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ONE HUNDRED TWELFTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON THE JUDICIARY

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April 27, 2012

The Honorable Paul Ryan
Chairman
House Committee on the Budget
207 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Ryan:

Pursuant to Section 201 of H. Con. Res. 112, I transmit to you the enclosed legislative language and accompanying materials from the Committee on the Judiciary.

Sincerely,



Lamar Smith
Chairman

cc: The Honorable John Conyers, Jr.



**RECONCILIATION SUBMISSION PURSUANT TO
SECTION 201 OF H.CON.RES. 112, 112TH CONGRESS**

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SUMMARY OF THE MAJOR POLICY DECISIONS IN THE LEGISLATION

The HEALTH Act is modeled on California’s legal reforms, which have been the law in that state for over 35 years. The HEALTH Act’s reforms include a \$250,000 cap on noneconomic damages, limits on the contingency fees lawyers can charge, and authorization for courts to require periodic payments for future damages instead of lump sum awards that prevent bankruptcies in which plaintiffs would receive only pennies on the dollar. Additionally, the HEALTH Act has a provision creating a “fair share” rule, by which damages are allocated fairly, in direct proportion to fault. It also includes reasonable guidelines—but not caps—on the award of punitive damages. The HEALTH 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. Finally, the HEALTH Act preserves any State law that otherwise caps damages or provides procedural or substantive protections for health care providers and health care organizations.

BACKGROUND AND NEED FOR THE LEGISLATION

The HEALTH Act’s reforms are necessary to help improve health care, make it more affordable, and save taxpayer money while reducing the federal deficit.

The HEALTH Act, modeled after California’s decades-old and highly successful health care litigation reforms, addresses the current crisis in health care by reigning in unlimited lawsuits

and thereby making 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 1975, has proved immensely successful in increasing access to affordable medical care. Overall, according to data of the National Association of Insurance Commissioners (with the latest data available from 2008), the rate of increase in medical professional liability premiums in California since 1976 has been a relatively modest 387%, whereas the rest of the United States have experienced a 1,089% rate of increase, a rate of increase 281% larger than that experienced in California.

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

MICRA's reforms, which have been the law in California for over 35 years, include a \$250,000 cap on noneconomic damages, limits on the contingency fees lawyers can charge, and authorization for courts to require periodic payments for future damages instead of lump sum awards that prevent bankruptcies in which plaintiff's would receive only pennies on the dollar. Additionally, the HEALTH Act has a provision creating a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault. It also includes reasonable guidelines—but not caps—on the award of punitive damages. The HEALTH 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. Finally, the HEALTH Act preserves any State law that otherwise caps damages or provides greater procedural or substantive protections for health care providers and health care organizations.

Enactment of the HEALTH 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.¹

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 State's current crisis in medical professional liability 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 or greater procedural or substantive protections for health care providers and health care organizations will be preserved under the HEALTH Act.

¹ See *Merrell Dow Pharm. Inc. v. Thompson*, 478 U.S. 804, 813 (1986).

The Huge Costs of Defensive Medicine Are Passed on to Taxpayers

The American medical liability system is broken. According to one study, 40 percent of claims are meritless, in that either no injury or no error occurred in the case. Attorneys' fees and administrative costs eat away 54% of the compensation that should be paid to plaintiffs. And completely meritless claims (which are nonetheless successful approximately one in four times) account for nearly a quarter of total administrative costs.²

Under current rules, health care workers seek to avoid these costs to themselves by conducting many additional costly tests and procedures and shifting those costs to taxpayers. As one physician explained, “[j]ust one successful lawsuit against a physician for a missed diagnosis can damage his ability to maintain his credentials, cost him . . . in increased liability insurance, jeopardize his financial assets, and even end his career. Why risk our own money when we can use somebody else’s to protect us, even if it costs millions?”³

Defensive Medicine Is Widespread, and the Solution Is Tort Reform

“Defensive medicine” is widely practiced. Skyrocketing medical liability insurance rates have distorted the practice of medicine. Costly, but unnecessary, tests have become routine as doctors try to protect themselves from frivolous lawsuits. Indeed, according to a Harvard University research study, 40% of medical malpractice lawsuits filed in the United States lack evidence of medical error or any actual patient injury.⁴

A survey released in 2010 found defensive medicine is an issue for all physicians. The results, published in the *Archives of Internal Medicine*, found that 91% of the 1,231 doctors who responded to their survey “reported believing that physicians order more tests and procedures than needed to protect themselves from malpractice suits.” That view was held by the vast majority of generalists (91%), medical specialists (89%), surgeons (93%) and other specialists (94%). The survey asked two questions: (1) “Do physicians order more tests and procedures than patients need to protect themselves from malpractice suits?”; and, (2) “Are protections against unwarranted malpractice lawsuits needed to decrease the unnecessary use of diagnostic tests?” Overall, 91 percent of doctors surveyed agreed with both statements.⁵

According to a 2008 survey conducted by the Massachusetts Medical Society, 83 percent of physicians reported that they practice defensive medicine.⁶ Another study in Pennsylvania put the figure at 93 percent.⁷

² “Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” David Studdert et al., *New England Journal of Medicine* (May 11, 2006).

³ Panda Bear, MD, “How I Am Learning to Throw Money Away with Both Hands and a Big Shovel” (February 5, 2008).

⁴ Available at <http://www.hsph.harvard.edu/faculty/articles/litigation.pdf>.

⁵ 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.

⁶ “Investigation of Defensive Medicine in Massachusetts,” Massachusetts Medical Society (November 2008).

⁷ David Studdert et al., “Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment,” *JAMA* (June 1, 2005) at 2609-2617.

Defensive medicine is widespread in specialty medical fields as well. According to another report:

[A] survey from *Emergency Physicians Monthly* [concludes] many tests performed in the ER [emergency room] are deemed unnecessary to good patient care. Here’s how doctors responded to the following question: “Given that in a typical shift of eight hours you see an average of two patients per hour (16 patients/shift), could you have eliminated any of the following tests and/or treatments without compromising the quality of care? If so, how many of each?” The results of the survey showed how many times ER doctors prescribe which types of tests unnecessarily to avoid unlimited lawsuits:

	None	1	2	3	4	More
Plain Film X-Rays	83%	20%	23%	15%	10%	9%
CT Scans	30%	32%	23%	6%	5%	5%
Lab Tests	17%	8%	19%	14%	15%	27%
Medication Orders	42%	14%	18%	10%	7%	10%
Other	45%	13%	17%	6%	6%	13%

As you can see, laboratory tests and CT scans comprised the greatest proportion of unnecessary tests.⁸

The same survey found that the HEALTH Act’s limit on noneconomic damages is essential to reducing defensive medicine: “The survey also found that non-economic caps are these physicians’ preferred choice of malpractice reform, with 84 percent of emergency physicians calling them a ‘non-negotiable part of health reform.’”⁹

Another report on defensive medicine in the emergency room summarized emergency room doctors’ incentives as follows:

The fear of missing something weighs heavily on every doctor’s mind. But the stakes are highest in the ER, and that fear often leads to extra blood tests and imaging scans for what might be harmless chest pains, run-of-the-mill head bumps and non-threatening stomachaches. Many ER doctors say the No. 1 reason is fear of malpractice lawsuits. “It has everything to do with it,” said Dr. Angela Gardner, president of the American College of Emergency Physicians.¹⁰

As one *Newsweek* reporter described the personal experience of individual doctors:

⁸ KevinMD.com “How Much Unnecessary Testing Goes On in the ER?” (September 30, 2009).

⁹ KevinMD.com “How Much Unnecessary Testing Goes On in the ER?” (September 30, 2009). And in 2003, the Florida Governor’s Select Task Force on Health Care Professional Liability Insurance made its official recommendations to Governor Bush. The Task Force concluded as follows: “the most important [recommendation] is a cap on noneconomic damages in the amount of \$250,000.” Governor’s Select Task Force on Healthcare Professional Liability Insurance (January 29, 2003) at xvi (Executive Summary).

¹⁰ Lindsey Tanner, “Fear Can Drive ERs To Do Tests to Excess,” Associated Press (June 21, 2010).

When I asked physicians which medical procedures were costly and commonly performed but did not help (at least some) patients, I expected more of them to justify almost everything they do. Some did. But as the *Newsweek* article on “medicine we can live without” showed, many physicians couldn’t get their nominees to me fast enough, so eager were they to spread the word about how much stupid, useless medical care there is.

The reason for that isn’t surprising: doctors hate practicing defensive medicine—that is, ordering tests, surgeries, or other procedures not because the doctor knows it will help the patient but to protect the physician from lawsuits. . . .

[M]ore typical was Angela Gardner, president of the American College of Emergency Physicians, who had a list as long as my arm of procedures ER docs perform, often for no patient benefit. They include following a bedside sonogram (looking for ectopic pregnancy, for instance) with an “official” sonogram (because if something is missed 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 (ORs won’t accept patients for an appendectomy without a CT); and . . . well, there were more. But in short, Gardner told me, “I think there is plenty we could cut out without hurting patients in any way.”

So why don’t they? Because although doctors may hate practicing defensive medicine, they do it so they don’t get sued. We’ve known that for a long time, but a recent survey of physicians is so replete with horror stories I can’t resist sharing them. . . .

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.

And now for those horror stories. The ER, said one doc in the Jackson survey, “should have a CT head scanner at the entrance door,” since “every patient gets a head CT.”

Another ER doc said he “routinely admit[s] low-risk chest pain patients because I know at some point in my career, one of them will go home and die from a heart attack. I will admit hundreds to avoid that one death (and possible lawsuit).” Another said he ordered 52 CT scans in one 12-hour shift: “That’s \$104K in one day.” And another: “Any patient who presents to the ER and mentions the magic words ‘chest pain,’ unless they are well known by the physician, is guaranteed to undergo multiple blood tests, ECGs, stress tests, perhaps CT scans, and will incur charges of several thousand dollars. A very large percentage of these patients will have very low probability of having ischemic chest pain, yet all patients will undergo testing to prevent ‘something from being missed’ in the name of defensive medicine.”

Like other physicians, this one bemoaned what he has to do to appease patients, such as a “paranoid new mom [who] insists her child needs a head CT after they bumped their head . . . to rule out a head bleed. So to appease the lawyers and hospital administration and everyone else, I have to consciously sedate a perfectly normal 15-month-old and put them at terrible risk just to prove to a mother that children don't get head bleeds from falling over and bumping their heads!” (That “terrible risk” refers to the fact that CTs deliver a lot of radiation and thus increase the risk of cancer.) And an anesthesiologist described how he orders “lab tests, X rays, cardiac consultations, and stress tests, [as well as] pregnancy tests . . . most often to cover our butts.”

Obstetricians really sounded off. One described having to admit to the hospital “pregnant patients with complaints such as stomach pain, cramps, excess vaginal discharge, headache, etc.” almost solely for defensive reasons: “You can't afford to give them any reason to point to you if their baby isn't perfect.”¹¹

And, according to a recent survey of heart doctors:

A substantial number of heart doctors—about one in four—say they order medical tests that might not be needed out of fear of getting sued, according to a new study . . . [A]bout 24 percent of the doctors said they had recommended the test in the previous year because they were worried about malpractice lawsuits . . . The study was released Tuesday by the journal *Circulation: Cardiovascular Quality and Outcomes*.¹²

Moreover, according to the Massachusetts Medical Society, and *White Coat Notes*, a publication of the Boston-area medical community:

The fear of being sued is driving Massachusetts physicians to order many tests, procedures, referrals to specialists and even hospitalizations for consumers that aren't needed and drive up health costs by more than \$1.4 billion a year, according to a new study that is the first of its kind.

The Massachusetts Medical Society surveyed 900 of its members, including family doctors, obstetricians and gynecologists and general surgeons, who reported practicing so-called “defensive medicine.”

The report found that 83 percent of physicians surveyed reported practicing defensive medicine and that an average of 18 to 28 percent of tests, procedures and referrals and consultations, and 13 percent of hospitalizations were ordered solely out of fear of being sued.¹³

¹¹ 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).

¹² Stephanie Nano, “Heart Doctors Admit They Order Unnecessary Tests Out of Fear of Being Sued,” Associated Press (April 14, 2010).

¹³ Kay Lazar, “Doctors' Practice of ‘Defensive Medicine’ Widespread, Costly,” *White Coat Notes* (November 17, 2008).

A recent Gallup survey of American physicians found the fear of lawsuits was the driver behind 21 percent of all the tests and treatments ordered by doctors, which equates to 26 percent of all health care dollars spent. That comes to a staggering \$650 billion.¹⁴ According to a study of medical liability costs and the practice of medicine in *Health Affairs*, overuse of imaging services alone, driven by fear of lawsuits, costs as much as \$170 billion a year nationally.¹⁵

The medical lawsuit crisis affects nurses as well. Nearly half of nurses say they are prohibited or discouraged from providing needed care by rules set up to avoid lawsuits.¹⁶

Defensive Medicine is Costly

As was recently reported, defensive medicine costs billions of dollars annually:

The latest estimate of the costs of defensive medicine, from an analysis just published in *Health Affairs*: \$45.6 billion annually (in 2008 dollars), accounting for more than 80% of the \$55.6 billion total yearly cost of the medical liability system. The authors from Harvard University and the University of Melbourne explain that their analysis doesn't attempt to estimate social costs or benefits of the malpractice system, such as damage to physicians' reputations or any deterrent effect it may provide [Their conclusions] include estimates of defensive medicine costs both for hospitals (\$38.8 billion) and for physicians (\$6.8 billion), calculated by looking at costs in high- and low-liability environments. The thought is that the difference represents [increased] spending due to fear of being sued—i.e. defensive medicine The total costs of the medical liability system constitute about 2.4% of total health-care spending, the authors write. That's "not trivial," they write, and because some of these costs "stem from meritless malpractice litigation," flaws in the system are worth addressing.¹⁷

A study by the Pacific Research Institute estimates that defensive medicine costs \$191 billion a year,¹⁸ while a separate study by PricewaterhouseCoopers puts the number even higher—\$239 billion.¹⁹ That follows another study by PricewaterhouseCoopers that found, "While the bulk of the premium dollar pays for medical services, those medical services include the cost of medical liability and defensive medicine Defensive tests and treatment can pose unnecessary medical risks and add unnecessary costs to healthcare."²⁰

The Consensus is that Defensive Medicine Caused by Unlimited Lawsuits is a Real Problem

¹⁴ "Price: Cutting Medical Costs without Obamacare," *Washington Times*, 3/18/10.

¹⁵ "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Care 11," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2003.

¹⁶ "Fear of Litigation Study, The Impact on Medicine," Harris Interactive (April 11, 2002).

¹⁷ Katherine Hobson, "How Much Does Defensive medicine Cost? One Study Says \$46 Billion," *Wall Street Journal Health Blog* (September 7, 2010).

¹⁸ Available at http://www.heartland.org/custom/semod_policybot/pdf/26161.pdf.

¹⁹ PricewaterhouseCoopers' Health Research Institute, *The Price of Excess: Identifying Waste in Healthcare Spending* (New York: PricewaterhouseCoopers 2008), endnote 18, at 18.

²⁰ "The Price of Excess: Identifying Waste in Healthcare Spending," PricewaterhouseCoopers, 2008.

President Obama himself acknowledged the harm caused by defensive medicine, stating “I want to work with the AMA so we can scale back the excessive defensive medicine that reinforces our current system, and shift to a system where we are providing better care, simply -- rather than simply more treatment.”²¹ The President himself weighed in on the issue in more detail, writing in the *New England Journal of Medicine* that “the current tort system does not promote open communications to improve patient safety. On the contrary, it jeopardizes patient safety by creating an intimidating liability environment.”²² In his 2011 State of the Union Address, President Obama said “I’m willing to look at other ideas to bring down costs, including one that Republicans suggested last year: medical malpractice reform to rein in frivolous lawsuits.” Although the Associated Press has written that “Republicans may be forgiven if [the President’s] offer makes them feel like Charlie Brown running up to kick the football, only to have it pulled away, again,”²³ the President should fulfill his promise and support time-tested reforms that have proven successful for over three decades in California.

A survey conducted for the bipartisan legal reform organization “Common Good,” whose Board of Advisors included Eric Holder, who is now President Obama’s Attorney General, 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.”²⁴

President Obama’s own doctor of over two decades also supports medical tort reform. David Scheiner was President Obama’s doctor from 1987 until he entered the White House. As was recently reported in *Forbes* magazine:

[Dr. Scheiner is] still an enthusiastic Obama supporter, but he worries about whether the health care legislation currently making its way through Congress will actually do any good, particularly for doctors like himself who practice general medicine. “I’m not sure [Obama] really understands what we face in primary care,” Scheiner says. . . .

Scheiner is critical of Obama’s pick for Health and Human Services secretary—Kansas Gov. Kathleen Sebelius, who used to work as the chief lobbyist for her state’s trial lawyers association. . . .

Scheiner says he never thought it was appropriate to talk about health policy with Obama, especially once he became a U.S. Senator. The one exception was medical malpractice reform. “I once briefly talked to him about malpractice, and he took the lawyers’ position,” he says. . . .

²¹ Text: Obama’s AMA Speech on Health Care (CBS News) (June 15, 2010).

²² “Making Patient Safety the Centerpiece of Medical Liability Reform,” Sen. Barack Obama and Sen. Hillary Clinton, *New England Journal of Medicine* (May 25, 2006).

²³ Associated Press, “Fact Check: Obama and His Imbalanced Ledger” (January 26, 2011).

²⁴ 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.

Scheiner, like most others in his profession, thinks that it should be harder to sue doctors and that awards should be capped. He says that he and other doctors must order too many tests and imaging studies just to avoid being sued.²⁵

The National Commission on Fiscal Responsibility and Reform

The National Commission on Fiscal Responsibility and Reform, which was created by President Obama, 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: 1) Modifying the “collateral source” rule to allow outside sources of income collected as a result of an injury (for example workers’ compensation benefits or insurance benefits) to be considered in deciding awards; 2) Imposing a statute of limitations – perhaps one to three years – on medical malpractice lawsuits; 3) 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; 4) Creating specialized “health courts” for medical malpractice lawsuits; and 5) Allowing “safe haven” rules for providers who follow best practices of care.

Many members of the Commission also believe that we should impose statutory caps on punitive and non-economic damages, and we recommend that Congress consider this approach and evaluate its impact.²⁶

Since President Obama signed the health care bill into law, the co-chairs of the Commission, Erskine Bowles and Alan Simpson, recommended that Congress enact a law to “[p]lay lawyers less and reduce the cost of defensive medicine” by “[e]nact[ing] comprehensive medical malpractice liability reform to cap non-economic and punitive damages and make other changes in tort law.”²⁷

The New York Times

According to the *New York Times*:

²⁵ David Whelan, “Obama’s Doctor Knocks ObamaCare,” *Forbes.com* (June 16, 2009).

²⁶ The National Commission on Fiscal Responsibility and Reform, “The Moment of Truth” (December 2010) at 34-35.

²⁷ Co-Chair Proposal, at 32, available at http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/CoChair_Draft.pdf.

The fear of lawsuits among doctors does seem to lead to a noticeable amount of wasteful treatment. Amitabh Chandra—a Harvard economist whose research is cited by both the American Medical Association and the trial lawyers’ association—says \$60 billion a year, or about 3 percent of overall medical spending, is a reasonable upper-end estimate.

Perhaps the best-known study of defensive medicine—by Dr. Mark McClellan, who later ran Medicare in the Bush administration, and Daniel Kessler—compared cardiology treatment in states that had capped malpractice awards in the 1980s and early ’90s with those that didn’t. In the states without caps, stenting and other treatments were more common, but the outcomes were no better. . . .

[T]he researchers in the field tend to agree about the scale of the problem—and how much malpractice reform might accomplish Dana Goldman, director of the Schaeffer Center for Health Policy at the University of Southern California, adds: “It is one of the things we need to address if we want to bend the cost curve.”²⁸

The *New York Times* also reported that Uwe E. Reinhardt, an economist at Princeton University, has written that the massive costs of lawsuit abuse in the United States distinguishes it from other countries:

Health-services researchers call the difference between these numbers [the health care spending of different countries], “excess spending.” That term [conveys] a difference driven by factors other than G.D.P. per capita. Prominent among these other factors are: . . . higher treatment costs triggered by our uniquely American tort laws, which in the context of medicine can lead to “defensive medicine” — that is, the application of tests and procedures mainly as a defense against possible malpractice litigation, rather than as a clinical imperative.²⁹

We know that our medical liability costs are at least twice those in other developed countries³⁰ and make up 10 percent of all tort cases. That’s the macro perspective, but what about the physicians, hospitals or other health care providers on the wrong end of a lawsuit? They can expect to pay an average of \$26,000 to defend a case that is dropped before trial and as much as \$140,000 if the case actually goes to court, regardless of the merits.³¹ So, even when good doctors win their lawsuits, which happens the vast majority of the time, they still lose. They lose valuable patient time, money, and peace of mind while watching their professional reputations impugned.

USA Today

The *USA Today* editorial board also recently came out supporting tort reform, citing the high cost of defensive medicine:

²⁸ David Leonhardt, “Medical Malpractice System Breeds More Waste,” *The New York Times* (September 23, 2009).

²⁹ Uwe E. Reinhardt, “Why Does U.S. Health Care Cost So Much? (Part I),” *The New York Times* (November 14, 2008).

³⁰ Manhattan Institute’s Center for Legal Policy study (2008).

³¹ “Reviving Tort Reform,” *Investor’s Business Daily*, 11/15/10.

A study last month 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. [And a] 2005 study in the *Journal of the American Medical Association* found 93% of Pennsylvania doctors practice defensive medicine. 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.³²

The editors of *USA Today* concluded that “one glaring omission” from the health care 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?”³³

The Director of Pediatric Neurosurgery at Johns Hopkins

One of the nation’s top surgeons, with credibility and acclaim the world over for the pioneering surgeries he has and his personal story of overcoming hardship, recently severely criticized the dominant health care legislation before Congress. Benjamin Carson, director of pediatric neurosurgery at the Johns Hopkins Medical Institutions in Baltimore, Maryland, and recipient of numerous awards including the Presidential Medal of Freedom, criticized in a recent interview the approach of the current bills for their mandate, creation of a “public option,” and lack of malpractice liability reform. He pointed to excessive litigation, pointing out how much malpractice insurance and other forms of “defensive medicine” to protect against lawsuits add to medical costs. In the interview with a local television station, Carson insisted that tort reform must go “hand in hand” as part of any true health care reform. According to Dr. Carson, “We have to bring a rational approach to medical litigation.” “We’re the only nation in the world that really has this problem. Why is it that everybody else has been able to solve this problem but us? Simple. Special interest groups like the trial lawyers’ association. They don’t want a solution.”³⁴

The Wall Street Journal

As summarized by Kimberly Strassel in the *Wall Street Journal*:

Tort reform is a policy no-brainer. Experts on left and right agree that defensive medicine—ordering tests and procedures solely to protect against Joe Lawyer—adds enormously to health costs. The estimated dollar benefits of reform range from a conservative \$65 billion a year to perhaps \$200 billion. In context, Mr. Obama’s plan would cost about \$100 billion annually. That the president won’t embrace even modest

³² USA Today editorial, “Our View on ‘Defensive’ Medicine: Lawyers’ Bills Pile High, Driving Up Health Care Costs,” *USA Today* (December 29, 2008).

³³ USA Today editorial, “Don’t try to repeal the new health care law – improve it” (November 18, 2010) at 9A.

³⁴ John Berlau, “‘Gifted Hands’ Surgeon Rips Into Obamacare,” *BogGovernment.com*, available at <http://biggovernment.com/2009/10/14/gifted-hands-surgeon-rips-into-obamacare/>.

change that would do so much, so quickly, to lower costs, has left Americans suspicious of his real ambitions.

It's also a political no-brainer. Americans are on board. Polls routinely show that between 70% and 80% of Americans believe the country suffers from excess litigation. The entire health community is on board. Republicans and swing-state Democrats are on board. State and local governments, which have struggled to clean up their own civil-justice systems, are on board. In a debate defined by flash points, this is a rare area of agreement. Former Democratic Sen. Bill Bradley, in a *New York Times* piece, suggested a "grand bipartisan compromise" in which Democrats got universal coverage in return for offering legal reform.

The only folks not on board are a handful of powerful trial lawyers, and a handful of politicians who receive a generous cut of those lawyers' contingency fees. The legal industry was the top contributor to the Democratic Party in the 2008 cycle, stumping up \$47 million. The bill is now due, and Democrats are dutifully making a health-care down payment.

During the markup of a bill in the Senate Health Committee, Republicans offered 11 tort amendments that varied in degree from mere pilot projects to measures to ensure more rural obstetricians. On a party line vote, Democrats killed every one.³⁵

The Further Hidden Costs of Defensive Medicine: More Radiation and No Advice by Telephone

Defensive medicine entails additional hidden costs. As was reported recently:

The result [of defensive medicine] can be extra costs, and potential harm -- including side effects from unneeded drugs and increased risk of future cancer from excessive radiation.

No one tells patients after a CT scan that the test "just imparted three years of radiation to your body as well as significant stress on your kidney, and Medicare just got charged lots of money."³⁶

As explained by another doctor:

Of course there is far more to defensive medicine than obstetric procedures. Many CT scans are entirely unnecessary, and in fact expose patients to radiation that may contribute to one in fifty cancers. But woe to the emergency room doc who didn't immediately scan the head of a trauma patient. Unnecessary blood tests, biopsies, and specialist referrals are all done to "spread the blame" and make lawsuits defensible.

³⁵ Kimberly A. Strassel, "The President's Tort Two-Step," *The Wall Street Journal* (September 11, 2009).

³⁶ Lindsey Tanner, "Fear Can Drive ERs To Do Tests to Excess," *Associated Press* (June 21, 2010).

Defensive medicine costs you more than money. When was the last time you asked for telephone advice? Doctors are very, very leery of giving meaningful advice over the phone, because we can't take the risk of this kind of conversation in front of a jury:

Attorney: You mean you refilled the medicine without performing another physical exam? If you had seen the patient in person, you would have found the cancer earlier!

Doctor: The medicine had nothing to do with cancer! I was just trying to help the patient! It's expensive to make them come in every month for a refill!

Anytime we tell anyone anything, any kind of advice, doctors must consider the risk of a lawsuit. Everything we say and do is supposed to be documented, too—to defend ourselves. Every wonder why the doc spends so much time scribbling in the chart, instead of talking to you? It's not because we like writing. It's because every single day we're reminded that the chart is our only defense.

Do you think this hasn't increased health care costs? Do you think it hasn't affected the relationships doctors have with patients?

The current medical malpractice system is a disgrace.³⁷

Defensive Medicine Causes All Those Harms Without Adding Any Benefits

Two top economic researchers have concluded: “[P]hysicians from states enacting liability reforms that directly reduce malpractice pressure experience lower growth over time in malpractice claims rates and in real malpractice insurance premiums. [Also], physicians from reforming states report significant relative declines in the perceived impact of malpractice pressure on practice patterns.”³⁸ One of those economists is Mark McClellan, who worked on health policy issues in President Clinton’s Treasury Department and who has been described by Senator Ted Kennedy as having “impressive credentials both as a physician and as an economist.”³⁹ These economists conducted two extensive studies using national data on Medicare populations and concluded that patients from states that adopted direct medical care litigation reforms, such as limits on damage awards, incur significantly lower hospital costs while suffering no increase in adverse health outcomes associated with the illness for which they were treated.

In sum, the studies concluded that in states with medical litigation reforms in place, there was an average reduction of 4.3% in hospital costs for patients in managed care programs,⁴⁰ and

³⁷ Roy Benaroch, MD, “Health Care Costs: Defensive Medicine,” *The Pediatric Insider* (2010).

³⁸ See Daniel P. Kessler and Mark B. McClellan, “The Effects of Malpractice Pressure and Liability Reforms on Physicians’ Perceptions of Medical Care,” 60 *Law and Contemporary Problems* 1: 81-106 (1997), at 105.

³⁹ Marc Kaufman, “Bush Adviser Tabbed for FDA,” *Washington Post* (September 25, 2002) at A25.

⁴⁰ Daniel P. Kessler and Mark B. McClellan, “Medical Liability, Managed Care, and Defensive Medicine,” National Bureau of Economic Research (NBER) Working Paper 7537 (February 2000) at 16.

an average reduction of 7.4% in hospital costs for patients in non-managed care programs.⁴¹ They have thereby quantified the cost of “defensive medicine,” in which doctors perform tests and prescribe medicines that are not necessary for health in order to avoid patients’ future claims that they suffered adverse health effects because the doctor didn’t do more. Former Senator George McGovern has written that “[l]egal fear drives [doctors] to prescribe medicines and order tests, even invasive procedures, that they feel are unnecessary. Reputable studies estimate that this ‘defensive medicine’ squanders \$50 billion a year, enough to provide medical care to millions of uninsured Americans.”⁴²

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.⁴³ Nevertheless, the litigation reforms in the HEALTH 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 HEALTH Act would largely dispel that fear and allow doctors to freely suggest improvements in medical care. The medical journal *Annals of Medicine* detailed reports of medical errors. As has been 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].”⁴⁴

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

⁴¹ Daniel P. Kessler and Mark B. McClellan, “Do Doctors Practice Defensive Medicine?” *The Quarterly Journal of Economics* (May 1996) at 386 (“Our analysis indicates that reforms that directly limit liability, caps on damage awards . . . and collateral source rule reforms – reduce hospital expenditures by 5 to 9 percent within three to five years of adoption . . .”). The researchers in this study analyzed populations in predominantly non-managed care programs in the mid-1980’s, and found that, of the populations studied with two different types of illnesses, direct health care litigation reforms would reduce hospital expenditures by 5.8% and 8.9% several years after their adoption. *Id.* at 367, 382.

