doctors from discussing medical errors and looking for ways to improve the delivery of health care.

The Protecting Access to Care Act would largely dispel that fear and allow doctors to freely suggest improvements in medical care.

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[16] *See* Tara F. Bishop, MD, Alex D. Federman, MD, MPH, Salomeh Keyhani, MD, MPH, "Physicians' Views on Defensive Medicine: A National Survey" Arch. Intern. Med. 2010; 170(12): 1081–1083.

[17] Sharon Begley, "Block That CT Scan!—Despite the massive overhaul of health care passed by Congress, many costs will remain high, thanks to doctors' fears of potential lawsuits," *Newsweek* (March 22, 2010).

[18] D. Mills, J. Boyden, and D. Rubsamen, "Report on the Medical Insurance Feasibility Study," (San Francisco: Sutter Publications 1977, sponsored jointly by the California Medical Association and California Hospital Association); A. Localio, A. Lawthers, T. Brennan, N. Laird, L. Hebert, L. Peterson, J. Newhouse, P. Weiler, and H. Hiatt, "Relation Between Malpractice Claims and Adverse Events Due to Negligence," New Engl. J. Med. 325:245–251 (1991).

The medical journal *Annals of Medicine* details reports of medical errors. As it has reported, "[c]reating a series of articles on [medical] mistakes was the idea of Dr. Robert M. Wachter, associate chairman of the department of medicine at the University of California at San Francisco . . . The series was inspired in part by a 1999 report by the Institute of Medicine, which found that mistakes in hospitals killed 44,000 to 98,000 patients a year . . . In an editorial about the new series, Dr. Wachter and his colleagues wrote that the medical profession 'for reasons that include liability issues . . . was not harnessing the full power of errors to teach [and thereby reduce errors].'" [19]

A survey conducted for the bipartisan legal reform organization "Common Good," whose Board of Advisors included former Senator George McGovern, Eric Holder, and former Senator Paul Simon, found that more than three-fourths of physicians feel that concern about malpractice litigation has hurt their ability to provide quality care in recent years. When physicians were asked, "Generally speaking, how much do you think that fear of liability discourages medical professionals from openly discussing and thinking of ways to reduce medical errors?" an astonishing 59% of physicians replied "a lot." [20]

THE CURRENT SYSTEM IS CAUSING A DOCTOR SHORTAGE

Lawsuit abuse drives doctors out of practice. There is a well-documented record of doctors leaving the practice of medicine and hospitals shutting down particular practices that have high liability exposure. This problem has been particularly acute in the fields of ob-gyn and trauma care, as well as in rural areas.[21]

The absence of doctors in vital practice areas is at best an inconvenience; at worst it can have deadly consequences.[22] Hundreds or even thousands of patients may die annually due to lack of doctors.[23]

According to the Massachusetts study, 38 percent of physicians have reduced the number of higher-risk procedures they provide, and 28 percent have reduced the number of higher-risk patients they serve, out of fear of liability.[24] The American College of Obstetricians and Gynecologists has concluded that the "current medicolegal environment continues to deprive women of all ages, especially pregnant women, of their most educated and experienced women's health care providers." [25]

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[19] Denise Grady, "Oops, Wrong Patient: Journal Takes on Medical Mistakes," *The New York Times* (June 18, 2002).

[20] *See* Harris Interactive, "Common Good Fear of Litigation Study: The Impact of Medicine," Final Report (April 11, 2002) ("Executive Summary") at 30 (Table 17), *available at* www.ourcommongood.com/news.html.

[21] For an extensive compilation of such instances see "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Care," U.S. Department of Health and Human Services (March 3, 2003).

[22] *See Hearing on Patient Access Crisis: The Role of Medical Litigation Before S. Comm. on the Judiciary* (2003) (testimony of Leanne Dyess); *Hearing on Medical Liability Reform: Stopping the Skyrocketing Price of Health care Before H. Comm. on Small Business* (2005) (testimony of Dr. Thomas Gleason).

[23] *See* Testimony of Theodore Frank, "Protecting Main Street from Lawsuit Abuse," Senate Republican Conference (March 16, 2009) ("The effect of the loss of productive doctors and the closing of emergency rooms . . . is in the hundreds of lives a year, and perhaps as high as 1,000 deaths and many exacerbated injuries."); "Tort Reform and Accidental Deaths," Paul Rubin and Joanna Shepherd, Emory Law and Economics Research Paper No. 05–17H (finding tort reforms saved approximately 2,000 lives in the year 2000 and 24,000 over a 20-year period).

[24] "Defensive Medicine in Massachusetts," pp. 4–5.

[25] "Overview of the 2009 ACOG Survey on Professional Liability."

As one doctor wrote:

> I am what you call a successful neurosurgeon, and I have nothing against "socialized medicine" as such. Everybody deserves good health care. But I am nonetheless worried about President Obama's health care reform, because without tort reform as part of the package, it can't address the labor shortage we face in my specialty. . . .
>
> Only because spinal problems affect nearly 80% of our aging population: It's one of the most common reasons patients visit a primary care physician, right behind the yearly physical, the common cold, prenatal care and anxiety-related disorders. Baby boomers are about to overwhelm the system with demand for treatment of spinal problems—including surgery—at precisely the moment the supply of neurosurgeons able to treat them is dwindling. . . .
>
> Thus we come to the second reason: the cost of malpractice insurance, which creates a very high cost of entry into this field. Unfortunately, the health care reforms of the Obama administration have done little to curb costs. These costs are imposed by hospital inefficiencies as unpoliced by government-run insurance plans and by the price of malpractice insurance undisciplined by tort reform.
>
> I believe that tort reform is the key to reducing both kinds of cost, because the malignant threat of malpractice haunts the hospitals as well as the physicians. Without such reform, the choice for practicing neurosurgeons like me is between retirement and working 24/7 just to cover my insurance overhead. My premature retirement will reduce the supply of surgeons capable of dealing with the spinal problems of an aging population—and that supply is already short and getting shorter. Meanwhile, a few more board-certified surgeons a year won't meet the growing demand. The lines at your doctor's office could get long.
>
> When Congress returns to consider the problem of health care, it must understand that without tort reform, neurosurgery of the kind I can provide to an aging population will be unavailable.[26]

A study from Northwestern University's Feinberg School of Medicine polled residents and found that many wish to leave the state to avoid its "hostile" malpractice environment. The study concluded that "Approximately one-half of graduating Illinois residents and fellows are leaving the state to practice . . . [T]he medical malpractice liability environment is a major consideration for those that plan to leave Illinois to practice."[27] Without a uniform law to control health care costs, many states will continue to suffer under doctor shortages.

As one local New Jersey official has written:

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[26] Dr. Michael Lavyne, "Obamacare Will Fail Without Tort Reforn: Malpractice Insurance Costs Are Crippling Medicine," *New York Daily News* (November 19, 2010).

[27] Northwestern University Feinberg School of Medicine, "Illinois New Physician Workforce Study: Final Report November 2010) at 4.

Let's say you are a woman over 40 who follows the American Cancer Society guidelines (regardless of the recent controversy about them) and faithfully gets a mammogram each year.

What would you do if you tried to make your 2010 appointment, only to learn this test is no longer available anywhere in the state? Would you take a day off from work to travel to Pennsylvania—or forgo your screening entirely?

Unfortunately, this is a very real possibility for New Jersey women. Eighty-nine percent of radiologists surveyed by the New Jersey Medical Care Availability Task Force said that new doctors in their specialty are unwilling to perform mammography or have asked for limited exposure to it.

Or, imagine getting pregnant and having your obstetrician tell you that you fall into a high-risk category. The good news is that you can be effectively treated by a specialist. The bad news? The closest specialist is in upstate New York. Do you leave your family for days at a time? Do you take a risk and allow your regular physician to do the best she can? This is a decision no woman should have to make, but many may face. Hospitals in New Jersey have reported a serious decline in the number of applicants for specialized obstetrics training—and no new candidates means steadily decreasing access to care.

Even as debate about national health care reform rages across the country, we in New Jersey must confront a homegrown crisis: Our state is losing doctors at an alarming rate. With or without a Federal mandate, if there are no doctors to treat New Jersey's patients, the details don't matter.

Why the exodus of physicians? To a significant degree, they are fleeing malpractice insurance premiums and legal exposure so enormous as to make the practice of many medical specialties in our state near untenable.

. . . Medical malpractice liability premiums had already spiraled out of control back in 2002, when huge crowds of physicians donned their white coats and demonstrated at the Statehouse to draw attention to the need for reform. Around the same time, Dr. Dolores Williams, an obstetrician, testified before an Assembly joint committee that her insurance premiums—which had escalated from $30,000 to an estimated $72,000—left her financially unable to continue delivering babies. Her decision to stop, she said, "was based on possibly losing my home, my assets, [and] my ability to fund my children's college tuition."

Seven years later, these problems have only gotten worse, not only in obstetrics but in a range of other specialties like orthopedics and neonatology.

"The cumulative effect of medical malpractice claims on the health care system in New Jersey is alarming," agrees

> Marcus Rayner, executive director of the New Jersey Lawsuit Reform Alliance. "Due to skyrocketing medical malpractice insurance premiums and the threat of a lawsuit, hospitals have fewer OB-GYNs willing to work in emergency departments, and fewer specialty physicians willing to work at all."
>
> Five years ago, a survey of New Jersey's neurosurgeons indicated that there were only 63 remaining in the state—to serve a population of more than 8.5 million. Someday it could be your teenager who suffers a head injury in a sports or car accident, and urgently needs the care of a neurosurgeon. What are the odds that one would be available? [28]

It is clear that no doctor is safe from lawsuit abuse, but as studies have shown, some are more vulnerable to abusive litigation than others because of their specialty or the location of their practice. Today, one-third of orthopedists, trauma surgeons, ER doctors and plastic surgeons will probably be sued in any given year.[29] Neurosurgeons face liability lawsuits more often—every 2 years on average.[30]

OB-GYN physicians are another favorite target of personal injury lawyers with nearly three out of five OB-GYNs sued at least twice in their careers. The American College of Obstetricians and Gynecologists (ACOG) 2009 Medical Liability Survey found nearly 91 percent of OB-GYNs surveyed had experienced at least one liability claim filed against them and, sadly we know most of the cases are without merit.[31]

Three out of four emergency rooms say they have had to divert ambulances because of a shortage of specialists and more than 25 percent lost specialist coverage due to medical liability issues.[32]

One emergency room physician was quoted as saying, "The lack of on-call specialists affects the numbers of patients referred to tertiary care facilities even for basic specialty related diseases (like orthopedics). This adds to emergency department crowding in some facilities, and it means that patients have to travel across town or greater distances for a relatively simple problem that could have been resolved if the specialist had been on call at the initial facility." [33]

The Association of American Medical Colleges (AAMC) has predicted that "the shortage of physicians across all specialties will more than quadruple to almost 63,000." [34] Another group, the

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[28] Amy H. Handlin, "Reduce Medical Liability Costs Before More Specialists Flee N.J.," *New Jersey Times* (November 22, 2009).

