Van Hollen
Velázquez
Waters
Watson
Watt
Waxman
Weiner
Woolsey

NOT VOTING—8

Aderholt
DeMint
Obey
Radanovich
Reyes
Scott (GA)
Tauzin
Wexler

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 1555

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

RECOGNIZING CONTRIBUTIONS OF PEOPLE OF INDIAN ORIGIN TO UNITED STATES AND BENEFITS OF WORKING TOGETHER WITH INDIA

The SPEAKER pro tempore. The unfinished business is the question of suspending the rules and agreeing to the concurrent resolution, H. Con. Res. 352.

The clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Nebraska (Mr. BEREUTER) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 352, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 415, nays 2, answered ''present'' 2, not voting 14, as follows:

[Roll No. 164]

YEAS—415

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chandler
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Ferguson
Filner
Flake
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gephardt
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—2

Johnson, Sam
Paul

ANSWERED ''PRESENT''—2

DeFazio
Sanders

NOT VOTING—14

Buyer
Cubin
DeMint
Duncan
Feeney
Istook
Kennedy (RI)
Miller, George
Rangel
Reyes
Roybal-Allard
Scott (GA)
Tauzin
Weller

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 1606

So (two-thirds having voted in favor thereof) the rules were suspended and the concurrent resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. MCCRERY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and to include extraneous material on the subject matter of H.R. 4279.

The SPEAKER pro tempore (Mr. LATHAM). Is there objection to the request of the gentleman from Louisiana?

There was no objection.

HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2004

Mr. SENSENBRENNER. Mr. Speaker, pursuant to House Resolution 638, I call up the bill (H.R. 4280) to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system, and ask for its immediate consideration.

The Clerk read the title of the bill.

The text of H.R. 4280 is as follows:

H.R. 4280

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2004''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—

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

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting

interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

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

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

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

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

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

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

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

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

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

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

SEC. 3. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

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

(1) upon proof of fraud;

(2) intentional concealment; or

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

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

SEC. 4. COMPENSATING PATIENT INJURY.

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

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

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

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

SEC. 5. MAXIMIZING PATIENT RECOVERY.

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

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

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

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

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

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

SEC. 6. ADDITIONAL HEALTH BENEFITS.

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

SEC. 7. PUNITIVE DAMAGES.

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

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

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

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

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

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

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

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

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

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

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

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

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

(1) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 9. DEFINITIONS.

In this Act:

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

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

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

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

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

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

(D) any other publicly or privately funded program.

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

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

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

(7) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

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

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

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

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

(12) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a

health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

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

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

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

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

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

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

SEC. 10. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

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

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

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

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

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

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

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

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

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

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this Act (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

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

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

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

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

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

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

SEC. 13. SENSE OF CONGRESS.

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

The SPEAKER pro tempore. Pursuant to House Resolution 638, the gentleman from Wisconsin (Mr. SENSENBRENNER) and the gentleman from Michigan (Mr. CONYERS) each will control 20 minutes; and the gentleman from Texas (Mr. BARTON) and the gentleman from Ohio (Mr. BROWN) each will control 10 minutes.

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

GENERAL LEAVE

Mr. SENSENBRENNER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to include extraneous material on H.R. 4280, currently under consideration.

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

There was no objection.

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

Mr. Speaker, the national medical insurance crisis, driven by unlimited lawsuits, is devastating our Nation's health care system to the detriment of patients everywhere. Medical professional liability insurance rates have soared, causing major insurers to either drop coverage or raise premiums to unaffordable levels. Doctors are being forced to abandon patients and practices or to retire early, particularly in high-risk specialties, such as emergency medicine, brain surgery, and obstetrics and gynecology. Women are particularly hard hit, as are low-income and rural neighborhoods.

H.R. 4280, the HEALTH Act, is modeled after California's highly successful health care litigation reforms enacted in 1975 and known under the acronym MICRA. California's reforms, which are included in the HEALTH Act, include reasonable limits on unquantifiable damages, limits on the contingency fees lawyers can charge, and authorization for defendants to introduce evidence to prevent double recoveries. The HEALTH Act also includes provisions creating a fair share rule, by which damages are allocated fairly in direct proportion to fault; reasonable guidelines on the award of punitive damages; and a safe harbor from punitive damages for products that meet applicable FDA safety requirements.

Information provided by the National Association of Insurance Commissioners shows that since 1975, premiums paid outside of California increased at five times the rate they increased in California. The Congressional Budget Office has concluded ''under the HEALTH Act, premiums for medical malpractice insurance ultimately would be an average of 25 percent to 35 percent below what they would be under current law.'' If California's legal reforms were implemented nationwide, we could spend billions of dollars more annually on patient care, meaning helping sick people get better.