⁴² See George McGovern and Alan Simpson, “We’re Reaping What We Sue,” *Wall Street Journal* (April 17, 2002) at A20.

⁴³ 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, et al., “Relation Between Malpractice Claims and Adverse Events Due to Negligence,” *New Engl. J. Med.* 325:245-251 (1991).

⁴⁴ Denise Grady, “Oops, Wrong Patient: Journal Takes on Medical Mistakes,” *New York Times* (June 18, 2002).

professionals from openly discussing and thinking of ways to reduce medical errors?” an astonishing 59% of physicians replied “a lot.”⁴⁵

Indeed, according to an exhaustive study by the RAND Corporation, California’s reduction in the number of health care lawsuits filed in that state is attributable to improved patient safety at California hospitals. According to the study:

Our results showed a highly significant correlation between the frequency of adverse events [medical errors] and malpractice claims: On average, a county that shows a decrease of *10 adverse events* in a given year would also see a decrease of *3.7 malpractice claims*. Likewise, a county that shows an increase of 10 adverse events in a given year would also see, on average, an increase of 3.7 malpractice claims. According to the statistical analysis, nearly three-fourths of the within-county variation in annual malpractice claims could be accounted for by the changes in patient safety outcomes. We also found that the correlation held true when we conducted similar analyses for medical specialties—specifically, surgeons, nonsurgical physicians, and obstetrician/gynecologists (OB-GYNs). Nearly two-thirds of the variation in malpractice claiming against surgeons and nonsurgeons can be explained by changes in safety. The association is weaker for OB-GYNs, but still significant.⁴⁶

With the passage of health care lawsuit reform in California, doctors, hospitals and other healthcare providers are able to share information needed to create a safer environment, without fear of lawsuits, and focus on their patients instead of worrying about getting sued.

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.⁴⁷

The absence of doctors in vital practice areas is at best an inconvenience; at worst it can have deadly consequences.⁴⁸ Hundreds or even thousands of patients may die annually due to lack of doctors.⁴⁹

⁴⁵ 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.

⁴⁶ Michael D. Greenberg, Amelia M. Haviland, J. Scott Ashwood, Regan Main, “Is Better Patient Safety Association with Less Malpractice Activity?” RAND Institute for Civil Justice (2010) at x.

⁴⁷ 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).

⁴⁸ See Testimony of Leanne Dyess, “Patient Access Crisis: The Role of Medical Litigation,” Senate Judiciary Committee (February 11, 2003); Testimony of Dr. Thomas Gleason, “Medical Liability Reform: Stopping the Skyrocketing Price of Health care,” House Small Business Committee (February 17, 2005).

⁴⁹ 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

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.⁵⁰ The American College of Obstetricians and Gynecologists has concluded that the “current medico-legal environment continues to deprive women of all ages, especially pregnant women, of their most educated and experienced women’s health care providers.”⁵¹

As one doctor wrote recently:

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 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.⁵²

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).

⁵⁰ “Defensive Medicine in Massachusetts,” pp. 4-5.

⁵¹ “Overview of the 2009 ACOG Survey on Professional Liability.”

⁵² Dr. Michael Lavyne, “Obamacare Will Fail Without Tort Reform: Malpractice Insurance Costs Are Crippling Medicine,” *New York Daily News* (November 19, 2010).

A new 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 “[a]pproximately 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.”⁵³ 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:

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

⁵³ Northwestern University Feinberg School of Medicine, “Illinois New Physician Workforce Study: Final Report (November 2010) at 4.

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?⁵⁴

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.⁵⁵ Neurosurgeons face liability lawsuits more often—every two years on average.⁵⁶

OB-GYNs 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.⁵⁷

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.⁵⁸

⁵⁴ Amy H. Handlin, “Reduce Medical Liability Costs Before More Specialists Flee N.J.,” *New Jersey Times* (November 22, 2009).

⁵⁵ “Defending the Practice of Medicine,” Richard E. Anderson, M.D., *Archives of Internal Medicine*, June 2004.

⁵⁶ “Effective Legal Reform and the Malpractice Insurance Crisis,” Richard E. Anderson, M.D., *Yale Journal of Health Policy, Law and Ethics*, December 2004.

⁵⁷ American College of Obstetrics and Gynecologists Medical Liability Survey, 9/09.

⁵⁸ Hospital Emergency Department Administration Survey, “Federal Medical Liability Reform,” 2004, the Schumacher Group, *Alliance of Specialty Medicine*, July 2005.

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.”⁵⁹

The Association of American Medical Colleges (AAMC) has predicted that once the new health care reform provisions take effect in 2015, in just four short years, “the shortage of physicians across all specialties will more than quadruple to almost 63,000.”⁶⁰ Another group, the American Academy of Family Physicians, has projected the shortfall of family physicians will reach 149,000 by 2020.⁶¹

AAMC also found the country will need 46,000 more surgeons and other specialists to meet demand in the next decade and that those living in rural or inner city locations will suffer the most severe impact. According to Dr. Atul Grover, of the AAMC, “This will be the first time since the 1930s that the ratio of physicians to the population will start to decline.”⁶²

Doctor Shortage Consequences: The Dyess Tragedy

Regardless of the merits of any given case, there are inherent problems with so-called “pain and suffering” or noneconomic damages: they are utterly standardless, unquantifiable, and subject to discriminatory application based of whether or not a particular person happens to be sympathetic or unsympathetic, and even whether or not a particular case has attracted media attention. Tony Dyess’s injury did not receive media attention. He was in a car accident in Mississippi. There were no longer any neurosurgeons in the area. They had stopped practicing because they couldn’t afford medical professional liability insurance. It took six hours to airlift Tony Dyess to a hospital that could treat his brain injury. It was too late. The “golden hour” had passed, and Tony Dyess has been left permanently brain damaged. As Tony Dyess’ wife Leanne has said, “[f]rom my perspective . . . this problem far exceeds any other challenge facing America’s health care—even the challenge of the uninsured. My family had insurance when Tony was injured. We had good insurance. What we didn’t have was a doctor. And now, no amount of money can relieve our pain and suffering. But knowing that others may not have to go through what we’ve gone through, could go a long way toward helping us heal.” When Leanne Dyess began telling this story, trial lawyers gave her false information about what happened the night her husband was injured, then tried to hire her. She refused.

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

⁵⁹ “National Report Card on the State of Emergency Medicine,” American College of Emergency Physicians, 2009.

⁶⁰ Association of American Medical Colleges Center for Workforce Studies estimates, 9/30/10.

⁶¹ “Doctor Shortage Looms as Primary Care Loses it Pull,” Janice Lloyd, *USA Today*, 8/18/09.

⁶² “Agencies warn of coming doctor shortage,” Tammy Worth, *Los Angeles Times*, 6/7/10.

The Department of Health and Human Services issued a report recently that included the following amazing statistics.⁶³ During the past half century, death rates among children and adults up to age 24 were cut in half. Mortality among adults 25-64 years fell nearly as much, and dropped among those 65 years and over by a third. The infant mortality rate—deaths before the first birthday—has plummeted 75 percent since 1950. These are amazing statistics. And they didn't just happen. They happened because America produces the best health care technology and the best health care providers to use it. But now there are fewer and fewer doctors to use that miraculous technology. We have the best brain scanning and brain operation devices in history, and fewer and fewer neurosurgeons to use them. According to the American Board of Neurological Surgery, in 2001 there were fewer active board-certified neurosurgeons (2,936) than there have been in the last decade. Also in 2001, 4.5 times as many board-certified neurosurgeons retired as retired a decade ago (1,400 retired in 2001, only 309 retired in 1990). Only about 100-200 neurosurgeons graduate from residency training programs each year, but it takes about 5 years of post-residency to become "board certified." Unlimited lawsuits are driving doctors out of the healing profession. They are reversing the clock. They are making us all less safe. All in the name of unlimited lawsuits and lawyers' lust for their cut of unlimited awards. But when someone gets sick, or is bringing a child into the world, we can't call our lawyers for help.

Women Are at Risk Under the Doctor Shortage Driven by Unlimited Lawsuits

Women pay an especially high price when it comes medical liability and access to care. According to Albert L. Strunk, M.D., deputy executive vice president of ACOG, "the medical liability situation for ob-gyns remains a chronic crisis and continues to deprive women of all ages—especially pregnant women—of experienced ob-gyns."⁶⁴ ACOG's own data proves the point. According to their 2009 survey, 63 percent of OB-GYNs said they had made changes to their practice because of the risk or fear of liability claims. Between seven and eight percent have stopped practicing obstetrics altogether. In fact, ACOG found that the average retirement age of practicing obstetrics was 48. Once upon a time, before the medical lawsuit abuse crisis, that was considered mid-point in a doctor's career.⁶⁵

Looking state by state, the picture is even more alarming. For example in 2007, Hawaiian women faced the harsh reality that 42 percent of the state's OB-GYNs had stopped providing prenatal care.⁶⁶ Dr. Francine Sinofsky, an OB-GYN in East Brunswick, N.J., says two of her practice's seven members no longer practice obstetrics due to the cost of medical liability. One who practices gynecology only pays \$14,000 a year for liability insurance while another who practices obstetrics as well pays more than \$100,000.⁶⁷ In 2008, 1,500 counties in America, including eight counties in New York alone, did not have a single obstetrician as liability issues chased good doctors out of obstetrics.⁶⁸

⁶³ Available at <http://www.cdc.gov/nchs/releases/02news/hus02.htm>.

⁶⁴ American College of Obstetricians and Gynecologists (ACOG) news release, 11/3/06.

⁶⁵ "Survey on Professional Liability, ACOG, 9/09.

⁶⁶ "Doctors Urging Lawmakers to Support Tort Reform," *KGMB9.com*.

⁶⁷ "The Doctor Drain," Lauren Otis, *The New Jersey Monthly*, 2/5/08.

⁶⁸ "Center for Health Workforce Studies, cited in "no Place to be Born," *New York Sun*, 8/25/08.

But the negative impact of lawsuit abuse on women’s health goes beyond obstetrics. Today, the number of radiologists willing to read mammograms is shrinking, exacerbated by the decreasing number of medical residents choosing radiology as their specialty. The reason is simple. A failure to diagnose properly is the number one allegation in most liability lawsuits.⁶⁹ That makes radiologists the number one group of physicians affected.⁷⁰ Abuse of the litigation system is putting women at risk.

Proven Reforms

The states have proven that legal reform works. While Democrats in Washington talk about the need to study the problem, states have acted to address it. Several states have limited noneconomic damages—such as those for “pain and suffering”—and dramatically lessened the burden of lawsuits. In states with such limits, premiums are 17 percent lower than they are in states without them.⁷¹

States also have had success with a variety of other reforms. A comprehensive study of these reforms suggests that attorney-fee limits, such as those in California, are particularly effective.⁷² The cumulative effect of all state reforms put together could be as much as a 74 percent reduction in premiums.⁷³

Proven Reforms in California

California’s Medical Injury Compensation Reform Act (called “MICRA”) has proved immensely successful in increasing access to affordable medical care in California since it was signed into law in 1975. It has kept California medical malpractice insurance rates consistently much lower than the average in the rest of the country.⁷⁴ Some critics claim that a California automobile insurance reform measure called Proposition 103 that required a “rollback” of insurance premiums—and not California’s health care litigation reforms—have controlled medical professional liability premiums in that state. However, according to the *Orange County Register*, “a rollback [under Proposition 103] never took place because the [California Supreme] court amended Prop. 103 to say that insurers could not be forced to implement the 20 percent rollback if it would deprive them of a fair profit.”⁷⁵ Further, since Proposition 103 went into effect, no medical professional liability insurer has been denied a requested premium increase.

⁶⁹ AMA News, 3/20/06.

⁷⁰ “Failure to Diagnose: Putting the Pieces Together, A Risk Management Review of Closed Claims in Selected Specialties 2002-2004,” Linda Greenwald, Doctors’ Insurance Services of New England, 2005.

⁷¹ “The Medical Malpractice ‘Crisis’: Trends and the Impact of State Tort Reforms,” Kenneth E. Thorpe, (January 21, 2004) at 20-30.

⁷² “Tort Law Tally: How State Tort Reforms Affect Tort Losses and Tort Insurance Premiums,” Nicole V. Crain, and W. Mark Crain, et al, Pacific Research Institute (2009).

⁷³ “Tort Law Tally: How State Tort Reforms Affect Tort Losses and Tort Insurance Premiums,” Nicole V. Crain, and W. Mark Crain, et al, Pacific Research Institute (2009).

⁷⁴ See http://www.micra.org/about-micra/docs/micra_access_and_affordability.pdf.

⁷⁵ *Orange County Register* (October 22, 1997).

**Comments of Supporters of California’s Health Care Litigation Reforms
(on which the HEALTH Act is modeled)**

Cruz Reynoso, Democratic Vice Chairman of the U.S. Commission on Civil Rights (appointed by former Senate Majority Leader George Mitchell in 1993), Professor of Law at UCLA, and former Justice of the California Supreme Court:

Medical insurance has been going up. I think there’s no question that what the legislature did and continues to do has had an influence on keeping those expenses down and that’s a very important public policy Publicly-funded medical centers were very supportive of the continued protection of MICRA because if their own insurance rates would go up they would be less able to serve the poor I personally have favored having as much access to the courts as possible, but at the same time you have to be careful that it doesn’t do so in a way that is destructive, for example, in the medical field, destructive of the ability of society to respond to the medical needs of the people.

Nancy Sasaki, President and CEO of Planned Parenthood, Los Angeles:

If the caps [on non-economic damages] in MICRA were to be increased, you actually would begin to see kind of a domino effect If insurance costs for the physicians go up they typically will then, as any business would, look at what services are their highest risks, which services are costing them the most, and they may no longer provide that. And that’s happened in the past, where physicians have stopped providing obstetric care because of costs.

Donna Stidham, Director of Managed Care and Patient Services, AIDS Health Care Foundation:

[An] increase in the MICRA cap . . . would increase our premiums phenomenally. In a single clinic setting it could probably increase their premiums maybe twenty or thirty thousand dollars. For multiple physicians, I’d hate to even guess, but it’d be in the hundreds of thousands, which would take away from direct patient care So it would directly take away from care, from the patients. You’d see us perhaps not being able to admit all types of patients. Right now we can take any kind of patient, whether they have the ability to pay or not.

**California Supreme Court Statements on the Purposes
of MICRA’s Limit on Noneconomic Damages**

The California Supreme Court has stated the following purposes of California Civil Code section 3333.2, which limits recovery of noneconomic damages to \$250,000:

One purpose is to provide a more stable base on which to calculate insurance rates by eliminating the “unpredictability of the size of large noneconomic damage awards,

resulting from the inherent difficulties in valuing such damages and the great disparity in the price tag which different juries placed on such losses.”⁷⁶

Another purpose is to “promote settlements by eliminating ‘the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble.’”⁷⁷

Another purpose is to be fair to medical malpractice plaintiffs by “reduc[ing] only the very large noneconomic damage awards, rather than to diminish the more modest recoveries from pain and suffering and the like in the great bulk of cases.”⁷⁸

Proven Reforms in Texas

After Texas adopted a new liability system in 2003, medical liability premiums fell dramatically, and thousands of new doctors flooded into the state.⁷⁹ Communities in Texas that once did not have primary or specialty care doctors now have a full complement of physicians.

A 2008 study from the Perryman Group found that perhaps the most visible economic impact of the lawsuit reforms are the benefits experienced by Texans who have better access to high-quality healthcare.⁸⁰ Doctors and hospitals are using their liability insurance savings to expand services and initiate innovative programs; those savings have allowed Texas hospitals to expand charity care by 24 percent.⁸¹

The total impact of tort reforms implemented since 1995 includes gains of \$112.5 billion in spending each year as well as almost 499,900 jobs in the state.⁸² The fiscal stimulus to the state from judicial reforms is almost a \$2.6 billion per year increase in state revenue.⁸³ In addition, these reforms are responsible for approximately 430,000 individuals having health insurance than would otherwise, and there has been an increase in the number of doctors, particularly in regions which have been facing severe shortages.⁸⁴

As the *Wall Street Journal* has observed:

Before the reform, Texas was a kind of holy place on the tort bar pilgrimage. Now it’s a Mecca for doctors, especially the emergency physicians, obstetricians and surgical specialists who elsewhere can face blue-sky malpractice premiums. Liability rates have fallen by 27.5% on average since 2003. The number of doctors applying to practice in Texas has increased 60%, even as the overall population grew by 14%.

⁷⁶ *Fein v. Permanent Medical Group*, 38 Cal.3d 137, 163 (1985); see also *Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* 8 Cal.4th 100, 112 (1984).

⁷⁷ *Fein v. Permanent Medical Group*, 38 Cal.3d 137, 163 (1985).

⁷⁸ *Id.*

⁷⁹ “Tort Reform: A Victory for Patient Access,” Texas Medical Association (July 5, 2006); “Texas-Style Health Care Reform is Bigger and Better,” Sally Pipes, *San Francisco Examiner* (July 24, 2009).

⁸⁰ Peggy Venable, “Tort Reform? We’ve Already Done It,” *Washington Post* (September 16, 2009).

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

All of this is helping to end an acute Lone Star physicians shortage, especially in rural areas. Twenty-three counties now have their first E.R. doctor, 10 their first OB-GYN. Hospitals are reinvesting the malpractice savings in scarce services like neurosurgery and neonatal units and expanding access to care. This Texas success has opened eyes in nearby Oklahoma, where even Democrats have been forced to agree to some legal reforms.⁸⁵

Barriers to Reform

The reason Democrats continue to refuse to add serious medical lawsuit reform to their health care legislation remains purely political, as was recently revealed by former DNC Chair Howard Dean. At a recent health care town hall meeting hosted by Rep. Jim Moran (D-VA), Dean responded to an angry constituent who wondered why a supposedly comprehensive “reform” of the health-care system does not include tort reform to lower costs of malpractice insurance and reduce defensive medicine. Dean responded remarkably candidly, stating:

“This is the answer from a doctor and a politician,” said Dean. “Here is why tort reform is not in the bill. When you go to pass a really enormous bill like that the more stuff you put in, the more enemies you make, right? And the reason why tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers in addition to everybody else they were taking on, and that is the plain and simple truth. Now, that’s the truth.”

Moreover, the Democrats’ health care law’s offer of HHS “demonstration projects” on tort reform, rings hollow given that the cabinet secretary tasked with implementing this proposal for demonstration projects is Kathleen Sebelius. Before she was governor of Kansas and the insurance commissioner of Kansas, she spent eight years as the head of the Kansas Trial Lawyers Association, now the Kansas “Association for Justice.” The KAJ’s total opposition to reform is highlighted on its website. And Sebelius is also the state executive who, according to the *New York Times*, “failed to make significant improvement in health coverage or costs during her two terms as governor.”

The top contributor to President Obama’s presidential campaign was the legal industry, whose donations came to more than \$43 million. More than 80 percent of the money given to Congress by lawyers, mostly from the plaintiffs’ bar, went to Democrats—almost \$22 million.

When President Obama spoke to the American Medical Association’s convention in June of 2009, he told the audience “I’m not advocating caps on malpractice awards.”

Support for Reform: The American People

⁸⁵ *Wall Street Journal* (editorial), “Loser Pays, Everyone Wins” (December 15, 2010).

The American people are demanding legal reform. A recent survey found that 83 percent of Americans believe that reforming the legal system needs to be a part of any health care reform plan.⁸⁶ As the Associated Press reported:

Most Americans want Congress to deal with malpractice lawsuits driving up the cost of medical care, says an Associated Press poll. Yet Democrats are reluctant to press forward on an issue that would upset a valuable political constituency—trial lawyers—even if President Barack Obama says he’s open to changes. The AP poll found that 54 percent of Americans favor making it harder to sue doctors and hospitals for mistakes taking care of patients, while 32 percent are opposed Support for limits on malpractice lawsuits cuts across political lines, with 58 percent of independents and 61 percent of Republicans in favor. Democrats are more divided. Still, 47 percent said they favor making it harder to sue, while 37 percent are opposed. The survey was conducted by Stanford University with the nonprofit Robert Wood Johnson Foundation In the poll, 59 percent said they thought at least half the tests doctors order are unnecessary, ordered only because of fear of lawsuits.⁸⁷

In a poll done by the Health Coalition on Liability and Access (HCLA) in October 2009, 69 percent of Americans said they wanted medical liability reform included in health care reform legislation. Seventy-two percent said that their access to quality medical care is at risk because lawsuit abuse forces good doctors out of the practice of medicine. A Rasmussen poll done at the same time found that 57 percent of people favored limiting jury awards.⁸⁸

The American people clearly understand the issue of liability reform and the motives behind the raft of lawsuits trial lawyers are bringing to stop reform in its tracks. The Health Coalition on Liability and Access poll done in October 2009 found that by a wide margin, 70 percent of Americans support full payment for lost wages and medical expenses *and* reasonable limits on awards for non-economic “pain and suffering.” Sixty-eight percent of those polled also favor a law to limit the fees personal injury attorneys can take from an award or settlement.

Blaming the Insurance Companies is Often a Red Herring

As Dr. Stanley Goldfarb, associate dean of clinical education at the University of Pennsylvania School of Medicine, has written: “The president points to for-profit insurance companies [as the source of the problem], but for-profit insurance companies only make up 25 percent of the system and they are not that profitable, ranking 85th among all U.S. industries. [Insurance] ‘Reform’ will redistribute the money, not reduce the overall costs. There is much that can be done to make our system more efficient. Tort reform is a great place to start.”⁸⁹

⁸⁶ “National Voter Survey: Health Care Reform and the Legal System 2009,” Clarus Research Group (August 2009).

⁸⁷ Ricardo Alonso-Zaldivar and Trevor Tompson, “AP: Support for Curbs on Malpractice Lawsuits,” The Associated Press (November 19, 2009).

⁸⁸ Rasmussen Research, 12/2/09.

⁸⁹ Stanley Goldfarb, “The Malpractice Problem: We Can’t Have Health Care Reform Without Tort Reform,” *The Weekly Standard* (October 27, 2009).

The Department of Health and Human Services concluded that the average award in medical malpractice cases has risen 76% in recent years, and that “mega-awards” for “pain and suffering” have occurred in states without any limits on what a plaintiff can recover.⁹⁰ Large numbers of these cases are meritless. The Harvard Medical Practice Study, for example, found that over half of the filed medical professional liability claims they studied were brought by plaintiffs who suffered either no injuries at all, or, if they did, such injuries were not caused by their health care providers, but rather by the underlying disease.⁹¹ These findings have been confirmed.⁹² Also, before the 1960s, only one physician in seven had ever been sued in their entire lifetime,⁹³ whereas today’s rate is about one in seven *per year*.⁹⁴

The medical insurance crisis caused insurers like St. Paul—an insurer of 42,000 doctors, 750 hospitals, 5,800 health care facilities, and 72,000 health care providers such as nurses—to leave the medical professional liability insurance business entirely.⁹⁵ In the words of Thomas A. Bradley, chief financial officer of St. Paul, the medical malpractice insurance crisis was “basically another World Trade Center loss for us this year.”⁹⁶ Other medical malpractice insurers have also left the market,⁹⁷ and many others have become insolvent. Licensed carriers’ medical professional liability insurance business has, on average, been unprofitable since 1990-2000.⁹⁸

The claim that sharp increases in medical liability insurance rates are due to insurer losses in the stock market is also dubious, as less than 15% of the assets of medical liability insurance companies are stocks.⁹⁹ Additionally, 60% of the doctors in the United States are insured by insurance companies that are owned and operated by other doctors and which operate primarily for their benefit.¹⁰⁰

⁹⁰ Department of Health and Human Services, “Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System” (July 24, 2002) at 9-10 (“These mega-awards for non-economic damages have occurred (as would be expected) in states that do not have limitations on the amounts that can be recovered.”).

⁹¹ See Harvard Medical Practice Study to the State of New York, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York at 11-5 (1990) (“[T]he tort system imposes the costs of defending claims on [health care] providers who may not even have been involved in an injury, let alone a negligent injury.”).

⁹² See D. Studdert et al., “Negligent Care and Malpractice Claiming Behavior in Utah and Colorado,” 38 Medical Care 3: 250-60, 250 (2000) (“Eighteen patients from our study sample filed claims: 14 were made in the absence of discernable negligence and 10 were made in the absence of any adverse event ... The poor correlation between medical negligence and malpractice claims that was present in New York in 1984 is also present in Utah and Colorado in 1992 ... [W]hen a physician is sued, there is a high probability that it will be for rendering *nonnegligent* care.”) (emphasis added).

⁹³ See “Opinion Survey of Medical Professional Liability,” *JAMA* 164:1583-1594 (1957).

⁹⁴ See R. Bovbjerg, “Medical Malpractice: Problems & Reforms,” The Urban Institute, Intergovernmental Health Policy Project (1995).

⁹⁵ See Joseph T. Hallinan, “St. Paul Gradually Will Pull Out Of Malpractice-Insurance Sector,” *The Wall Street Journal* (December 13, 2001) at B2.

⁹⁶ “St. Paul to Exit Medical Malpractice, Pose \$900 Million Charge,” *Best’s Insurance News* (December 12, 2001).

⁹⁷ See Meg Green, “Med Malcontent: Top medical malpractice writer St. Paul Cos. Abandons the Unprofitable Business. Who Will Fill the Void?” *Best’s Review* (February 1, 2002) at 12.

⁹⁸ See American Medical Association, “Trends Report: Medical Professional Liability Insurance” (April 2002) at 5.

⁹⁹ See Physician Insurers Association of America, “Bordering on Malpractice: Serious Errors Found in Consumer Federation of America Report on Medical Liability Insurance” (May 9, 2002).

¹⁰⁰ Physician Insurers Association of America.

The “Patient Protection and Affordable Care Act” (PPACA) Is a Trial Lawyers’ Bailout Bill

The “Patient Protection and Affordable Care Act” (PPACA) not only fails to contain any of the tort reforms the CBO concluded would save billions in health care costs, but it also contains a provision that explicitly allows trial lawyers to “opt-out” of any alternative liability system. This means that if their frivolous lawsuit is limited by the alternative system, they can simply “opt-out” of the alternative system and file in court like they always have. Section 10607 of the Democrats’ bill states that any states’ “proposed alternative” must “provide[] patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative.”¹⁰¹ So the bill literally prohibits any alternative to litigation, or any new limits on litigation, from being enforced.

Moreover, not only does PPACA prevent non-economic damages caps from being enforced, but the law requires that the Secretary of Health and Human Services provide states with “guidance on [the award] of non-economic damages . . . in determining appropriate payment.”¹⁰² Consequently, not only does this legislation prevent states from taking part in the demonstration projects if they seek to enforce the reforms the CBO said would save billions; it also requires the Secretary of Health and Human Services to encourage states to adopt lawsuit damages criteria the CBO has concluded would *raise* health care costs, not lower them. That’s not tort reform. It’s tort *deform*.

Further, because the health care bill signed into law by President Obama calls for the federal government and its regulators to create all manner of new standards and guidelines for medical professionals to follow, it opens up many more opportunities for trial lawyers to sue doctors if they deviate at all from those federal standards and guidelines. The House-passed version of the legislation, H.R. 3962, contained a provision that made clear that the new government guidelines provided for by the bill “shall not be construed to establish the standard of care or duty of care owed by health care providers to their patients in any medical malpractice action or claim.”¹⁰³ But the bill signed into law by President Obama fails to contain such a provision, which can only be read as an invitation to trial lawyers to sue doctors whenever they deviate one iota from whatever guidelines or standards are handed down from Washington, D.C. That’s a step backward for legal reform, and yet another cause of defensive medicine.

The Need for Federal Lawsuit Reform that Appropriately Uses Congress’ Commerce Clause Power

Over 20 State supreme courts have judicially nullified reasonable litigation management provisions enacted by State legislatures, many of which sought to address the crisis in medical

¹⁰¹ 42 U.S.C.A. § 280g-15(c)(2)(g).

¹⁰² 42 U.S.C.A. § 280g-15(f)(2)(A).

¹⁰³ See H.R. 3962 (111th Cong. 1st Sess.) (passed November 7, 2009) (SEC. 261. CONSTRUCTION REGARDING STANDARD OF CARE. (a) IN GENERAL.—The development, recognition, or implementation of any guideline or other standard under a provision described in subsection (b) shall not be construed to establish the standard of care or duty of care owed by health care providers to their patients in any medical malpractice action or claim . . .”).

professional liability that reduces patients' access to health care. Consequently, in such States, passage of federal legislation by Congress is the only means of addressing the State's current crisis in medical professional liability and restoring patients' access to health care. Many more may do so unless Congress acts under its Supremacy Clause and Commerce Clause authority to let doctors treat patients wherever they are, not just where States have enacted legal reforms that can be upheld under their state constitutions.¹⁰⁴

Furthermore, federal legislation is needed to stem the flow of doctors from one state to another, as they flee states to avoid excessive liability costs. Doctors should feel free to practice medicine wherever they want in this country, and patients everywhere should be able to obtain the medical care they need.

While tort reform is usually adopted at the state level in the first instance, it can also be adopted at the federal level, when the effects of tort law present a threat to state autonomy. Indeed, James Madison described the purpose of the Constitution's Commerce Clause as follows: "A very material object of this power [of Congress] was the relief of the States which import and export through other States, from the improper contributions levied on them by the latter. Were these [States] at liberty to regulate the trade between State and State, it must be foreseen that ways would be found out to load the articles of import and export, during the passage through their jurisdiction, with duties which would fall on the makers of the latter and the consumers of the former. *We may be assured by past experience, that such a practice would be introduced by future contrivances; and both by that and a common knowledge of human affairs, that it would nourish unceasing animosities, and not improbably terminate in serious interruptions of the public tranquility.*"¹⁰⁵ Clearly, Madison predicted that states would see in the future the rise of new forms of rules and regulations that would increase the costs of things nationwide, but which could not be foreseen at the time of the Founding, and that Congress would need its Commerce Clause authority to counter those cost-increasing influences.¹⁰⁶ Indeed, one modern manifestation

¹⁰⁴ See Rept. 107-693 pt. 1 (107th Cong., 2d Sess.) at 13 and n.14.