[29] "Defending the Practice of Medicine," Richard E. Anderson, M.D., *Archives of Internal Medicine,* June 2004.

[30] "Effective Legal Reform and the Malpractice Insurance Crisis," Richard E. Anderson, M.D., *Yale Journal of Health Policy, Law and Ethics*, December 2004.

[31] American College of Obstetrics and Gynecologists Medical Liability Survey, 9/09.

[32] Hospital Emergency Department Administration Survey, "Federal Medical Liability Reform," 2004, the Schumacher Group, *Alliance of Specialty Medicine,* July 2005.

[33] "National Report Card on the State of Emergency Medicine," American College of Emergency Physicians, 2009.

[34] Association of American Medical Colleges Center for Workforce Studies estimates, 9/30/10.

American Academy of Family Physicians, has projected the shortfall of family physicians will reach 149,000 by 2020.[35]

THE PROTECTING ACCESS TO CARE ACT ALLOWS UNLIMITED ECONOMIC DAMAGES

Nothing in the Protecting Access to Care Act denies injured plaintiffs the ability to obtain adequate redress, including compensation for 100% of their economic losses (essentially anything to which a receipt can be attached), including their medical costs, the costs of pain relief medication, their lost wages, their future lost wages, rehabilitation costs, and any other economic out-of-pocket loss suffered as the result of a health care injury. "Economic damages" include anything whose value can be quantified, including lost wages or home services (including lost services provided by stay-at-home mothers), medical costs, the costs of pain reducing drugs and lifetime rehabilitation care. Indeed, the terms "non-economic damages" and "pain and suffering damages" (which the Federal legislation limits to $250,000 unless a state law provides for a higher or lower limit) are misnomers: only "economic damages"—which the Federal legislation does not limit—can be used to pay for drugs and services that actually reduce pain.

Cases from California show that reasonable legal reforms such as those in the Protecting Access to Care Act still allow for very large, multi-million dollar awards to deserving victims, including homemakers and children. For example, a 5-year-old boy with cerebral palsy and quadriplegia was awarded $84 million in economic damages. A 3-year-old girl with cerebral palsy was awarded $59 million in economic damages. And a 30-year-old homemaker with brain damage was awarded $12 million in economic damages.

Hearings

The Committee on the Judiciary held no hearings on H.R. 1215.

Committee Consideration

On February 28, 2017, the Committee met in open session and ordered the bill H.R. 1215 favorably reported, with an amendment, by a rollcall vote of 18 to 17, a quorum being present.

Committee Votes

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the Committee advises that the following rollcall votes occurred during the Committee's consideration of H.R. 1215.

1. An amendment offered by Mr. Conyers to exempt claims based on intentional tort liability from the bill. Defeated 12–16.

ROLLCALL NO. 1

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman		X	
Mr. Sensenbrenner, Jr. (WI)		X	

[35] "Doctor Shortage Looms as Primary Care Loses it Pull," Janice Lloyd, *USA Today,* 8/18/09.

ROLLCALL NO. 1—Continued

	Ayes	Nays	Present
Mr. Smith (TX)		X	
Mr. Chabot (OH)		X	
Mr. Issa (CA)			
Mr. King (IA)		X	
Mr. Franks (AZ)		X	
Mr. Gohmert (TX)		X	
Mr. Jordan (OH)		X	
Mr. Poe (TX)			
Mr. Chaffetz (UT)		X	
Mr. Marino (PA)		X	
Mr. Gowdy (SC)			
Mr. Labrador (ID)		X	
Mr. Farenthold (TX)		X	
Mr. Collins (GA)			
Mr. DeSantis (FL)			
Mr. Buck (CO)		X	
Mr. Ratcliffe (TX)		X	
Ms. Roby (AL)		X	
Mr. Gaetz (FL)		X	
Mr. Johnson (LA)			
Mr. Biggs (AZ)			
Mr. Conyers, Jr. (MI), Ranking Member	X		
Mr. Nadler (NY)	X		
Ms. Lofgren (CA)			
Ms. Jackson Lee (TX)			
Mr. Cohen (TN)	X		
Mr. Johnson (GA)	X		
Mr. Deutch (FL)	X		
Mr. Gutierrez (IL)			
Ms. Bass (CA)	X		
Mr. Richmond (LA)			
Mr. Jeffries (NY)			
Mr. Cicilline (RI)	X		
Mr. Swalwell (CA)	X		
Mr. Lieu (CA)	X		
Mr. Raskin (MD)	X		
Ms. Jayapal (WA)	X		
Mr. Schneider (IL)	X		
Total	12	16	

2. An amendment offered by Mr. Cohen to exempt from the bill lawsuits concerning wrong-patient or wrong-site surgeries and foreign objects left inside body. Defeated 12–16.

ROLLCALL NO. 2

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman		X	
Mr. Sensenbrenner, Jr. (WI)		X	
Mr. Smith (TX)			
Mr. Chabot (OH)		X	
Mr. Issa (CA)		X	
Mr. King (IA)		X	
Mr. Franks (AZ)		X	
Mr. Gohmert (TX)		X	

ROLLCALL NO. 2—Continued

	Ayes	Nays	Present
Mr. Jordan (OH)			
Mr. Poe (TX)			
Mr. Chaffetz (UT)		X	
Mr. Marino (PA)		X	
Mr. Gowdy (SC)		X	
Mr. Labrador (ID)		X	
Mr. Farenthold (TX)		X	
Mr. Collins (GA)			
Mr. DeSantis (FL)			
Mr. Buck (CO)		X	
Mr. Ratcliffe (TX)		X	
Ms. Roby (AL)		X	
Mr. Gaetz (FL)			
Mr. Johnson (LA)			
Mr. Biggs (AZ)		X	
Mr. Conyers, Jr. (MI), Ranking Member	X		
Mr. Nadler (NY)	X		
Ms. Lofgren (CA)			
Ms. Jackson Lee (TX)			
Mr. Cohen (TN)	X		
Mr. Johnson (GA)	X		
Mr. Deutch (FL)	X		
Mr. Gutierrez (IL)			
Ms. Bass (CA)	X		
Mr. Richmond (LA)			
Mr. Jeffries (NY)			
Mr. Cicilline (RI)	X		
Mr. Swalwell (CA)	X		
Mr. Lieu (CA)	X		
Mr. Raskin (MD)	X		
Ms. Jayapal (WA)	X		
Mr. Schneider (IL)	X		
Total	12	16	

3. An amendment offered by Mr. Johnson (GA) to exempt lawsuits concerning nursing homes or long-term care facilities from the bill. Defeated 13–15.

ROLLCALL NO. 3

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman		X	
Mr. Sensenbrenner, Jr. (WI)			
Mr. Smith (TX)			
Mr. Chabot (OH)		X	
Mr. Issa (CA)		X	
Mr. King (IA)		X	
Mr. Franks (AZ)		X	
Mr. Gohmert (TX)			
Mr. Jordan (OH)		X	
Mr. Poe (TX)			
Mr. Chaffetz (UT)			
Mr. Marino (PA)		X	
Mr. Gowdy (SC)		X	
Mr. Labrador (ID)		X	

ROLLCALL NO. 3—Continued

	Ayes	Nays	Present
Mr. Farenthold (TX)		X	
Mr. Collins (GA)			
Mr. DeSantis (FL)			
Mr. Buck (CO)		X	
Mr. Ratcliffe (TX)		X	
Ms. Roby (AL)		X	
Mr. Gaetz (FL)			
Mr. Johnson (LA)		X	
Mr. Biggs (AZ)		X	
Mr. Conyers, Jr. (MI), Ranking Member	X		
Mr. Nadler (NY)	X		
Ms. Lofgren (CA)			
Ms. Jackson Lee (TX)	X		
Mr. Cohen (TN)	X		
Mr. Johnson (GA)	X		
Mr. Deutch (FL)	X		
Mr. Gutierrez (IL)			
Ms. Bass (CA)	X		
Mr. Richmond (LA)			
Mr. Jeffries (NY)			
Mr. Cicilline (RI)	X		
Mr. Swalwell (CA)	X		
Mr. Lieu (CA)	X		
Mr. Raskin (MD)	X		
Ms. Jayapal (WA)	X		
Mr. Schneider (IL)	X		
Total	13	15	

4. An amendment offered by Mr. Johnson (GA) to exempt from the bill's preemption provision the preemption of any state constitutional provisions. Passed 16–15.