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 that they have in the world. The Department of Health and Human Services issued a report recently that includes the following amazing statistics: during the past half century, death rates among children and adults up to age 24 were cut in half, and the infant mortality rate plummeted 75 percent. Mortality among adults between the ages of 25 and 64 fell nearly as much, and dropped among those 65 years and older by a third. In 2000, Americans enjoyed the longest life expectancy in our history, almost 77 years.

These amazing statistics just did not happen. There are faces behind the statistics, and they are our doctors. These statistics happen because America produces the best health care technology and the best doctors to use it. But now there are fewer and fewer doctors to use that miraculous technology or to use that technology where their patients are. We have the best brain scanning and best brain operation devices in history and fewer and fewer neurosurgeons to use them.

Unlimited lawsuits are driving doctors out of the healing profession. They are making us all less safe, all in the name of unlimited lawsuits and the personal injury lawyers' lust for their cut of unlimited awards for unquantifiable damages. But when someone gets sick or is bringing a child into the world, and we cannot call the doctor, who will we call? When you pick up the phone and call the hospital because someone you love has suffered a brain injury, and you are told, sorry, lawsuits made it too expensive for brain surgeons to practice here, who will save your loved one? You cannot call a lawyer. A lawyer cannot perform brain surgery.

We all need doctors. And we, as our Nation's representatives, have to choose, right here and today. Do we want the abstract ability to sue a doctor for unlimited, unquantifiable jackpot damage awards when doing so means that there will be no doctors to treat ourselves and our loved ones in the first place? Of course not. So on behalf of all 287 million Americans, all of whom are patients, let us pass this bill.

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

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

My colleagues, it is slightly incredible that with all the pressing legislative challenges facing us today, we have nothing better to do than redebate and revote the same tired medical malpractice proposals that have been brought forward by a conservative Congress over the last decade. This is the fifth time in 14 months that we have had this bill before the House of Representatives. Sooner or later somebody is going to get it, that this bill is not likely ever to go anywhere because it insults the commonsense health care needs of the American people.

Now, how can you put so many bad things in one bill? Let me explain how devious this thing can get. The bill before us would first supersede the law in every State in the Union, and these are states-righters over here, to cap noneconomic damages, to cap punitive damages, to cap attorneys' fees for those lawyers that would represent the poor, to reduce the statute of limitations, to eliminate joint and several liability and eliminate the collateral source rule. All in one bill. Six incredible things.

Embarrassed? No, I do not think they are. Rather than helping, when this Nation faces a national health care system crisis of growing proportions, instead of helping Americans that seek health care remedies and remedies for bad medical practice, and to help the medical profession itself, the bill before us does none of that; but it does enrich the insurance companies of America, the HMOs of this country, and the manufacturers and distributors of medical products, which sometimes are defective, as well as the pharmaceuticals that might be involved, too.

In other words, all the bad, unpleasant negative parts of our health care system are being protected. And who do we do it at the expense of? The innocent victims of medical malpractice, particularly women and children and the elderly poor.

I am embarrassed that this measure is on the floor for the sixth time in 14 months.

It's amazing to me that with all of the pressing problems facing us today, the Majority has nothing better to do than redebate and revote the same tired old medical malpractice proposals they have been pushing for the last ten years. In fact, this is the fifth time the Congress has voted on this bill in the past 14 months.

The bill before us today would supersede the law in all 50 states to cap non-economic damages, cap and limit punitive damages, cap attorney's fees for poor victims, shorten the statute of limitations, eliminate joint and several liability, and eliminate collateral source.

Rather than helping doctors and victims, the bill before us pads the pockets of insurance companies, HMOs, and the manufacturers and distributors of defective medical products and pharmaceuticals. And it does so at the expense of innocent victims, particularly women, children, the elderly and the poor.

We need to cut the charades and get to the heart of the problem. The insurance industry is a good place to start. We have seen in the past that the insurance industry goes through boom and bust cycles, with premiums ebbing and flowing as companies enter and exit the market and investment income rises and falls. We also know from past experience that the insurance industry—which is exempt from the antitrust laws—is not immune from collusion, price fixing and other anticompetitive problems.

It is also clear that the legislative solution largely focused on limiting victims rights available under our state tort system will do little other than increase the incidence of medical malpractice—already the third leading cause of preventable death in our nation. In other words, by limiting liability, we will increase incentives for misconduct.