¹⁰⁵ *The Federalist Papers*, Federalist No. 42 at 267-68 (Clinton Rossiter ed., 1961) (emphasis added).

¹⁰⁶ At the time of the Founding and soon thereafter, out-of-control state litigation was kept in check in the states by strict limits on lawyers' fees, which no longer prevail. During the American Colonial period, lawyers were roundly despised and subjected to strict limits on lawsuits. According to one historian, "[i]n every one of the Colonies, practically throughout the Seventeenth Century, a lawyer or attorney was a character of disrepute and of suspicion In many Colonies, persons acting as attorneys were forbidden to receive any fee . . . in all, they were subjected to the most rigid restrictions as to fees and procedure." Charles Warren, *A History of the American Bar* 4 (William S. Hein & Co., Inc. 1913). Early American observer Benjamin Austin wrote, "if we look through the different counties throughout the Commonwealth, we shall find that the troubles of the people arise principally from debts enormously swelled by tedious law-suits." Benjamin Austin, *Observations on the Pernicious Practice of the Law* 4 (1786). As one historian summarized the situation in early America, "[l]awsuits were often begun or continued for no other purpose than to embarrass an enemy by making him incur legal costs." Anton-Hermann Chroust, *The Rise of the Legal Profession in America: The Colonial Experience* vol. 1, 82 (U. of Okla. Press 1965). Attorneys were so despised in early America that they often inspired violence. As one historian wrote:

During Shay's Rebellion, in 1786 people actually demanded that all inferior courts and all lawyers be entirely eliminated . . . In Vermont and New Hampshire vociferous demands were made to suppress the legal profession completely, or at least to reduce the number of lawyers and, incidentally, to cut down substantially the usual legal fees. In Vermont, where the general populace was particularly vehement in its actions and denouncements, courthouses were set afire . . . As early as 1786 the town of Braintree,

of the problem Madison foresaw is that, today, some states' tort law allows unbounded lawsuits that increase the costs of selling products or services (including medical services) that cross into their jurisdictions. There is even a word for this modern phenomenon. It is called the "tort tax," and when it's applied to national industries, it's passed on to consumers everywhere. The result is higher prices, and potentially lost jobs, across multiple states, or nationwide. When that happens, Congress can, and often should, enact federal tort reform to preserve federalism principles. While some argue that businesses can avoid tort liability by simply avoiding states that have oppressive tort laws, James Madison clearly rejected that argument against Congressional action, arguing instead that Congress should have the power to enact rules that allow businesses to enter into a state "jurisdiction" without having to worry that doing so would dramatically increase the price of their products elsewhere. Likewise, Alexander Hamilton wrote in the *Federalist Papers* that "The government of the Union must be empowered to pass all laws, and to make all regulations which have relation to them. The same must be the case in respect to commerce, and to every other matter to which its jurisdiction is permitted to extend."¹⁰⁷

Massachusetts, passed a resolve "to crush ... that order of Gentlemen denominated Lawyers ... whose ... conduct appears ... to tend rather to the destruction than the preservation of this Commonwealth."

Anton-Hermann Chroust, *The Rise of the Legal Profession in America: The Revolution and the Post-Revolutionary Era* vol. 2, 26-27 (U. of Okla. Press 1965) (citing *Laws and Resolves of Mass.*, c. 23, § 2, (1785); John Adams, *The Adams Papers: Diary and Autobiography of John Adams* vol. 1, 342 (1902); John Quincy Adams, *Three Episodes of Massachusetts History* 897 (1893)).

Fear that the legal profession would abuse its power to generate lawsuits was also reflected in limits on attorneys' fees. In 1784, Connecticut by statute limited attorneys' fees according to a "Table of Fees." *Acts and Laws of the State of Connecticut in America* 10-11 (1784). In 1792, Georgia regulated attorneys' fees as follows: for "each cause commenced and tried in the superior or inferior courts," eighteen shillings and eight pence. *A Digest of the Laws of the State of Georgia* 476 (1800). In 1714, Massachusetts fixed attorneys' fees at twelve shillings "at the superiour court of judicature . . . and at the inferiour court, ten shillings, and no more." *Acts and Laws, of Her Majesties Province of the Massachusetts-Bar in New-England* 185 (1714). In 1719, Rhode Island attorneys' fees were fixed at a maximum of twelve shillings. *Charter Granted by His Majesty King Charles the Second to the Colony of Rhode Island and Providence-Plantations in America* 21 (1719). In 1766 these fees were reduced to a maximum of five shillings. *Acts and Laws of His Majesty's Colony of Rhode-Island and Providence-Plantations in America* 98 (1767). By 1748, the New Jersey Legislature passed a statute establishing an elaborate schedule of lawyer's fees. *The Acts of the General Assembly of the Province of New-Jersey* 167 (Allinson ed. 1776). In 1778, in Virginia, attorneys' fees were fixed by statute in the General Court and the High Court of Chancery depending on the nature of the action. Anton-Hermann Chroust, *The Rise of the Legal Profession in America: The Revolution and the Post-Revolutionary Era* vol. 2, 261-62 (U. of Okla. Press 1965) (citing *9 Statutes at Large of Virginia* 529 (Hening ed. 1823)). In 1795, in Pennsylvania, attorneys' fees in the Court of Common Pleas were set for filing a lawsuit and entering an appearance as follows: "if the suit is ended before or during the sitting of the first court," at \$1.67; for every suit "ended after the first court and before judgment," \$3.34; and for "every suit prosecuted to judgment," \$4.00. *15 Statutes at Large of Pennsylvania*, c. 1863, § 1, 360 (1911). In 1801, New York enacted the comprehensive *Act Regulating the Fees of Several Officers and Ministers of Justice within the State*, which included limits on attorneys' fees. *5 Laws of the State of New York Passed at the Session of the Legislature Held in the Year 1801*, c. 190, 553-71 (1871). In 1810, in Maryland, a statute was enacted providing "no attorney of any of the county courts shall be authorized to charge more ... than the sum of three dollars and thirty-three cents and one third of a cent in any one suit." *Laws of Maryland of 1810*, c. 126, § 2; *1 The General Public Statutory Law of Maryland* 601 (1840). Delaware had its own unique method for reducing litigiousness. In 1793, Delaware passed the *Act for Regulating and Establishing Fees* providing that for all pleadings in an action subsequent to a declaration, the fee would be one cent for every written line, twelve words to a line. Anton-Hermann Chroust, *The Rise of the Legal Profession in America: The Revolution and the Post-Revolutionary Era* vol. 2, 256 (U. of Okla. Press 1965).

¹⁰⁷ *The Federalist Papers*, *Federalist No. 23* at 155 (Clinton Rossiter ed., 1961).

James Madison and the Founders clearly supported the power of the People’s national representatives in Congress to preserve citizens’ access to privately-provided goods and services. Madison said, in the seminal speech he gave defending the Commerce Clause at the Virginia convention called to ratify the Constitution, that “All agree that the general government ought to have power for the regulation of commerce ... There are regulations in different states which are unfavorable to the inhabitants of other states ... This will not be the case when uniform regulations will be made” by Congress.¹⁰⁸ Indeed, that’s what Congress did when it passed the Protection of Lawful Commerce in Arms Act in 2006, which prohibits lawsuits in either state or federal court against the firearms industry for damages resulting from the unlawful use of firearms by others. That federal tort reform law was upheld as coming within Congress’ Commerce Clause authority by the Second Circuit Court of Appeals, which said “We find that Congress has not exceeded its authority in this case, where there can be no question of the interstate character of the industry in question and where Congress rationally perceived a substantial effect on the industry of the litigation that the Act seeks to curtail.”¹⁰⁹ The same holds true where there can be no question of the interstate character of the health care industry and where Congress rationally perceives a substantial effect lawsuits have on that industry.¹¹⁰ Congress has enacted many federal tort reform statutes.¹¹¹

Of note, Congress passed the Partial-Birth Abortion Ban Act of 2003, which prohibited a specific medical procedure that involves a particularly gruesome form of abortion procedure, under its Commerce Clause authority. That Act was upheld by the Supreme Court in *Gonzales v. Carhart*,¹¹² in which the Court upheld Congress’ “legislative power, exercised in this instance under the Commerce Clause, to regulate the medical profession,”¹¹³ concluding that

¹⁰⁸ James Madison, “Speech in the Virginia Ratifying Convention” in Madison: Writings (1999) at 378-79.

¹⁰⁹ *City of New York v. Beretta Corp.*, 524 F.3d 384, 394 (2008), cert. denied 129 S.Ct. 1579 (2009).

¹¹⁰ Congress has acted many times to enact federal tort reforms, including the Volunteer Protection Act of 1997, which creates immunity for volunteers to nonprofits or government bodies. 42 U.S.C.A. §§ 14501 *et seq.* Congress has also passed the Partial-Birth Abortion Ban Act of 2003, which prohibited a specific medical procedure that involves a particularly gruesome form of abortion procedure. That Act was upheld by the Supreme Court in *Gonzales v. Carhart*, 550 U.S. 124 (2007), in which the Court upheld Congress’ “legislative power, exercised in this instance under the Commerce Clause, to regulate the medical profession,” *id.* at 166, concluding that “Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends.” *Id.*

¹¹¹ See, e.g., Employers Liability Act of 1908, 35 Stat. 65, c. 149; Price-Anderson Act, 42 U.S.C. § 2210(e); Atomic Testing Liability Act, 42 U.S.C. § 2212; National Childhood Vaccine Injury Compensation Act of 1986 42 U.S.C. §§ 300aa-1-300aa-34; Comprehensive Environmental Response, Compensation, and Liability Act (Superfund); General Aviation Revitalization Act, P.L. 103-298, 49 U.S.C. § 40101 note; Cruise Ship Liability, P.L. 104-324, § 1129; Bill Emerson Good Samaritan Food Donation Act, P.L. 104-210, 42 U.S.C. § 1791; Volunteer Protection Act of 1997, P.L. 105-1, 42 U.S.C. §§ 14501-14505; Amtrak Reform and Accountability Act of 1997, P.L. 105-134, § 161, 49 U.S.C. § 28103; Aviation Medical Assistance Act of 1998, P.L. 105-170 (1998), 49 U.S.C. § 44701 note; Biomaterials Access Assurance Act of 1998, P.L. 105-230, 21 U.S.C. §§ 1601-1606; Y2K Act, P.L. 106-37, 15 U.S.C. §§ 6601-6617; Cardiac Arrest Survival Act of 2000, P.L. 106-505, § 404, 42 U.S.C. § 238q; Air Transportation Safety and System Stabilization Act, P.L. 107-42, § 201(b); September 11th Victim Compensation Fund of 2001, 49 U.S.C. § 40101 note; Paul D. Coverdell Teacher Protection Act of 2001, P.L. 107-110, §§ 2361-2368; Multiparty, Multiforum Trial Jurisdiction Act of 2002, P.L. 107-273, § 11020; Homeland Security Act of 2002, P.L. 107-296, §§ 304, 863, 890, 1201, 1402, and 1714-1717.

¹¹² 550 U.S. 124 (2007).

¹¹³ *Id.* at 166.

“Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends.”¹¹⁴

Also, federal tort reform regarding vaccine liability has been the law for several decades. In the late 1980’s, Congress enacted the National Vaccine Injury Compensation Program,¹¹⁵ a federal program that preempts state court tort awards, to protect vaccine manufacturers from bankruptcy in the face of otherwise unlimited state tort jury awards. The Act overrides the state court system, putting compensation decisions in the hands of a congressionally created Office of Special Masters, which currently consists of one Chief Special Master and seven Associate Special Masters who are appointed by the U.S. Court of Federal Claims to serve for four-year terms. To this day, that Act has never been successfully challenged on constitutional grounds. If it were, millions of children could be forced to go without necessary vaccines because manufacturers would refrain from providing them. Note that while the federal vaccine compensation program completely overrides state courts and juries, the HEALTH does not go nearly so far because the HEALTH Act allows state lawsuits to proceed, but with reasonable limits on a narrow category of damages and other process reforms.

The Congressional Research Service has concluded that “enactment of tort reform legislation generally would appear to be within Congress’s power to regulate commerce, and would not appear to violate principles of due process or federalism In concluding that Congress has the authority to enact tort reform ‘generally,’ we refer to reforms that have been widely implemented at the state level, such as caps on damages and limitations on joint and several liability and on the collateral source rule.”¹¹⁶ Caps on damages and limitations on joint and several liability are precisely the reforms contained in the HEALTH Act.

Moreover, 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 HEALTH Act, as the HEALTH Act provides that “No provision of this Act 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 compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether or not such monetary amount is greater or lesser than is provided for under this Act” Some States have limited noneconomic damages in medical malpractice actions, but at levels higher than \$250,000. Some States place aggregate limits on medical malpractice awards. Those limits would be preserved under the HEALTH Act. Additionally, the HEALTH Act provides that it “shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations.”

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

¹¹⁴ *Id.*

¹¹⁵ 42 U.S.C. § 300aa-10 through -34.

¹¹⁶ Henry Cohen, Legislative Attorney, American Law Division, CRS Report to Congress, Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes (February 26, 2003) at 1.

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 specifically recommended “eliminate joint and several liability,”¹¹⁷ “provide for periodic payments of future economic damages,”¹¹⁸ “schedule [limit] contingency fees”¹¹⁹ of attorneys, and “limit non-economic damages to a fair and reasonable amount.”¹²⁰ 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.”¹²¹

All of these recommended reforms are part of the HEALTH Act. The report also contains an extensive discussion of the harmful effects tort law has on “medical malpractice” insurance,¹²² and a discussion and charts describing the impact of rising malpractice jury awards.¹²³

**State Laws that Limit Damages to Specific Amounts
are Preserved Under the HEALTH Act**

Laws passed by States that have already provided for, or may in the future provide for, different limits on damages in health care lawsuits are preserved under the HEALTH Act. The HEALTH Act specifically provides that “[n]o provision of this Act shall be construed to preempt . . . any State statutory limit (whether enacted before, on, or after the date of the enactment of this Act) on the amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, whether or not such State limit permits the recovery of a specific dollar amount of damages that is greater or lesser than is provided for under this Act”

¹¹⁷ 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.

¹¹⁸ *Id.* at 69.

¹¹⁹ *Id.* at 72.

¹²⁰ *Id.* at 66.

¹²¹ *Id.* at 66.

¹²² *Id.* at 21-24.

¹²³ *Id.* at 36-37, 39-40.

The following outlines state law in all fifty States and the District of Columbia regarding specific limits on damages in health care lawsuits.

Alabama – None; \$400,000 cap on non-economic damages; \$1 million cap on wrongful death damages, overturned by *Smith v. Shulte*, 671 So.2d 1331 (1991), *cert. denied*, 517 U.S. 1220 (1996).

Alaska – \$250,000 cap on non-economic damages for claims involving personal injury, and a \$400,000 cap on non-economic damages for claims involving wrongful death or a severe permanent physical impairment that is more than seventy percent disabling. A single cap applies regardless of the number of health care providers against whom the claim is asserted or the number of causes of action filed. (2005).

Arizona – None; Article 2 sec. 31 and Article 18 sec. 6 of Arizona’s constitution prohibits limiting recoverable damages.

Arkansas – None; Article 5 sec. 32 of Arkansas’ constitution prohibits limiting damages recoverable for injury or death.

California – \$250,000 cap on non-economic damages (since 1975); upheld in *Fein v. Permanente Medical Group*, 38 Cal. 3d 137, 695 P.2d 665 (1985).

Colorado – \$1 million cap on total damages, including any derivative claim by any other claimant, of which non-economic losses shall not exceed \$250,000 (including any derivative claim by any other claimant). Upon good cause shown and if the court determines such limit would be unfair, the court may award damages in excess of the limit. In this case, the court may award the present value of additional future damages only for loss of such excess future earnings or such excess future medical and other health care costs, or both. (1988). Upheld in *Scholz v. Metropolitan Pathologists P.C.*, 851 P.2d 901 (1993). Effective July 1, 2003, the non-economic damages cap was raised to \$300,000.

Connecticut – None.

Delaware – None.

District of Columbia – None.

Florida – For providers, \$500,000 cap on non-economic damages for causes of action for injury or wrongful death due to medical negligence of physicians and other health care providers. Cap applies per claimant regardless of the number of defendants. Cap increases to \$1 million for certain exceptions. For non-providers, \$750,000 cap on non-economic damages per claimant for causes of action for injury or wrongful death due to the medical negligence of nonpractitioners, regardless of the number of nonpractitioner defendants. Cap increases to \$1.5 million for certain exceptions. (2003) Previous law upheld but subject to rules on voluntary arbitration, *Univ. of Miami v. Echarte*, 618 So.2d 189 (1993).

Georgia – None; previous reforms included the following but were held unconstitutional in *Atlanta Oculoplasty Surgery, P.C. v. Nestlehutt*, 691 S.E.2d 219 (Ga. 2010) (statute limiting awards of noneconomic damages in medical malpractice cases to a predetermined amount violated state constitutional right to jury trial): \$350,000 cap on non-economic damages awarded against all health care providers and a separate \$350,000 cap on non-economic damages awarded against a single medical facility that can increase to \$700,000 if more than one facility is involved. No more than \$1.05 million can be awarded in a medical liability cause of action. *Health Care Providers*- Any judgment in a medical liability action, including wrongful death, against a health care provider shall not exceed \$350,000 in non-economic damages regardless of the number of defendant health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based. The cap applies to each claimant, however, the term “claimant” is defined as including all persons claiming to have sustained damages as a result of the bodily injury or death of a single person. *Medical Facilities* – Establishes a separate \$350,000 cap on non-economic damages awarded in medical liability actions, including wrongful death, against a single medical facility including all persons and entities for which vicarious liability theories may apply, regardless of the number of separate causes of action on which the claim is based. If the lawsuit involves more than one medical facility, the total amount of non-economic damages that can be awarded against the facilities is \$700,000 with a single facility not liable for more than \$350,000. (2005).

Hawaii – \$375,000 cap on non-economic damages, with exceptions for certain types of damages, such as mental anguish. (1986).

Idaho – \$250,000 cap on non-economic damages per claimant in personal injury and wrongful death actions. The cap will be adjusted annually beginning July 1, 2004 based on the average annual wage. The limit does not apply to causes of action arising out of willful or reckless misconduct, or felonious actions. (2003) Upheld, *Kirkland v. Blaine County Medical Center*, 134 Idaho 464, 4 P.3d 1115 (2000).

Illinois – None; reforms struck down in *LeBron v. Gottlieb Memorial Hospital*, 930 N.E.2d 895 (Ill. 2010) (holding unconstitutional caps on non-economic damages and requirement of periodic payments of damages). Reforms that were struck down included the following: \$500,000 cap on non-economic damages for awards in a medical liability cause of action, including wrongful death, against a physician, the physician’s business or corporate entity, and personnel or health care professionals. Separate \$1 million cap on non-economic damages for awards in a medical liability cause of action, including wrongful death, against a hospital and its personnel or hospital affiliates. Both caps apply to all plaintiffs in any civil action arising out of the care. The caps apply to injuries that occur after the effective date of the act. (2005); previous \$500,000 cap on non-economic damages, overturned *Best v. Taylor Machine Works*, 689 N.E.2d 1057 (Ill. 1997). \$500,000 cap on economic and non-economic damages, overturned *Wright v. Central DuPage Hospital Assn.*, 63 Ill.2d 313, 347 N.E.2d 736 (1976).

Indiana – \$750,000 cap on total damages for any act of malpractice that occurs after 12/31/89 and before 7/1/99. \$1.25 million total cap for any act of malpractice that occurs after 6/30/99. Health care providers are not liable for more than \$250,000 for an occurrence of malpractice any

amount awarded in excess of \$250,000 will be paid through the Patient Compensation Fund. (1975) Upheld, *Johnson v. St. Vincent Hospital*, 404 N.E. 2d 585 (1980).

Iowa – None.

Kansas – \$250,000 cap on non-economic damages. This is the total amount of non-economic damages recoverable by each party from all of the defendants. (1988) Upheld, *Samsel v. Wheeler Transport Services, Inc.*, 246 Kan. 336 (1990); previous law struck down as unconstitutional, *Kansas Malpractice Victims Coalition v. Bell*, 243 Kan. 333, 757 P.2d 251 (1988).

Kentucky – None. Section 54 of Kentucky’s Constitution prohibits cap on damages.

Louisiana – \$500,000 cap on total damages, excluding damages recoverable for medical care. A health care provider covered by the Patient’s Compensation Fund shall not be liable for more than \$100,000. The Patient’s Compensation Fund will cover the excess amount awarded up to the cap. (1975); Upheld caps on total damages, but future medical expenses are excluded from cap, *Butler v. Flint Goodrich Hospital of Dillard University*, 607 So. 2d 517 (1992); ruled unconstitutional by Louisiana Court of Appeal, Third Circuit in *Arrington v. ER Physicians Group*, No. 04-1235 (La. Ct. App. Sept. 2006). Vacated and set aside by Louisiana Supreme Court *Arrington v. Galen-Med, Inc.* (La. 06-2968 Feb. 2007).

Maine – \$400,000 cap on non-economic damages in wrongful death actions. (1999).

Maryland – The limit on non-economic damages is frozen at \$650,000 until January 1, 2009, after which time the cap will increase annually by \$15,000 per year. Cap applies in aggregate to all claims and defendants arising from the same medical injury. (Cap also applies in wrongful death actions if the claim involves only one claimant or beneficiary). In wrongful death actions involving two or more claimants or beneficiaries, then the total cap on non-economic damages is \$812,500 (125% of the cap). (2005); previous law upheld as constitutional, *Murphy v. Edmunds*, 325 MD 342, 601 A.2d 102 (1992).

Massachusetts – \$500,000 cap on non-economic damages, with exceptions for proof of substantial disfigurement or permanent loss or impairment, or other special circumstances which warrant a finding that imposition of such limitation would deprive the plaintiff of just compensation for the injuries sustained. (1986).

Michigan – \$280,000 cap on non-economic damages, adjusted annually for inflation, except in cases where the plaintiff is hemiplegic, paraplegic, or quadriplegic due to an injury to the brain or spinal cord, or where the plaintiff has permanently impaired cognitive capacity rendering him incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of normal, daily living, or the plaintiff has had permanent loss or damage to a reproductive organ resulting in the inability to procreate, then non-economic damages shall not exceed \$500,000. As of 2003 the \$280,000 cap is \$359,000 and the \$500,000 cap is \$641,000. (1993) Upheld, *Zdrojewski v. Murphy*, 202 Mich. App. Lexis 1566 (2002); Upheld *Smith v. Botsford General Hospital* (6th Cir. 2005).

Minnesota – None.

Mississippi – \$500,000 cap on non-economic damages per plaintiff for medical liability causes of action filed against a health care provider. (2004).

Missouri – \$350,000 cap on non-economic damages per plaintiff irrespective of the number of defendants. Law specifies that multiple caps cannot apply to a single defendant. The law also specifies that in a personal injury case a spouse who claims loss of consortium shall be considered the same plaintiff as their spouse. In wrongful death cases, all individuals asserting a claim shall be considered a single plaintiff. (2005); previous law upheld, *Adams v. Children's Mercy Hospital*, 848 S.W. 2d 535 (1993).

Montana – \$250,000 cap on non-economic damages per occurrence. If a single incident of malpractice injures multiple, unrelated patients, the \$250,000 cap applies to each patient and all claims deriving from injuries to that patient. (1995, 1997).

Nebraska – \$1.75 million in total damages. Health care providers who qualify under the Hospital-Medical Liability Act (i.e. carry minimum levels of liability insurance and pay surcharge into excess coverage fund) shall not be liable for more than \$500,000 in total damages. Any excess damages shall be paid from the excess coverage fund. (1976, 1984, 1986, 1992, 2003); upheld, *Prendergast v. Nelson*, 256 N.W.2d 657 (1977); *Gourley ex. rel. Gourley v. Nebraska Methodist Health System Inc.*, 265 Neb. 918, 633 N.W.2d 43 (Neb. 2003).

Nevada – \$350,000 cap on non-economic damages awarded to each plaintiff from each defendant. (2004).

New Hampshire – None; \$875,000 cap on non-economic damages, overturned, *Brannigan v. Usitalso*, 587 A.2d 1232 (N.H. 1991). \$250,000 cap on non-economic damages in medical malpractice, overturned, *Carson v. Maurer*, 424 A.2d 825 (N.H. 1980).

New Jersey – None.

New Mexico – \$600,000 cap on total damages, excluding punitive damages and past and future medical care. Health care providers personal liability shall not exceed \$200,000, any award in excess of this amount shall be paid by the patient compensation fund. (1992) Upheld, *Fed. Express Corp. v. United States*, 228 F. Supp. 2d 1267 (NM 2002).

New York – None.

North Carolina – None.

North Dakota – \$500,000 cap on non-economic damages. (1995) Economic damage awards in excess of \$250,000 are subject to judicial review for reasonableness. (1987); previous law struck down as unconstitutional. *Arneson v. Olson*, 270 N.W.2d (N.D. 1978).

Ohio – Establishes a sliding cap on non-economic damages. The cap shall not exceed the greater of \$250,000 or three times the plaintiff’s economic loss up to a maximum of \$350,000 for each plaintiff or \$500,000 per occurrence. The maximum cap will increase to \$500,000 per plaintiff or \$1,000,000 per occurrence for a claim based on either (A) a permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or (B) a permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and person life sustaining activities. (2002) Note: The Ohio Legislature’s previous attempts to enact a law with a cap on non-economic damages were overturned by the Ohio Supreme Court. For example, \$250,000-500,000 sliding scale cap on non-economic damages, overturned, *State ex rel. Ohio Academy of Trial Lawyers v. Sheward*, 86 Ohio 3d 451, 715 N.E. 2d (1999).

Oklahoma – Two caps, one for obstetric cases and care provided in an emergency room and a separate cap for all other medical liability causes of action. \$300,000 cap on non-economic damages for cases involving pregnancy, labor and delivery, care provided immediately post partum. The cap also applies in cases involving emergency-room care or medical services provided as a follow up to such care. The judge may lift the cap if the judge makes a finding, out of the presence of the jury, that there is clear and convincing evidence of negligence. The cap applies regardless of the number of parties against whom the medical negligence action is brought. (2003). \$300,000 cap on non-economic damages for all other medical liability causes of action. The cap applies only if the defendant has made an offer of judgment (i.e. offer to settle) and the amount of the verdict awarded to the plaintiff is less than 1½ times the amount of the final offer of judgment. The cap applies to each medical injury regardless of the number of actions brought and adjusts annually based on any increases in the Consumer Price Index. The cap will not apply if nine or more members of the jury find by clear and convincing evidence that the defendant committed negligence or if nine or more members find by a preponderance of the evidence that the defendant’s conduct was willful or wanton. These questions, however, will only be proposed to the jury if the judge makes a threshold finding that there is evidence to support such findings. (2004). Neither cap applies in wrongful death cases because the Oklahoma Constitution specifically limits damage limitations in those types of cases.

Oregon – None; \$500,000 cap on non-economic damages, overturned, *Lakin v. Senco Products*, 987 P.2d 463 (Or. 1999). However, an earlier decision, *Greist v. Phillips*, 322 Or. 281, 906 P.2d 789 (1995), upheld the cap for wrongful death cases.

Pennsylvania – None. Article III sec. 18 of Pennsylvania’s Constitution prohibits limiting damages for personal injuries or death. Punitive damages are capped at 2 times actual damages.

Rhode Island – None.

South Carolina – \$350,000 stacked cap on non-economic damages. A claim for non-economic damages in a medical liability action against a single health care provider or single health care institution cannot exceed \$350,000. If the award is against more than one health care provider or institution, the total award for non-economic damages cannot exceed \$1.05 million, with each defendant not liable for more than \$350,000. The cap applies separately to each claimant and adjusts annually for inflation based on the Consumer Price Index. (2005).

South Dakota – \$500,000 cap on total general (non-economic) damages. (1985, revived by 1996 court decision). Struck down cap on total damages, revived cap on non-economic damages, *Knowles ex. rel. Knowles v. United States*, 544 N.W. 2d 183 (SD 1996).

Tennessee – None.

Texas – \$250,000 cap on non-economic damages for claims against physicians and other health care providers. The cap applies per claimant regardless of the number of defendants. Also provides a \$250,000 cap on non-economic damages awarded against a single health care institution and a \$500,000 cap on non-economic damages if a judgment is rendered against two or more health care institutions, with the total amount of non-economic damages for each individual institution, not exceeding \$250,000 per claimant, irrespective of the number defendants, causes of action, or vicarious liability theories involved. The *total* amount of noneconomic damages for health care institutions cannot exceed \$500,000. Combining the liability limits for physicians, health care providers, and institutions, the maximum non economic damages that a claimant could recover in a health care liability claim is capped at \$750,000. (2003). Proposition 12, a ballot initiative to amend the Texas Constitution to specifically allow the legislature to enact laws that place limits on non-economic damages in health care and medical liability cases, was approved by the voters on September 13, 2003. \$500,000 cap on all civil damages for wrongful death, indexed for inflation since 1977. The cap does not apply to medical, hospital, and custodial care received before judgment or required in the future. In 2002 the cap reached approximately \$1.4 million. (1977, limited by 1990 court decision). \$500,000 cap on non-economic damages (adjusted annually), overturned as applied to cases other than wrongful death, *Rose v. Doctors Hospital*, 801 S.W. 2d 841 (Tex. 1990).