ROLLCALL NO. 4

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman		X	
Mr. Sensenbrenner, Jr. (WI)	X		
Mr. Smith (TX)			
Mr. Chabot (OH)		X	
Mr. Issa (CA)			
Mr. King (IA)		X	
Mr. Franks (AZ)		X	
Mr. Gohmert (TX)			
Mr. Jordan (OH)		X	
Mr. Poe (TX)		X	
Mr. Chaffetz (UT)		X	
Mr. Marino (PA)		X	
Mr. Gowdy (SC)		X	
Mr. Labrador (ID)	X		
Mr. Farenthold (TX)		X	
Mr. Collins (GA)			
Mr. DeSantis (FL)			
Mr. Buck (CO)		X	
Mr. Ratcliffe (TX)		X	
Ms. Roby (AL)		X	

ROLLCALL NO. 4—Continued

	Ayes	Nays	Present
Mr. Gaetz (FL)			
Mr. Johnson (LA)		X	
Mr. Biggs (AZ)		X	
Mr. Conyers, Jr. (MI), Ranking Member	X		
Mr. Nadler (NY)	X		
Ms. Lofgren (CA)			
Ms. Jackson Lee (TX)	X		
Mr. Cohen (TN)	X		
Mr. Johnson (GA)	X		
Mr. Deutch (FL)	X		
Mr. Gutierrez (IL)	X		
Ms. Bass (CA)	X		
Mr. Richmond (LA)			
Mr. Jeffries (NY)			
Mr. Cicilline (RI)	X		
Mr. Swalwell (CA)	X		
Mr. Lieu (CA)	X		
Mr. Raskin (MD)	X		
Ms. Jayapal (WA)	X		
Mr. Schneider (IL)	X		
Total	16	15	

5. Motion to order the previous question. Passed 19–15.

ROLLCALL NO. 5

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman	X		
Mr. Sensenbrenner, Jr. (WI)	X		
Mr. Smith (TX)			
Mr. Chabot (OH)	X		
Mr. Issa (CA)	X		
Mr. King (IA)	X		
Mr. Franks (AZ)	X		
Mr. Gohmert (TX)			
Mr. Jordan (OH)	X		
Mr. Poe (TX)		X	
Mr. Chaffetz (UT)	X		
Mr. Marino (PA)	X		
Mr. Gowdy (SC)	X		
Mr. Labrador (ID)	X		
Mr. Farenthold (TX)	X		
Mr. Collins (GA)			
Mr. DeSantis (FL)	X		
Mr. Buck (CO)	X		
Mr. Ratcliffe (TX)	X		
Ms. Roby (AL)	X		
Mr. Gaetz (FL)	X		
Mr. Johnson (LA)	X		
Mr. Biggs (AZ)	X		
Mr. Conyers, Jr. (MI), Ranking Member		X	
Mr. Nadler (NY)		X	
Ms. Lofgren (CA)			
Ms. Jackson Lee (TX)		X	

ROLLCALL NO. 5—Continued

	Ayes	Nays	Present
Mr. Cohen (TN)		X	
Mr. Johnson (GA)		X	
Mr. Deutch (FL)		X	
Mr. Gutierrez (IL)			
Ms. Bass (CA)		X	
Mr. Richmond (LA)			
Mr. Jeffries (NY)		X	
Mr. Cicilline (RI)		X	
Mr. Swalwell (CA)		X	
Mr. Lieu (CA)		X	
Mr. Raskin (MD)		X	
Ms. Jayapal (WA)		X	
Mr. Schneider (IL)		X	
Total	19	15	

6. Motion to reconsider the Johnson Amendment. Passed 19–15.

ROLLCALL NO. 6

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman	X		
Mr. Sensenbrenner, Jr. (WI)	X		
Mr. Smith (TX)			
Mr. Chabot (OH)	X		
Mr. Issa (CA)	X		
Mr. King (IA)	X		
Mr. Franks (AZ)	X		
Mr. Gohmert (TX)			
Mr. Jordan (OH)	X		
Mr. Poe (TX)		X	
Mr. Chaffetz (UT)	X		
Mr. Marino (PA)	X		
Mr. Gowdy (SC)	X		
Mr. Labrador (ID)	X		
Mr. Farenthold (TX)	X		
Mr. Collins (GA)			
Mr. DeSantis (FL)	X		
Mr. Buck (CO)	X		
Mr. Ratcliffe (TX)	X		
Ms. Roby (AL)	X		
Mr. Gaetz (FL)	X		
Mr. Johnson (LA)	X		
Mr. Biggs (AZ)	X		
Mr. Conyers, Jr. (MI), Ranking Member		X	
Mr. Nadler (NY)		X	
Ms. Lofgren (CA)			
Ms. Jackson Lee (TX)		X	
Mr. Cohen (TN)		X	
Mr. Johnson (GA)		X	
Mr. Deutch (FL)		X	
Mr. Gutierrez (IL)			
Ms. Bass (CA)		X	
Mr. Richmond (LA)			
Mr. Jeffries (NY)		X	
Mr. Cicilline (RI)		X	

ROLLCALL NO. 6—Continued

	Ayes	Nays	Present
Mr. Swalwell (CA)		X	
Mr. Lieu (CA)		X	
Mr. Raskin (MD)		X	
Ms. Jayapal (WA)		X	
Mr. Schneider (IL)		X	
Total	19	15	

7. Motion to order the previous question. Passed 18–16.

ROLLCALL NO. 7

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman	X		
Mr. Sensenbrenner, Jr. (WI)		X	
Mr. Smith (TX)	X		
Mr. Chabot (OH)	X		
Mr. Issa (CA)	X		
Mr. King (IA)	X		
Mr. Franks (AZ)	X		
Mr. Gohmert (TX)			
Mr. Jordan (OH)	X		
Mr. Poe (TX)		X	
Mr. Chaffetz (UT)	X		
Mr. Marino (PA)	X		
Mr. Gowdy (SC)	X		
Mr. Labrador (ID)	X		
Mr. Farenthold (TX)	X		
Mr. Collins (GA)			
Mr. DeSantis (FL)	X		
Mr. Buck (CO)	X		
Mr. Ratcliffe (TX)	X		
Ms. Roby (AL)	X		
Mr. Gaetz (FL)	X		
Mr. Johnson (LA)	X		
Mr. Biggs (AZ)	X		
Mr. Conyers, Jr. (MI), Ranking Member		X	
Mr. Nadler (NY)		X	
Ms. Lofgren (CA)			
Ms. Jackson Lee (TX)		X	
Mr. Cohen (TN)		X	
Mr. Johnson (GA)		X	
Mr. Deutch (FL)			
Mr. Gutierrez (IL)		X	
Ms. Bass (CA)		X	
Mr. Richmond (LA)			
Mr. Jeffries (NY)		X	
Mr. Cicilline (RI)		X	
Mr. Swalwell (CA)		X	
Mr. Lieu (CA)		X	
Mr. Raskin (MD)		X	
Ms. Jayapal (WA)		X	
Mr. Schneider (IL)		X	
Total	18	16	

8. An amendment offered by Mr. Johnson (GA) to exempt from the bill's preemption provision the preemption of any state constitutional provisions. Defeated 17–17.

ROLLCALL NO. 8

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman		X	
Mr. Sensenbrenner, Jr. (WI)		X	
Mr. Smith (TX)			
Mr. Chabot (OH)		X	
Mr. Issa (CA)		X	
Mr. King (IA)		X	
Mr. Franks (AZ)		X	
Mr. Gohmert (TX)			
Mr. Jordan (OH)		X	
Mr. Poe (TX)	X		
Mr. Chaffetz (UT)			
Mr. Marino (PA)		X	
Mr. Gowdy (SC)		X	
Mr. Labrador (ID)	X		
Mr. Farenthold (TX)		X	
Mr. Collins (GA)			
Mr. DeSantis (FL)		X	
Mr. Buck (CO)		X	
Mr. Ratcliffe (TX)		X	
Ms. Roby (AL)		X	
Mr. Gaetz (FL)		X	
Mr. Johnson (LA)		X	
Mr. Biggs (AZ)		X	
Mr. Conyers, Jr. (MI), Ranking Member	X		
Mr. Nadler (NY)	X		
Ms. Lofgren (CA)			
Ms. Jackson Lee (TX)	X		
Mr. Cohen (TN)	X		
Mr. Johnson (GA)	X		
Mr. Deutch (FL)	X		
Mr. Gutierrez (IL)	X		
Ms. Bass (CA)	X		
Mr. Richmond (LA)			
Mr. Jeffries (NY)	X		
Mr. Cicilline (RI)	X		
Mr. Swalwell (CA)	X		
Mr. Lieu (CA)	X		
Mr. Raskin (MD)	X		
Ms. Jayapal (WA)	X		
Mr. Schneider (IL)	X		
Total	17	17	

9. An amendment offered by Ms. Jackson Lee to exempt from the bill health care lawsuits alleging irreversible injury. Defeated 14–19.

ROLLCALL NO. 9

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman		X	

ROLLCALL NO. 9—Continued

	Ayes	Nays	Present
Mr. Sensenbrenner, Jr. (WI)		X	
Mr. Smith (TX)			
Mr. Chabot (OH)		X	
Mr. Issa (CA)		X	
Mr. King (IA)		X	
Mr. Franks (AZ)		X	
Mr. Gohmert (TX)			
Mr. Jordan (OH)		X	
Mr. Poe (TX)		X	
Mr. Chaffetz (UT)		X	
Mr. Marino (PA)		X	
Mr. Gowdy (SC)		X	
Mr. Labrador (ID)		X	
Mr. Farenthold (TX)		X	
Mr. Collins (GA)			
Mr. DeSantis (FL)			
Mr. Buck (CO)		X	
Mr. Ratcliffe (TX)		X	
Ms. Roby (AL)		X	
Mr. Gaetz (FL)		X	
Mr. Johnson (LA)		X	
Mr. Biggs (AZ)		X	
Mr. Conyers, Jr. (MI), Ranking Member	X		
Mr. Nadler (NY)	X		
Ms. Lofgren (CA)			
Ms. Jackson Lee (TX)	X		
Mr. Cohen (TN)	X		
Mr. Johnson (GA)	X		
Mr. Deutch (FL)	X		
Mr. Gutierrez (IL)			
Ms. Bass (CA)	X		
Mr. Richmond (LA)			
Mr. Jeffries (NY)	X		
Mr. Cicilline (RI)	X		
Mr. Swalwell (CA)	X		
Mr. Lieu (CA)	X		
Mr. Raskin (MD)	X		
Ms. Jayapal (WA)	X		
Mr. Schneider (IL)	X		
Total	14	19	

10. An amendment offered by Mr. Swalwell to exempt from the bill lawsuits concerning faulty medical treatment for injuries resulting from sexual assault or rape. Defeated 13–17.