Under this proposal, Congress would be saying to the American people that we don't care if you lose your ability to bear children, we don't care if you are forced to live in excruciating pain for the remainder of your life, and we don't care if you are permanently disfigured or crippled. The majority in this bill would limit recovery in tens of thousands of these cases, regardless of their merits.

The proposed new statue of limitations takes absolutely no account of the fact that many injuries caused by malpractice or faulty drugs take years or even decades to manifest themselves. Under the proposal, a patient who is negligently inflicted with HIV-infected blood and develops AIDS six years later would be forever barred from filing a liability claim.

The so-called periodic payment provisions are nothing less than a federal installment plan for HMO's. The bill would allow insurance companies teetering on the verge of bankruptcy to delay and then completely avoid future financial obligations. And they would have no obligation to pay interest on amounts they owe their victims.

And guess who else gets a sweetheart deal under this legislation? The drug companies. The producers of killer devices like the Dalkon Shield, the Cooper-7 IUD, high absorbency tampons linked to toxic shock syndrome, and silicone gel implants all would have completely avoided billions of dollars in damages had this bill been law.

Nearly 100,000 people die in this country each and every year from medical malpractice. At a time when 5 percent of the health care professionals cause 54 percent of all medical malpractice injuries, the last thing we need to do is exacerbate this problem while ignoring the true causes of the medical malpractice crisis in America. I urge my colleagues to reject this anti-patient, anti-victim legislation.

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

□ 1615

Mr. BARTON of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me say before I give my prepared statement that I too am embarrassed that this issue is on the floor for the sixth time in so many months because the other body is yet to do anything about it. It is past time that we should have passed this and the other body should have passed it, and we should have all attended a signing ceremony with the President of the United States so we can bring some medical malpractice reform to the health care providers of our country.

We are facing a crisis in this country, and I do not use that term lightly, that dramatically affects our efforts to improve access to high-quality, affordable health care. Doctors in at least 19 States are facing astronomical increases in their medical malpractice insurance premiums. They have had their premiums doubled, and in some cases tripled. A hostile liability environment has forced doctors to stop performing certain procedures. In my own congressional district, I know of doctors who have retired because they cannot afford the medical malpractice insurance to continue their practices.

This means as there are fewer doctors to provide health care, patients are going to be left with fewer treatment options. Fewer OB-GYNs means less preventive health care for women. It means less regular screenings for reproductive cancers, high blood pressure, infections and other health risks, and less preventive care means higher health care costs down the road.

As insurance premiums continue to skyrocket, doctors will look to cut back on or eliminate care for higher-risk patients such as the uninsured.

This will also affect how we recruit new doctors. Our country already has a difficult time providing access to high-quality health care in many underserved areas. We already lack a true health care marketplace where patients can shop freely for health care services and have a direct say about which doctor they will see. We do not need to make these problems worse, we need to fix them.

The bill before us would begin the effort to fix them. The medical liability crisis is driving doctors out of the practice of medicine. Even if you have health insurance, what is it worth if there is no doctor available to treat you? It is not right that our courts have become a legal lotto system rather than a fair system that judges meritorious claims.

We all agree if a patient is injured through malpractice or negligence, that patient should be compensated fairly for his injuries; but that is not happening today. Injured patients have to wait on average 5 years before a medical injury case is complete. Adding insult to injury, patients lose on average almost 60 percent of their compensation to attorneys and the courts.

Even though 60 percent of medical malpractice claims against doctors are dropped or dismissed, we all pay the price. According to HHS, the direct cost of malpractice insurance and the indirect cost from defensive medicine raises the Federal Government's health care share of the cost by at least $28 billion a year.

H.R. 4280 will help all Americans. It speeds recovery for injured patients who truly deserve compensation. It removes the perverse incentives in our current medical liability system that force doctors to look at patients as potential lawsuits. It will encourage employers to increase the scope of their health insurance benefits, and it will allow for greater investment in life-saving technologies which help make America's health care system the best in the world.

This legislation encompasses the best policy that can actually fix the medical malpractice crisis. It is high time for this legislation to become law.

Again, I share the concerns of the gentleman from Michigan (Mr. CONYERS) that we have had to vote on this a number of times on the House floor. The problem is not that the House is continuing to vote on it, the problem is that the other body will not bring it up for a vote. I hope that we can pass it today and get the other body to bring it up and we can go to a signing ceremony with the President of the United States.

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

Mr. CONYERS. Mr. Speaker, I ask unanimous consent to yield the balance of my time to the gentleman from Virginia (Mr. SCOTT) from the Committee on the Judiciary, and that he may control that time.