Utah – \$450,000 cap on non-economic damages.

Vermont – None.

Virginia – \$1.5 million cap on total damages for acts occurring on or after Aug. 1, 1999. This cap is increased by \$50,000 annually beginning on or after July 1, 2000 until July 1, 2006. On July 1, 2007 and July 1, 2008 the cap is increased by \$75,000. The last increase shall be July 1, 2008. (1976, 1977, 1983, 1999, 2001) Upheld, *Etheridge, et.al. v. Medical Center Hospitals*, 237 Va. 87, 376 S.E.2d 525 (Va. 1989).

Washington – None; sliding cap on non-economic damages, overturned, *Sophie v. Fiberboard Corp.*, 771 P.2d 711 (Wash. 1989).

West Virginia – \$250,000 cap on non-economic damages per occurrence, regardless of the number of plaintiffs and number of defendants. The cap increases to \$500,000 per occurrence, for the following types of injuries; permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system; or permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities. The limits only apply to defendants who have at least \$1,000,000 per occurrence in medical liability insurance. The limits will be adjusted

annually for inflation up to \$375,000 per occurrence or \$750,000 for injuries that fall within the exception. (2003). Upheld previous cap on non-economic damages, *Robinson v. Charleston Area Med. Center*, 186 W.Va. 720 (1991); *Verba v. Ghaphery* 552 S.E. 2d 406 (W.Va. 2001).

Wisconsin – \$750,000 cap on non-economic damages. (Enacted 2006). \$350,000 cap on non economic medical malpractice damages overturned as unconstitutional. *Ferdon v. Wisconsin Patients Compensation Fund*, 701 N.W.2d. 440 (Wis. 2005).

Wyoming – None; constitution prohibits caps.

States Whose Courts Have Abused “Open Courts” Provisions to Strike Down Tort Reforms Enacted by State Legislatures

State constitutions often contain provisions that are very malleable in the hands of activist state judges and provide an opportunity for a judge who perceives the judiciary to be the dominant branch of government to easily forget the appropriate powers of its co-equal branch, the legislature. For example, a number of state constitutions have so-called “open courts” provisions. As a practical matter, they are intended to provide citizens of a state with justice and reasonable access to the courts. Open court provisions, however, can be stretched to suggest that *any* time a legislature in *any* way limits any person’s rights to sue, it is violative of the “open courts” provision. There is no state constitutional history that suggests this extreme result. Respect for fundamental principles of separation of powers counsels against such an interpretation. Nevertheless, in the area of civil justice reform and judicial nullification of legislative efforts to improve the system of justice, such interpretations have spread.

The following cases are representative of those in which state courts have used a generic state constitutional provision providing that “the courts shall be open” to prohibit state legislatures from enacting tort reform:

Jackson v. Mannesmann Demag Corp., 435 So. 2d 725 (Ala. 1983) (holding statute of repose regarding improvements to real property violated open courts provision of state constitution)

Smith v. Dep’t of Ins., 507 So. 2d 1080 (Fla. 1987) (statute setting \$450,000 limit on noneconomic damages awards violated access to courts provision of state constitution); *Owens-Corning Fiberglass Corp. v. Corcoran*, 679 So. 2d 291 (Fla. Dist. Ct. App. 1996) (holding application of former statute of repose to latent asbestos injury violated access to courts provision of state constitution)

Martin v. Richey, 711 N.E.2d 1273 (Ind. 1999) (finding two-year occurrence-based statute of limitations as applied to plaintiff was an unconstitutional violation of the privileges and immunities clause and the open courts provision of the Indiana Constitution); *Van Dusen v. Stotts*, 712 N.E.2d 491 (Ind. 1999) (holding same); *Harris v. Raymond*, 715 N.E.2d 388 (Ind. 1999) (holding same)

McCullum v. Sisters of Charity of Nazareth Health Corp., 799 S.W.2d 15 (Ky. 1990) (holding five-year statute of repose for health care liability actions violated open courts provision of state

constitution); *Perkins v. N.E. Log Homes*, 808 S.W.2d 809 (Ky. 1991) (holding that seven-year statute of repose for improvements to real property violated state constitutional prohibition against “special legislation” and, according to the court, any remedial legislation would violate provisions in the state constitution providing for open courts and limits on the power of the legislature)

Strahler v. St. Luke’s Hosp., 706 S.W.2d 7 (Mo. 1986) (finding statute of limitations for health care liability actions violated access to courts provision of state constitution insofar as the statute applied to minors)

Sorrell v. Thevenir, 633 N.E.2d 504 (Ohio 1994) (holding statute providing offset of collateral source benefits received by plaintiff violated right to jury trial, due process, equal protection, right to open courts, and right to meaningful recovery provisions of state constitution); *Samuels v. Coil Bar Corp.*, 579 N.E.2d 558 (Ohio 1991) (finding same as applied to wrongful death actions)

Daugaard v. Baltic Coop. Bldg. Supply Ass’n, 349 N.W.2d 419 (S.D. 1984) (holding that six-year statute of repose for improvements to real property violated open courts provision of state constitution)

Limits on Attorneys’ Fees Mean More Money Goes to Victims

The HEALTH Act’s limits on attorneys’ fees—the same as those provided for in California’s law—will reduce lawyers’ incentives to bring frivolous lawsuits while allowing more money to go directly to injured patients.

Currently, limited resources can either fund lawyers or they can fund patients in our health care system. Under the HEALTH Act, the larger a victim’s demonstrable, real-life, quantifiable economic damages are, the more they will receive because lawyers will be allowed to take only 15% of awards over \$600,000.

Standard attorney contingency fee agreements allow lawyers to take one-third—a full 33.3%—of their client’s awards, so victims are left with only 66%. The HEALTH Act would allow victims to keep roughly 75% of awards under \$600,000, and 85% of awards over \$600,000. Under the HEALTH Act, victims who demonstrate large losses get more, and lawyers get less.

The HEALTH Act Allows Unlimited Economic Damages

Nothing in the HEALTH 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, and anything to which a receipt can be attached. Indeed, the terms “noneconomic 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.

Consequently, the HEALTH Act does nothing to hurt women and children. Any lawyer can easily produce charts proving the economic value of a stay-at-home-mom’s services. Anything necessary to replace those services are economic damages that the HEALTH Act does not limit one bit. Similarly, the future income lost by an injured child constitutes economic damages that are easily proved and which would be fully available from responsible parties under the HEALTH Act.

The following are some recent, very large awards to victims of medical malpractice under California’s legal reforms, which cap non-economic damages at \$250,000, but which do not cap quantifiable economic damages. The HEALTH Act is modeled on California’s legal reform. These cases show that reasonable legal reforms such as those in the HEALTH Act still allow for very large, multi-million dollar awards to deserving victims. Also, loses due to disfigurement *can* be economically quantified. The Veterans Administration, for example, has a rating schedule that quantifies the economic costs of disfigurement.¹²⁴

August 2010, Contra Costa County
\$5,500,000

February 2010, Riverside County
\$16,500,000

February 2010, Los Angeles County
\$12,000,000

November 2009, Los Angeles County
\$5,000,000

October 2009, Sacramento County
\$5,750,000

September 2009, Los Angeles County

¹²⁴ See L.E. Johnson, Robert D. Ley, and Paul T. Benshoof, “Estimating Economic Loss for a Facially Disfigured Minor: A Case Study,” *Journal of Legal Economics* (July, 1993) (The V.A. rating schedule was obtained from a Veterans Benefits Office at the V.A. Center in St. Paul, Minnesota after being advised that the V.A. disability ratings are for economic loss exclusively. The percentage disability ratings contained in the V.A. S-R-D are based on case study data on economic loss from facial disfigurement. This data was initially collected during World War II by the V.A. and has been updated from that time ... The first component of economic loss is termed social loss. Social loss refers to the additional cost of job search which results from facial disfigurement. The second component of economic loss is what the V.A. terms industrial loss. Industrial loss refers to lost income because of lost earning capacity.”).

\$7,300,000

January 2009, San Diego County

\$16,000,000

September 2008, Los Angeles County

\$9,000,000

April 2008, San Francisco County

\$5,100,000

July 2007, Los Angeles County

\$96,400,000

June 2007, Orange County

\$11,700,000

May 2007, San Diego County

\$5,700,000

The Key to Reducing Health Care Costs is a Firm Cap on Noneconomic Damages

Caps on noneconomic damages are essential to the success of the HEALTH Act's reforms. Indeed, the savings of \$54 billion over ten years that CBO concluded would be significantly diminished if the cap were raised over time. The key to the success of the legal reforms in California is its cap on noneconomic damages at \$250,000, which is not indexed to inflation. The recent reforms in Texas also do not index the caps to inflation. The California cap has stood the test of time and remains an effective check on medical professional liability rates precisely because it was not indexed to inflation back in 1975. What may have been described by some as an arbitrary figure in 1975 has become the keystone of the only proven, long-term, legislative solution to the current crisis in access to medical care. A 2010 study showed that doubling California's cap on noneconomic damages would cost that state between \$1.3 and \$2.4 billion in employee and retiree benefits over a 10-year period.¹²⁵ If one extrapolates from that number, it becomes clear that linking the HEALTH Act's cap on noneconomic damages to the Consumer Price Index, or similarly linking it to inflation, would cost federal taxpayers around \$14 billion or more.

The Consumer Price Index and noneconomic damages are also apples and oranges. "Pain and suffering" cannot be measured and there is no consumer price index for "pain and suffering." However, quantifiable economic damages are not limited by the HEALTH Act, and because those damages can be measured, they can and are adjusted upward in future years to account for inflationary effects on economic goods and services that can be quantified.

¹²⁵ C. Paul Wazzan, Ph.D. and Dawn Eash, M.S., "Estimated Increases in State of California Employee and Retiree Costs Caused by Doubling the MICRA Cap" (June 9, 2010) at 3.

Congress Should Enact a Fair Share Rule

Respect for the law is fostered when it is fair and just and punishments are proportionate to the wrongs committed. As Thomas Jefferson noted, “if the punishment were only proportional to the injury, men would feel that their inclination as well as their duty to see the laws observed.”¹²⁶

The rule of joint liability, commonly called joint and several liability, provides that when two or more persons engage in conduct that might subject them to individual liability and their conduct produces a single injury, each defendant will be liable for the total amount of damages.¹²⁷ Joint liability is unfair because it puts full responsibility on those who may have been only marginally at fault.¹²⁸

Relevant to the “fair share” rule in the HEALTH Act are Senator Lieberman’s observations that

There is a concept, joint and several liability, started out in the law as a way of proportioning responsibility when an accident was caused by a number of different parties working together in a way that caused negligence, and often it was not clear which one actually caused it. So they said everybody could be held liable regardless of the percentage of negligence. It now has grown to a point where what it really means is that somebody who is not liable, or liable very little, if they happen to have deep pockets, they can be held fully liable. That is the wrong message to send If you hurt somebody, you have to pay. If you do not, you should not have to pay. What kind of cynicism is developed when somebody who did little or no wrong ends up having to pay the whole bill because somebody else slipped up.¹²⁹

Joint and several liability, although motivated by a desire to insure that plaintiffs are made whole, leads to a search by plaintiffs’ attorneys for “deep pockets” and to a proliferation of lawsuits against those minimally liable or not liable at all. The HEALTH Act, by providing for a “fair share” rule that apportions damages in proportion to a defendant’s degree of fault, prevents unjust situations in which hospitals can be forced to pay for all damages resulting from an injury even when the hospital is minimally at fault. For example, say a drug dealer staggers into the emergency room with a gunshot wound after a deal goes bad. The surgeon who works on him does the best he can, but it is not perfect. The drug dealer sues.¹³⁰ The jury finds the drug dealer

¹²⁶ Thomas Jefferson, A Bill for Proportioning Crimes and Punishments in Cases Heretofore Capital, in 2 *The Papers of Thomas Jefferson* 492, 493 (Julian P. Boyd ed., 1950).

¹²⁷ See *Coney v. J.L.G. Indus., Inc.*, 454 N.E.2d 197 (Ill. 1983).

¹²⁸ For example, in *Walt Disney World Co. v. Wood*, 515 So.2d 198 (Fla. 1987), Disney was required to pay an entire damages award, even though it was found only 1% at fault for the claimant’s harm.

¹²⁹ Senator Lieberman, floor statement on the Common Sense Product Liability and Legal Reform Act (April 27, 1995).

¹³⁰ This hypothetical is not fanciful. See Ray Flanagan, “After Stabbing Son, Mom Sues Doctors,” *The Scranton Time Tribune* (May 29, 2002) (“Mrs. Taylor and her husband, Brian, are suing ... the obstetricians who treated her in

responsible for the vast majority of his own injuries, but it also finds the hospital 1% responsible because the physician was fatigued after working too long. Today the hospital can be made to pay 100% of the damages if no other defendant has the means to pay their share of the damages. That is unfair.

The Volunteer Protection Act of 1997¹³¹ abolished joint liability for non-economic damages for volunteers of nonprofit organizations. That law was overwhelmingly supported by a bipartisan majority of Congress.¹³² Joint liability also brought about a serious public health crisis that critically threatened the availability of implantable medical devices, such as pacemakers, heart valves, artificial blood vessels, and hip and knee joints. Companies had ceased supplying raw materials and component parts to medical implant manufacturers because they found the costs of responding to litigation far exceeded potential sales revenues, even though courts were not finding the suppliers liable. Congress responded to the crisis and enacted legislation, the Biomaterials Access Assurance Act of 1998,¹³³ that allows medical device suppliers to obtain early dismissal, without extensive discovery or other legal costs, in certain tort suits involving finished medical implants.

The HEALTH Act Does Not Cap Punitive Damages, But Does Include Reasonable Guidelines for Their Use

The United States Supreme Court has observed that punitive damages have “run wild” in the United States, jeopardizing fundamental constitutional rights.¹³⁴ The Supreme Court has also emphasized that “the impact of [a punitive damages award] is unpredictable and potentially substantial.”¹³⁵

The HEALTH Act does not cap punitive damages. Rather, it includes reasonable guidelines that would govern their award. Under these guidelines, a punitive damages award could not exceed the greater of \$250,000, or two times the amount of economic damages that are awarded (and economic damages under the HEALTH Act are not limited at all). Federal legislation should put reasonable parameters on punitive damages to make the punishment fit the offense.¹³⁶ Proportionality has been an important part of the United States Supreme Court’s

the months before she exploded in violence that left her son, Zachary, with two punctured lungs, a severed jugular vein and scalp wounds on July 14, 2000 ... They accuse the doctors and their employers of not adequately responding as she became more psychotic, delusional and depressed as the end of her pregnancy neared.”).

¹³¹ Pub. L. No. 105-19, 111 Stat. 218.

¹³² See Dan Carney, Volunteer Liability Limit Heads to President, Cong. Q., May 24, 1997, at 1199 (“The measure passed the House on May 21 by a vote of 390-35, and the Senate cleared it by voice vote later that day. An earlier Senate version passed May 1 by a vote of 99-1.”) (omitting references to bill numbers).

¹³³ P.L. No. 105-230, 21 U.S.C. §§ 1601-1606.

¹³⁴ *Pacific Mutual Life Ins. Co. v. Haslip*, 499 U.S. 1, 18 (1991). See also *Honda Motor Co., Ltd. v. Oberg*, 512 U.S. 415, 432 (1994) (stating that punitive damages “pose an acute danger of arbitrary deprivation of property,” raising serious due process concerns).

¹³⁵ *International Bhd. of Elec. Workers v. Foust*, 442 U.S. 42, 50 (1979).

¹³⁶ Congress included a cap on punitive damages for individuals and small businesses in the Year 2000 Readiness and Responsibility Act, Pub. L. 106-37, 113 Stat. 135 (1999). The “Y2K Act” established procedures and legal standards for lawsuits stemming from Year 2000 date-related computer failures.

consideration of the validity of criminal punishment.¹³⁷ Even serious crimes such as larceny, robbery, and arson have sentences defined with a maximum set forth in a statute.¹³⁸ As former Supreme Court Justice Lewis Powell wrote, “It is long past time to bring the law of punitive damages into conformity with our notions of just punishment.”¹³⁹ Under the HEALTH Act, the larger the economic losses suffered by the victim, the larger the punishment can be.

At the state level, ten States base punitive damages awards on a similar formula.¹⁴⁰ Academic groups have also recommended limiting punitive damages to prevent excessive punitive damages awards.¹⁴¹

Opponents of punitive damages reform argue that changes in the law are not needed because large punitive damages awards are often reduced on appeal. However, the practical reality is that the impact of potentially infinite punitive damages stretches beyond an actual award. As Yale law professor George Priest has observed: “[T]he availability of unlimited punitive damages affects the 95% to 98% of cases that settle out of court prior to trial. It is obvious and indisputable that a punitive damages claim increases the magnitude of the ultimate settlement and, indeed, affects the entire settlement process, increasing the likelihood of litigation.”¹⁴²

It has also been argued that unlimited punitive damages are needed to police wrongdoing. However, there is no credible evidence that the behavior of profit-making enterprises is less safe in either those states that have set limits on punitive damages or in the six states—Louisiana, Nebraska, Washington, New Hampshire, Massachusetts, and Michigan—that do not permit punitive damages at all.¹⁴³ Furthermore, plaintiffs in these six states have no more difficulty

¹³⁷ See *Solem v. Helm*, 463 U.S. 277, 284 (1983) (“The principle that a punishment should be proportionate to the crime is deeply rooted and frequently repeated in common-law jurisprudence”); *Weems v. United States*, 217 U.S. 349, 366-67 (1910) (it is “a precept of the fundamental law” as well as “a precept of justice that punishment should be graduated and proportioned to the offense”).

¹³⁸ Some examples of federal criminal fines, even for particularly egregious crimes, do not exceed \$250,000 and include the following: tampering with consumer products (\$250,000 if death results), U.S. Sentencing Guidelines Manual §§ 2N1.1, 5E1.2 (1998); assault on the President (\$30,000), U.S. Sentencing Guidelines Manual §§ 2A6.1, 5E1.2 (1998); bank robbery (\$75,000), U.S. Sentencing Guidelines Manual §§ 2B3.1, 5E1.2; and sexual exploitation of children (\$100,000), U.S. Sentencing Guidelines Manual §§ 2G2, 5E1.2 (1998). See generally Jonathan Kagan, Comment, “Toward a Uniform Application of Punishment: Using the Federal Sentencing Guidelines as a Model for Punitive Damages Reform,” 40 *UCLA L. Rev.* 753 (1993).

¹³⁹ Lewis Powell, “The Bizarre Results of Punitive Damages,” *Wall Street Journal* (March 8, 1995), at A21.

¹⁴⁰ AL, AK, CO, CT, FL, IN, NJ, NC, ND, TX.

¹⁴¹ See American Bar Association, Special Committee on Punitive Damages of the American Bar Association, Section on Litigation, *Punitive Damages: A Constructive Examination* (1986) at 64-66 (recommending that punitive damages awards in excess of three-to-one ratio to compensatory damages be considered presumptively “excessive”); American College of Trial Lawyers, *Report on Punitive Damages of the Committee on Special Problems in the Administration of Justice* 15-16 (1989), at 15 (proposing that punitive damages be awarded up to two times a plaintiff’s compensatory damages or \$250,000, whichever is greater); American Law Institute, *2 Enterprise Responsibility for Personal Injury – Reporters’ Study* (1991), at 258-59 (endorsing concept of ratio coupled with alternative monetary ceiling).

¹⁴² George L. Priest, *Punitive Damages Reform: The Case of Alabama*, 56 *La. L. Rev.* 825, 830 (1996).

¹⁴³ See W. Kip Viscusi, “Punitive Damages: The Social Costs of Punitive Damages Against Corporations In Environmental and Safety Torts,” 87 *Geo. L.J.* 285, 294 (1998).

obtaining legal representation than in those states where punitive damages are potentially limitless.

Regarding reasonable guidelines for punitive damages, Senator Lieberman has supported an amendment providing that “punitive damages, which have been much discussed here and are an essential part of the continued bullying and bluffing that goes on in our tort system—be limited to \$250,000 or three times economic damages.”¹⁴⁴ The HEALTH Act limits punitive damages to two times economic damages.

The “Clear and Convincing” Rule Is Appropriately Applied to Claims for Quasi-Criminal Punitive Damages

The HEALTH Act provides that punitive damages may be awarded against a person in a health care lawsuit only if it proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. The “clear and convincing evidence” burden of proof standard is appropriate because it reflects the quasi-criminal nature of punitive damages. Such a standard takes a middle ground between the burden of proof standard ordinarily used in civil cases—that is, proof by a “preponderance of the evidence” —and the criminal law standard—that is, proof “beyond a reasonable doubt.”

The “clear and convincing evidence” standard is the law in twenty-nine states and the District of Columbia¹⁴⁵ and it has been recommended by the principal academic groups that have analyzed the law of punitive damages over the past 15 years, including the American Bar Association, the American College of Trial Lawyers, and the National Conference of Commissioners on Uniform State Laws.¹⁴⁶ The Supreme Court has also specifically endorsed the

¹⁴⁴ Senator Lieberman, floor statement on the Common Sense Product Liability and Legal Reform Act (April 27, 1995).

¹⁴⁵ See Ala. Code § 6-11-20; Alaska Stat. § 09.17.020; Cal. Civ. Code § 3294(a); Fla. Stat. ch. 768.73; Ga. Code Ann. § 51-12-5.1; Iowa Code Ann. § 668A.1; Kan. Stat. Ann. § 60-3701(c); Ky. Rev. Stat. Ann. § 411.184(2); Minn. Stat. Ann. § 549.20; Miss. Code Ann. § 11-1-65(1)(a); Mont. Code Ann. § 27-1-221(5); N.J. Stat. Ann. § 2A:15-5.12; Nev. Rev. Stat. Ann. § 42-005(1); N.C. Gen. Stat. 10-15(b); N.D. Cent. Code § 32-03.2-11; Ohio Rev. Code Ann. § 2307.80(A); Okla. Stat. Ann. tit. 23, § 9.1; Or. Rev. Stat. § 18.537; S.C. Code Ann. § 15-33-135; S.D. Codified Laws Ann. § 21-1-4.1; Tex. Civ. Prac. & Rem. Code § 41.003; Utah Code Ann. § 78-18-1; *Linthicum v. Nationwide Life Ins. Co.*, 723 P.2d 675 (Ariz. 1986); *Jonathan Woodner, Co. v. Breeden*, 665 A.2d 929 (D.C. 1995); *Masaki v. General Motors Corp.*, 780 P.2d 566 (Haw. 1989); *Travelers Indem. Co. v. Armstrong*, 442 N.E.2d 349 (Ind. 1982); *Tuttel v. Raymond*, 494 A.2d 1353 (Me. 1985); *Owens-Illinois v. Zenobia*, 601 A.2d 633 (Md. 1992); *Rodriguez v. Suzuki Motor Corp.*, 936 S.W.2d 104 (Mo. 1996); *Hodges v. S.C. Toof & Co.*, 833 S.W.2d 896 (Tenn. 1992); *Wangen v. Ford Motor Co.*, 294 N.W.2d 437 (Wis. 1980). One state, Colorado, requires proof “beyond a reasonable doubt” in punitive damages cases. See Colo. Rev. Stat. § 13-25-127(2).

¹⁴⁶ See American Bar Association, Special Committee on Punitive Damages of the American Bar Association, Section on Litigation, Punitive Damages: A Constructive Examination 19 (1986); American College of Trial Lawyers, Report on Punitive Damages of the Committee on Special Problems in the Administration of Justice 15-16 (1989); National Conference Of Commissioners On Uniform State Laws, Uniform Law Commissioners' Model Punitive Damages Act § 5 (approved on July 18, 1996); see also American Law Institute, 2 Enterprise Responsibility for Personal Injury -- Reporters' Study 248-49 (1991).

“clear and convincing evidence” standard in punitive damages cases.¹⁴⁷ There is also support for the “clear and convincing evidence” standard at the federal level. The Volunteer Protection Act of 1997,¹⁴⁸ which was enacted with strong bipartisan support, requires “clear and convincing evidence” of punitive damages liability before punitive damages can be imposed against volunteers of nonprofit organizations.

Bifurcated Procedures for Considering Punitive Damages Prevent Unfair and Prejudicial Awards

The HEALTH Act also contains a procedural reform called “bifurcation.” Under such a procedure, at either party’s request, a trial would be divided so that the proceedings on punitive damages would be separate from and subsequent to the proceedings on compensatory damages. This procedure would achieve judicial economy by having the same jury determine both compensatory damages and punitive damages issues.

Bifurcated trials are fair because they prevent evidence that is highly prejudicial and relevant only to the issue of punishment from being heard by jurors and improperly considered when they are determining underlying liability. For example, plaintiffs’ lawyers routinely introduce evidence of a company’s net worth. Although a jury is often instructed to ignore such evidence unless it decides to punish the defendant, this is very difficult as a practical matter for jurors to do. The net result may be that jurors overlook key issues regarding whether a defendant is liable for compensatory damages and make an award simply because they believe the defendant can afford to pay it. Bifurcation would help prevent that unfair result because evidence of the defendant’s net worth would be inadmissible in the first, compensatory damages phase of the case. Bifurcation also helps jurors compartmentalize a trial, allowing them to more easily separate the burden of proof that is required for compensatory damage awards—that is, proof by a preponderance of the evidence—from a higher burden of proof for punitive damages, that is, proof by clear and convincing evidence.

Bifurcation of punitive damages is supported by the American Bar Association, the American College of Trial Lawyers, and the National Conference of Commissioners on Uniform State Laws, among other well-known organizations.¹⁴⁹

¹⁴⁷ See *Pacific Mutual Life Ins. Co. v. Haslip*, 499 U.S. 1, 23 n.11 (1991) (stating that “[t]here is much to be said in favor of a state’s requiring, as many do ... a standard of ‘clear and convincing evidence’”).

¹⁴⁸ Pub. L. No. 105-19, 111 Stat. 218.

¹⁴⁹ See American Bar Association, Special Committee on Punitive Damages of the American Bar Association, Section on Litigation, *Punitive Damages: A Constructive Examination* (1986) at 19; American College of Trial Lawyers, *Report on Punitive Damages of the Committee on Special Problems in the Administration of Justice* (1989) at 18-19; National Conference Of Commissioners On Uniform State Laws, *Uniform Law Commissioners' Model Punitive Damages Act § 5* (approved on July 18, 1996) at § 11; American Law Institute, *2 Enterprise Responsibility for Personal Injury – Reporters’ Study* 248-49 (1991) at 255 n.41.

Congress Should Enact a Safe Harbor from Punitive Damages for FDA Compliance

Litigation is threatening the viability of the life-saving drug industry.¹⁵⁰ To help encourage new drug development and contain the costs of life-saving drugs, the HEALTH Act contains a safe harbor from punitive damages for defendants whose drugs or medical products comply with rigorous regulations.

FDA standards and regulations are rigorous. The regulatory objectives of the Food, Drug, and Cosmetics Act (“FDCA”) are to ensure that the manufacturer shares all risk information with the FDA so that the agency may make informed risk-benefit judgments about the utility of a pharmaceutical. These judgments occur throughout the life of the drug. The agency determines which drugs reach the market and the labeling for those that do. The receipt of new safety information can lead the agency, after holding a hearing, to withdraw approval for marketing of a drug.¹⁵¹ The Secretary of Health and Human Services also has the authority to order the withdrawal of marketing approval without a hearing where there appears to be an “imminent hazard to public health.”¹⁵²

To obtain FDA approval for marketing a prescription drug, a pharmaceutical applicant must generate substantial pre-marketing safety and efficacy information through human clinical trials. The FDA must ensure that the proposed new drug complies with the FDCA mandate that safety be established and that “substantial evidence” of efficacy be demonstrated for the drug’s proposed uses.¹⁵³ The FDA review process often takes years of evaluation. Ultimately, approval by the FDA reflects a risk-benefit judgment that the product will enhance public health. The entire process is a lengthy one, typically taking between five and seven years to complete.

¹⁵⁰ See Michael Freedman, “The Tort Mess” *Forbes* (May 13, 2002) (“The pharmaceutical industry has always been a ripe target for suits. The difference nowadays is simply that the dollar amounts have gotten bigger If a drug saves 100 lives for every one it loses, someone who faces certain death should not hesitate to use it. But what happens if the tort system says every death must be paid for? The average payout on a wrongful death claim increased from \$1 million in 1994 to \$5.7 million in 2000 (the most recent data point available), according to Jury Verdict Research. To merely break even, the drug’s maker would have to charge \$57,000 for every dose. It can’t get away with that. So a potential wonder drug may never see the light of day. A study in the *Journal of the American Medical Association* estimates that 100,000 people die each year in the U.S. from drug-related deaths. If the families of each sued and won that average of \$5.7 million, total liability would hit \$570 billion. That’s twice the combined revenues of the top 12 drug companies Steven Garber, a researcher at the Rand Research Institute for Civil Justice, says drug companies are willing to take on the risk of lawsuits in marketing blockbusters like Viagra and Vioxx. But in other cases the chance of liability is too great. Garber says companies once stopped making new products for use during pregnancy because of the high risk of birth defects. Companies also limit research on orphan drugs -- those that cure rare, often fatal illnesses -- because the potential tort liability outweighs the profit potential.”).

¹⁵¹ See 21 U.S.C. § 355(e)(1); 21 C.F.R. § 5.82.

¹⁵² See 21 U.S.C. § 355(e).

¹⁵³ See 21 U.S.C. § 355(d) (1988) (“[S]ubstantial evidence” means evidence consisting of adequate and well-controlled investigations, including clinical investigations, by experts qualified . . . to evaluate the effectiveness of the drug involved, on the basis of which it could fairly and responsibly be concluded by such experts that the drug will have the effect it purports or is represented to have under the conditions of use prescribed, recommended, or suggested in the labeling or proposed labeling thereof.”).