ROLLCALL NO. 10

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman		X	
Mr. Sensenbrenner, Jr. (WI)			
Mr. Smith (TX)			
Mr. Chabot (OH)		X	
Mr. Issa (CA)		X	
Mr. King (IA)		X	
Mr. Franks (AZ)		X	

ROLLCALL NO. 10—Continued

	Ayes	Nays	Present
Mr. Gohmert (TX)			
Mr. Jordan (OH)			
Mr. Poe (TX)		X	
Mr. Chaffetz (UT)		X	
Mr. Marino (PA)		X	
Mr. Gowdy (SC)		X	
Mr. Labrador (ID)		X	
Mr. Farenthold (TX)			
Mr. Collins (GA)			
Mr. DeSantis (FL)		X	
Mr. Buck (CO)		X	
Mr. Ratcliffe (TX)		X	
Ms. Roby (AL)		X	
Mr. Gaetz (FL)		X	
Mr. Johnson (LA)		X	
Mr. Biggs (AZ)		X	
Mr. Conyers, Jr. (MI), Ranking Member	X		
Mr. Nadler (NY)	X		
Ms. Lofgren (CA)	X		
Ms. Jackson Lee (TX)	X		
Mr. Cohen (TN)			
Mr. Johnson (GA)	X		
Mr. Deutch (FL)	X		
Mr. Gutierrez (IL)	X		
Ms. Bass (CA)			
Mr. Richmond (LA)			
Mr. Jeffries (NY)			
Mr. Cicilline (RI)	X		
Mr. Swalwell (CA)	X		
Mr. Lieu (CA)	X		
Mr. Raskin (MD)	X		
Ms. Jayapal (WA)	X		
Mr. Schneider (IL)	X		
Total	13	17	

11. An amendment by Mr. Raskin to strike the bill's "fair share" provision. Defeated 14–16.

ROLLCALL NO. 11

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman		X	
Mr. Sensenbrenner, Jr. (WI)			
Mr. Smith (TX)			
Mr. Chabot (OH)		X	
Mr. Issa (CA)		X	
Mr. King (IA)		X	
Mr. Franks (AZ)		X	
Mr. Gohmert (TX)			
Mr. Jordan (OH)		X	
Mr. Poe (TX)			
Mr. Chaffetz (UT)		X	
Mr. Marino (PA)		X	
Mr. Gowdy (SC)		X	
Mr. Labrador (ID)		X	

ROLLCALL NO. 11—Continued

	Ayes	Nays	Present
Mr. Farenthold (TX)			
Mr. Collins (GA)			
Mr. DeSantis (FL)			
Mr. Buck (CO)		X	
Mr. Ratcliffe (TX)		X	
Ms. Roby (AL)		X	
Mr. Gaetz (FL)		X	
Mr. Johnson (LA)		X	
Mr. Biggs (AZ)		X	
Mr. Conyers, Jr. (MI), Ranking Member	X		
Mr. Nadler (NY)	X		
Ms. Lofgren (CA)	X		
Ms. Jackson Lee (TX)	X		
Mr. Cohen (TN)	X		
Mr. Johnson (GA)			
Mr. Deutch (FL)	X		
Mr. Gutierrez (IL)	X		
Ms. Bass (CA)			
Mr. Richmond (LA)			
Mr. Jeffries (NY)	X		
Mr. Cicilline (RI)	X		
Mr. Swalwell (CA)	X		
Mr. Lieu (CA)	X		
Mr. Raskin (MD)	X		
Ms. Jayapal (WA)	X		
Mr. Schneider (IL)	X		
Total	14	16	

12. An amendment in the nature of a substitute offered by Mr. King. Passed 18–16.

ROLLCALL NO. 12

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman	X		
Mr. Sensenbrenner, Jr. (WI)			
Mr. Smith (TX)	X		
Mr. Chabot (OH)	X		
Mr. Issa (CA)	X		
Mr. King (IA)	X		
Mr. Franks (AZ)	X		
Mr. Gohmert (TX)			
Mr. Jordan (OH)	X		
Mr. Poe (TX)			
Mr. Chaffetz (UT)	X		
Mr. Marino (PA)	X		
Mr. Gowdy (SC)	X		
Mr. Labrador (ID)	X		
Mr. Farenthold (TX)	X		
Mr. Collins (GA)			
Mr. DeSantis (FL)			
Mr. Buck (CO)	X		
Mr. Ratcliffe (TX)	X		
Ms. Roby (AL)	X		
Mr. Gaetz (FL)	X		

ROLLCALL NO. 12—Continued

	Ayes	Nays	Present
Mr. Johnson (LA)	X		
Mr. Biggs (AZ)	X		
Mr. Conyers, Jr. (MI), Ranking Member		X	
Mr. Nadler (NY)		X	
Ms. Lofgren (CA)		X	
Ms. Jackson Lee (TX)		X	
Mr. Cohen (TN)		X	
Mr. Johnson (GA)			
Mr. Deutch (FL)		X	
Mr. Gutierrez (IL)		X	
Ms. Bass (CA)		X	
Mr. Richmond (LA)		X	
Mr. Jeffries (NY)		X	
Mr. Cicilline (RI)		X	
Mr. Swalwell (CA)		X	
Mr. Lieu (CA)		X	
Mr. Raskin (MD)		X	
Ms. Jayapal (WA)		X	
Mr. Schneider (IL)		X	
Total	18	16	

13. Final passage. Passed 18–17.

ROLLCALL NO. 13

	Ayes	Nays	Present
Mr. Goodlatte (VA), Chairman	X		
Mr. Sensenbrenner, Jr. (WI)			
Mr. Smith (TX)	X		
Mr. Chabot (OH)	X		
Mr. Issa (CA)	X		
Mr. King (IA)	X		
Mr. Franks (AZ)	X		
Mr. Gohmert (TX)			
Mr. Jordan (OH)	X		
Mr. Poe (TX)		X	
Mr. Chaffetz (UT)	X		
Mr. Marino (PA)	X		
Mr. Gowdy (SC)	X		
Mr. Labrador (ID)	X		
Mr. Farenthold (TX)	X		
Mr. Collins (GA)			
Mr. DeSantis (FL)			
Mr. Buck (CO)	X		
Mr. Ratcliffe (TX)	X		
Ms. Roby (AL)	X		
Mr. Gaetz (FL)	X		
Mr. Johnson (LA)	X		
Mr. Biggs (AZ)	X		
Mr. Conyers, Jr. (MI), Ranking Member		X	
Mr. Nadler (NY)		X	
Ms. Lofgren (CA)		X	
Ms. Jackson Lee (TX)		X	
Mr. Cohen (TN)		X	

ROLLCALL NO. 13—Continued

	Ayes	Nays	Present
Mr. Johnson (GA)			
Mr. Deutch (FL)		X	
Mr. Gutierrez (IL)		X	
Ms. Bass (CA)		X	
Mr. Richmond (LA)		X	
Mr. Jeffries (NY)		X	
Mr. Cicilline (RI)		X	
Mr. Swalwell (CA)		X	
Mr. Lieu (CA)		X	
Mr. Raskin (MD)		X	
Ms. Jayapal (WA)		X	
Mr. Schneider (IL)		X	
Total	18	17	

Committee Oversight Findings

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

New Budget Authority and Tax Expenditures

Clause 3(c)(2) of rule XIII of the Rules of the House of Representatives is inapplicable because this legislation does not provide new budgetary authority or increased tax expenditures.

Congressional Budget Office Cost Estimate

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the Committee sets forth, with respect to the bill, H.R. 1215, the following estimate and comparison prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 22, 2017.

Hon. BOB GOODLATTE, CHAIRMAN,
Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1215, the "Protecting Access to Care Act of 2017."

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lara Robillard, who can be reached at 226–9010.

Sincerely,

MARK P. HADLEY
FOR KEITH HALL,
DIRECTOR.

Enclosure

cc: Honorable John Conyers, Jr.
Ranking Member

H.R. 1215—Protecting Access to Care Act of 2017.

As ordered reported by the House Committee on the Judiciary on February 28, 2017.

SUMMARY

H.R. 1215 would impose limits on medical malpractice litigation in state and Federal courts by capping awards and attorney fees, modifying the statute of limitations, and eliminating joint and several liability.

CBO expects that enacting H.R. 1215 would, on balance, lower costs for health care both directly and indirectly: directly, by lowering premiums for medical liability insurance; and indirectly, by reducing the use of health care services prescribed by providers when faced with less pressure from potential malpractice suits. Those reductions in costs would, in turn, lead to lower spending in Federal health programs and to lower premiums for private health insurance.

In total, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation would reduce deficits by about $14 billion over the 2017–2022 period, and almost $50 billion over the 2017–2027 period. Off-budget revenues account for about $2 billion of that reduction. CBO estimates that implementing the legislation would reduce discretionary costs by about $1.5 billion over the 2017–2027 period, assuming appropriations actions consistent with the legislation.

CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

H.R. 1215 would preempt state laws governing health care lawsuits in the areas of statutes of limitation, joint and several liability, product liability, and contingency fees. Those preemptions would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill also would require courts (including state courts) to direct periodic payments of damages in some circumstances. CBO estimates that the costs of complying with those mandates would be insignificant and well below the threshold established in UMRA ($78 million in 2017, as adjusted for inflation).

This bill would impose private-sector mandates as defined in UMRA, on plaintiffs who file medical malpractice claims or medical product liability claims and on attorneys. CBO estimates that the aggregate cost of the mandates would exceed the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for inflation) in at least four of the first five years the mandates are in effect.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the legislation is shown in the following table. The spending effects of this legislation fall within multiple budget functions, primarily functions 550 (health) and 570 (Medicare).

These estimates are based on CBO's assumption that the legislation will be enacted near the beginning of fiscal year 2018. Assuming an earlier enactment date would not change CBO's estimate of the budgetary effects of the legislation.