The SPEAKER pro tempore (Mr. SWEENEY). Is there objection to the request of the gentleman from Michigan?

There was no objection.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 30 seconds to the gentleman from Michigan (Mr. CONYERS), the ranking member of the Committee on the Judiciary.

Mr. CONYERS. Mr. Speaker, I appreciate the comments of the gentleman from Texas (Mr. BARTON), the chairman of the Committee on Energy and Commerce, who explains to us why this keeps coming up, and he refers charitably to the other body.

The other body for the last 10 years has been controlled by the gentleman's party. The last 10 years. The present head of the Senate is not only a Member of the gentleman's party, but he is a medical doctor.

I ask the gentleman, what could he and I do together to help the other body get the message here?

Mr. BARTON of Texas. Mr. Speaker, how much time remains for each side?

The SPEAKER pro tempore. The gentleman from Wisconsin (Mr. SENSENBRENNER) has 15 minutes remaining, the gentleman from Virginia (Mr. SCOTT) has 16 minutes remaining; the gentleman from Texas (Mr. BARTON) has 6 minutes remaining, and the gentleman from Ohio (Mr. BROWN) has 10 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. CONYERS) to engage in a colloquy.

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

Mr. BARTON of Texas. Mr. Speaker, will the gentleman yield?

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

Mr. BARTON of Texas. Mr. Speaker, I share the frustration that the gentleman has with the other body. If we could work together to get Members from the other body on both sides of the aisle to vote for cloture, and as the gentleman well knows, regardless of who controls the other body, it takes 60 votes to agree to limit debate, and a fair number of Members of the gentleman's party in the other body have failed to vote for cloture on this issue. I would be happy to work with the gentleman to work for cloture to bring the bill up.

Mr. CONYERS. I would be interested; and is the gentleman interested in the six points that I just raised that make this bill problematic? We cannot work together on two different bills.

Mr. BARTON of Texas. Mr. Speaker, if the gentleman would continue to yield, if we can at least let some bill come up for a vote, we can solve this in conference. The policy difference can be worked out in conference, but unless there is a conference with the other body, there is not going to be anything to work out.

Mr. CONYERS. Mr. Speaker, it is my experience in conferences the lights frequently go out and measures get substituted and all kinds of weird things go on. Let us do this in broad daylight, with everybody looking and listening. Conferences have not been the way the democratic process has been enhanced in my career in Congress, sir.

Mr. BARTON of Texas. Mr. Speaker, if the gentleman would continue to yield, the conference mechanism may not be as perfect as it should be, but it is a mechanism where policy differences can be worked on.

Mr. CONYERS. Mr. Speaker, could I recommend that the gentleman and I and my chairman, the gentleman from Wisconsin (Mr. SENSENBRENNER), perhaps we can enter into an informal colloquy with some of the leaders in the other body and see if we can end this constant repetition of what is going on here in the House today.

Mr. BARTON of Texas. Mr. Speaker, I am interested in doing that.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would remind Members to confine their remarks to factual references to the other body and avoid characterizations of Senate action or inaction, remarks urging Senate action or inaction, or references to particular Senators.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I share the consternation of the gentleman from Michigan (Mr. CONYERS). In this country we are facing problems in Iraq, yet this House does nothing. We are listening to seniors say please fix the Medicare discount card program bill; this House does nothing. We are hearing from people in my State of Ohio that we have lost 200 jobs every day in the Bush administration; we are doing nothing about that. We will not extend unemployment benefits or anything else. We are hearing people talk about drug prices being one-half and one-third in Canada what they are here; we are not doing anything about that. We have lost so much manufacturing in this country, 1 out of 7 manufacturing jobs has simply disappeared since George Bush took office.

Yet for the fifth time in 14 months, as the gentleman from Michigan said, we are debating a medical malpractice bill that does not do anything about medical malpractice. I support malpractice reform, as most Members of this body do, but I oppose this bill.

The Republicans lay the blame for rising medical malpractice premiums on the victims of medical malpractice. The bill does not have one provision acknowledging the insurance industry's accountability for skyrocketing premiums, not one provision to keep the insurance industry accountable.

Insurers have tripled their investment in the stock market over the past 10 years, now they are trying to recoup their losses from doctors and premiums from hospitals and other medical providers, and from patients. Insurers low-

balled their rates to attract new customers, and then they went overboard and depleted their reserves. That is not our fault, that is not the patients' fault or doctors' fault. Rates have to exceed costs to stabilize those reserves, and the recklessness on the part of insurers is clearly a factor in the recent rate spikes.