The FDCA and its implementing regulations ensure that a manufacturer shares risk information with the FDA even after the product has been marketed.¹⁵⁴ Post-marketing surveillance consists of two primary components: reports of individual adverse experiences and epidemiologic studies. Serious reactions must be reported within fifteen working days of receipt of the information.¹⁵⁵ A comprehensive, post-marketing system of reporting and record-keeping requirements ensures that the manufacturer reports adverse drug experiences discovered in clinical, epidemiological, or surveillance studies, through review of the medical literature, or otherwise.¹⁵⁶ Post-marketing reporting obligations include the disclosure of data regarding adverse reactions outside the United States.

A few states have already specifically focused on pharmaceuticals and punitive damages and statutorily provide an FDA regulatory compliance defense against such damages.¹⁵⁷

Research has also confirmed that the reason drug prices generally are so high in the United States compared to Canada, for example, is because of the much larger liability risks drugs are exposed to in this country. One researcher, for example, has concluded that

A large part of the observed variation in the price differential [of drugs in the United States and Canada] is attributable to anticipated liability cost, and liability effects explain virtually all of the very big price differences observed [T]his work indicates that liability costs must have a role in any complete explanation of international price differences. The fact that liability risk plays such a vital role in the model implies that any study of international drug pricing which ignores differences in tort law environments across countries is seriously flawed. The size of these effects is simply too large to ignore.¹⁵⁸

Statute of Limitations

Statutes of limitation define the time period following an injury in which a suit must be brought, in order to protect defendants from the prejudice of stale claims by requiring trials while the best evidence is still available. The best way to allow every patient her day in court while preventing prejudice to health care providers is to codify a reasonable statute of limitations, which the HEALTH Act does.

The HEALTH Act provides that a medical malpractice lawsuit must be filed no later than one year after a person discovers an injury, or within three years at the latest. The HEALTH Act makes an exception for minors under the age of six, extending the time within which a suit must

¹⁵⁴ See 21 C.F.R. § 314.80.

¹⁵⁵ See 21 C.F.R. § 314.80(c)(1).

¹⁵⁶ See 21 C.F.R. §§ 310.303(a), 314.80(c).

¹⁵⁷ The five states that have proscribed punitive damages where the manufacturer has complied with the FDCA are Arizona, Az.Rev.State.Ann. § 12-701; New Jersey, N.J.Sata.Ann. § 2A:58C-5(c); Ohio, Ohio.Rev.Code Ann. § 2307.80(c); Oregon, Or.Rev.Stat. § 30.927; and Utah, Utah Code Ann. § 78-18-2.

¹⁵⁸ Richard Manning, "Products Liability and Prescription Drug Prices in Canada and the United States," 40 *Journal of Law and Economics* 203, 234 (1997).

be filed to the longer of three years or the date on which the minor reaches the age of eight. These provisions are based on California's MICRA law.¹⁵⁹ The HEALTH Act's statute of limitations provisions are designed to protect, for example, OB-GYNs, who should not have to worry about being sued a decade or more after they have delivered a baby. Also, like the HEALTH Act, California's MICRA law includes no exception for latent injuries.

REPORT LANGUAGE: SECTION BY SECTION

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

Section 1. Short Title.

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.

Section 3. Provides for a \$250,000 cap on noneconomic damages. Additionally, this section provides for a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault.

Section 4. Provides for a sliding scale limits on the contingency fees lawyers can charge.

Section 5. Provides guidelines for the award of punitive damages, including guidelines for punitive damages awards not to exceed the greater of \$250,000 or twice economic damages. Also provides a safe harbor from punitive damages for products that meet applicable FDA safety requirements, with exceptions for cases in which information required to be given to the FDA was withheld, in which illegal payments were made to the FDA, and in which the medical product was misbranded or adulterated. Additionally, includes a provision protecting pharmacists and doctors from being named in lawsuits for forum-shopping purposes.

Section 6. Provides authorization for courts to require periodic payments for future damages.

Section 7. Definitions.

Section 8. Provides that except as provided in the Act nothing in the Act shall affect any federal vaccine-related injury or any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

Section 9. Provides a savings clause that saves from preemption state laws that limit damages to specific amounts or that provide greater procedural or substantive protections than the provisions of this Act.

Section 10. Provides that the Act shall apply to any health care lawsuit brought in a federal or State court that is initiated on or after the date of the enactment of this Act, except that

¹⁵⁹ See Cal.C.C.P. § 340.5.

any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

ADVISORY ON EARMARKS

In accordance with clause 9 of rule XXI of the Rules of the House of Representatives, the HEALTH Act 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.

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.

CONSTITUTIONAL AUTHORITY STATEMENT

The Committee finds authority for this legislation in article I, section 8, clause 3 of the Constitution.

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 roll call votes occurred during the Committee's consideration of the HEALTH Act:

1. An amendment by Mr. Scott to strike the provision in the bill creating the fair share rule. Defeated 7 to 11.
2. An amendment by Mr. Johnson to specify that nothing in the bill shall preempt any applicable State constitutional provisions. Defeated 10 to 15.
3. An amendment by Ms. Waters to exclude lawsuits involving preexisting conditions, as defined in the Patient Protection and Affordable Care Act, from the HEALTH Act's coverage. Defeated 9 to 15.
4. An amendment by Ms. Waters to exempt claims involving rescission of health insurance from the HEALTH Act's coverage. Defeated 10 to 15.
5. An amendment by Ms. Waters to allow for unlimited non-economic damages in cases that involve catastrophic injury, vegetative state, or death. Defeated 11 to 15.
6. An amendment by Mr. Nadler to increase the \$250,000 caps on noneconomic damages and punitive damages to \$1,977,500 and index the caps to the Consumer Price Index. Defeated 10 to

15.

7. An amendment by Mr. Nadler to index the \$250,000 caps for noneconomic and punitive damages to the Consumer Price Index. Defeated 9 to 14.

8. An amendment by Mr. Nadler to strike the HEALTH Act's provisions related to medical products. Defeated 9 to 13.

9. An amendment by Mr. Nadler to add restrictions on when judges may issue protective orders and the sealing of cases and settlements. Defeated 7 to 9.

10. An amendment by Ms. Jackson Lee to add a section to the HEALTH Act exempting actions by minors from the limits on damages. Defeated 9 to 14.

11. An amendment by Ms. Jackson Lee to modify the HEALTH Act's statute of limitation provision to change the timeframe related to the manifestation or discovery of an injury related to a minor. Defeated 9 to 12.

12. An amendment by Mr. Cohen to exclude from the bill's limits on damages lawsuits related to a foreign object being left inside a patient or performing a procedure on the wrong patient or body part. Defeated 9 to 13.

13. An amendment by Mr. Deutch to apply the bill's provisions to lawsuits brought by health care providers, health care organizations, and pharmaceutical and device manufacturers. Defeated 11 to 16.

14. An amendment by Mr. Deutch and Mr. Quigley to strike the punitive damages exemption for products that comply with FDA Standards. Defeated 10 to 16.

15. An amendment by Mr. Johnson to strike the references in the bill to "State or Federal court or pursuant to an alternative dispute resolution system" and replaces those references with "Federal Court." Defeated 14 to 16.

16. Motion to order the HEALTH Act favorably transmitted to the House Budget Committee. Approved 16 to 14.

CHANGES IN EXISTING LAW (RAMSAYER SUBMISSION)

The Committee advises that existing law will not change as a result of the enactment of this legislation.

PERFORMANCE GOALS

The Committee states that pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the HEALTH Act will 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.

DISSENTING VIEWS

INTRODUCTION

Under H. Con. Res. 112, the Committee on the Judiciary is instructed to “submit changes in laws within its jurisdiction sufficient to reduce the deficit” by \$100,000,000 for the period of fiscal years 2012 and 2013; by \$11,200,000,000 for the period of fiscal years 2012 through 2017; and by \$39,700,000,000 for the period of fiscal years 2012 through 2022.”¹ By design, these numbers parallel the reduction in spending projected by the Congressional Budget Office when it last analyzed H.R. 5, the “Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act).”²

As a consequence, instead of addressing jobs or the economy—or even the rising cost of healthcare—the Committee has now considered H.R. 5³ twice in the same Congress. The HEALTH Act, like the “reconciliation” vehicle that carries it, is dead on arrival in the Senate. Nevertheless, the substance of the bill is as dangerous and one-sided as it was when it was first proposed almost two decades ago.⁴ The medical malpractice “crisis” it purports to address does not exist—and, if it did exist, H.R. 5 would not solve it.

I. Background

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 the “common law,” or judge-made law, of the United States civil justice system. Traditionally, tort claims have been reserved to the states.⁵ All fifty states have considered some version of limited liability for medical malpractice.⁶

¹ H.R. Con. Res. 112, 112th Cong. § 201(b)(4) (2012).

² U.S. Congressional Budget Office, “Cost Estimate for H.R. 5 as ordered Reported by the House Committee on the Judiciary on February 16, 2011,” March 10, 2011, *available at* <http://cbo.gov/ftpdocs/120xx/doc12095/hr5.pdf>.

³ Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, H.R. 5, 112th Cong. (2012) (as considered in the H. Comm. on the Judiciary on April 17, 2012) [hereinafter *HEALTH Act*].

⁴ *See* Common Sense Product Liability and Legal Reform Act of 1995, H.R. 956, 104th Cong. (1995).

⁵ “Tort law at present is almost exclusively state law rather than federal law.” U.S. CONGRESSIONAL RESEARCH SERVICE, *Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes*, 95-797 (Jan. 28, 2010), at 1.

The National Conference of State Legislatures maintains that “American federalism contemplates diversity among the states in establishing these rules.”⁷

The tort system provides various benefits to society. First, it compensates patients who have been injured by the bad acts 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 these harmful products or practices, thereby adding to public health and public safety.⁸

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.”⁹ In medical malpractice cases, this legal standard is based on the practices of the medical profession,¹⁰ and is usually determined based on the testimony of expert witnesses.

As with other torts, there are two types of remedy for medical malpractice. Courts may award compensatory damages for economic and noneconomic losses such as medical expenses, lost wages, pain and suffering, reduced life expectancy and diminished quality of life. Courts may also award punitive damages to punish and deter willful and wanton conduct.

Medical malpractice liability reform has historically attracted the attention of Congress during insurance industry “crisis” periods, which occurred during the mid-1970s, the mid-1980s, and the early 2000s.¹¹ These periods were marked by increases in insurance premiums, reported 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 does not exhibit crisis symptoms.¹² Moreover, the industry’s

⁶ See Michael I. Krauss & Robert A. Levy, *Can Tort Reform and Federalism Coexist?* 514 CATO INST. POL’Y ANALYSIS (2004).

⁷ National Conference of State Legislatures, *2010-2011 Policies for the Jurisdiction of the Law and Criminal Justice Committee: Medical Malpractice*, http://www.ncsl.org/default.aspx?TabID=773&tabs=855,27,671#Medical_Malpractice (last visited April 24, 2012) [hereinafter *NCSL Policy*].

⁸ Joan Claybrook, *Consumers and Tort Law*, 34 FED. B. NEWS & J. 127 (1987).

⁹ RESTATEMENT (SECOND) OF TORTS § 282 (1965).

¹⁰ DAVID M. HARNEY, *MEDICAL MALPRACTICE* 413 (2d ed. 1987).

¹¹ U.S. CONGRESSIONAL RESEARCH SERVICE, *Medical Malpractice: Overview and Legislation in the 112th Congress*, R41693 (March 16, 2012).

¹² *Id.*

cycle of “crisis” and “calm” appears to be driven more by the investment practices of insurance companies than by litigation or the legal system.¹³

Still, the federal government has a role to play in encouraging the states to adopt more efficient medical malpractice liability systems. In September 2009, President Obama directed the Department of Health and Human Services to help state governments and health care providers try alternative methods of resolving malpractice allegations.¹⁴ Under this directive, the Agency for Healthcare Research and Quality has already funded seven demonstration and various planning grants, for a total amount of \$25 million, and is currently soliciting applications for additional demonstration projects.¹⁵ These grants support evidence-based patient safety and medical liability projects designed to reduce preventable harms, inform injured patients promptly, and promote settlement of cases through alternative dispute resolution.¹⁶

On March 23, 2010, President Obama signed into law comprehensive health care reform, the Patient Protection and Affordable Care Act.¹⁷ Among other important reforms, the bill authorizes \$50 million for grants to the states to develop, implement, and evaluate alternatives to current tort litigation systems.¹⁸ Preference is given to states that have developed alternatives in consultation with relevant stakeholders to enhance patient safety, reduce medical errors and adverse events, and improve access to medical malpractice liability insurance.¹⁹

President Obama’s FY2012 budget called for “a more aggressive effort to reform our medical malpractice system” and encouraged “Republicans to work constructively with him on medical malpractice as part of an overall effort to restrain health costs.”²⁰ In addition, the

¹³ *Id.*

¹⁴ See THE WHITE HOUSE, OFFICE OF THE PRESS SECRETARY, *FACT SHEET: Patient Safety and Medical Liability Reform Demonstration* (Sept. 17, 2009), available at <http://www.whitehouse.gov/the-press-office/fact-sheet-patient-safety-and-medical-liability-reform-demonstration>.

¹⁵ See U.S. DEP’T OF HEALTH & HUMAN SERVICES, AGENCY FOR HEALTH CARE RESEARCH AND QUALITY, *Medical Liability Reform & Patient Safety Initiative*, <http://www.ahrq.gov/qual/liability/>.

¹⁶ *Id.*

¹⁷ Pub. L. No. 111-148.

¹⁸ *Id.* § 10607.

¹⁹ *Id.*

²⁰ THE WHITE HOUSE OFFICE OF MANAGEMENT AND BUDGET, *Fiscal Year 2012 Budget of the United States Government*, at 25, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/budget.pdf>.

President’s FY2012 budget requested funding for “\$250 million in grants to states to reform the way they resolve medical malpractice reform.”²¹ Although Congress did not fund these grants in FY2012, the President made the same \$250 million request in FY2013.²²

II. Description of the Legislation

H.R. 5 is not “designed brilliantly to cooperate with the States in trying to encourage better practices in medicine,” as its supporters maintain.²³ Rather, the bill preempts state law in all fifty states with a rigid, uniform set of rules designed to cut off restitution for victims of medical malpractice.²⁴

Although it is often described as a “medical malpractice” bill, H.R. 5 extends far beyond the field of medical malpractice liability. The bill applies to all “health care lawsuits,” and defines the term as “any health care liability claim concerning the provision of health care goods or services or any medical product . . . brought in a State or a Federal court or pursuant to an alternative dispute resolution system.”²⁵ Because this definition is so broad, the bill offers new protections to medical device and pharmaceutical manufacturers, nursing homes, hospitals, HMOs, and insurance companies, among others.

This legislation limits the amount of non-economic damages—i.e., damages for pain and suffering—to \$250,000. In addition, H.R. 5 eliminates joint and several liability for economic and non-economic loss.²⁶ Joint and several liability ensures that injured patients are fully compensated for their losses.

²¹ *Id.* at 737.

²² THE WHITE HOUSE OFFICE OF MANAGEMENT AND BUDGET, *Fiscal Year 2013 Budget of the United States Government*, at 231, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf>.

²³ *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee’s Oversight Plan*, 112th Cong., Feb. 16, 2011 (statement of Rep. Trent Franks, Member, House Comm. on the Judiciary).

²⁴ U.S. CONGRESSIONAL RESEARCH SERVICE, *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys on Tort Reform Proposals*, R41661 (March 28, 2011).

²⁵ HEALTH Act, 112th Cong. § 7(7).

²⁶ *Id.* § 3(d). The so-called “Fair Share” rule provides: “In any health care lawsuit, each party shall be liable for that party’s several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party’s percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party.” *Id.*

The bill dramatically limits a patient's ability to recover punitive damages. First, the bill imposes a heightened standard for the recovery of punitive damages, requiring either clear and convincing evidence that the defendant acted with malicious intent to injure the victim, or that the defendant understood that the defendant understood the victim was substantially certain to suffer unnecessary injury yet deliberately failed to avoid such injury.²⁷ Even if a patient can meet this burden, the bill limits punitive damages to two times the amount of economic damages or \$250,000, whichever is greater.²⁸

The second category of punitive damages affected by the bill relates to manufacturers and distributors of drugs and medical devices. Specifically, the bill bans punitive damage liability for: (1) manufacturers of drugs and devices that are approved by the FDA, (2) manufacturers of drugs and devices that are not FDA-approved but are "generally recognized as among qualified experts as safe and effective," and (3) all manufacturers or sellers of drugs with respect to packaging or labeling defects.²⁹ These changes have the effect of sidestepping federal safety regulations in addition to limiting a patient's ability to recover damages in court.

H.R. 5 sets strict limits on the amount an attorney may receive in contingency fee payments. The total amount of all contingent fees for representing all claimants in a health care lawsuit may not exceed: (1) 40% of the first \$50,000 recovered by the claimant(s); (2) 33 1/3 % of the next \$50,000 recovered by the claimant(s); (3) 25% of the next \$500,000 recovered by the claimant(s); and (4) 15% of any amount by which the recovery by the claimant(s) is in excess of \$600,000.³⁰ The bill also gives courts the authority to approve fees lower than those provided for by this formula.

H.R. 5 also imposes a restrictive statute of limitations for medical malpractice actions. A "health care lawsuit may be commenced no later than 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, *whichever occurs first*."³¹ Although disguised as a three-year statute of limitations, the effect of this provision is that a claimant often has only one year from the date of discovering the injury to file suit. A claimant will, quite often, *discover* an injury on the same day an injury *manifests* itself. This provision cuts in the opposite direction for patients whose injuries have long latency periods. A patient might manifest symptoms of HIV or hepatitis long before discovering the cause of the injury, but have no recourse if the three-year deadline has expired.

²⁷ HEALTH Act, 112th Cong. § 5(a).

²⁸ *Id.* § 5(b)(2).

²⁹ *Id.* § 7(c)(1).

³⁰ *Id.* § 4(a).

³¹ *Id.* § 2 (emphasis added).

H.R. 5 further disadvantages patients by requiring judges to permit periodic payments at the request of the defendant.³² To the extent that a patient can successfully negotiate the obstacles set up by the bill, actual payment of damages could take years—assuming the defendant remains solvent.

Finally, the provisions of H.R. 5 is written to be “one-way preemptive”—i.e., with one limited exception, they only supersede state laws that are more favorable to victims. The Congressional Research Service has conducted a fifty-state survey and concluded that H.R. 5 would preempt important patient and consumer protections in all fifty states.³³ Moreover, because the bill applies to all “health care liability claims” regardless of the “theory of liability on which the claim is based,” the legislation limits recovery against insurance companies for violations of even the most popular provisions of the Affordable Care Act—such as the prohibition on denying coverage for a pre-existing condition, the lifting of lifetime recovery ceilings, and mandated coverage for adult children under the age of 26.

III. General Concerns

A review of the empirical evidence gathered over the last two decades supports a number of conclusions. First, despite perennial claims to the contrary, the judicial system is not in crisis with respect to medical malpractice liability. Second, no significant savings are likely to be realized through federal “tort reform.” Third, medical malpractice is a serious problem in the United States.

Opposition to the HEALTH Act includes, but is not limited to: Alliance for Justice, the Center for Justice and Democracy, the Consumer Federation of America, Consumer Watchdog, the National Consumers League, the National Consumer Voice for Quality Long-Term Care, the National Women’s Health Network, and Public Citizen.

A. The cycle of “crisis” and “calm” is driven by the investment practices of insurance companies.

In past sessions of Congress, supporters of the bill have pointed to a common set of symptoms in the insurance market—most often, “skyrocketing” insurance premiums and difficulties in finding medical malpractice liability coverage.³⁴ Restricting the ability of patients

³² *Id.* § 8(a). “In any health care lawsuit, if an award of future damages . . . 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.” *Id.* (emphasis added).

³³ U.S. CONGRESSIONAL RESEARCH SERVICE, *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys on Tort Reform Proposals*, R41661 (March 28, 2011).

³⁴ *See, e.g.*, 151 Cong. Rec. H6990 (daily ed. July 28, 2005). “The costs of the tort system continue to take their toll on the Nation’s economy. Medical professional liability insurance rates have skyrocketed, causing major insurers to drop coverage or raise premiums to unaffordable

to recover damages for malpractice, they argued, would reduce the frequency of malpractice lawsuits. This would, in theory, lower medical malpractice premiums, making insurance more available to doctors and doctors more available to patients. This policy assumption—that discouraging litigation mitigates the insurance “crisis”—does not square with the facts.

From a historical perspective, Congress paid closest attention to medical malpractice liability insurance during “crisis” periods in the mid-1970s, the mid-1980s, and the early 2000s.³⁵ These periods are punctuated by the same symptoms described by supporters of H.R. 5—increases in malpractice insurance premiums, claims of insurance scarcity, and stories of physicians abandoning specialties or communities because of the high cost of insurance.³⁶ In each instance, the “crisis” abated when the financial market stabilized.³⁷

Experts attribute this cycle of crisis and calm to the investment practices of the insurance industry—not to the frequency of litigation or the size of jury awards. Joanne Doroshow, Executive Director for the Center for Justice and Democracy, testified at a hearing of the Subcommittee on Commercial and Administrative Law in the 108th Congress and explained:

Insurers make their money from investment income. During years of high interest rates and/or insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. More specifically, insurers engage in severe underpricing to insure very poor risks just to get premium dollars to invest. But when investment income decreases because interest rates drop, the stock market plummets, and/or cumulative price cuts make profits become unbearably low, the industry responds by sharply increasing premiums and reducing coverage, creating a “liability insurance crisis.”³⁸

This market-driven cycle repeats itself over and over again.

levels. We have heard case after case where this last occurred nationwide The HEALTH Act . . . addresses this crisis by eliminating frivolous lawsuits by making health care more accessible and more affordable.” *Id.* (statement of Rep. Steve Chabot).

³⁵ U.S. CONGRESSIONAL RESEARCH SERVICE, *Medical Malpractice: Overview and Legislation in the 112th Congress*, R41693 (March 16, 2012).

³⁶ *Id.*

³⁷ See, e.g., U.S. CONGRESSIONAL RESEARCH SERVICE, *Medical Malpractice Insurance: An Economic Introduction and Review of Historical Experience*, RL31886 (Oct. 2, 2009).

³⁸ *Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care? Hearing on H.R. 4600 Before the Subcomm. on Commercial and Admin. Law of the H. Comm. On the Judiciary*, 107th Cong. 15 (2002) (statement of Joanne Doroshow, Executive Director, Center for Justice & Democracy).

During the “crisis” of the 1970s, insurance companies increased premiums for medical malpractice insurance by large margins and denied coverage to doctors in certain specialties.³⁹ In response, the states initiated reforms designed to provide alternative sources of insurance and to reduce the volume and costs of medical malpractice claims. Physician- and hospital-owned insurance companies emerged as an alternative to traditional insurance providers, and, for at least a decade, insurance was accessible and affordable in a market dominated by these companies.

Prior to the “crisis” of the mid-1980s, a favorable investment market allowed the insurance industry to offer stable and affordable premium rates for medical malpractice insurance. When interest rates dropped in 1984, however, insurance providers responded by drastically increasing the cost of medical malpractice insurance.⁴⁰ In some instances, insurance rates more than tripled for manufacturers, municipalities, doctors, nurses, midwives, daycare centers, nonprofit groups, and other customers of liability insurance.⁴¹

The roots of the most recent “crisis” were described by Raul King, an economist and insurance industry expert with Congressional Research Service, at a forum held by House Democrats in 2003:

What has happened in the 1990s, after the last medical malpractice in the mid-’80s, is that in the 1990s the markets were up. For an extended period of time, interest rates were relatively low, but the bottom line is that investments were very, very high, and they can continue to price their business in such a way to maximize premium for investment purposes.

Some would argue that, starting in 2000, when not only the medical malpractice area but insurance in general, not just medical malpractice but all P&C, property and casualty insurance, when the market cycle started to turn, investments were not what they expected. Interest rates were low, and across the board rates started firming up.

Incidentally, when the market is considered soft, coverage is readily available. Prices are relatively low. The insurance company will make their products available in the marketplace, and they will aggressively sell as much as they can because they want the business, and it’s intensely competitive.

Some would argue that this soft market that went beyond the six years but right close to ten years, and this is what the consumer groups have argued is cash flow underwriting—what Bob Hunter, for example, would argue is cash flow

³⁹ U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, *Impact of Legal Reforms on Medical Malpractice Costs*, Pub. No. OTA-BP-H-119, at 13 (1993).

⁴⁰ *Id.* at 15.

⁴¹ *Id.*

underwriting. They run into a problem. Their investments can't cover their premium losses and underwriting losses.

So what they have to do is increase premiums dramatically. They have to in some cases withdraw from the marketplace, change the amount of insurance they'll make available, in the marketplace. Rather than selling a \$500,000 policy, they'll sell only a \$250,000 policy, and that's all that's available in a given state.⁴²

Once again, when the bottom dropped out on the investment market, premiums increased and availability of coverage declined. Although each crisis "brought about attempts at malpractice reform in many states, it only subsided when the economy finally recovered and interest rates rose."⁴³

Both the American Medical Association and members of the insurance industry acknowledge that these periods of "crisis" are market driven. In a 2003 internal memo, the AMA's Board of Trustees recognized that "the insurance underwriting cycle is now at a point where insurers have both pricing power and a need to increase revenues through premiums as returns on investments are no longer able to subsidize underwriting losses and as insurers have suffered large claim losses in other areas."⁴⁴ The memo explains further:

For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market surged, investments by these historically conservative insurers rose to 10.6% in 1999, up from a more typical 3% in 1992. With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates. The industry reported realized capital gains of \$381 million last year, down 30% from the high point in 1998, according to the A.M. Best Company, one of the most comprehensive sources of insurance industry data.⁴⁵

When investment income became scarce, insurance companies increased premiums to turn a profit. This observation has been confirmed by the National Conference of State Legislatures.⁴⁶

⁴² Democratic Forum on Malpractice, Feb. 11, 2003, Transcript at 32-33.

⁴³ Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 PENN. ST. L. REV. 1077 (2004).

⁴⁴ AMERICAN MEDICAL ASS'N, REPORT 35 OF THE BOARD OF TRUSTEES (A-02) ON LIABILITY REFORM, at 2.

⁴⁵ *Id.*

⁴⁶ Peter Eisler, et al., *Hype Outpaces Facts in Malpractice Debate*, USA TODAY, Mar. 5, 2003 available at http://www.usatoday.com/news/nation/2003-03-04-malpractice-cover_x.htm.

The Physicians Insurers Association of America reported that investment income constituted 47% of insurance company income during the “calm” of 1995, but only 31% during the “crisis” of 2001.⁴⁷

H.R. 5 does nothing to address this boom-and-bust cycle. It does nothing about the investment practices of the insurance industry. It does nothing to repeal the anomalous McCarran-Ferguson antitrust exemption for the insurance industry, which is critical to stabilizing the medical malpractice insurance market.⁴⁸ It does nothing to require that premium increases be justified, or to permit health care providers to challenge increases when they occur. Instead, H.R. 5 pretends that a series of restrictions on patients’ rights will prevent the next “crisis.”

B. No insurance “crisis” exists today.

Although supporters of H.R. 5 may suggest otherwise, the evidence shows that there is no insurance “crisis” today. According to the Medical Liability Monitor, premiums for medical malpractice insurance “have eased nationwide.”⁴⁹ In 2009, 58 percent of premiums stayed level and 36 percent of premiums fell.⁵⁰ According to A.M. Best, after reaching an average annual increase of 14.2 percent during the height of the “crisis” in 2003, medical malpractice premiums began to fall—declining by 6.6 percent in 2007, and by an additional 5.3 percent in 2008.⁵¹ Without any of the federal intervention contemplated by H.R. 5, the “crisis” of the mid-2000s appears to have peaked in 2004 and abated by 2006. Premiums have dropped in every state—whether or not court systems have been modified to limit liability for medical malpractice defendants.⁵²

⁴⁷ *Id.*

⁴⁸ See *Medical Liability Reform – Cutting Costs, Spurring Investment, Creating Jobs, Hearing Before the H. Comm. on the Judiciary*, 112th Cong., Jan. 20, 2011 (statement of Joanne Doroshow, Executive Director, Center for Justice and Democracy).

⁴⁹ Amy Lynn Sorrel, *Liability Premiums Stay Stable, but Insurers Warn This Might Not Last*, AM. MED. NEWS (Nov. 23, 2009) available at <http://www.ama-assn.org/amendnews/2009/11/23//pr1121123.htm>. <http://www.ama-assn.org/amendnews/2009/11/23//pr121123.htm> See also Medical Liability Monitor (Oct. 2008).

⁵⁰ *Id.*

⁵¹ U.S. CONGRESSIONAL RESEARCH SERVICE, *Medical Malpractice Insurance: An Economic Introduction and Review of Historical Experience*, RL31886 (October 2, 2009) (citing A.M. BEST STATISTICAL STUDY, *Continued Improvement in 2005 Results as Medical Malpractice Premium Growth Subsides* (Aug. 28, 2006), and A.M. BEST’S SPECIAL REPORT, *U.S. Medical Professional Liability 2008 Market Review* (Apr. 27, 2009).

⁵² Americans for Ins. Reform, *True Risk: Medical Liability, Malpractice Insurance and Health Care* (July 2009) available at <http://insurance-reform.org/pr/090722.html>.