	By Fiscal Year, in Millions of Dollars												
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2017-2022	2017-2027
CHANGES IN DIRECT SPENDING													
Estimated Budget Authority[a]	0	-30	-570	-2,440	-4,280	-5,290	-5,500	-5,710	-6,220	-6,690	-7,140	-12,610	-43,870
Estimated Outlays	0	-30	-570	-2,440	-4,280	-5,290	-5,500	-5,710	-6,220	-6,690	-7,140	-12,610	-43,870
CHANGES IN DIRECT SPENDING													
Estimated Revenues[b]	0	-9	83	240	516	691	764	816	875	935	999	1,521	5,909
On-budget	*0*	*-13*	*49*	*138*	*342*	*470*	*523*	*562*	*606*	*651*	*700*	*985*	*4,026*
Off-budget[c]	*0*	*4*	*34*	*102*	*174*	*221*	*241*	*255*	*269*	*284*	*300*	*535*	*1,883*
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND RECEIPTS													
Impact on the Deficit	0	-21	-653	-2,680	-4,796	-5,981	-6,264	-6,526	-7,095	-7,625	-8,139	-14,131	-49,779
On-budget	*0*	*-17*	*-619*	*-2,578*	*-4,622*	*-5,760*	*-6,023*	*-6,272*	*-6,826*	*-7,341*	*-7,840*	*-13,595*	*-47,896*
Off-budget[c]	*0*	*-4*	*-34*	*-102*	*-174*	*-221*	*-241*	*-255*	*-269*	*-284*	*-300*	*-535*	*-1,883*
CHANGES IN SPENDING SUBJECT TO APPROPRIATION													
Estimated Authorization Level	0	-1	-20	-90	-150	-180	-190	-200	-210	-220	-230	-441	-1,491
Estimated Outlays	0	-1	-20	-90	-150	-180	-190	-200	-210	-220	-230	-441	-1,491

Notes: Components may not sum to totals because of rounding.

a. Includes estimated savings by the Postal Service, whose spending is classified as off-budget.

b. For revenues, positive numbers indicate a decrease in the deficit and negative numbers indicate an increase in the deficit.

c. Off-budget effects indicate a change in Social Security payroll tax revenues.

BASIS OF ESTIMATE

The legislation would establish:

- A 3-year statute of limitations for medical malpractice claims, with certain exceptions, from the date of an injury;
- A cap of $250,000 on awards for noneconomic damages;
- Replacement of joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury;
- Sliding-scale limits on the contingency fees that lawyers can charge; and
- A safe harbor from product liability litigation for health care providers who prescribe or dispense products approved by the Food and Drug Administration.

Over the 2017–2027 period, CBO and the staff of the Joint Committee on Taxation estimate that enacting the legislation would reduce direct spending by about $44 billion and increase Federal revenues by about $6 billion. The combined effect of those changes would be to reduce Federal deficits by almost $50 billion over that period.

In addition, CBO estimates that implementing the legislation would reduce discretionary costs for the Federal Employees Health Benefits (FEHB) program, Department of Defense (DoD), and Department of Veterans Affairs (VA) by about $1.5 billion over the 2017–2027 period.

Effects on National Spending for Health Care

CBO reviewed recent research on the effects of proposals to limit costs related to medical malpractice ("tort reform"), and estimates that enacting the legislation would reduce national health spending by about 0.4 percent.[1] That figure comprises a direct reduction in spending for medical liability premiums and an additional indirect reduction from slightly less utilization of health care services. CBO's estimate takes into account the fact that, because many states have already implemented some elements of the legislation, a significant fraction of the potential cost savings has already been realized. Moreover, the estimate assumes that the spending reduction of about 0.4 percent would be phased in over a period of four years, as providers gradually change their practice patterns.

Direct Spending

Consistent with CBO's estimate of the bill's effect on national health spending, we estimate that enacting the legislation would reduce Federal direct spending by about 0.4 percent for Medicare, Medicaid, FEHB, DoD's TRICARE-for-Life program, and subsidies for enrollees in health insurance marketplaces. Those reductions would total roughly $44 billion over the 2017–2027 period.

Revenues

Much of private-sector health care is paid for through employment-based insurance, which represents nontaxable compensation. In addition, since 2014, refundable tax credits have been available to certain individuals and families to subsidize health insurance purchased through health insurance marketplaces. (The portion of those tax credits that exceed taxpayers' liabilities are classified as outlays, while the portions that reduce taxpayers' liabilities are recorded as reductions in revenues.)

Lower costs for health care arising from enactment of the legislation would lead to an increase in taxable compensation and a reduction in subsidies for health insurance purchased through a marketplace. Conversely, the limitation on attorney's fees would slightly reduce taxable income, causing a loss of revenues. In the first year, that revenue loss would exceed the gains from other increases in compensation. The net effect of those changes would be to in-

[1] See Congressional Budget Office, letter to the Honorable Orrin G. Hatch regarding CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice, (October 9, 2009). http://www.cbo.gov/ftpdocs/106xx/doc10641/10–09-Tort_Reform.pdf. The estimated effect on national health spending reported in that letter is different from the estimated effect for this legislation because the two proposals would impose different limits on medical malpractice litigation.

crease Federal tax revenues by an estimated $5.9 billion over the 2017–2027 period, according to estimates by JCT. Social Security payroll taxes, which are off-budget, account for $1.9 billion of that increase in revenues.

Spending Subject to Appropriation

CBO estimates that implementing the legislation also would reduce Federal costs for health insurance for Federal employees covered through the FEHB program by about 0.4 percent and would thus reduce costs for health insurance and health care services paid for by the Departments of Defense and Veterans Affairs. In CBO's estimation, the cost of health insurance and health care services funded through appropriation acts would be reduced by $1.5 billion over the 2017–2027 period, assuming appropriation actions consistent with the legislation.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 1215 would preempt state laws governing health care lawsuits in the areas of statutes of limitation, joint and several liability, product liability, and contingent fees. Those preemptions would be intergovernmental mandates as defined by UMRA. Although the preemptions would limit the application of state laws, they would impose no duty on states that would result in additional spending or a loss of revenues. The bill also would require courts (including state courts) to direct periodic payments of damages in some circumstances. That intergovernmental mandate would place administrative responsibilities on court officials, but CBO estimates that the costs would be insignificant and well below the threshold established in UMRA ($78 million in 2017, as adjusted for inflation).

ESTIMATED IMPACT ON THE PRIVATE SECTOR

H.R. 1215 contains private-sector mandates as defined in UMRA on plaintiffs and their attorneys in medical malpractice claims. By establishing a cap on noneconomic damages in medical malpractice claims, the bill would impose a mandate on plaintiffs as it would limit their ability to recover the entire amount of compensatory damages that could be collected under current law. Additionally, by imposing a cap on fees for attorneys representing plaintiffs in medical malpractice claims the bill would impose a mandate because it would restrict amounts that attorneys might otherwise be able to collect from their clients. The bill also would impose a mandate on plaintiffs who file medical product liability claims. Such claims may allege an injury caused by a defective or dangerous medical product (a drug, device, or biological product). The bill would eliminate a right to file such claims against health care providers by exempting those providers from liability if they prescribe or dispense a medical product that is approved by the Food and Drug Administration. Eliminating an existing right of action is a mandate on plaintiffs because their right to seek redress and recover damages is restricted or lost. The cost of a mandate that restricts or eliminates an existing right of action is the value of forgone awards and settlements in such cases.

CBO estimates the aggregate cost of the mandates in the bill would exceed the annual threshold established in UMRA for private-sector mandates ($156 million in 2017, adjusted annually for

inflation) in four of the first five years the mandates are in effect. On the basis of evidence from studies on damages in malpractice cases, CBO estimates that the aggregate cost of the mandates would amount to more than $2.0 billion over the 2018–2022 period.

ESTIMATE PREPARED BY:

Federal Costs: Lara Robillard and Anna Anderson-Cook
Revenues: Staff of the Joint Committee on Taxation
Impact on State, Local, and Tribal Governments: Zachary Byrum
Impact on the Private Sector: Amy Petz

ESTIMATE APPROVED BY:

Holly Harvey
Deputy Assistant Director for Budget Analysis

Duplication of Federal Programs

No provision of H.R. 1215 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

Disclosure of Directed Rule Makings

The Committee estimates that H.R. 1215 specifically directs to be completed no specific rule makings within the meaning of 5 U.S.C. § 551.

Performance Goals and Objectives

The Committee states that pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, H.R. 1215 is designed to lower health care costs and increase access to health care by placing reasonable limits on health care lawsuits.

Advisory on Earmarks

In accordance with clause 9 of rule XXI of the Rules of the House of Representatives, H.R. 1215 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(e), 9(f), or 9(g) of Rule XXI.

Section-by-Section Analysis

The following discussion describes the bill as reported by the Committee.

Sec. 1. Short Title; Table of Contents. Section 1 sets forth the short title of the bill as the Protecting Access to Care Act and presents a table of contents.

Sec. 2. Encouraging Speedy Resolution of Claims. Section 2 provides for a 3-year statute of limitations with certain exceptions for minors, fraud, intentional concealment, and the presence of a foreign body. Preserves state laws that specify shorter statutes of limitations, a different period for the filing of lawsuits by a minor, triggers different time periods based on the date of alleged negligence, or establishes a statute of repose.

Sec. 3. Compensating Patient Injury. Section 3 provides for a $250,000 cap on noneconomic damages and a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault. Preserves any state law that provides for any other monetary amount for damages (whether higher or lower).

Sec. 4. Maximizing Patient Recovery. Section 4 provides for sliding scale limits on the contingency fees lawyers can charge. Preserves state laws that provide for lesser recoveries by lawyers.

Sec. 5. Authorization of Payments of Future Damages to Claimants in Health Care Lawsuits. Section 5 provides authorization for courts to require periodic payments for future damages exceeding $50,000. Preserves state laws that specify periodic payments at other amounts, or which mandate them.

Sec. 6. Product Liability for Health Providers. Section 6 includes a provision protecting pharmacists and doctors from being named in lawsuits for forum-shopping purposes.

Sec. 7. Definitions. Restricts application of the bill to liability claims concerning the provision of goods or services for which coverage was provided in whole or in part via a Federal program, subsidy or tax benefit.

Sec. 8. Effect on Other Laws. Section 8 provides this Act does not affect vaccine compensation programs under title XXI of the Public Health Service Act.

Sec. 9. Rules of Construction. Section 9 makes clear that state laws governing issues not covered by the bill are preserved.

Sec. 10. Effective Date. Section 10 provides the effective date of the Act.