Democrats have repeatedly tried to negotiate with the Republican majority on this issue. We asked the majority to consider insurance reforms; they absolutely refused even to talk about it. We asked the majority to subpoena insurance company records so we really could understand and get to the bottom of the rate spikes and so we could be sure we were solving the real problems; the Republicans refused to even talk about it.

There were avenues we could take to stabilize medical malpractice premiums: reinsurance pools, rate bands, loss ratio requirements, reserve requirements, and improved transparency, but the insurance industry opposes these changes. The insurance industry gives a lot of money to President Bush and the Republican leadership, so the Republican leadership does not even consider these insurance company issues. This bill assumes the insurance industry's business decisions play no role in setting premiums. It is always the patient's fault.

In the Committee on Energy and Commerce and in the Subcommittee on Health, I had an amendment that said whatever money we save from the caps has to go towards lower premiums for doctors and hospitals. Because the insurance industry gives a lot of money to Republicans, it was voted down on behalf of the insurance industry on a party-line vote.

This bill is doomed to fail, even if it would become law, and the proof is in California. California has had damage caps since the 1970s. It now has the most stringent caps in the country; but caps alone did nothing. They were a colossal failure in California. Premiums for medical malpractice were higher than the national average. They were growing faster than the national average.

□ 1630

Eventually, California recognized its mistake and implemented a set of malpractice insurance reforms. Since then, premiums have moderated. But this bill does not emulate California's successes. It only imitates California's mistakes.

It is bad enough the bill ignores the failure of a cap-only approach. It takes another swipe at patients with a cap system that says the same injury causes more harm in dollar terms if it happens to a CEO than it does if it happens to his gardener. Like its predecessor, this bill contains provisions wholly unrelated to the medical malpractice issue. It says HMOs that deny patients needed medical care cannot be held accountable, yet HMOs continue to post robust profits, earning $6 billion in the first 9 months of 2003, a 52 percent increase over last year.

This bill says drug companies who sell medicine with toxic side effects are not responsible. Yet they are protecting the drug industry which has been the most profitable industry in America for 20 years running. And the bill says manufacturers of defective medical equipment get a free pass. They are doing all right, too.

In this bill, businesses are never at fault, patients are greedy, the U.S. Congress knows better than a jury of your peers in your community, and State laws are just cast aside without a second thought. If my friends in this body really wanted malpractice reform, if they really wanted to help doctors deal with these outrageous premiums they are paying, they would not use this bill to help their drug company contributors, they would not use this bill to help their insurance company contributors, they would not use this bill to help their HMO contributors. That is what this bill is all about.

At a time when the public is calling for greater corporate accountability, this bill turns on the public itself and says injured patients, not the system that is designed to protect them, are at fault. This is not reform. It is callous injustice.

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

Mr. SENSENBRENNER. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Tennessee (Mrs. BLACKBURN).

Mrs. BLACKBURN. Mr. Speaker, America's health care system is facing a malpractice abuse crisis. This single issue has driven up costs, it has increased the number of uninsured, and it has forced health providers out of our rural areas. Doctors are facing mounting costs. The sky-high noneconomic damage awards, which end up lining the pockets of the powerful trial lawyer lobby, are responsible for many of the elements that are plaguing this system.

Most of our medical liability claims, up to 70 percent, do not result in any payments to the patients. The lawyers' fees account for 40 percent or more of these multimillion-dollar payouts. The effect is clear. The lawsuits and the trial lawyers force this situation with enormous insurance rates. They then charge you and me and businesses across the country higher prices.

Employers can attest to what the high cost of health care is doing to them. They hurt when they cannot afford to offer coverage to their workers. Our rural communities understand this issue. The family doctor who grew up with them there in the town is disappearing. They are being squeezed out by this vicious cycle. This should be an easy vote. It is common sense, and it is going to help save rural health care and save lives.

Mr. BARTON of Texas. Mr. Speaker, I ask unanimous consent that the gentleman from Pennsylvania (Mr. GREENWOOD) control the balance of my time.

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

There was no objection.

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

Mr. WEXLER. Mr. Speaker, once again Republicans are attempting to pass ineffective anticonsumer legislation that caps medical malpractice awards at $250,000. The habitual Republican response to the malpractice crisis, punish the victims. This bill fails to reduce medical malpractice costs. In States that recently capped medical malpractice awards, the rates have not gone down as promised. In Florida, which capped rates last year, one insurer requested an inconceivable 45 percent increase in rates.

Mr. Speaker, why not look at the root cause of this health care emergency and adopt desperately needed insurance reform? I urge my colleagues to vote against this shortsighted measure and support real insurance reform which protects victims and provides relief to doctors and health care providers.