Medical malpractice cases are also rare and declining in number. According to the National Center for State Courts, only 4.4 percent of the civil caseload is comprised of tort cases; of these, only 2.8 percent are medical negligence cases.⁵³ Even that share has declined by fifteen percent over the past ten years.⁵⁴ The National Practitioner Databank, which tracks all medical malpractice payments by all physicians in the United States, confirms the same downward trend.⁵⁵

Juries decide against medical malpractice plaintiffs more than three-quarters of the time, and damage awards in medical malpractice cases are generally proportionate to the severity of the injury.⁵⁶ In addition, jury awards are stable. An actuarial analysis conducted by J. Robert Hunter, Director of Insurance of the Consumer Federation of America, shows that the average medical malpractice payout hovered at just under \$30,000 for an entire decade—from 1990 to 2000—without adjustment for inflation.⁵⁷ According to a more recent study by the National Center for State Courts, medical malpractice claims actually declined 15 percent from 1999 to 2008.⁵⁸ Insurance industry data shows that claims have dropped 45 percent after adjusting for inflation.⁵⁹

H.R. 5 attempts to contain allegedly “rampant” punitive damages, but the evidence shows that punitive damages are rarely rewarded. According to the Bureau of Justice Statistics, in 1996 only 1.1 percent of medical malpractice plaintiffs who prevailed at trial were awarded punitive damages.⁶⁰ Only 1.2 percent of those awards were awarded by juries.⁶¹ In 2005, there were too few medical malpractice cases in which punitive damages were awarded to provide a statistically reliable estimate of the amount of punitive damages in state courts.⁶²

⁵³ Nat’l Center for State Courts, *Examining the Work of State Courts: An Analysis of 2008 State Court Caseloads* (2010) available at http://www.ncsconline.org/d_research/csp/2008_files/EWSC-2008-Online%20Version%20v2.pdf.

⁵⁴ *Id.*

⁵⁵ Nat’l Practitioner Databank, *Annual Report* (2006) available at http://www.npdb-hipdb.hrsa.gov/pubs/stats/2006_NPDB_Annual_Report.pdf.

⁵⁶ Nat’l Center for State Courts, *Caseload Highlights: Medical Malpractice Litigation in State Courts* (April 2011) available at http://www.courtstatistics.org/~media/Microsites/Files/CSP/Highlights/18_1_Medical_Malpractice_In_State_Courts.ashx.

⁵⁷ Letter from J. Robert Hunter, Director of Insurance, Consumer Federation of America, to Joanne Doroshow, Executive Director, Center for Justice & Democracy (Oct. 13, 2001).

⁵⁸ National Center for State Courts, *supra* note 55.

⁵⁹ *See* Americans for Ins. Reform, *supra* note 52.

⁶⁰ U.S. DEP’T OF JUSTICE, BUREAU OF JUSTICE STAT., *Tort Bench and Jury Trials in State Courts, 2005* (Nov. 2009).

⁶¹ *Id.*

⁶² *Id.*

C. Medical malpractice is the real crisis.

At best, H.R. 5 is untimely—it is designed to lower premium rates that have already dropped, and curb damages that are rare and trending downward. In practice, the bill ignores the real medical malpractice crisis in America.

Medical error is the fifth leading cause of death in the United States.⁶³ In 1999, the Institute of Medicine of the National Academy of Sciences estimated that between 44,000 and 98,000 hospital deaths in the United States each year are attributable to medical mismanagement—at a cost of \$29 billion annually.⁶⁴ This estimate does not include losses for medical errors at outpatient centers, physician offices, or clinics. During the period of study, the number deaths due to medical malpractice was greater than the number of people who died due to motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).⁶⁵

The Congressional Budget Office estimated 181,000 severe injuries occurred due to medical negligence in 2003.⁶⁶ According to a 2008 report by the Institute for Healthcare Improvement, there are fifteen million incidents of negligent medical harm each year.⁶⁷ The Joint Commission Center on Transforming Healthcare reports as many as forty wrong site, wrong side, and wrong patient procedures every week.⁶⁸ The Journal of American Medicine reports that there are 1,500 incidents of surgical tools left in patients each year.⁶⁹

Medical malpractice pervades American society. A November 2010 study by the Office of the Inspector General of the Department of Health and Human Services found that approximately one in seven hospital patients experience a medical error, and that these errors cost Medicare \$4.4 billion every year.⁷⁰ This sum does not include “additional costs required for

⁶³ CENTERS FOR DISEASE CONTROL, NAT’L CENTER FOR HEALTH CARE STAT., *Deaths/Mortality, 2010*, <http://www.cdc.gov/nchs/fastats/deaths.htm>.

⁶⁴ TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM, (Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Institute of Medicine, National Academy Press 1999) [hereinafter *IOM Report*].

⁶⁵ *Id.*

⁶⁶ U.S. CONGRESSIONAL BUDGET OFFICE, *Key Issues* 150-54 (Dec. 2008).

⁶⁷ Institute for Healthcare Improvement, *Campaign – FAQs*, <http://www.ihl.org/IHI/Programs/Campaign/Campaign.htm?TabId=6>.

⁶⁸ American Ass’n for Justice, *Medical Negligence: The Role of America’s Civil Justice System in Protecting Patients’ Rights* (Feb. 2011) (citing Joint Commission Center for Transforming Healthcare, Wrong Site Surgery Project <http://www.centerfortransforminghealthcare.org/projects/display.aspx?projectid=4>).

⁶⁹ See Nagy, et al., *Radio Frequency Identification Systems Technology in the Surgical Setting*, SURGICAL INNOVATION, Vol. 13, No. 1 (March 2006).

⁷⁰ U.S. DEP’T OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (Nov. 2010), at i-ii.

follow-up care after the sample hospitalizations.”⁷¹ Medical errors occur in more than one in ten cases involving children with complex medical problems.⁷² Two in five chronically ill patients receive care inconsistent with medical literature.⁷³ One fifteen-year observational study showed that 45.8 percent of patients experience least some error while receiving medical treatment.⁷⁴

These figures may even be under-reported. Twenty-three states have no medical error detection programs, and even those with mandatory programs likely miss a majority of the harm.⁷⁵ The *New England Journal of Medicine* reports that “Most medical centers continue to depend on voluntary reporting to track institutional safety, despite repeated studies showing the inadequacy of such reporting.”⁷⁶ The only national database of malpractice claims, the National Practitioners Databank, remains closed to the public.⁷⁷ The American Medical Association goes so far as to offer its members a primer on “How to evade a report to the NPDB.”⁷⁸

Changes to court systems that ignore patient safety do little to reverse this trend. After Texas enacted its cap on non-economic damages, complaints against Texas doctors to the state medical board rose from 2,942 to 6,000, more than half of which were focused on poor quality of medical care.⁷⁹ And yet, according to a lengthy investigation by the *Houston Chronicle*, “Texas has fumbled attempts to establish a medical error reporting system, often leaving patients to discover errors the hard way—when a mistake costs them their livelihood or the life of a loved one.”⁸⁰

The costs of medical malpractice are staggering. CRS has found that “the damage from medical malpractice usually requires additional treatment to repair, sometimes an entire lifetime

⁷¹ *Id.* at ii-iii.

⁷² Eisler et al., *supra* note 46.

⁷³ Lee Harris, *Tort Reform as Carrot-and-Stick*, 46 HARV. J. ON LEGIS. 163, 169 (2009).

⁷⁴ *Id.* (citing Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357 (2005)).

⁷⁵ Cathleen F. Crowley & Eric Nalder, *Year After Report, Patients Still Face Risks*, TIMES UNION, Sept. 20, 2010.

⁷⁶ Christopher P. Landrigan et al., *Temporal Trends in Rates of Patient Harm Resulting from Medical Care*, 363 N. ENGL. J. MED 2124-34 (2010).

⁷⁷ American Ass’n for Justice, *supra* note 68, at 9.

⁷⁸ AMA webpage on the National Practitioner Databank, <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/business-management-topics/national-practitioner-data-bank.shtml>.

⁷⁹ Terry Langford, *Texas Laws are Vague, Abandoned or Unfunded*, HOUSTON CHRONICLE, July 30, 2009.

⁸⁰ *Id.*

of medical treatment.”⁸¹ In addition to these human costs, the total financial cost of medical malpractice—including lost income, lost household production, disability and health care costs—is estimated by the Centers for Disease Control to be between \$17 billion and \$29 billion each year.⁸²

And yet, there is a profound disconnect between the actual incidence of medical malpractice and the insurance industry. According to one analysis published in the *Harvard Journal on Legislation*: “Bad doctors are not penalized by insurance companies, which do not normally take into account previous performance when assessing medical malpractice insurance rates.”⁸³ Instead, insurance companies charge premiums based on general factors like physician speciality, without giving an “account for the competence skill, and quality of medical services provided by the physician.”⁸⁴ The problem is compounded by lax discipline for habitually negligent health care providers. In one study published by N.Y.U., state licensing boards were found to have disciplined less than 17 percent of doctors with five or more medical malpractice payouts on record.⁸⁵

This disconnect between medical malpractice and insurance coverage is the foundation for H.R. 5. By enacting sweeping changes to the court systems in all fifty states, this bill gives all health care providers—all physicians, hospitals, clinics, pharmaceutical manufacturers, device manufacturers, and insurance companies—the benefit of additional liability protection in cases of medical malpractice. By forcing the states to cap non-economic damages, the bill disproportionately penalizes members of vulnerable groups, such as women, children, and minorities, all of whom are more likely to realize comparatively substantial non-economic losses. Capping damages “only serves to compel the most grievously injured at the hands of the most clearly negligent and/or reckless to bear the brunt of reform.”⁸⁶

Fortunately, there appear to be effective policy solutions for addressing the medical malpractice crisis. For example, the *Wall Street Journal* has found that, by committing to patient safety, anesthesiologists have halved the rate with which they are sued for malpractice, and pay for malpractice insurance at rates lower than the rates they paid twenty years ago.⁸⁷

Along these lines and under the leadership of the Obama Administration, the Affordable Care Act provides financial incentives for health care providers to improve care and reduce

⁸¹ U.S. CONGRESSIONAL RESEARCH SERVICE, *supra* note 51.

⁸² *See* CENTERS FOR DISEASE CONTROL, *supra* note 63.

⁸³ Lee Harris, *supra* note 78 at 178.

⁸⁴ *Id.* (citing Catherine Sharkey, *Unintended Consequences of Medical Malpractice Damage Caps*, 80 N.Y.U.L. REV. 391, 410 (2005) (noting that physicians are not experience-rated and, thus, both “negligent and non-negligent physicians pay similar premiums”)).

⁸⁵ *Id.*

⁸⁶ Mitchell J. Nathanson, *supra* note 46 at 1109.

⁸⁷ Joseph Hallinan, *Heal Thyself: Once Seen as Risky, One Group of Doctors Changes Its Ways*, WALL ST. J., June 21, 2005, at 1.

unnecessary errors. For example, Medicare payments will be reduced for “hospital acquired conditions”⁸⁸ and high rates of readmission.⁸⁹ The Act also creates the “Hospital Value Based Purchasing Program,” which gives health care providers incentives to perform well on a set of quality measures that include efficiency, outcome, and patient experience of care.⁹⁰ These reforms are the first steps towards a national plan to address medical malpractice. The Act instructs the Center for Medicare and Medicaid Innovation to develop new concepts for improving patient care and reducing costs.⁹¹

Unfortunately, H.R. 5 ignores this progress. Instead of encouraging health care providers to make fewer mistakes, the bill cuts off a patient’s right to be made whole when mistakes are made. Effective legislation would address the real crisis directly. H.R. 5 addresses a crisis that does not exist.

D. Even if the crisis did exist, H.R. 5 would not lower medical malpractice insurance premiums.

In his pitch for H.R. 5, Chairman Smith argued that, because of a statewide \$250,000 cap on noneconomic damages, “the rate of increase in medical professional liability premiums in California since 1976 has been 280% lower than the rate of increase experienced in other states.”⁹² A closer look at the evidence will show that regulation of the insurance industry, not “tort reform,” stabilized the cost of insurance in California.⁹³

The California experience is instructive. H.R. 5 is based largely on California’s “Medical Injury Compensation Reform Act” (MICRA).⁹⁴ Enacted in 1975, MICRA caps noneconomic

⁸⁸ Central line infections and surgical site infections are common examples of “hospital acquired conditions.” Pub. L. No. 111-148 § 3008.

⁸⁹ *Id.* § 3025.

⁹⁰ *Id.* § 3001

⁹¹ *Id.* § 3021.

⁹² *Markup of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee’s Oversight Plan*, 112th Cong., Feb. 9, 2011 (statement of Rep. Lamar Smith, Chairman, House Comm. on the Judiciary).

⁹³ *See Study Finds No Link Between Tort Reforms and Insurance Rates*, LIABILITY WEEK, July 19, 1999 (quoting Sherman Joyce, President, American Tort Reform Association); Michael Prince, *Tort Reforms Don’t Cut Liability Rates, Study Says*, BUS. INS., July 19, 1999 (quoting Victor Schwartz, General Counsel, American Tort Reform Association); Press Release, *AIA Cites Fatal Flaws in Critic’s Reports on Tort Reform*, Am. Ins. Ass’n, Mar. 13, 2002.

⁹⁴ H.R. 5 incorporates “California’s time-tested reforms at the Federal level.” *Markup of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee’s Oversight Plan*, 112th Cong., Feb. 9, 2011 (statement of Rep. Lamar Smith, Chairman, House Comm. on the Judiciary).

damages at \$250,000,⁹⁵ eliminates joint and several liability for noneconomic damages,⁹⁶ limits attorneys' fees on a sliding scale,⁹⁷ and imposes a strict statute of limitations on medical malpractice claims.⁹⁸ These new protections for defendants had mixed success, at best.

In 1995, a comprehensive study of MICRA's impact found: (1) per capita health care expenditures in California exceeded the national average every year between 1975 and 1993; (2) the rise in the cost of health care in California exceeded the rate of inflation every year between 1975 and 1993; (3) hospital patient costs were higher in California than in almost any other state; and (4) California's medical malpractice liability premiums nearly doubled in the twelve years following the enactment of MICRA.⁹⁹ In 1999, the California State Assembly Committee on the Judiciary concluded that medical malpractice premiums had not declined since the enactment of MICRA—California had, at best, experienced a slower rate of premium increase.¹⁰⁰ Further, MICRA altogether failed to decrease the number of malpractice cases filed in California courts.¹⁰¹

To the extent that the cost of insurance stabilized in California after 1975, much of the credit is owed to Proposition 103, which became law in 1988. Among other reforms of the insurance industry, Proposition 103 required insurance companies to hold public hearings before increasing premiums more than 15 percent. This requirement effectively froze the cost of medical malpractice liability insurance for many health care providers.¹⁰² Under the rollback provisions of Proposition 103, insurance companies refunded over \$1.2 million to policyholders.¹⁰³ Within three years, medical malpractice insurance had dropped in cost, on average, by 20.2 percent.¹⁰⁴ Reform of the insurance industry, not of the court system, lowered the cost of insurance.

E. H.R. 5 will have no substantial effect on “defensive medicine.”

⁹⁵ Cal. Civ. Code § 3333.2.

⁹⁶ *Id.* § 1431.2.

⁹⁷ Cal. Bus. & Prof. Code § 6146.

⁹⁸ Cal. Civ. Proc. Code § 340.5.

⁹⁹ Proposition 103 Enforcement Project, *MICRA: The Impact on Health Care Costs of California's Experiment with Restrictions on Medical Malpractice Lawsuits*, 1995.

¹⁰⁰ Brian A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J. L. & MED. 501, 506 (2004).

¹⁰¹ *Id.*

¹⁰² Testimony of Harvey Rosenfeld, Before the House Comm. on Energy and Commerce, Feb. 10, 2003; *see also* Joseph B. Treaster, *Malpractice Insurance: No Clear or Easy Answers*, N.Y. TIMES, Mar. 5, 2003.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

Supporters of H.R. 5 frequently invoke “the waste in our health care system caused by so-called ‘defensive medicine.’”¹⁰⁵ Defensive medicine occurs, they argue, “when doctors are forced by the threat of lawsuits to conduct tests and prescribe drugs that aren’t medically required.”¹⁰⁶ The majority’s briefing memo for the markup of H.R. 5 cites to a “survey from *Emergency Physicians Monthly*” as proof that “the HEALTH Act’s limits on noneconomic damages are essential to reducing defensive medicine,” mostly because “‘non-economic caps are . . . physicians’ preferred choice of malpractice reform.’”¹⁰⁷ Although doctors certainly have financial incentives to prefer damage caps, there is little evidence that the practice of defensive medicine exists, and even less to suggest that H.R. 5 would reduce its frequency.

A landmark study by the non-partisan Office of Technology Assessment found that “[c]onventional tort reforms that tinker with the existing process for resolving malpractice claims while retaining the personal liability of the physician are [unlikely to] alter physician behavior.”¹⁰⁸ Most defensive medicine studies since have failed to demonstrate any real impact on medical practice arising from higher malpractice premiums.¹⁰⁹

The reality is that much of “defensive medicine” results, not from threat of litigation, but from financial incentives to order unnecessary tests and procedures. In a fee-for-service health care system, health care providers benefit financially by providing additional services.¹¹⁰ The GAO has criticized the use of “self-serving” defensive medicine surveys—such as the one highlighted by the majority in its briefing memo—citing to low response rates and unscientific questioning, and concluding that “so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by positive (albeit small) benefits to patients.”¹¹¹

A June 1, 2009, article in *New Yorker* magazine framed the issue in more direct terms. Why had the cost of health care risen so high in McAllen, Texas?

¹⁰⁵

Markup of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee’s Oversight Plan, 112th Cong., Feb. 9, 2011 (statement of Rep. Lamar Smith, Chairman, House Comm. on the Judiciary).

¹⁰⁶ *Id.*

¹⁰⁷ Memorandum from Lamar Smith, Chairman, House Comm. on the Judiciary, to Members of the Committee (Feb. 4, 2011) at 2 (on file with author).

¹⁰⁸ U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 42, at 92.

¹⁰⁹ Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595 (2002).

¹¹⁰ *Id.*

¹¹¹ U.S. GENERAL ACCOUNTING OFFICE, *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (Aug. 29, 2003).

“It’s malpractice,” a family physician who had practiced here for thirty-three years said. “McAllen is legal hell,” the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone though the lawyers here were worse than elsewhere.

That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn’t lawsuits go down? “Practically to zero,” the cardiologist admitted.

“Come on,” the general surgeon finally said. “We all know these arguments are bullshit. There is overutilization here, pure and simple.” Doctors, he said, were racking up charges with extra tests, services, and procedures.”¹¹²

Additional studies have shown that doctors’ fear of lawsuits is “out of proportion to the risk of being sued,” that damage caps have little impact on these perceptions, and that many doctors will, wittingly or unwittingly, “exaggerate their concern about being sued, using it as a justification for high-spending behavior that is rewarded by fee-for-service payment systems.”¹¹³

That type of overstatement was evident in the Committee’s January hearing on medical liability reform, where one Republican witness testified that “the cost of the practice of defensive medicine [is estimated] to be between \$70 billion and \$126 billion per year.”¹¹⁴ When pressed by Rep. Scott, however, Dr. Hoven had difficulty justifying her claim:

Mr. SCOTT. And are you suggesting that \$70 billion to \$126 billion worth of cases, services were rendered that were not medically necessary, were not needed?

Dr. HOVEN. That is not what I said, Congressman.

Mr. SCOTT. Well, what are you saying?

Dr. HOVEN. I am saying that health care delivered in the examining room, in the operating room, is driven by what is based on clinical judgment and based on

¹¹² Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care*, NEW YORKER, June 1, 2009.

¹¹³ David Katz, *Physicians Still Fear Malpractice Lawsuits, Despite Tort Reforms*, HEALTH AFFAIRS, Sept. 2010, Vol. 29, Issue 9 available at <http://content.healthaffairs.org/content/29/9.toc>.

¹¹⁴ *Medical Liability Reform – Cutting Costs, Spurring Investment, Creating Jobs, Hearing Before the H. Comm. on the Judiciary*, 112th Cong., Jan. 20, 2011 (unofficial transcript) (testimony of Dr. Ardis Hoven, Chair, Board of Trustees of the American Medical Association).

assurance testing, which is documentation and proving that, in fact, that is what is wrong with a patient.

When we talk about cost control in this country, we are talking about the fact that—and this goes to the whole issue of cost containment, which is, if, in fact, you would recognize my medical judgment and allow me to decide when it is important to do a test or not, then our patients would be better served.

Mr. SCOTT. By not providing the services?

Dr. HOVEN. If, in my judgment, they don't need it.

Mr. SCOTT. And you are not able to—and you charge for services that, in your judgment, are not needed to the tune of \$70 billion to \$126 billion?

Dr. HOVEN. I do not do that.¹¹⁵

Supporters of H.R. 5 can speak about defensive medicine in the abstract, but their expert on the phenomenon was unwilling or unable to discuss specifics.

A nonpartisan analysis confirms that the changes proposed by H.R. 5 will have a negligible impact on the behavior of physicians. The CBO has found not found significant evidence that “defensive medicine” exists as a pervasive problem, and projects a scant 0.3 percent savings “from slightly less utilization of health care services” if H.R. 5 were to be enacted.¹¹⁶ Once again, supporters of H.R. 5 point to a crisis that does not exist, and propose legislation that would not solve the problem the problem if it did.

F. H.R. 5 will not have a significant impact on the cost of health care or on federal spending.

Although supporters of H.R. 5 argue that limits on medical malpractice liability will help lower the cost of health care, they have targeted a minuscule segment of annual health care spending. According to the National Association of Insurance Commissioners, medical malpractice premiums totaled approximately \$11.2 billion in 2008.¹¹⁷ The overall cost of health

¹¹⁵ *Id.*

¹¹⁶ U.S. CONGRESSIONAL BUDGET OFFICE, *Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (“Tort Reform”)*, Letter to the Hon. Orrin G. Hatch, Oct. 9, 2009, available at <http://www.cbo.gov/doc.cfm?index=10641> [hereinafter *CBO Letter*].

¹¹⁷

NAIC, *Countrywide Summary of Medical Malpractice Insurance, Calendar Years 1991-2008* (Sept. 1, 2009).

care that year totaled \$2.6 trillion.¹¹⁸ In practice, H.R. 5 purports to impact health care spending by taking aim at 0.004 percent of the annual health care budget.

Proponents of H.R. 5 also mention the possibility of federal budget savings, citing to a 2009 CBO study that concludes a proposal like H.R. 5 would result in a \$54 billion in budget savings over ten years¹¹⁹ and a 2012 CBO review of H.R. 5 as it was considered on the House floor.¹²⁰ Their use of these CBO reports are troubling for several reasons. First, it is ironic that the same House Republicans who casually dismissed \$230 billion in savings identified by the CBO in the Affordable Care Act now apply such importance to asserted savings from H.R. 5. Second, \$13 billion of the savings identified by the CBO has nothing to do with federal spending; rather, it results from the increased taxes health professionals will pay if H.R. 5 is enacted.¹²¹

Third, at least one provision of H.R. 5 is projected to increase costs. The CBO concluded that “reform of joint-and-several liability rules ... is likely to increase the financial liability of the providers assigned the greatest share of responsibility in malpractice cases – typically physicians.”¹²² Fourth, “because many states have already implemented some of the changes in the package, a significant fraction of the potential cost savings has already been realized.”¹²³

Finally, supporters of H.R. 5 miss the narrow scope of the CBO analysis. CBO only concerns itself with the immediate effects of this legislation on the federal budget. It does not account for the full social and financial cost of enacting H.R. 5. The CBO admits as much: “There is less evidence about the effects of tort reform on people’s health, however, than about the effects of on health care spending—because many studies of malpractice costs do not examine health outcomes.”¹²⁴

In the long term, victims of malpractice who are injured but denied full restitution require additional support from Medicare, Medicaid, and other government programs. Moreover, the CBO letter acknowledges that, if the changes contemplated in H.R. 5 are enacted, the U.S. morality rate will increase by as much as 0.2%.¹²⁵ That constitutes an additional 4,853 Americans

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CBO Letter, *supra* note 116

¹¹⁹ *Id.*

¹²⁰ U.S. Congressional Budget Office, “Cost Estimate for H.R. 5 as ordered Reported by the House Committee on the Judiciary on February 16, 2011,” March 10, 2011, *available at* <http://cbo.gov/ftpdocs/120xx/doc12095/hr5.pdf>.

¹²¹ CBO letter, *supra* note 116.

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ CBO letter, *supra* note 116.

killed every year, or 48,250 Americans over the ten-year period CBO examines.¹²⁶ In our judgment, that is too high a price to pay for this legislation. H.R. 5 leaves the families of these patients without full recourse, and leans on the federal government to make up much of the difference.

IV. States' Rights and Federalism Concerns

The majority has sent decidedly mixed messages with respect to states' rights. In the first markup of the bill, supporters of H.R. 5 argued that "bringing a medical liability lawsuit is an activity that substantially affects interstate commerce. There is no federalism concern with this legislation."¹²⁷ This claim did not sit well with many members of the majority.¹²⁸ Notably, six members of the majority did not support H.R. 5 when it was on the House floor: Reps. Chaffetz and Marino did not vote; Reps. King and Sensenbrenner voted "present"; Reps. Gohmert and Poe voted "no."

Proponents of H.R. 5 conceded at least the existence of a states' rights problem, promising to work on an amendment to address the issue prior to debate on the House floor.¹²⁹ No such amendment was ever shared with the Democratic members of the committee, and none was introduced on the House floor. In fact, in both 2011 and 2012, the majority voted down amendments that would have addressed this issue directly.

Simply put, H.R. 5 is a direct attack on states' rights. The Congressional Research Service has concluded that the bill preempts the law in all fifty states. Its so-called "state flexibility" provision does almost nothing to mitigate serious federalism concerns.

A. The states set the rules for their own court systems, and federalism permits diverse systems to coexist.

¹²⁶ Based on 2,436,264 annual deaths, according to the Center for Disease Control and Prevention. CENTERS FOR DISEASE CONTROL, *supra* note 63.

¹²⁷ *Markup of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan*, 112th Cong., Feb. 9, 2011 (statement of Rep. Lamar Smith, Chairman, House Comm. on the Judiciary).

¹²⁸ "I got problems with that. I think it's a violation of the Tenth Amendment, and I don't believe the Federal Government has any more authority to regulate health care under the Commerce Clause than it does to regulate liability caps in states under the Commerce Clause." *Id.* (statement of Rep. Ted Poe, Member, House Comm. on the Judiciary).

¹²⁹ "I want to reassure the gentleman from Georgia and the gentleman from North Carolina, and particularly two gentlemen from Texas on my side, that we are actively working on an amendment for the House floor that would empower States to have control over what aspect of this law would apply to the States or whether the law would apply to those States at all." *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan*, 112th Cong., Feb. 16, 2011 (statement of Rep. Lamar Smith, Chairman, House Comm. on the Judiciary).

Historically, the states have been allowed to set their own rules for their own court systems. The two litigants in a medical malpractice case are usually an in-state plaintiff and an in-state physician.¹³⁰ Except in limited circumstances, malpractice cases can only be filed in state court.¹³¹ Even when malpractice cases can be filed in federal court, those courts apply state malpractice law.

All fifty states have considered some changes to their tort systems, and different states have adopted different approaches to the issue of medical malpractice liability. The National Conference of State Legislatures (NCSL), a bipartisan organization representing the elected legislators and professional staffs of all fifty state legislatures, maintains that “American federalism contemplates diversity among the states in establishing these rules.”¹³²

All fifty states have statutes of limitations in place with respect to negligence cases.¹³³ All fifty states have rules of evidence to provide for the full and fair adjudication of lawsuits.¹³⁴ Some states—Colorado, Florida, Illinois, Maryland, Michigan, Texas, and West Virginia, among others—have already enacted medical malpractice damage caps of their own.¹³⁵ Other states—including Arizona, Connecticut, Iowa, Kentucky, New York, Oregon, Tennessee, and Wyoming—have expressly chosen not to limit medical malpractice damages, in some instances by amendment to the state constitution or popular referendum.¹³⁶ Federalism allows each state to choose the rules for medical malpractice cases that best fit the particular needs of its citizens, and permits diverse systems to flourish and to coexist.

B. H.R. 5 preempts state law in all fifty states.

H.R. 5 overturns this entire federalist approach to medical malpractice liability reform to impose a uniform set of rules on the states. No state is immune.¹³⁷ No state has adopted the bill’s

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See Michael I. Krauss & Robert A. Levy, *supra* note 6.

¹³¹ Medical malpractice cases filed in federal court are based on diversity jurisdiction; e.g., where the parties reside in different states.

¹³² NCSL Policy, *supra* note 7.

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ Colo. Rev. Stat. § 12-64-302; Fla. Stat. §§ 766.118 and 768.73; 735 Ill. Comp. Stat. § 5/2-1115; Md. Code, Cts. & Jud. Proc § 3-2A-09; Mich. Comp. Laws § 600.1483; Tex. Civ. Proc. & Rem. Code § 74.301; W. Va. Code § 55.7B.8.

¹³⁶ *See, e.g.*, Ariz. Const., Art. 2, sec. 31. “No law shall be enacted in this state limiting the amount of damages to be recovered for causing the death or injury of any person.” *Id.* *See also* Ark. Const. Art.5, sec. 32; Ky. Const. Sec. 54; Penn. Const., Art III, sec. 18.

¹³⁷ U.S. CONGRESSIONAL RESEARCH SERVICE, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages*, RL31692 (Jan. 18, 2006).

precise regime of \$250,000 caps on noneconomic damages, \$250,000 caps on punitive damages, elimination of joint-and-several liability, and a three-year limited statute of limitations¹³⁸. Moreover, no state has attempted to capture every action against “a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based,”¹³⁹ in a law to reform “medical malpractice” liability.