Dissenting Views

H.R. 1215, the "Protecting Access to Care Act of 2017," will do little to protect Americans' access to safe and affordable health care. Instead, it will undermine the ability of victims of medical malpractice and defective medical products to be fully compensated for their injuries. It does this by imposing onerous restrictions on lawsuits against health care providers concerning their provision of health care goods or services, regardless of the merits of a case, the misconduct at issue, or the severity of the victim's injury. By imposing these one-size-fits-all Federal standards on traditionally state court proceedings, H.R. 1215 would also trample states' rights. The Committee has considered similar so-called medical malpractice reforms on 11 prior occasions going back to 1995 and, like the prior iterations of this bill, H.R. 1215 raises the same core issues of fairness and federalism with little regard for the consequences.

H.R. 1215 is highly problematic for many reasons. To begin with, it intrudes deeply on state sovereignty by preempting several areas of tort law that traditionally have been governed by the jurisprudence of each individual state or by state legislatures. Additionally, the bill's scope is broader than medical malpractice, potentially imposing new restrictions on claims concerning nursing home negligence and defective pharmaceuticals or medical devices. Further yet, H.R. 1215 could prevent victims from having their day in court by providing unjustified immunity for health care providers who dispense defective or dangerous pharmaceuticals or medical devices, by instituting an extremely short statute of limitations pe-

riod, and by imposing limitations on attorney contingent fee arrangements that will discourage lawyers from representing victims. Finally, H.R. 1215 imposes various requirements that will significantly diminish a victim's ability to be fully compensated for their injuries, including: (1) the elimination of joint and several liability with respect to claims for both economic and noneconomic damages, (2) an extremely low cap on noneconomic damages such as those for pain and suffering, which will particularly limit compensation for members of vulnerable groups like the poor, the elderly, children, women, and other groups who tend to have less in terms of lost wages or other economic loss, and (3) the allowance for periodic payments of future damages of $50,000 or more, which will put the risk of future loss on plaintiffs rather than defendants.

In recognition of these significant concerns, a coalition of 30 consumer and public interest groups, including the Center for Justice and Democracy, Consumer Federation of America, National Association of Consumer Advocates, National Women's Health Network, and Public Citizen, oppose H.R. 1215 because it "would limit the legal rights of injured patients and families of those killed by negligent health care" as well as those injured by "unsafe drugs and nursing home abuse and neglect." [1] Similarly, Consumers Union opposes H.R. 1215 because the bill "would put patient safety at higher risk, by significantly undermining the accountability of those who provide patients with medical care." [2] In addition, the American Bar Association, in its opposition to the bill, observes that for "200 years, the authority to determine medical liability law has rested in the states" and that this "is a hallmark of the American justice system." [3]

For these reasons, and for those discussed below, we respectfully dissent from the Committee's report and oppose H.R. 1215.

DESCRIPTION AND BACKGROUND

DESCRIPTION

H.R. 1215 would preempt state law generally to the extent that state laws are more protective than the bill's provisions of the rights of medical malpractice victims and the victims of defective medical products. It would replace such victim-protective laws with new requirements and limitations that would restrict or undermine the ability of injured persons to be fully compensated for their injuries or even to have their claims heard in court. The following describes some of the bill's most troubling provisions.

Section 10(a) sets forth the general rule that the bill's provisions preempt state law. It specifies that, except as otherwise provided in the bill, the legislation's provisions governing health care lawsuits preempt state law to the extent that state law prevents the application of any provisions of law established by or under this

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[1] Letter from 30 consumer groups to Chairman Bob Goodlatte (R-VA) and Ranking Member John Conyers, Jr. (D-MI), H. Comm. on the Judiciary (Feb. 27, 2017) (on file with H. Comm. on the Judiciary Democratic Staff).

[2] Letter from George P. Slover, Senior Policy Council, Consumers Union, to Members of the H. Comm. on the Judiciary (Feb. 27, 2017) (on file with H. Comm. on the Judiciary Democratic Staff).

[3] Letter from Thomas M. Susman, Director of the Governmental Affairs Office, American Bar Association, to Chairman Bob Goodlatte (R-VA) and Ranking Member John Conyers, Jr. (D-MI), H. Comm. on the Judiciary (Feb. 27, 2017) (on file with H. Comm. on the Judiciary Democratic Staff).

legislation. The bill at various points sets forth exceptions to this general preemption provision generally for state laws that are more restrictive for plaintiffs than the bill's provisions would be. Section 10(c) specifies that no provision of this legislation may be construed to preempt any *defense* available to a party in a health care lawsuit under any provision of state or Federal law.

The bill defines "health care lawsuit" to include not only medical malpractice claims, but also claims concerning medical products. Specifically, section 8(7) defines "health care lawsuit" to mean "any health care liability claim concerning the provision of *goods* or services for which coverage was provided in whole or in part via a Federal program, subsidy or tax benefit, or any health care liability action concerning the provision of goods or services for which coverage was provided in whole or in part via a Federal program, subsidy or tax benefit." This definition appears to cover any claim arising from health care products or services paid for at least in part by programs such as Medicare, Medicaid, a subsidy under the Affordable Care Act (ACA),[4] Veterans Administration-provided health care, or the Employee Retirement Income Security Act of 1974. Moreover, "health care lawsuit" includes lawsuits brought in state and Federal courts or pursuant to an alternative dispute resolution (ADR) system against a health care provider, regardless of the theory of liability, but does not include criminal liability, civil fines and penalties, or antitrust claims.

The bill defines "health care liability action" as a civil action brought in state or Federal court or pursuant to an ADR system against a health care provider in which the plaintiff alleges a health care liability claim. "Health care liability claim," in turn, is defined as "a demand by any person, whether or not pursuant to ADR, against a health care provider . . . which [is] based upon the provision or use of (or the failure to provide or use) health care services or medical products." The bill defines "health care provider" as "any person or entity required by law to be licensed, registered, or certified to provide health care services" and defines "health care services" to mean "the provision of any goods or services by a health care provider" or any individual working under such person's supervision that relates to the diagnosis, prevention, or treatment of human disease or impairment or an assessment or care of human health. This definition is broad enough that it could include not just physicians and hospitals, but also nursing homes and long-term care facilities.

Section 2 creates a statute of limitations for "health care lawsuits." Claimants must commence a health care lawsuit within 3 years of the date of injury or within 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

Section 3 caps non-economic damages in "health care lawsuits" at $250,000 regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury. This section also eliminates joint and several liability in health care lawsuits for both economic and noneconomic damages claims. Joint and several liability means that where there are several defendants each is liable joint-

[4] Pub. L. No. 111–148, 124 Stat. 119 (2010).

ly with the others for the amount of the judgment against them, and that each is also individually liable for the full amount. In sum, the plaintiff can collect from any one of them or any group. By eliminating joint and several liability for health care lawsuits, each defendant would be liable only for that defendant's share of any damages and not for the share of any other person and each party is liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. When a judgment of liability is rendered as to any party, a separate judgment must be rendered against each such party for the amount allocated to such party.

Section 4 places limitations on the amount of contingent fees that a plaintiff's lawyer may recover as compensation in a "health care lawsuit." In particular, section 4(a) provides that the total of all contingent fees for representing all claimants in a health care lawsuit must not 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); or (4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

Section 6 provides that where a claim for future damages of $50,000 or more is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court must, at the request of any party, enter a judgment order that the future damages be paid by periodic payments.

Finally, section 7 provides complete immunity for health care providers who prescribe or dispense pursuant to a prescription a medical product "approved, licensed, or cleared by the Food and Drug Administration" in a product liability lawsuit involving such product and provides that health care providers shall not be liable to a plaintiff in a class action lawsuit against the manufacturer, distributor, or seller of such product.

BACKGROUND

Every year, as many as 440,000 Americans die from preventable medical errors, making it the third leading cause of death.[5] Even where death does not result from such errors, the injuries suffered by patients can be severe and permanent. In fact, there are 20 times as many serious, yet nonfatal, preventable injuries to patients. According to the National Patient Safety Foundation, "The health care system continues to operate with a low degree of reliability, meaning that patients frequently experience harms that could have been prevented or mitigated."[6] Common medical errors include the 40 surgeries per week in the United States performed on the wrong patient or the wrong body part,[7] the average of more

[5] Marla Paul, *How to Prevent 440,000 Yearly Deaths Due to Medical Errors*, Northwestern Now, Nov. 16, 2016, available at https://news.northwestern.edu/stories/2016/11/how-to-prevent-440000-yearly-deaths-due-to-medical-errors.

[6] National Patient Safety Foundation. *Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human.* National Patient Safety Foundation, 2015, available at http://www.npsf.org/?page=freefromharm.

[7] According to the American Association for Justice, there are 40 wrong-patient or wrong-site procedures performed every week. American Ass'n for Justice, Medical Negligence: The Role of America's Civil Justice System in Protecting Patients' Rights (Feb. 2011) (citing Joint Commis-

Continued

than 100 incidents per year of foreign objects being left inside patients,[8] and failures to properly diagnose life-threatening conditions like cancer or to prescribe proper medication.[9] In addition to cases of medical errors are instances where a health care provider intentionally harms a patient, including cases where a provider rapes or sexually assaults a patient.

A medical malpractice claim is a tort-based legal claim for damages arising out of an injury caused by a health care provider. Tort claims are part of "common law" or judge-made law of the U.S. civil justice system and typically reserved to the states.[10]

Product liability actions are actions brought against the manufacturer or seller of a defective or dangerous product by a consumer who is injured as a result of that product. Like other areas of tort law, products liability is governed by state laws on negligence, breach of warranty, or strict liability.

The tort system provides various benefits to society. First, it compensates victims who have been injured by the negligent conduct of others. Second, it deters future misconduct and carelessness that may cause injury and punishes wrongdoers who inflict such injury. Third, it prevents future injury by removing dangerous products and practices from the marketplace. Fourth, it informs an otherwise unknowing public of such harmful products or practices thereby expanding public health and safety.[11]

Most medical malpractice claims are based on the tort of "negligence," defined as conduct "which falls below the standard established by law for the protection of others against unreasonable risk and harm."[12] In medical malpractice cases, this legal standard is based on the practices of the medical profession,[13] and is usually determined based on testimony of expert witnesses. As with other torts, remedies for medical malpractice may consist of: (1) compensatory damage awards for economic losses such as medical expenses, lost wages, pain and suffering, reduced life expectancy and diminished quality of life; and (2) punitive damages to punish and deter willful and wanton conduct.