Mr. GREENWOOD. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. COX), the coauthor of this bill.

Mr. SENSENBRENNER. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. COX).

The SPEAKER pro tempore. The gentleman from California (Mr. COX) is recognized for 2 minutes.

Mr. COX. Mr. Speaker, this is Cover the Uninsured Week, organized by patients, physicians and hospitals to promote access to care to all Americans. They are calling on Congress to act. We are here to answer that call. We are here today because patients are losing. They are losing their access to care. Many have already lost it. The General Accounting Office has confirmed it. In at least 10 percent of these United States, sky-high medical liability costs are preventing patients from getting emergency surgery. They are preventing expectant mothers from having access to doctors to deliver their babies.

It has been 10 years since I first wrote this legislation that is now the Greenwood-Cox bill before us today. In that time, the number of medical lawsuits has risen 25 percent. The median damage award for medical lawsuits against hospitals, physicians and nurses right now is rising 43 percent per year. In some States, liability insurance premiums are rising 100 percent or more for so-called high-risk specialties, high risk because of the lawsuits, not because of the medical procedures involved, such as general surgery, 130 percent; internal medicine 130 percent; and obstetrics, OB–GYN, 165 percent. The money for these lawsuits comes directly from our health care system. Doctors and hospitals now

spend more on liability insurance than they do on medical equipment.

The bill before the House today will ensure that patients have access to the medical care that they need. It is based on our law in California where I come from that was enacted by a Democratic legislature and signed by a Democratic Governor, and it works.

In our State since these reforms have taken place, California's health liability insurance premiums in constant dollars have fallen by 40 percent. This while we are having crises in other States. Injured patients in California receive more compensation and receive it more quickly than in the United States as a whole. They receive a greater share of the recoveries in these lawsuits. California does not suffer from the flight of doctors or the closure of emergency rooms because we have the reforms in this bill. This bill balances the interests of billionaire lawyers and middle-class patients. It is time that patients have access to the care that they need.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, I rise today in opposition to not only this bill but the package of bills. In all honesty, in this bill people do not get sued for malpractice in Federal court typically. It is in State court. Like the State of California, the States can deal with that issue.

I rise in opposition to these bills simply because we have more important pressing needs of our health care system, the fact that 44 million Americans are without health insurance. This week is National Cover the Uninsured Week; and coming from the great State of Texas, I find it alarming that over 30 percent of Texans are without health insurance.

My hometown, Houston, is the home of the world-class Texas Medical Center. Yet without health insurance, too many Texans do not have access to lifesaving medical research and treatments performed at the medical center. Tackling this country's health care problems does not call for the unsuccessful piecemeal approach that we are considering this week. Passing these three bills would just be like rearranging the deck chairs on the Titanic. Our focus needs to be on providing all Americans with health insurance so that they will get the preventive care needed to keep them healthy and out of the emergency rooms. That is the way to keep health care costs down.

Unfortunately, policies enacted by this Congress and the States have taken health care in the wrong direction. Our fiscal policies have starved the States of crucial health care funding. State cuts in the CHIP program in Texas have dropped almost 170,000 children, and there is no way to ensure that our children get health care. To get our country's health care system out of this ditch, we have to stop digging. Let us give our children a healthy start and re-enroll them in CHIP. Let us also make sure that their parents can have access to the same care. In other words, pass legislation here to create a CHIP for parents. In my home State of Texas, that policy option alone would provide 67 percent of these parents with health insurance.

The uninsured in this country too often fall through the cracks of our health care system. For the health of our Nation, we must provide Americans with health insurance, not last year's ideas that these bills give them.

Mr. SENSENBRENNER. Mr. Speaker, I yield 1½ minutes to the gentleman from Iowa (Mr. KING).

Mr. KING of Iowa. I thank the gentleman for yielding me this time.

Mr. Speaker, not too long ago I got on an airplane ride. Across the aisle from me was a young woman holding her 7- or 8-month-old daughter. This young woman was also an OB-GYN. She began to talk to me about the practice that she has invested in had a 600 percent increase in the premiums in one single year. That is the worst I have heard of, but there are many out there that run 200, 300, 400 percent increases in premiums.

I represent a part of the State of Iowa. Iowa is last in the Nation in Medicare reimbursement rates. Now we are seeing an increase in medical malpractice premiums. Good things do come out of California. This is a good idea. It is a good model, and it is a good pattern. I am happy to follow the lead of the gentleman from California (Mr. COX) on this issue. We are losing access to health care in Iowa because of the cost of premiums, because Medicare reimbursement rates are the last in the Nation. Our issue is access to health care. We must reform this practice. Three percent of the gross domestic product of the United States of America is being consumed by litigation. Here is a place to start. I would like to do very much more.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself 6 minutes.