The National Conference of State Legislatures categorically rejects the “one-size-fits-all approach to medical malpractice envisioned in H.R. 5” and has reached the “resounding bipartisan conclusion” that “federal medical malpractice legislation is unnecessary.”¹⁴⁰ In a letter to the Chairman and Ranking Member of the Judiciary Committee, NCSL argues further that its opposition to H.R. 5 “will extend to any bill or amendment that directly or indirectly preempts any state law governing the awarding of damages by mandatory, uniform amounts or the awarding of attorney’s fees.”¹⁴¹

With two limited exceptions, H.R. 5 explicitly preempts the states in every area of law it reaches—statutes of limitation, attorney’s fees, rules of evidence, suits against pharmaceutical and device manufacturers, and caps on punitive damages.¹⁴²

The first exception exists solely to further disadvantage victims of medical malpractice. H.R. 5 does not preempt any law “that imposes greater procedural or substantive protections for healthcare providers and healthcare organizations.”¹⁴³ In effect, any state law that goes further than H.R. 5 to favor defendants—e.g., a law that provides for shorter statutes of limitation, imposes lower caps on punitive damages, or removes consumer protections in instances of fraud¹⁴⁴ or bribery¹⁴⁵—stays on the books.

The second exception to general preemption—the “State Flexibility” provision—is, at best, misnamed. Any state law that “specifies a particular monetary amount of compensatory or

¹³⁸ *Id.*

¹³⁹ HEALTH Act, 112th Cong. § 7(7).

¹⁴⁰ Letter from Nevada Assemblyman William Horne, Chair, NCSL, and Texas Rep. Jerry Madden, Immediate Past Chair, NCSL, to Rep. Lamar Smith and Rep. John Conyers, Feb. 16, 2011. *See also* Letter from South Dakota Sen. Joni Cutler, Co-Chair, NCSL Committee on Law and Criminal Justice, and Mississippi Rep. Tommy Reynolds, Co-Chair, NCSL Committee on Law and Criminal Justice, to Speaker John Boehner and Minority Leader Nancy Pelosi, March 14, 2012.

¹⁴¹ *Id.*

¹⁴² HEALTH Act, 112th Cong. § 9(a).

¹⁴³ *Id.* § 9(b)(2).

¹⁴⁴ *Id.* § 5(c)(4).

¹⁴⁵ *Id.*

punitive damages” avoids preemption by the \$250,000 cap on noneconomic damages imposed by H.R. 5.¹⁴⁶ This provision allows existing monetary caps on medical liability damages to stand. But it also forces states without the full range of damage caps contemplated by H.R. 5 to adopt a specific scheme. For example:

¹⁴⁶ *Id.* § 9(c).

Arizona. The Arizona state constitution explicitly prohibits any statutory limit on the amount of damages recoverable by a plaintiff in a medical malpractice suit.¹⁴⁷ H.R. 5 would preempt the state constitution and force Arizona to adopt a \$250,000 cap on noneconomic damages in all health care lawsuits. H.R. 5 also preempts similar provisions in the state constitutions of Arkansas, Kentucky, and Pennsylvania.

Connecticut. Connecticut imposes several procedural requirements on medical malpractice litigants, but does not include caps on damages.¹⁴⁸ H.R. 5 would preempt state law and force Connecticut to adopt a \$250,000 cap on noneconomic damages in all health care lawsuits.

California. California caps only noneconomic damages for medical malpractice claims involving licensed medical professionals.¹⁴⁹ Under H.R. 5, it would be forced to cap damages on cases involving nursing homes, pharmaceutical companies, and the insurance industry.

Indiana. Indiana caps total compensatory damages at \$1,250,000 overall and \$250,000 per health care provider, with no limit for wrongful death claims.¹⁵⁰ Under H.R. 5, it would be forced to cap damages in wrongful death suits, as well as in cases involving nursing homes, pharmaceutical manufacturers, and insurance companies.

Texas. Texas caps noneconomic damages in cases involving medical professionals and health care institutions, but not in cases involving the drug and device industry.¹⁵¹ Under H.R. 5, it would be forced to adopt a \$250,000 cap in such cases.

In sum, no state will go unaffected by the H.R. 5. The “state flexibility” provision provides for very little actual flexibility.

C. The majority sends mixed messages on states’ rights and H.R. 5.

The federal government has an important role to play in controlling the costs of health care. Supporters of H.R. 5 have invoked a broad “effect on interstate commerce” as constitutional justification for the bill.¹⁵² Specifically, they find that “the health care insurance industries

¹⁴⁷ Ariz. Const., Art. 2, sec. 31.

¹⁴⁸ Conn. Gen. Stat. §§ 51-251c and 52-584.2.

¹⁴⁹ Cal. Civ. Code § 3333.2.

¹⁵⁰ Ind. Code § 34-18-4-3.

¹⁵¹ Tex. Civ. Proc. & Rem. Code § 74.301.

¹⁵² Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, H.R. 5, 112th Cong. (2011) (as considered in the H. Comm. on the Judiciary on Feb. 9, 2011; the findings section was struck in the version considered this year), § 2(a)(2).

affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care.”¹⁵³ Because the health care and insurance industries have a massive impact on the national economy, Congress has the authority and reason to act where the individual states are unable to address the issue separately.

For the past two years, supporters of H.R. 5 have argued precisely the opposite with respect to the Affordable Care Act.¹⁵⁴

In fact, the majority has argued both sides of the states’ rights question on the same day. On the morning of February 16, 2011, in a full committee hearing on “The Constitutionality of the Patient Individual Mandate,” Republican members described the Affordable Care Act as a massive overreach of the federal government and a clear violation of the Tenth Amendment.¹⁵⁵ Chairman Smith argued further that “if the individual mandate is upheld” by the Supreme Court, “it would be the end of federalism.”¹⁵⁶ Later that afternoon, in the continued markup of H.R. 5, Republican members of the committee voted twice—by party line both times—to reject amendments to the bill that would have allowed existing state laws to stand.¹⁵⁷

¹⁵³ *Id.*

¹⁵⁴ See, e.g., Rep. Lamar Smith, *Updated Health Care Frequently Asked Questions (FAQ)* available at <http://lamarsmith.house.gov/Issues/Issue/?IssueID=13970> (“I co-sponsored legislation that increases funding for state-based programs providing health insurance to individuals unable to obtain affordable insurance from private insurers. This bill passed by Congress is a massive overreach of government control.”).

¹⁵⁵ “I think that [the Affordable Care Act] expanded the Commerce Clause beyond the intentions of the Founding Fathers and the concepts that we basically hold today [I]f Obamacare is upheld as constitutional . . . then what could be constrained by the Commerce Clause?” *The Constitutionality of the Patient Individual Mandate: Hearing Before the H. Comm. on the Judiciary*, 112th Cong. (Feb. 16, 2011) (statement of Rep. Steve King, member, H. Comm. on the Judiciary).

¹⁵⁶ *Id.* (statement of Rep. Lamar Smith, chairman, H. Comm. on the Judiciary).

¹⁵⁷ *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee’s Oversight Plan*, 112th Cong., Feb. 16, 2011. Amendments introduced by Rep. Hank Johnson would have struck preemption language in H.R. 5 and permitted existing state medical malpractice liability laws (or, in the alternative, relevant provisions of state constitutions) to remain in effect. At least two members of the majority were “noticeably absent from the room” when these amendments were rejected. Brett Coughlin, *House Judiciary Approves Tort Reform*, POLITICO, Feb. 16, 2011 available at <http://www.politico.com/news/stories/0211/49703.html>.

The majority's position on states' rights took an even stranger turn when the committee considered an amendment to "repair certain provisions in the McCarran-Ferguson Act which currently exempt medical malpractice insurers from Federal antitrust laws."¹⁵⁸ In opposition to the amendment, the majority argued:

Under our current system, Mr. Chairman, State regulation of health insurance, State regulators have authority to prevent rates that are excessive, inadequate, or unfairly discriminatory By letting Department of Justice and FTC second guess State insurance regulator's competition policies, this amendment would disrupt subtle law in nearly every State in the Union.¹⁵⁹

The majority opposed this amendment because it would have preempted state law. To summarize: the majority was in favor of states' rights in the morning and opposed to states' rights in the afternoon—except while debating this amendment, when the majority favored states' rights again.

To their credit, some members of the majority have made public comments pointing out this inconsistency.¹⁶⁰ Others are content to repeat the fiction that H.R. 5 "specifically exempts state laws and does not change what states have already adopted."¹⁶¹

V. Specific Concerns with the Legislation

H.R. 5 imposes new restrictions on medical malpractice cases. It applies these restrictions across the board—no matter how much merit a case may have, regardless of the negligence at issue or the severity of the injury. The provisions of H.R. 5 are unjust and unfair. The following are just a few of the most pressing problems with the bill.

¹⁵⁸ *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan*, 112th Cong., Feb. 16, 2011 (statement of Rep. Maxine Waters, member, H. Comm. on the Judiciary).

¹⁵⁹ *Id.* (statement of Rep. Trent Franks, member, H. Comm. on the Judiciary).

¹⁶⁰ Comparing the Affordable Care Act to H.R. 5, Rep. Ted Poe remarked: "to be consistent, they're both not covered under the Interstate Commerce [Clause]. I don't think the Constitution gives the Federal government any authority in either one of those areas." *Markup of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan*, 112th Cong., Feb. 9, 2011 (statement of Rep. Ted Poe, member, H. Comm. on the Judiciary). Notably, Rep. Poe voted against final passage of H.R. 5 on the House floor on March 22, 2012.

¹⁶¹ *Id.* (statement of Rep. Lamar Smith, Chairman, H. Comm. on the Judiciary).

A. The \$250,000 cap on noneconomic damages is unfair and discriminatory.

The \$250,000 cap on noneconomic damages is manifestly unfair. It discriminates against women, children, and other vulnerable members of society and does account for the effects of inflation. The bill's sweeping definition of "health care lawsuit" gives the cap a particularly insidious reach.

H.R. 5 imposes an arbitrarily low cap on noneconomic damages in every case, regardless of the negligence or the extent of injury involved. This one-size-fits-all approach objectifies patients and gives the courts little room to restore any loss that does not come with a price tag. The cap does nothing but stop the most severely injured patients from receiving adequate compensation.¹⁶² It is patently unfair.

Some malpractice cases clearly call for damages that exceed \$250,000. At a forum hosted by Democratic members in 2003, Kathy Olsen described her son's injuries.¹⁶³ When Steve Olsen was two-years-old, he fell on a stick in the woods. His infection was severe enough that the Olsens asked for a CAT scan, but Steve's doctor administered a steroid injection and sent him home without further treatment. The next day, Steve returned to the hospital in a coma, permanently blind and brain damaged from a growing brain abscess. At trial, a jury concluded that the doctor had committed malpractice. Given the magnitude of the injury—Steve had no lost wages, but he would never play sports, work, or enjoy normal relationships with his peers—the jury awarded the Olsens \$7.1 million in "noneconomic" damages. Because the case was subject to California's medical malpractice cap, the judge was forced to reduce the award to \$250,000.

Mrs. Olsen testified: "California's malpractice law has failed innocent patients, consumers, and taxpayers. Under this law people are victimized twice, once by the wrongdoer and again by the laws that deny them the right to hold the wrongdoer accountable."¹⁶⁴ As to the cap on damages, Mrs. Olsen observed that the "law is regressive by hurting the most seriously injured victims, those who are permanently and catastrophically injured by medical negligence. . . . In California, and now proposed nationwide, no matter how old you are or how disabled you

¹⁶² A survey by the RAND Corporation found that the "most significant impact" of California's \$250,000 cap "falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes." ConsumerWatchDog.com, RAND Study: California Patients Killed or Maimed by Malpractice Lose Most Under Damage Caps, <http://www.consumerwatchdog.org/newsrelease/rand-study-california-patients-killed-or-maimed-malpractice-lose-most-under-damage-caps>.

¹⁶³ Democratic Forum on Malpractice, Feb. 11, 2003, Transcript at 60.

¹⁶⁴ *Id.* at 62.

become or how catastrophic your injuries are, there is a one size fits all limit on your pain and suffering.”¹⁶⁵

The \$250,000 cap is a particular burden on women, children, seniors, and the poor. Proportionally, these patients have more trouble demonstrating lost wages and other economic losses. Studies of medical malpractice cases show that women recover economic damages in lower amounts because they receive lower overall wages.¹⁶⁶ Women are three times more likely than men to receive noneconomic damages.¹⁶⁷ Women are far more likely to suffer severe noneconomic loss (e.g., loss of fertility or disfigurement) or to be a victim of the type of conduct that leads to punitive damages (e.g., sexual assault, fraud, false imprisonment, and extreme violation of medical standards).¹⁶⁸ With the cap on noneconomic damages in place, a woman without a salary is limited to \$250,000 to compensate for these injuries.

These effects are more than theoretical. After undergoing a double mastectomy, Linda McDougal was told that she had never had breast cancer—a pathologist had mixed up her charts with those of another patient.¹⁶⁹ Although she recovered \$8,000 in lost wages and \$48,000 in medical bills, her actual losses were profound:

My scars are not only physical, but emotional as well My disfigurement from medical negligence is almost entirely noneconomic I could never have predicted or imagined in my worst nightmare that I would end up having both of my breasts removed needlessly because of a medical error. No one plans on being a victim of medical malpractice, but it happened.¹⁷⁰

The cap on non-economic damages puts a price tag on the worst types of physical and psychological trauma. Under H.R. 5, Mrs. McDougal would be entitled to \$250,000 for her permanent disfigurement, nothing more.

On May 29, 2010, Connie Spears went to a San Antonio hospital reporting excruciating leg pain. Mrs. Spears had experienced blood clots before, so frequently and some so severe that doctors had installed a filter in one of her heart’s main veins. In the San Antonio emergency room, however, the doctor on call diagnosed Mrs. Spears with “bilateral leg pain” and told her to follow up with her primary care physician. Three days later, in immense pain and with her legs a

¹⁶⁵ *Id.*

¹⁶⁶ See Thomas Koenig & Michael Rustad, *His and Her Tort Reform: Gender Injustice in Disguise*, 70 WASH. L. REV. 1 (1995).

¹⁶⁷ *Id.* at 84.

¹⁶⁸ *Id.*

¹⁶⁹ Democratic Forum on Malpractice, February 11, 2003, Transcript at 48.

¹⁷⁰ *Id.* at 50-51.

burgundy color, Spears called 911 and was transported by ambulance to a different hospital. This time, doctors determined that the 54-year-old's vein filter was severely clotted and had led to tissue death in her legs and kidney failure. When Mrs. Spears regained consciousness weeks later, she learned that doctors had amputated both of her legs to save her life.¹⁷¹ “Do you know what it’s like not to have any legs?” Mrs. Spears asked tearfully, trembling as she lifted her dress to reveal the thick pink scars stretched like pillow seams across her thighs. ‘It’s ruined all of our lives.’”¹⁷² Under H.R. 5, Mrs. Spears would be limited to \$250,000 as compensation for the trauma of losing her legs.

The \$250,000 cap in H.R. 5 is pegged to the amount adopted by California in 1975, at a time when noneconomic damages rarely exceeded \$250,000. More than thirty years later, inflation has taken its toll.¹⁷³ Translated into 2011 dollars, the \$250,000 cap imposed in 1975 is worth about \$61,000 today. If adjusted to reflect inflation in medical care value, the cap would be worth almost \$2 million today.

Many states have adopted some form of cap on medical malpractice damages, but no state has capped damages in all “health care lawsuits,” as H.R. 5 defines the term.¹⁷⁴ H.R. 5 reaches all suits “concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce.”¹⁷⁵ The bill is an unprecedented experiment in limiting the rights of patients as they face insurance companies, HMOs, pharmaceutical and device manufacturers, and other entities that have nothing to do with traditional medical malpractice.

Because of the uncertain interaction between the bill’s definition of “economic damages” and existing state law, caps on noneconomic damages have a particularly harmful effect on children. In the 2011 markup, Rep. Debbie Wasserman Schultz offered an amendment to exempt minors from the \$250,000 cap on noneconomic damages. She reasoned: “the basis of the amendment is just common sense. Children don’t work. Like women and the elderly who tend to be in lower wage jobs, children are even more disproportionately impacted by these

¹⁷¹ Emily Ramshaw, *State’s Tort Reform Makes Lawyers Wary of Taking on Patients*, N.Y. TIMES, Dec. 19, 2010, at A39.

¹⁷² *Id.*

¹⁷³ See U.S. CONGRESSIONAL RESEARCH SERVICE, *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys on Tort Reform Proposals*, R41661 (March 28, 2011).

¹⁷⁴ *Id.*

¹⁷⁵ HEALTH Act, 112th Cong. § 7(7).

noneconomic damage.”¹⁷⁶ In response, supporters of H.R. 5 argued that “the reality is that the economic damages accrue to the parents, and the parents certainly have the right to sue on behalf of economic damages in a limitless capacity.”¹⁷⁷ Although the majority was unable to name a single malpractice case in which parents recovered economic damages on behalf of an injured child, they defeated the amendment along party lines.¹⁷⁸

H.R. 5 defines “economic damages” as “objectively verifiable monetary losses . . . such as past and future medical expense, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.”¹⁷⁹ On its face, this provision appears to be of limited use to children, who do not work, and the elderly, who may not have significant future earnings.

These limits on recovery have real consequences. In 2008, 17-year-old Olivia Cull was in the process of finishing her senior year at the Archer School for Girls, where she was an accomplished scholar, actress, and musician. She had been accepted early into Smith College and planned to major in Classical Studies and Ancient Arts and Languages. That year, Olivia underwent a routine cardiac catheterization to assess a congenital heart condition. The procedure was without incident, but later, while Olivia was still under general anesthesia, a cardiology fellow-in-training pulled the catheter lines and caused Olivia’s heart rate, pulse, and blood pressure to drop rapidly. Basic cardiopulmonary resuscitation was not started for more than ten minutes. Olivia suffered severe and extensive brain damage, never regained consciousness, and died on January 20, 2009.¹⁸⁰ It is difficult to put a price tag on the loss caused to Olivia’s parents, but it cannot be measured by “objectively verifiable monetary losses” and should not be capped at \$250,000.

B. The abolition of joint and several liability creates an unfair standard for the patient (Section 3(d)).

¹⁷⁶ *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee’s Oversight Plan*, 112th Cong., Feb. 16, 2011 (statement of Rep. Debbie Wasserman Schultz, member, H. Comm. on the Judiciary).

¹⁷⁷ *Id.* (statement of Rep. Trent Franks, member, H. Comm. on the Judiciary).

¹⁷⁸ Rep. Jackson-Lee offered these amendments again on April 17, 2012. They were again defeated on party lines. *Full Committee Markup of: Committee Print of Material to be Transmitted to the Committee on the Budget Pursuant to Section 201 of H. Con. Res. 112*, 112th Cong. April 17, 2012.

¹⁷⁹ HEALTH Act, 112th Cong. § 7(6).

¹⁸⁰ American Ass’n for Justice, *The Real Victims of H.R. 5* (Feb. 2011).

Joint and several liability has been part of American common law for centuries.¹⁸¹ The doctrine provides that all tortfeasors who are responsible for an injury are “jointly and severally” liable for the claimant’s damages. A patient can sue all responsible defendants and recover from each one in proportion to degree of fault, or sue any one defendant and recover the total amount of damages. A defendant who pays more than his or her share is then entitled, under the doctrine of contribution, to seek compensation from other responsible parties based on their degree of fault.¹⁸² The doctrine is designed to ensure that patients of wrongful conduct are able to fully recover damages for their injuries, especially when one or more of the defendants is insolvent.

H.R. 5 replaces this doctrine with its so-called “Fair Share” rule, which provides: “each party shall be liable for that party’s share of any damages only and not for the share of any other person A separate judgment shall be rendered against each party for the amount allocated to such party.”¹⁸³ In practice, H.R. 5 would require a patient to demonstrate each defendant’s proportional responsibility for an injury.

This burden is unfair. Plaintiffs would be required to bring a separate case against each defendant, “each requiring a finding of duty of care, a breach of that duty, proximate cause, finding damages, and a determination of what part of total damages are attributed to which malpractice. Each case requires an expert witness, depositions, and the full expense of complicated litigation.”¹⁸⁴ The rule is also unnecessary. As Rep. Scott argued in the 2011 markup: “Health care providers already can agree, in advance, how to apportion responsibility and they provide insurance and all pay premiums and set fees for services accordingly.”¹⁸⁵ Although H.R. 5 is based on California’s medical malpractice law, not even California eliminates joint and several liability for economic damages. The CBO notes that this particular proposal will actually increase the overall cost of health care.¹⁸⁶

Rather than engage in debate on the facts, supporters of H.R. 5 turned to a tired anecdote to support this provision:

¹⁸¹ See, e.g., Michael L. Rustad & Thomas H. Koenig, *Taming the Tort Monster: The American Civil Justice System As A Battleground of Social Theory*, 68 BROOK L. REV. 1 (Fall 2002); Matthew W. Light, *Who’s the Boss?: Statutory Damage Caps, Courts, and State Constitutional Law*, 58 WASH. & LEE L. REV. 315 (Winter, 2001).

¹⁸² RESTATEMENT (THIRD) OF TORTS § 23 (1999).

¹⁸³ HEALTH Act, 112th Cong. § 3(d).

¹⁸⁴ *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee’s Oversight Plan*, 112th Cong., Feb. 16, 2011 (statement of Rep. Robert Scott, member, H. Comm. on the Judiciary).

¹⁸⁵ *Id.*

¹⁸⁶ CBO letter, *supra* note 116. <http://www.cbo.gov/doc.cfm?index=10641>

Say a drug dealer staggers into an emergency room with a gunshot wound after a deal dealing drugs goes bad. The surgeon works on him, does the best he possibly can, but it is not perfect, and drug dealer sues him. The jury finds the drug dealer 99 percent responsible for his own injuries. But it also finds the hospital 1 percent responsible because the physician was fatigued after working too long. But today, the hospital can be made to pay 100 percent of the damages because the drug dealer is without means.¹⁸⁷

First, this story is borrowed from past debates. It has been used by the majority to defend this proposal nearly every time H.R. 5 has been considered by the committee.¹⁸⁸ Second, its premise is factually incorrect. All fifty states have adopted some form of contributory negligence or comparative negligence standard that bars plaintiffs from recovering for damages for which they are substantially responsible.¹⁸⁹ Even if the “drug dealer” could somehow bring a colorable malpractice claim against the “hospital,” he would not be entitled to recover damages if he were “99 percent” responsible. Third, it goes to show how little consideration has been given to the effect of preempting state law in all fifty states. Supporters of H.R. 5 appear to be unaware of how state law applies in instances of joint and several liability, let alone prepared for the unintended consequences of wiping out centuries of jurisprudence in the United States.

C. Punitive damages caps protect the most egregious instances of malpractice (Sections 5(a) and (b)).

The bill’s limits on punitive damages are problematic for two reasons. First, the heightened standard is practically impossible for patients to prove. Second, the \$250,000 cap is inadequate in cases extreme enough to warrant punitive damages.

Under H.R. 5, punitive damages are only available if a plaintiff can prove by “clear and convincing evidence” that a defendant “acted with malicious intent to injure the claimant” or “deliberately failed to avoid unnecessary injury” that he or she was “substantially certain” the

¹⁸⁷ *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee’s Oversight Plan*, 112th Cong., Feb. 16, 2011 (statement of Rep. Trent Franks, member, H. Comm. on the Judiciary).

¹⁸⁸ *See, e.g., Markup of Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2002*, 107th Cong. (statement of Rep. Bachus, member, H. Comm. on the Judiciary).

¹⁸⁹ *See, e.g., Board of County Comm’r of Garret County v. Bell Atlantic*, 695 A.2d 171 (Md. 1997) (outlining a standard of pure contributory negligence in Maryland); *Liv v. Yellow Cab*, 119 Cal. Rptr. 858 (1975) (outlining a standard of pure comparative fault in California); O.C.G.A. § 51-11-7 (codifying a 50 percent bar rule in Georgia); and Tex. Civ. Prac. & Rem. Code §§ 33.001-33.017 (codifying a 51 percent bar rule in Texas).

patient would suffer.¹⁹⁰ Because proving state of mind in this manner is virtually impossible, perpetrators of the most extreme forms of malpractice will now go unpunished.

Even if a patient is somehow able to show malicious intent, recovery of punitive damages is limited at \$250,000 or two times the amount of economic damages awarded.¹⁹¹ This cap eliminates much of the deterrent effect of punitive damages—\$250,000 for grossly negligent conduct would merely be the price of doing business for many hospitals, pharmaceutical manufacturers, insurance companies, and other wealthy health care providers. Worse, the cap applies in the most outrageous instances of medical malpractice, including cases involving drug abuse, alcohol abuse, and sexual assault.¹⁹² Under H.R. 5, the patients in this case—children, some as young as three months old, with no economic damages to prove—would be entitled seek no more than \$250,000 in punitive damages.

D. Shielding drug and device manufacturers from punitive damages places consumers at grave risk (Section 5(c)).

H.R. 5 provides blanket immunity from punitive damages to the manufacturers of drugs and devices that have been approved by the Federal Drug Administration.¹⁹³ This provision alone would be troubling enough. Simply because a product has been approved by the FDA does not mean that a company should be immunized from punitive liability when that product causes sever harm to a consumer. Medical devices cause approximately 53 deaths and more than 1,000 serious injuries every year, with a cost of more than \$26 billion annually.¹⁹⁴ Government safety standards, at their best, establish only a minimum level of protection for the public. At their worst, they are outdated, under-protective, and under-enforced.

Moreover, the bill completely insulates manufacturers and distributors of drugs and devices from defects arising during the manufacturing process, which occurs *after* the FDA has given its approval of the device. This means that a drug company distributing an FDA-approved product that is manufactured in a flawed manner and harms consumers would be insulated from punitive damages, even if the flawed manufacture was intentional or reckless.

¹⁹⁰ HEALTH Act, 112th Cong. § 5(a).

¹⁹¹ *Id.* § 5(b)(2).

¹⁹² Public Citizen found that “47.7% of doctors [found to have been disciplined for sexual abuse or misconduct by a disciplinary board] were allowed to continue practicing, their behavior probably unknown to most if not all of their patients.” SIDNEY WOLFE ET AL., 20,125 QUESTIONABLE DOCTORS (2000).

¹⁹³ HEALTH Act, 112th Cong. § 5(c)(1)(A)(i).

¹⁹⁴ See Robert Cohen & J. Scott Orr, *Faulty Medical Implants Enter Market Through Flawed System*, NEWHOUSE NEWS SERVICE, 2002.

H.R. 5 goes even further, extending this immunity to manufacturers and distributors of drugs and devices that are “generally recognized among qualified experts as safe and effective,” whether or not FDA approval has been sought.¹⁹⁵ In these cases, so long as a defendant can find an expert witness to vouch for its product, federal safety standards are sidestepped altogether. Unless the defendant company has withheld or misrepresented information from the FDA or attempted to bribe an FDA official,¹⁹⁶ punitive damages are not available, no matter how flagrant the harm.

E. Limits on contingency fees deny patients access to the justice system.

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.¹⁹⁷ Because contingency fee agreements require little or no money up front, injured plaintiffs who could not otherwise afford legal representation have access to counsel. And 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.¹⁹⁸ Lawyers will not incur the risk of taking a contingency fee case with little merit.

In an unusual position for the traditionally free-market majority, supporters of H.R. 5 prefer that state and federal courts to step into attorney-client agreements and “supervise the arrangements for payment of damages.”¹⁹⁹ The bill requires that all contingency fee arrangements adhere to a specific formula: “(1) Forty percent of the first \$500,000 recovered by the claimant(s). (2) Thirty-three percent and one-third percent of the next \$500,000 recovered by the claimant(s). (3) Twenty-five percent of the next \$500,000 recovered by the claimant(s). (4) Fifteen percent of the next \$500,000 recovered by the claimant.”²⁰⁰

This provision purports to limit conflict of interest “in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome,”²⁰¹ but the contingency fees formula will have the effect of making it more difficult for poor patients to secure legal

¹⁹⁵ HEALTH Act, 112th Cong. § 7(c)(1)(A)(ii).

¹⁹⁶ *Id.* § 7(c)(4).

¹⁹⁷ See Herbert M. Kritzer, *Lawyer Fees and Lawyer Behavior in Litigation: What does the Empirical Literature Really Say?*, 80 TEX. L. REV. 1943 (2002); and Herbert M. Kritzer, *Economic Policy Litigation Conference Seven Dogged Myths Concerning Contingency Fees*, 80 WASH. U. L.Q. 739 (Fall 2002).

¹⁹⁸ *Id.*

¹⁹⁹ HEALTH Act, 112th Cong. § 4.

²⁰⁰ *Id.*

²⁰¹ *Id.*

representation in medical malpractice cases. Although the stated purpose of this bill is curb the costs of lawsuits and lower insurance premiums, contingency fees do not change the size of a jury award or an insurance company's obligation to pay damages on behalf of a health care provider. Moreover, the one-sided formula does nothing to limit conflicts of interest on the other side of the case. Defense counsels are paid by the hour and have direct financial incentive to engage in unnecessary litigation and drive up costs. The bill's stated concern about legal ethics notwithstanding, this proposal is a naked attempt to prevent plaintiffs from accessing the courts.

F. Periodic payments shift the risks of bankruptcy to individual patients.

If H.R. 5 passes, courts will no longer have discretion in structuring payment of damages over time. At the request of a defendant found to have committed malpractice, “the court *shall* . . . enter a judgment ordering that future damages be paid by periodic payments.”²⁰² As with the other defendant-friendly provisions of this bill, this requirement harms patients and protects proven bad actors.