Medical malpractice liability insurance has historically attracted the attention of Congress during industry "crisis" periods, which occurred during the mid-1970's, the mid-1980's, and the early 2000's. These periods were all marked by increases in insurance premiums, difficulties in finding malpractice insurance for certain medical specialties, and reports of physicians leaving geographical areas or retiring to avoid insurance difficulties. Currently, the medical liability insurance market is not exhibiting crisis symptoms. Indeed, according to a 2016 article in a medical malpractice insurance industry trade publication, the "medical professional liability

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sion Center for Transforming Healthcare, Wrong Site Surgery Project http://www.centerfortransforminghealthcare.org/projects/display.aspx?projectid=4).

[8] The Joint Commission, *Sentinel Event Alert,* Issue 51, Oct. 17, 2013, available at https://www.jointcommission.org/assets/1/6/SEA_51_URFOs_10_17_13_FINAL.pdf.

[9] Failure to diagnose a disease and medication errors are the two most common bases for filing a medical malpractice lawsuit. Rachel Rettner, *Failure to Diagnose Is No. 1 Reason for Suing Doctors,* Live Science, Jul. 18, 2013, available at http://www.livescience.com/38289-malpractice-claims-missed-diagnoses.html

[10] "Tort law at present is almost exclusively state law rather than federal law [.]" Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes, Congressional Research Service, Rep. No. 95–797A, at 1.

[11] Joan Claybrook, Consumers and Tort Law, 34 Fed. B. News & J. 127 (1987).

[12] Restatement (Second) of Torts § 282 (1965).

[13] David M. Harney, Medical Malpractice § 21.2, at 413 (2d ed. 1987).

insurance industry is continuing its unprecedented run of consecutive profitable years in 2016. Never before has the industry witnessed such an unbroken string of annual favorable results, many of which were very favorable."[14] That same publication, describing a survey of medical professional liability insurance rates, noted that for the "vast majority (75 percent) of [medical malpractice] insurers in the survey, rates have remained flat between 2015 and 2016."[15]

CONCERNS WITH H.R. 1215

I. H.R. 1215 VIOLATES STATE SOVEREIGNTY.

H.R. 1215, like many so-called "tort reform" measures that the Committee has considered, represents a deep intrusion into state sovereignty. Although tort law is an area historically developed and shaped by the states, H.R. 1215 raises broad federalism concerns as it preempts several areas of tort law that traditionally have been governed by the jurisprudence of each individual state or by state legislatures. The bill mandates that, with certain very limited and defendant-friendly exceptions, each of the bill's provisions "governing health care lawsuits set forth in this Act preempt . . . State law to the extent that State law prevents the application of any provisions of law established by or under this Act."[16] In particular, H.R. 1215 preempts state law governing joint and several liability, the availability of damages, attorneys' fees, and periodic payments of future damages. In short, H.R. 1215 does nothing to address the fundamental concerns about states' rights raised by our *Republican* Committee colleagues as it intrudes just as deeply as its predecessor bills into areas traditionally determined by the states.

As with previous versions of this legislation, many provisions of H.R. 1215 are written to be "one-way preemptive"—that is, they only supersede state laws that are generally more favorable to victims, rather than preempting state law equally across the board. For instance, the bill does not preempt any *defenses* available to defendants under state law. In addition, H.R. 1215 leaves intact damage caps determined by states even if they exceed those in the bill, but would impose them on states lacking such damage caps. Similarly, the bill leaves in place state limitations periods that are shorter than those provided for in the bill, but not those that may be longer; state laws that provide for lower contingent fee payments to plaintiffs' attorneys, but not those that may authorize higher payments; and state laws that specify periodic payments for future damages at any amount other than $50,000, but not those state laws that prohibit periodic payments. This is true even though the absence of the defendant-protective features provided in H.R. 1215 represent a state judiciary's established legal precedents or the valid public policy choices made by a state's legislature.

Examples of state provisions that H.R. 1215 would preempt include state constitutional provisions in Arizona, Arkansas, Kentucky, Pennsylvania, and Wyoming that prohibit caps on dam-

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[14] Paul Greve & Allison Milford, *Do Still Waters Still Run Deep? Medical Professional Liability in 2016,* Medical Liability Monitor, Vol. 41, No. 10 (Oct. 2016).
[15] *Id.* at 5.
[16] H.R. 1215, 115th Cong. § 10(a) (2017) (as amended).

ages.[17] In addition, 22 states' laws provide for some form of joint and several liability, which would be preempted by this bill.[18] By applying a numerically specific sliding scale on contingent fee arrangements, the bill also preempts the law in 33 states and the District of Columbia that either do not have any specific statutory limits on attorneys' fees, require or allow a court to determine a "reasonable" fee award, leave attorney compensation arrangements entirely to the parties to determine, or impose a sliding scale with higher compensation limits than the bill provides.[19]

In light of the fact that H.R. 1215 fundamentally upends our Nation's Federal constitutional structure, Representative Hank Johnson (D-GA) offered an amendment that would have added a rule of construction requiring that the bill not be construed to preempt any state constitutional provision. In support of his amendment, Representative Johnson noted that "the bill only overrides those [state] laws which are more protective of injured patients and families so that defendants . . . can gain an unfair advantage in courts"[20] and that such "sweeping preemption of state law . . . comes at the expense of individuals hurt by medical malpractice or dangerous products, as well as families suffering under the weight of crippling medical bills and lost wages caused by medical negligence."[21] The Committee initially *adopted* this amendment by a bipartisan 16 to 15 vote.[22] In response to the adoption of this amendment, however, the Committee Majority proceeded to engage in a number of extraordinary procedural maneuvers to reconsider the amendment,[23] cut off debate,[24] and hold a second vote on whether to adopt this amendment.[25] On the second vote, the Committee rejected the amendment by a tie vote of 17 to 17, notwithstanding continued bipartisan support in favor of adopting the amendment.[26]

II. H.R. 1215 APPLIES WELL BEYOND MEDICAL MALPRACTICE.

H.R. 1215 makes sweeping changes to the ground rules for "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 enactment of this Act. . . ."[27] The bill, in turn, defines a "health care lawsuit" as:

> any health care liability claim concerning the provision of health care goods or services for which coverage was pro-

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[17] The relevant state constitutional provisions are Arizona (Article 2 sec. 31 and Article 18 sec. 6); Arkansas (Article 5, § 32); Kentucky (Section 54); Pennsylvania (Article III sec. 18); and Wyoming (Section 97–10–004 (a)).

[18] Alabama, Hawaii, Illinois, Indiana, Iowa, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, and Virginia.

[19] Alabama, Alaska, Arizona, Arkansas, Colorado, District of Columbia, Georgia, Hawaii, Idaho, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, Virginia, Washington, and West Virginia.

[20] Unofficial Tr. for Markup of H.R. 1215, the "Protecting Access to Care Act of 2017," by the H. Comm. on the Judiciary, 115th Cong. 105 (Feb. 28, 2017) [hereinafter "Markup Tr."], available at https://judiciary.house.gov/wp-content/uploads/2017/02/2.28-Markup-Transcript.pdf.

[21] *Id.*

[22] *Id.* at 119.

[23] *Id.* at 132–36, 148.

[24] *Id.* at 136, 142, 153, 158.

[25] *Id.* at 158.

[26] *Id.* at 164.

[27] H.R. 1215, 115th Cong. § 11 (2017) (as amended).

> vided in whole or in part via a Federal program, subsidy or tax benefit, or any health care liability action concerning the provision of goods or services for which coverage was provided in whole or in part via a Federal program, subsidy or tax benefit, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider regardless of the theory of liability on which the claim is based. . . .[28]

Importantly, H.R. 1215 defines "health care provider" to include a person or entity licensed or certified to provide health care services, which could include hospitals, surgery centers, nursing homes, assisted living facilities, rehabilitation facilities, and insurance companies. Although it is often described as a "medical malpractice" measure, H.R. 1215 is not limited to medical malpractice lawsuits because its health care lawsuit definition covers all "health care liability claims," including claims based on the provision of *medical products* by a health care provider, and to "any theory of liability on which the claim is based," including those based on actions taken by drug and medical device manufacturers, nursing homes, insurance companies, and health maintenance organizations.

Finally, although H.R. 1215's proponents may assert the bill is narrower than its predecessors, it is, in fact, almost as broad. The definition of "health care lawsuit" attempts to limit the bill's scope to claims arising from Federal Government-subsidized health insurance programs, such as Medicare, Medicaid, the ACA, and veterans health plans. If anything, the addition of this language to the definition of "health care lawsuit" means that the bill's onerous provisions would be particularly targeted at claims by the elderly, the poor, veterans, and other vulnerable groups, who disproportionately depend on government-subsidized health insurance.

Given the bill's broad scope, including its potential application to claims for abuse or negligence against nursing homes and long-term care facilities, Representative Hank Johnson (D-GA) offered an amendment that would have exempted from H.R. 1215's unjustified and burdensome provisions all claims concerning nursing homes and long-term care facilities. The Committee, however, rejected this amendment by a party-line vote of 13 to 15.[29]

III. H.R. 1215 RESTRICTS HEALTH CARE LAWSUITS THAT WILL DIMINISH OR COMPLETELY BLOCK VICTIMS' ABILITY TO BE COMPENSATED FOR THEIR INJURIES.

A. H.R. 1215 Provides Unjustifiable Immunity for Health Care Providers Who Dispense Defective or Dangerous Pharmaceuticals or Medical Devices.

H.R. 1215 threatens to undermine the ability of victims of defective or dangerous medical products, including prescription pharmaceuticals and medical devices, to be made whole. The bill adds a new provision, not contained in previous iterations of this measure, that gives a complete liability shield for health care providers who provide defective or dangerous products to a plaintiff if such product was "approved, licensed, or cleared by the Food and Drug Ad-

[28] *Id.,* § 8(7).
[29] Markup Tr. at 101.

ministration."[30] Specifically, this provision prohibits any health care provider from even being named in any lawsuit concerning the prescribing or dispensing of a drug or medical device under such circumstances. Moreover, a health care provider cannot be held liable in any product liability class action against a manufacturer of such defective or dangerous drug or medical device.