Mr. Speaker, this bill does nothing to improve the system. It does nothing to deal with the insurance rates and the increases in premiums, but it does deny victims compensation when they are victims of malpractice. I think it may be helpful to go a little section by section to see what is actually in the bill to see how it actually does what some of the people are talking about.

Section 3, for example, is entitled ''Encouraging Speedy Resolution of Claims.'' Mr. Speaker, injured parties do not need encouragement to get a speedy resolution of the claim. This section only invalidates bona fide claims that are filed after a set deadline. It also creates a confusing matrix because some State deadlines are preempted. Others are not. And so you have that confusing matrix of deadlines and may even miss the deadline by mistake.

Section 4 is called ''Compensating Patient Injury.'' Actually, that is the section which limits compensation to innocent victims. It also has what is called the ''fair share rule.'' I think most States, but at least Virginia and many States, allow a victim to collect all of the damages from one defendant. That defendant can then seek contribution from others involved. In practice, that contribution is worked out in advance by who pays for what insurance.

This so-called fair share requires the victim not only to prove a separate case against each and every defendant who may be involved but it also requires the plaintiff to decide and prove what percentage each one owes. Often the plaintiff does not know what happened. All they know is they are a victim of malpractice. This provision will require the plaintiff to have a separate case and pay for the expenses of separate cases against each and every person. Otherwise they may be afflicted with the ''empty chair defense'' where everybody in the courtroom starts pointing to an empty chair and says somebody else had 10 percent or 20 percent.

Section 5 is ''Maximizing Patient Recovery.'' Actually, that is a provision that limits attorneys' fees making it likely that a plaintiff will not even be able to hire a lawyer. You do not hear any victims groups clamoring for limitation on attorneys' fees. The defendants are not affected by the plaintiff attorneys' fees. They do not pay the plaintiff attorneys' fees. If the award is $100,000 and the plaintiff's attorney charges 50 percent, the defendant pays $100,000. If the lawyer charges 25 percent, still $100,000. If the lawyer does not charge anything at all, just the same, $100,000. The only way that this will help malpractice premiums is if the plaintiff cannot bring the bona fide case at all, cannot bring the case because they cannot hire a lawyer with the fees. That is not fair. It is even more likely when you have this fair share thing where the lawyer has to have five and six cases in the same case.

There is another provision called ''Additional Health Benefits.'' That is a provision that says if the victim has health insurance, the benefit of that health insurance goes to the one who committed the malpractice. In Virginia and many other States, if you have health insurance, you benefit. In other States, the health insurance company can get its money back after the case is settled because the malpractice recovery will pay the health expenses. Presumably under that case, the premiums will be lower. But in this bill, the benefit goes to the one who committed the malpractice. This bill is so bizarre that if you are working for a self-insured employer who is obligated to pay the health expenses of an employee and that employee is a victim of malpractice and runs up a $50,000 hospital bill, the business has to pay that $50,000 bill even though the one committing the malpractice is fully insured and could have paid. I cannot

wait for some small businesses to come to us and ask why they had to pay the bill as a result of malpractice.

Mr. Speaker, there is another provision under ''Punitive Damages.'' This bill provides that if a jury finds by the preponderance of the evidence that the doctor acted with malicious intent to intentionally injure a patient, not just recklessly negligent, acted with malicious intent to injure, that is not enough under the bill, because the evidence does not have to be just by the preponderance of the evidence; it has to be by clear and convincing evidence.

Mr. Speaker, this bill will not help injured victims of malpractice, and it is unlikely to reduce premiums. A chart of States in order of the costs of malpractice premiums shows some States at the top with caps, some with caps at the bottom, some with caps in the middle. There is no pattern to the chart. They are all over the place. The caps apparently did not make any difference at all.

We have heard a lot about the doctor shortage. This is not limited to doctors. This tort reform bill affects the health care provider, a health care organization, an HMO, manufacturer, distributor, supplier, marketer, promoter, a seller of a medical product regardless of the theory of liability on which the claim is based. This does not help victims. It probably will not even reduce premiums.

Mr. Speaker, I would hope that we would defeat the bill so that it will not be enacted. That has been the judgment of the United States Congress for the last 14 months. I hope it is still the judgment of the United States Congress.