Periodic payment plans allow a negligent party to stall while the patient assumes the risk. The defendant (or the defendant's insurance company) can invest and earn interest on 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. There may be instances where a court, in its discretion, finds good reason to structure payment of damages over time. H.R. 5 removes that discretion, however, and the one-sidedness of this provision is unjustifiable.

G. A strict statute of limitations denies patients a chance to be heard in court.

H.R. 5 requires that a health care lawsuit commence “3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.”²⁰³ The bill provides an oddly limited exception for minors under the age of six.²⁰⁴

In most cases, this three-year statute of limitations is, in effect, a one-year statute of limitations in disguise. Because most patients will discover an injury when it manifests itself, the one-year statute of limitations will begin to run immediately. In other cases, the three-year statute of limitations alone cuts off patients from bringing legitimate claims—particularly in cases that involve diseases with long latency periods. For example, a child infected with HIV

²⁰² *Id.* § 6(a) (emphasis added).

²⁰³ *Id.* § 2.

²⁰⁴ “Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of six years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday.” *Id.*

from a tainted blood infusion may manifest symptoms long before a diagnosis is sought. If the child is at least six and more than three years have passed since the symptoms first began to manifest, H.R. 5 cuts off all legal recourse. These patients deserve their day in court.

CONCLUSION

Collectively, the “reforms” proposed by H.R. 5 would limit a patient’s ability to recover compensation for damages caused by medical negligence, defective products, and irresponsible insurance practices. In addition to raising core issues of fairness, H.R. 5 preempts the law in all fifty states, with little regard for the consequences. This legislation was designed more than twenty years ago to resolve an insurance “crisis,” but all available evidence shows that the insurance market is not in crisis today. H.R. 5 does not make insurance more available, does not cut spending to any appreciable degree, and does not address issues of access to justice or patient safety. Because H.R. 5 solves few problems facing Americans and exacerbates many real ones, we believe that Congress should reject this bill.

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APRIL 12, 2012

JUDICIARY COMMITTEE PRINT 112-6
PROPOSED RECONCILIATION SUBMISSION TO THE
COMMITTEE ON THE BUDGET

1 **SECTION 1. SHORT TITLE.**

2 This matter may be cited as the “Help Efficient, Ac-
3 cessible, Low-cost, Timely Healthcare (HEALTH) Act of
4 2011”.

5 **SEC. 2. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

6 The time for the commencement of a health care law-
7 suit shall be 3 years after the date of manifestation of
8 injury or 1 year after the claimant discovers, or through
9 the use of reasonable diligence should have discovered, the
10 injury, whichever occurs first. In no event shall the time
11 for commencement of a health care lawsuit exceed 3 years
12 after the date of manifestation of injury unless tolled for
13 any of the following—

14 (1) upon proof of fraud;

15 (2) intentional concealment; or

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

19 Actions by a minor shall be commenced within 3 years
20 from the date of the alleged manifestation of injury except

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

9 **SEC. 3. COMPENSATING PATIENT INJURY.**

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

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

21 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC
22 DAMAGES.—For purposes of applying the limitation in
23 subsection (b), future noneconomic damages shall not be
24 discounted to present value. The jury shall not be in-
25 formed about the maximum award for noneconomic dam-

1 ages. An award for noneconomic damages in excess of
2 \$250,000 shall be reduced either before the entry of judg-
3 ment, or by amendment of the judgment after entry of
4 judgment, and such reduction shall be made before ac-
5 counting for any other reduction in damages required by
6 law. If separate awards are rendered for past and future
7 noneconomic damages and the combined awards exceed
8 \$250,000, the future noneconomic damages shall be re-
9 duced first.

10 (d) FAIR SHARE RULE.—In any health care lawsuit,
11 each party shall be liable for that party's several share
12 of any damages only and not for the share of any other
13 person. Each party shall be liable only for the amount of
14 damages allocated to such party in direct proportion to
15 such party's percentage of responsibility. Whenever a
16 judgment of liability is rendered as to any party, a sepa-
17 rate judgment shall be rendered against each such party
18 for the amount allocated to such party. For purposes of
19 this section, the trier of fact shall determine the propor-
20 tion of responsibility of each party for the claimant's
21 harm.

22 **SEC. 4. MAXIMIZING PATIENT RECOVERY.**

23 (a) COURT SUPERVISION OF SHARE OF DAMAGES
24 ACTUALLY PAID TO CLAIMANTS.—In any health care law-
25 suit, the court shall supervise the arrangements for pay-

1 ment of damages to protect against conflicts of interest
2 that may have the effect of reducing the amount of dam-
3 ages awarded that are actually paid to claimants. In par-
4 ticular, in any health care lawsuit in which the attorney
5 for a party claims a financial stake in the outcome by vir-
6 tue of a contingent fee, the court shall have the power
7 to restrict the payment of a claimant's damage recovery
8 to such attorney, and to redirect such damages to the
9 claimant based upon the interests of justice and principles
10 of equity. In no event shall the total of all contingent fees
11 for representing all claimants in a health care lawsuit ex-
12 ceed the following limits:

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

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

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

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

21 (b) **APPLICABILITY.**—The limitations in this section
22 shall apply whether the recovery is by judgment, settle-
23 ment, mediation, arbitration, or any other form of alter-
24 native dispute resolution. In a health care lawsuit involv-
25 ing a minor or incompetent person, a court retains the

1 authority to authorize or approve a fee that is less than
2 the maximum permitted under this section. The require-
3 ment for court supervision in the first two sentences of
4 subsection (a) applies only in civil actions.

5 **SEC. 5. PUNITIVE DAMAGES.**

6 (a) IN GENERAL.—Punitive damages may, if other-
7 wise permitted by applicable State or Federal law, be
8 awarded against any person in a health care lawsuit only
9 if it is proven by clear and convincing evidence that such
10 person acted with malicious intent to injure the claimant,
11 or that such person deliberately failed to avoid unneces-
12 sary injury that such person knew the claimant was sub-
13 stantially certain to suffer. In any health care lawsuit
14 where no judgment for compensatory damages is rendered
15 against such person, no punitive damages may be awarded
16 with respect to the claim in such lawsuit. No demand for
17 punitive damages shall be included in a health care lawsuit
18 as initially filed. A court may allow a claimant to file an
19 amended pleading for punitive damages only upon a mo-
20 tion by the claimant and after a finding by the court, upon
21 review of supporting and opposing affidavits or after a
22 hearing, after weighing the evidence, that the claimant has
23 established by a substantial probability that the claimant
24 will prevail on the claim for punitive damages. At the re-

1 quest of any party in a health care lawsuit, the trier of
2 fact shall consider in a separate proceeding—

3 (1) whether punitive damages are to be award-
4 ed and the amount of such award; and

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

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

12 (b) DETERMINING AMOUNT OF PUNITIVE DAM-
13 AGES.—

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

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

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

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

24 (D) the number of products sold or med-
25 ical procedures rendered for compensation, as

1 the case may be, by such party, of the kind
2 causing the harm complained of by the claim-
3 ant;

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

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

10 (2) MAXIMUM AWARD.—The amount of punitive
11 damages, if awarded, in a health care lawsuit may
12 be as much as \$250,000 or as much as two times
13 the amount of economic damages awarded, which-
14 ever is greater. The jury shall not be informed of
15 this limitation.

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

18 (1) IN GENERAL.—

19 (A) No punitive damages may be awarded
20 against the manufacturer or distributor of a
21 medical product, or a supplier of any compo-
22 nent or raw material of such medical product,
23 based on a claim that such product caused the
24 claimant's harm where—

1 (i)(I) such medical product was sub-
2 ject to premarket approval, clearance, or li-
3 censure by the Food and Drug Administra-
4 tion with respect to the safety of the for-
5 mulation or performance of the aspect of
6 such medical product which caused the
7 claimant's harm or the adequacy of the
8 packaging or labeling of such medical
9 product; and

10 (II) such medical product was so ap-
11 proved, cleared, or licensed; or

12 (ii) such medical product is generally
13 recognized among qualified experts as safe
14 and effective pursuant to conditions estab-
15 lished by the Food and Drug Administra-
16 tion and applicable Food and Drug Admin-
17 istration regulations, including without
18 limitation those related to packaging and
19 labeling, unless the Food and Drug Admin-
20 istration has determined that such medical
21 product was not manufactured or distrib-
22 uted in substantial compliance with appli-
23 cable Food and Drug Administration stat-
24 utes and regulations.

1 (B) RULE OF CONSTRUCTION.—Subpara-
2 graph (A) may not be construed as establishing
3 the obligation of the Food and Drug Adminis-
4 tration to demonstrate affirmatively that a
5 manufacturer, distributor, or supplier referred
6 to in such subparagraph meets any of the con-
7 ditions described in such subparagraph.

8 (2) LIABILITY OF HEALTH CARE PROVIDERS.—
9 A health care provider who prescribes, or who dis-
10 penses pursuant to a prescription, a medical product
11 approved, licensed, or cleared by the Food and Drug
12 Administration shall not be named as a party to a
13 product liability lawsuit involving such product and
14 shall not be liable to a claimant in a class action
15 lawsuit against the manufacturer, distributor, or
16 seller of such product. Nothing in this paragraph
17 prevents a court from consolidating cases involving
18 health care providers and cases involving products li-
19 ability claims against the manufacturer, distributor,
20 or product seller of such medical product.

21 (3) PACKAGING.—In a health care lawsuit for
22 harm which is alleged to relate to the adequacy of
23 the packaging or labeling of a drug which is required
24 to have tamper-resistant packaging under regula-
25 tions of the Secretary of Health and Human Serv-

1 ices (including labeling regulations related to such
2 packaging), the manufacturer or product seller of
3 the drug shall not be held liable for punitive dam-
4 ages unless such packaging or labeling is found by
5 the trier of fact by clear and convincing evidence to
6 be substantially out of compliance with such regula-
7 tions.

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

10 (A) a person, before or after premarket ap-
11 proval, clearance, or licensure of such medical
12 product, knowingly misrepresented to or with-
13 held from the Food and Drug Administration
14 information that is required to be submitted
15 under the Federal Food, Drug, and Cosmetic
16 Act (21 U.S.C. 301 et seq.) or section 351 of
17 the Public Health Service Act (42 U.S.C. 262)
18 that is material and is causally related to the
19 harm which the claimant allegedly suffered

20 (B) a person made an illegal payment to
21 an official of the Food and Drug Administra-
22 tion for the purpose of either securing or main-
23 taining approval, clearance, or licensure of such
24 medical product; or

1 (C) the defendant caused the medical prod-
2 uct which caused the claimant's harm to be
3 misbranded or adulterated (as such terms are
4 used in chapter V of the Federal Food, Drug,
5 and Cosmetic Act (21 U.S.C 351 et seq.)).

6 **SEC. 6. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**
7 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**
8 **SUITS.**

9 (a) IN GENERAL.—In any health care lawsuit, if an
10 award of future damages, without reduction to present
11 value, equaling or exceeding \$50,000 is made against a
12 party with sufficient insurance or other assets to fund a
13 periodic payment of such a judgment, the court shall, at
14 the request of any party, enter a judgment ordering that
15 the future damages be paid by periodic payments, in ac-
16 cordance with the Uniform Periodic Payment of Judg-
17 ments Act promulgated by the National Conference of
18 Commissioners on Uniform State Laws.

19 (b) APPLICABILITY.—This section applies to all ac-
20 tions which have not been first set for trial or retrial be-
21 fore the effective date of this Act.

22 **SEC. 7. DEFINITIONS.**

23 In this Act:

24 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
25 TEM; ADR.—The term “alternative dispute resolution

1 system” or “ADR” means a system that provides
2 for the resolution of health care lawsuits in a man-
3 ner other than through a civil action brought in a
4 State or Federal court.

5 (2) CLAIMANT.—The term “claimant” means
6 any person who brings a health care lawsuit, includ-
7 ing a person who asserts or claims a right to legal
8 or equitable contribution, indemnity, or subrogation,
9 arising out of a health care liability claim or action,
10 and any person on whose behalf such a claim is as-
11 serted or such an action is brought, whether de-
12 ceased, incompetent, or a minor.

13 (3) COMPENSATORY DAMAGES.—The term
14 “compensatory damages” means objectively
15 verifiable monetary losses incurred as a result of the
16 provision of, use of, or payment for (or failure to
17 provide, use, or pay for) health care services or med-
18 ical products, such as past and future medical ex-
19 penses, loss of past and future earnings, cost of ob-
20 taining domestic services, loss of employment, and
21 loss of business or employment opportunities, dam-
22 ages for physical and emotional pain, suffering, in-
23 convenience, physical impairment, mental anguish,
24 disfigurement, loss of enjoyment of life, loss of soci-
25 ety and companionship, loss of consortium (other

1 than loss of domestic service), hedonic damages, in-
2 jury to reputation, and all other nonpecuniary losses
3 of any kind or nature. The term “compensatory
4 damages” includes economic damages and non-
5 economic damages, as such terms are defined in this
6 section.

7 (4) CONTINGENT FEE.—The term “contingent
8 fee” includes all compensation to any person or per-
9 sons which is payable only if a recovery is effected
10 on behalf of one or more claimants.

11 (5) ECONOMIC DAMAGES.—The term “economic
12 damages” means objectively verifiable monetary
13 losses incurred as a result of the provision of, use
14 of, or payment for (or failure to provide, use, or pay
15 for) health care services or medical products, such as
16 past and future medical expenses, loss of past and
17 future earnings, cost of obtaining domestic services,
18 loss of employment, and loss of business or employ-
19 ment opportunities.

20 (6) HEALTH CARE LAWSUIT.—The term
21 “health care lawsuit” means any health care liability
22 claim concerning the provision of health care goods
23 or services or any medical product affecting inter-
24 state commerce, or any health care liability action
25 concerning the provision of health care goods or

1 services or any medical product affecting interstate
2 commerce, brought in a State or Federal court or
3 pursuant to an alternative dispute resolution system,
4 against a health care provider, a health care organi-
5 zation, or the manufacturer, distributor, supplier,
6 marketer, promoter, or seller of a medical product,
7 regardless of the theory of liability on which the
8 claim is based, or the number of claimants, plain-
9 tiffs, defendants, or other parties, or the number of
10 claims or causes of action, in which the claimant al-
11 leges a health care liability claim. Such term does
12 not include a claim or action which is based on
13 criminal liability; which seeks civil fines or penalties
14 paid to Federal, State, or local government; or which
15 is grounded in antitrust.

16 (7) HEALTH CARE LIABILITY ACTION.—The
17 term “health care liability action” means a civil ac-
18 tion brought in a State or Federal court or pursuant
19 to an alternative dispute resolution system, against
20 a health care provider, a health care organization, or
21 the manufacturer, distributor, supplier, marketer,
22 promoter, or seller of a medical product, regardless
23 of the theory of liability on which the claim is based,
24 or the number of plaintiffs, defendants, or other par-

1 ties, or the number of causes of action, in which the
2 claimant alleges a health care liability claim.

3 (8) HEALTH CARE LIABILITY CLAIM.—The
4 term “health care liability claim” means a demand
5 by any person, whether or not pursuant to ADR,
6 against a health care provider, health care organiza-
7 tion, or the manufacturer, distributor, supplier, mar-
8 keter, promoter, or seller of a medical product, in-
9 cluding, but not limited to, third-party claims, cross-
10 claims, counter-claims, or contribution claims, which
11 are based upon the provision of, use of, or payment
12 for (or the failure to provide, use, or pay for) health
13 care services or medical products, regardless of the
14 theory of liability on which the claim is based, or the
15 number of plaintiffs, defendants, or other parties, or
16 the number of causes of action.

17 (9) HEALTH CARE ORGANIZATION.—The term
18 “health care organization” means any person or en-
19 tity which is obligated to provide or pay for health
20 benefits under any health plan, including any person
21 or entity acting under a contract or arrangement
22 with a health care organization to provide or admin-
23 ister any health benefit.

24 (10) HEALTH CARE PROVIDER.—The term
25 “health care provider” means any person or entity

1 required by State or Federal laws or regulations to
2 be licensed, registered, or certified to provide health
3 care services, and being either so licensed, reg-
4 istered, or certified, or exempted from such require-
5 ment by other statute or regulation.

6 (11) HEALTH CARE GOODS OR SERVICES.—The
7 term “health care goods or services” means any
8 goods or services provided by a health care organiza-
9 tion, provider, or by any individual working under
10 the supervision of a health care provider, that relates
11 to the diagnosis, prevention, or treatment of any
12 human disease or impairment, or the assessment or
13 care of the health of human beings.

14 (12) MALICIOUS INTENT TO INJURE.—The
15 term “malicious intent to injure” means inten-
16 tionally causing or attempting to cause physical in-
17 jury other than providing health care goods or serv-
18 ices.

19 (13) MEDICAL PRODUCT.—The term “medical
20 product” means a drug, device, or biological product
21 intended for humans, and the terms “drug”, “de-
22 vice”, and “biological product” have the meanings
23 given such terms in sections 201(g)(1) and 201(h)
24 of the Federal Food, Drug and Cosmetic Act (21
25 U.S.C. 321(g)(1) and (h)) and section 351(a) of the

1 Public Health Service Act (42 U.S.C. 262(a)), re-
2 spectively, including any component or raw material
3 used therein, but excluding health care services.

4 (14) NONECONOMIC DAMAGES.—The term
5 “noneconomic damages” means damages for phys-
6 ical and emotional pain, suffering, inconvenience,
7 physical impairment, mental anguish, disfigurement,
8 loss of enjoyment of life, loss of society and compan-
9 ionship, loss of consortium (other than loss of do-
10 mestic service), hedonic damages, injury to reputa-
11 tion, and all other nonpecuniary losses of any kind
12 or nature.

13 (15) PUNITIVE DAMAGES.—The term “punitive
14 damages” means damages awarded, for the purpose
15 of punishment or deterrence, and not solely for com-
16 pensatory purposes, against a health care provider,
17 health care organization, or a manufacturer, dis-
18 tributor, or supplier of a medical product. Punitive
19 damages are neither economic nor noneconomic
20 damages.

21 (16) RECOVERY.—The term “recovery” means
22 the net sum recovered after deducting any disburse-
23 ments or costs incurred in connection with prosecu-
24 tion or settlement of the claim, including all costs
25 paid or advanced by any person. Costs of health care

1 incurred by the plaintiff and the attorneys' office
2 overhead costs or charges for legal services are not
3 deductible disbursements or costs for such purpose.

4 (17) STATE.—The term “State” means each of
5 the several States, the District of Columbia, the
6 Commonwealth of Puerto Rico, the Virgin Islands,
7 Guam, American Samoa, the Northern Mariana Is-
8 lands, the Trust Territory of the Pacific Islands, and
9 any other territory or possession of the United
10 States, or any political subdivision thereof.

11 **SEC. 8. EFFECT ON OTHER LAWS.**

12 (a) VACCINE INJURY.—

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

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

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

22 (2) If there is an aspect of a civil action
23 brought for a vaccine-related injury or death to
24 which a Federal rule of law under title XXI of the
25 Public Health Service Act does not apply, then this

1 Act or otherwise applicable law (as determined
2 under this Act) will apply to such aspect of such ac-
3 tion.

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

8 **SEC. 9. STATE FLEXIBILITY AND PROTECTION OF STATES'**
9 **RIGHTS.**

10 (a) HEALTH CARE LAWSUITS.—The provisions gov-
11 erning health care lawsuits set forth in this Act preempt,
12 subject to subsections (b) and (c), State law to the extent
13 that State law prevents the application of any provisions
14 of law established by or under this Act. The provisions
15 governing health care lawsuits set forth in this Act super-
16 sede chapter 171 of title 28, United States Code, to the
17 extent that such chapter—

18 (1) provides for a greater amount of damages
19 or contingent fees, a longer period in which a health
20 care lawsuit may be commenced, or a reduced appli-
21 cability or scope of periodic payment of future dam-
22 ages, than provided in this Act; or

23 (2) prohibits the introduction of evidence re-
24 garding collateral source benefits, or mandates or

1 permits subrogation or a lien on collateral source
2 benefits.

3 (b) PROTECTION OF STATES' RIGHTS AND OTHER
4 LAWS.—(1) Any issue that is not governed by any provi-
5 sion of law established by or under this Act (including
6 State standards of negligence) shall be governed by other-
7 wise applicable State or Federal law.

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

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

15 (1) any State law (whether effective before, on,
16 or after the date of the enactment of this Act) that
17 specifies a particular monetary amount of compen-
18 satory or punitive damages (or the total amount of
19 damages) that may be awarded in a health care law-
20 suit, regardless of whether such monetary amount is
21 greater or lesser than is provided for under this Act,
22 notwithstanding section 303(a); or

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

1 **SEC. 10. APPLICABILITY; EFFECTIVE DATE.**

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





CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

April 26, 2012

Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2011

As approved by the House Committee on the Judiciary on April 25, 2012

SUMMARY

H. Con. Res. 112, the Concurrent Budget Resolution for fiscal year 2013, as passed by the House of Representatives on March 29, 2012, instructed several committees of the House to recommend legislative changes that would reduce deficits over the 2012-2022 period. As part of that reconciliation process, the House Committee on the Judiciary has approved legislation that 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.

In total, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation would not have any budgetary effect in fiscal year 2012, and would reduce deficits by \$0.1 billion over the 2012-2013 period, \$13.6 billion over the 2012-2017 period, and \$48.6 billion over the 2012-2022 period. (About \$1.9 billion of that \$48.6 billion total would be off-budget because of effects on revenues from Social Security payroll taxes).

CBO expects that those changes 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 private health insurance premiums.

Because employers would pay less for health insurance for employees, more of their employees' compensation would be in the form of taxable wages and other fringe benefits. As discussed below, the bill would also increase revenues because it would result in lower subsidies for health insurance. In total, CBO and JCT estimate that enacting the legislation would increase federal revenues by about \$7 billion over the 2012-2022 period.

Enacting the legislation also would reduce direct spending for Medicare, Medicaid, the government's share of premiums for annuitants under the Federal Employees Health Benefits (FEHB) program, subsidies for individuals enrolled in health insurance through health insurance exchanges, and other federal health benefits programs. CBO and JCT estimate that direct spending would decline by about \$41 billion over the 2012-2022 period.

Federal spending for active workers participating in the FEHB program is included in the appropriations for federal agencies, and is therefore discretionary. The legislation would also affect discretionary spending for health care services paid by the Departments of Defense (DoD) and Veterans Affairs (VA). CBO estimates that implementing the legislation would reduce discretionary costs by about \$1 billion over the 2012-2022 period, assuming appropriation actions consistent with the legislation.

The legislation contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would preempt state laws that provide less protection for health care providers and organizations from liability, loss, or damages (other than caps on awards for damages). CBO estimates the cost of complying with the mandate would be small and would fall well below the threshold established in UMRA for intergovernmental mandates (\$73 million in 2012, adjusted annually for inflation).

The legislation contains several mandates on the private sector, including caps on damages and on attorney fees, the statute of limitations, and the fair share rule. The cost of those mandates would exceed the threshold established in UMRA for private-sector mandates (\$146 million in 2012, adjusted annually for inflation) in four of the first five years in which the mandates were effective.

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 on or near October 1, 2012. 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											2012-	2012-
		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2017	2022
CHANGES IN DIRECT SPENDING														
Estimated Budget Authority	0	-100	-650	-2,250	-3,850	-4,850	-5,200	-5,500	-5,900	-6,300	-6,700	-11,700	-41,300	
Estimated Outlays	0	-100	-650	-2,250	-3,850	-4,850	-5,200	-5,500	-5,900	-6,300	-6,700	-11,700	-41,300	
CHANGES IN REVENUES														
Estimated Revenues														
On-budget	0	4	54	231	411	651	731	760	802	850	900	1,352	5,394	
Off-budget	0	4	29	93	167	231	255	266	280	295	310	524	1,929	
Total	0	8	83	324	578	882	985	1,026	1,082	1,145	1,210	1,875	7,323	
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND RECEIPTS														
Impact on the Deficit														
On-budget	0	-104	704	-2,481	-4,261	-5,501	-5,931	-6,260	-6,702	-7,150	-7,600	-13,052	-46,694	
Off-budget	0	-4	-29	-93	-167	-231	-255	-266	-280	-295	-310	-524	-1,929	
Total	0	-108	-733	-2,574	-4,428	-5,732	-6,185	-6,526	-6,982	-7,445	-7,910	-13,575	-48,623	
CHANGES IN SPENDING SUBJECT TO APPROPRIATION														
Estimated Authorization Level	0	0	-5	-40	-95	-140	-155	-165	-175	-180	-190	-280	-1,145	
Estimated Outlays	0	0	-5	-40	-95	-140	-155	-165	-175	-180	-190	-280	-1,145	

BASIS OF ESTIMATE

The legislation would establish:

- A three-year statute of limitations for medical malpractice claims, with certain exceptions, from the date of discovery of an injury;
- A cap of \$250,000 on awards for noneconomic damages;
- A cap on awards for punitive damages that would be the larger of \$250,000 or twice the economic damages, and restrictions on when punitive damages may be awarded;
- 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 punitive damages for products that meet applicable safety requirements established by the Food and Drug Administration.

Over the 2012-2022 period, CBO and the staff of the Joint Committee on Taxation estimate that enacting the legislation would reduce direct spending by about \$41 billion and increase federal revenues by about \$7 billion. The combined effect of those changes in direct spending and revenues would reduce federal deficits by almost \$49 billion over that period, with changes in off-budget revenues accounting for nearly \$2 billion of that reduction in deficits.

In addition, CBO estimates that implementing the legislation would reduce discretionary costs for the FEHB program, DoD, and VA by about \$1 billion over the 2012-2022 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 realized over a period of four years, as providers gradually change their practice patterns.

Revenues

CBO estimates that private health spending would be reduced by about 0.4 percent. Much of private-sector health care is paid for through employment-based insurance that represents nontaxable compensation. In addition, beginning in 2014, refundable tax credits will be available to certain individuals and families to subsidize health insurance purchased through new health insurance exchanges. (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

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.

purchased through an exchange. Those changes would increase federal tax revenues by an estimated \$7.3 billion over the 2012-2022 period, according to estimates by JCT. Social Security payroll taxes, which are off-budget, account for \$1.9 billion of that increase in revenues.

Direct Spending

CBO estimates that enacting the legislation would reduce direct spending for Medicare, Medicaid, the Children's Health Insurance Program, the Federal Employees Health Benefits program, the Defense Department's TRICARE for Life program, and subsidies for enrollees in health insurance exchanges. We estimate those reductions would total roughly \$41 billion over the 2012-2022 period.

For programs other than Parts A and B of Medicare, the estimate assumes that federal spending for acute care services would be reduced by about 0.4 percent, in line with the estimated reductions in the private sector.

CBO estimates that the reduction in federal spending for services covered under Parts A and B of Medicare would be larger—about 0.5 percent—than in the other programs or in national health spending in general. That estimate is based on empirical evidence showing that the impact of tort reform on the utilization of health care services is greater for Medicare than for the rest of the health care system.²

Spending Subject to Appropriation

CBO estimates that implementing the legislation would reduce federal costs for health insurance for federal employees covered through the FEHB program by about 0.4 percent—in line with the estimated reductions in the private sector—and would reduce costs for health insurance and health care services paid for by the Departments of Defense and Veterans Affairs by lesser amounts. CBO expects that the impact on those agencies would be proportionally smaller than the impact on overall health spending because medical malpractice costs are already lower than average for entities covered by the Federal Tort Claims Act. In CBO's estimation, the cost of health insurance and health care services funded through appropriation acts would be reduced by \$1.1 billion over the 2012-2022 period, assuming appropriation actions consistent with the legislation.

2. One possible explanation for that disparity is that the bulk of Medicare's spending is on a fee-for-service basis, whereas most private health care spending occurs through plans that manage care to some degree. Such plans limit the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as "defensive" medicine), thus leaving less potential for savings from the reduction of utilization in those plans than in fee-for-service systems.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The legislation contains an intergovernmental mandate as defined in UMRA because it would preempt state laws that provide less protection for health care providers and organizations from liability, loss, or damages (other than caps on awards for damages). CBO estimates the cost of complying with the mandate would be small and would fall well below the threshold established in UMRA for intergovernmental mandates (\$73 million in 2012, adjusted annually for inflation).

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The legislation contains several mandates on the private sector, including caps on damages and on attorney fees, the statute of limitations, and the fair share rule.³ The cost of those mandates would exceed the threshold established in UMRA for private-sector mandates (\$146 million in 2012, adjusted annually for inflation) in four of the first five years in which the mandates were effective.

PREVIOUS CBO ESTIMATE

On March 19, 2012, CBO transmitted a cost estimate for H.R. 5 as posted on the Web site of the House Committee on Rules on March 12, 2012. Title I of that bill was very similar to the reconciliation legislation, and CBO's cost estimates for this legislation and for title I of H.R. 5 are identical.

ESTIMATE PREPARED BY:

Federal Costs: Tom Bradley and Kirstin Nelson
Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum
Impact on the Private Sector: Stuart Hagen

ESTIMATE APPROVED BY:

Holly Harvey
Deputy Assistant Director for Budget Analysis

3. Under the fair share rule, 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.



CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

April 26, 2012

Honorable Lamar Smith
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2011.

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

Sincerely,

A handwritten signature in cursive script that reads "Douglas W. Elmendorf".

Douglas W. Elmendorf

Enclosure

cc: Honorable John Conyers Jr.
Ranking Member

Dissenting Views to Accompany the Committee Print of Material to be Transmitted to the
Committee on the Budget Pursuant to Section 201 of H. Con. Res. 112

Shulayev

Joel Peltz

Frank Johnson

Steve Cohen

Philip Jackson

Mike Ainsworth

Joseph Miller

BWSST

Harold P. Green

Melvin L. Watt

Red Deutch

Raymond Waters