This provision could prevent victims from receiving just compensation for injuries in many cases. For example, where the health care provider is also the manufacturer of the defective or dangerous product, such as in the case of certain pharmacists, the victim may be left without someone to sue for his or her injury. Similarly, where a manufacturer successfully shifts blame onto the provider for negligent dispensing or use of a drug or device, a victim may lose any access to restitution since she cannot sue the provider. This excessively broad liability shield for health care providers—which, effectively, could also provide legal protection for drug and device manufacturers—is both unjust and unjustifiable.

B. H.R. 1215 Imposes an Excessively Short Statute of Limitations Period.

H.R. 1215 imposes an extremely restrictive statute of limitations for medical malpractice actions that significantly reduces the time that an injured person has to file a lawsuit. It provides that "the time for the commencement of a health care lawsuit shall be no later than 3 years after the date of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, *whichever occurs first.*"[31] The effect of this language is that a victim has, at most, 3 years, and as little as 1 year, to file suit.

Although disguised as a 3-year statute of limitations, the effect of this provision is that the claimant often has exactly 1 year from the date of discovering the injury to file suit. A claimant will, quite often, "discover" an injury on the same day or shortly after an injury occurs. This provision also cuts in the opposite direction, hindering patients who are injured by diseases with long latency periods. For example, a patient who was infected with HIV through a negligent blood transfusion may not discover his injury until more than 3 years after the date of the injury because the symptoms of his injury may manifest more than 3 years after the negligent transfusion. To the extent that the bill's statute of limitations period is shorter than those currently available under state law, it works to deny victims their day in court.

C. H.R. 1215 Makes It Harder for Victims To Obtain Adequate Legal Representation.

H.R. 1215 severely limits the amount an attorney may receive in the form of contingency fee payments. Contingency fee arrangements—where attorneys forgo immediate payment in exchange for a share of the damages if a plaintiff prevails in court—serve a useful and essential function in the legal system.[32] Because contin-

[30] H.R. 1215, 115th Cong. § 7 (2017) (as amended).
[31] *Id.,* § 2 (emphasis added).
[32] *See* Herbert M. Kritzer, *Lawyer Fees and Lawyer Behavior in Litigation: What does the Empirical Literature Really Say?,* 80 TEX. L. REV. 1943 (2002); Herbert M. Kritzer, *Economic Policy Litigation Conference Seven Dogged Myths Concerning Contingency Fees,* 80 WASH. U. L.Q. 739 (Fall 2002).

gency fee agreements require little or no money up front, injured plaintiffs who could not otherwise afford legal representation have access to counsel. In short, competent legal representation comes at a cost and H.R. 1215 would undermine the ability of plaintiffs to obtain such legal representation. Moreover, because attorneys who take losing cases are paid little or nothing for their efforts, contingency fees also serve as a screening mechanism for "frivolous" cases.[33]

H.R. 1215 would sharply erode the incentives provided by contingency fee arrangements and threaten the ability of injured plaintiffs to obtain legal representation by capping the total amount of all contingent fees for representing all claimants in a health care lawsuit to: (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), and (4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000. The bill also authorizes the courts to approve fees lower than those provided for by this formula in cases involving a minor or incompetent person. This provision is clearly intended to dis-incentivize lawyers from taking health care cases and thereby make it harder for plaintiffs to have their day in court.

D. By Eliminating Joint and Several Liability for Economic and Noneconomic Damages, H.R. 1215 Makes It Very Difficult for Victims in Health Care Lawsuits To Be Made Whole.

H.R. 1215 eliminates joint and several liability for economic and noneconomic loss. Joint liability ensures that injured patients are fully compensated for their losses by allowing one lawsuit to be brought against multiple defendants and having the defendants apportion fault among them. The doctrine is designed to ensure that victims of wrongful conduct are able to recover the full amount of damages for their injuries, especially when one or more of the defendants is insolvent. Many states recognize joint and several liability based on the principle that it is the injured patient, rather than the multiple negligent providers, who rightly should be given the greatest measure of protection under the law. By eliminating joint and several liability, H.R. 1215 threatens the ability of plaintiffs to be made whole.

Given the harm to victims that would result from eliminating joint and several liability, Representative Jamie Raskin (D-MD) offered an amendment to strike this provision from the bill. The Committee, however, rejected this amendment by a party-line vote of 14 to 16.[34]

E. H.R. 1215 Unjustifiably Caps Noneconomic Damages, Which Will Have a Disproportionately Adverse Impact on Women, the Poor, and Other Vulnerable Groups.

H.R. 1215 caps noneconomic damages at an aggregate amount of $250,000, regardless of the total number of defendants or claims brought with respect to the same injury. Noneconomic damages, such as those for pain and suffering and loss of consortium, com-

[33] *Id.*
[34] Markup Tr. at 199.

pensate victims for real injuries such as the loss of sight, loss of a limb, severe disfigurement, and loss of fertility. As a result of such an extremely restrictive cap on noneconomic damages, many victims injured as a result of medical malpractice of defective medical products will be denied full compensation. Women, children, the poor, the elderly, and the disabled will be particularly hurt by H.R. 1215's cap on noneconomic damages because they may have less substantial amounts of lost wages or other kinds of economic loss that must be documented for an award of economic damages.

Representative Jerrold Nadler (D-NY) explained that he would have offered two amendments to increase this $250,000 cap, a level that he noted was set more than 40 years ago in a California statute. One amendment would have indexed the $250,000 cap to inflation and the other would have increased the cap to reflect the present value of $250,000 in 1975 dollars and then indexed that amount to inflation.[35] In the interest of time, however, he did not offer these amendments.

F. H.R. 1215 Inequitably Imposes the Risk of Loss on Victims Rather than Wrongdoers.

H.R. 1215 provides that, upon request of a party, payments of future damages—i.e., damages accrued after judgment, settlement, or resolution of the case—in excess of $50,000 may be made in periodic payments rather than a lump sum payment to victims. Periodic payment plans allow a negligent party to stall while the patient assumes the risk of loss. The defendant (or the defendant's insurance company) can, in the meantime, invest and earn interest on the compensation owed to the patient. If a defendant files for bankruptcy—or simply refuses to pay—it is the patient's responsibility to retain counsel and press the matter in court. This would be an unjust outcome.

IV. H.R. 1215 PROVIDES NO EXCEPTIONS TO ITS ONEROUS PROVISIONS FOR THOSE WHO HAVE SUFFERED EVEN THE MOST HORRIFIC INJURIES OR ARE THE VICTIMS OF THE WORST KINDS OF MISCONDUCT.

H.R. 1215's onerous requirements apply even in cases where a health care provider has intentionally harmed a patient or when the medical error is especially egregious. For instance, the bill's extremely low cap on noneconomic damages would likely prevent full compensation for a child who has been sexually molested by a health care provider, a woman who had a healthy breast removed after a misdiagnosis of breast cancer, or a low-income person who had the wrong leg amputated by a surgeon. The bill's other provisions would likewise make it far less likely that victims of such egregious medical misconduct will be fully compensated for their injuries or even have their day in court.

For the foregoing reasons, Ranking Member John Conyers, Jr. (D-MI) offered an amendment that would have exempted from H.R. 1215 all health care claims arising from an intentional tort. At a minimum, the bill's onerous provisions should not apply with respect to the most egregious kinds of conduct, such as rape, sexual assault, or other intentional harm caused by a health care provider. This amendment would have avoided the bill's many obsta-

[35] *Id.* at 63–64.

cles to justice for victims at least in cases where the underlying conduct was most serious and grave. Unfortunately, the Committee rejected this amendment by a party-line vote of 12 to 16.[36]

Representative Sheila Jackson Lee (D-TX) offered an amendment that would have exempted from H.R. 1215 all cases concerning irreversible injury. At a minimum, victims of medical malpractice or defective medical products who suffer severe and permanent injury should be able to seek justice in court without the unnecessary and unjustified burdens imposed by this bill. Notwithstanding this concern, the Committee rejected this amendment by a party-line vote of 14 to 19.[37]

Similarly, Constitution and Civil Justice Subcommittee Ranking Member Steve Cohen (D-TN) offered an amendment to exempt from H.R. 1215 all cases arising from a claim of wrong-site, wrong-patient surgery or where a device had been left inside of a patient. As with the intentional tort exemption, this narrow amendment would have provided relief from the bill's onerous and unfair provisions for victims of particularly egregious medical errors, such as cases where the wrong body part had been amputated or where the wrong patient was operated on through the negligence of a health care provider. Notwithstanding these concerns, the Committee rejected this amendment by a party-line vote of 12 to 16.[38]

Finally, Representative Eric Swalwell (D-CA) offered an amendment to exempt from H.R. 1215 all cases concerning the provision of goods or services for treatment of an injury sustained by a rape or sexual assault victim as a result of such rape or sexual assault. This amendment would have protected victims of such horrific crimes from being further victimized by the bill's many hurdles to compensation for medical injuries. The Committee, however, rejected this amendment by a party-line vote of 13 to 17.[39]

CONCLUSION

While House Republicans appear to proffer H.R. 1215 as part of their effort to "repeal and replace" the ACA and that law's guarantee of adequate and affordable health insurance coverage for all Americans, the bill actually undermines those goals by heightening the risks of harm to patients and consumers of medical products. It does this by significantly undermining their ability to pursue a case in court and by imposing various restrictions on victims' ability to be fully compensated for their injuries, making it harder to hold wrongdoers accountable and to deter future misconduct. Additionally, the bill represents a deep intrusion into state sovereignty as state legislatures and state courts traditionally set the rules governing tort liability. For these reasons, and those articulated above, we strongly oppose H.R. 1215.

MR. CONYERS, JR.
MR. NADLER.
MS. LOFGREN.
MS. JACKSON LEE.
MR. COHEN.

[36] *Id.* at 63.
[37] *Id.* at 132.
[38] *Id.* at 87.
[39] *Id.* at 183.

MR. JOHNSON, JR.
MR. DEUTCH.
MR. GUTIERREZ.
MS. BASS.
MR. RICHMOND.
MR. JEFFRIES.
MR. CICILLINE.
MR. SWALWELL.
MR. LIEU.
MR. RASKIN.
MS. JAYAPAL.

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