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

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

This bill is on the floor for one reason and one reason alone. That reason is that across this country there is a crisis. The crisis is that the cost of medical malpractice insurance is so expensive that trauma centers have to close, that obstetricians cannot deliver babies anymore, that neurosurgeons cannot preserve lives, that orthopedic surgeons cannot do what they are supposed to do. It is a crisis. It also so happens that if this bill is passed, it will, according to the CBO, reduce the cost of medical malpractice insurance by 25 percent which will go a long way to solving that crisis.

It also has some side benefits. By making the cost of medical malpractice insurance less expensive, it makes the cost of health care less expensive which means that more employers can offer more of their employees insurance.

□ 1645

In fact, according to the CBO, 3.9 million Americans who do not have health care today would get health care just because we passed this bill. We ought to do it. Another side benefit, according to the CBO, is that because these costs are built into the costs of Medicaid and Medicare, we would save $15 million in those programs over the next 10 years, which we could apply to real important health care needs.

The gentleman from Michigan (Mr. CONYERS) has said we are passing this bill on the floor, it is never going to pass in the Senate. This bill went to the Senate and Majority Leader FRIST made a motion to consider the bill, and the Democrats objected to the consideration of the bill, to even having the debate. And then when it came time to vote on whether to have that debate, the Democrats voted no, we do not want to even debate this bill. So one can debate the fine points. One can say I have a better way to solve this problem or another Senator can say I do not like the cap here or I do not like this aspect of it. The most deliberative body on the face of the Earth is supposed to come to the floor of the Senate with their ideas, with their amendments, and engage in a debate. Instead, all that they have done is obstruct.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SWEENEY). The Chair will once again remind Members to confine their remarks to factual references to the other body and avoid characterizations of Senate action or inaction, remarks urging Senate action or inaction, or references to particular Senators.

Mr. BROWN of Ohio. Mr. Speaker, I yield the balance of my time to the gentlewoman from Colorado (Ms. DEGETTE).

Mr. SCOTT of Virginia. Mr. Speaker, I yield 1 minute to the gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, every so often in this body, I think it is important to talk about facts. Instead of legislating by an anecdote, I would like to actually look at some facts today.

Those on the other side would have us believe that limiting patients' access to the courts will relieve high malpractice insurance premiums. But the fact is there has been no increase in the rate of malpractice claims filed in recent years, and the fact is the average payout has remained steady for a decade. The fact is that California, the State that has been most successful in curbing malpractice costs, only did so after passing a voter initiative that also reformed the insurance system.

Despite this evidence, proponents of this bill continue to represent it as relief for physicians. In reality, it is a bald effort by the insurance industry to pass off their costs on already suffering patients. This bill will disproportionately affect women, low-income individuals, and children because the caps on noneconomic damages will affect them. Since they do not make a lot of money, they will not have a lot of economic damages to be awarded by the courts.

Real people will suffer a second injustice under this legislation, people like Heather Lewinski, who came before our committee and testified, a 17-year-old girl who suffered permanent facial disfigurement at the hands of a plastic surgeon who lied to her and her family. And this young woman came before us and said her greatest fear was she would never have a date. People like Linda McDougal. This is Linda McDougal in this poster right here. Linda McDougal's breasts were amputated after she had been misdiagnosed with cancer, and here she is today. She was completely fine. And the family of Jesica Santillan, a little girl who died because the hospital failed to ensure that the heart and lungs she was about to receive would be compatible with her blood type. Her family will be denied just compensation for her suffering.

If we really wanted to fix the crisis that is plaguing our Nation's doctors, we should take a good look at the insurance industries, as we heard from my colleague from Ohio. Instead, we are considering a bill that is akin to curing a headache by amputating an arm. Arbitrarily limiting patients' rights is not fair, and it will not solve the problem.

Let me talk for a minute about some of the anecdotes upon which we are basing this legislation. We heard that obstetrics wards were closing down because of liability insurance premiums. The example given by the AMA said that Pennsylvania's Jefferson Health System closed its obstetrics ward because of this reason, but 2 years later this obstetrics ward is still up and running and accepting new patients. In May, 2003, the AMA said that a group of 10 neurosurgeons in Washington State had been dropped by their malpractice insurer. As of 2004, the group is doing just fine and taking new patients. Finally, in January 2004, just a few months ago, President Bush said there was a doctor in Arkansas who stopped delivering babies because of rising insurance costs. That turned out to be completely untrue.

If there is a problem here, let us let the States fix it. Let us not put it on people like Linda McDougal.

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

Mr. Speaker, what the gentlewoman from Colorado did not tell us is what is not getting media attention, and that is that doctors are closing up their practices. When the Committee on the Judiciary heard testimony on this issue, the wife of a man named Tony Dyess came and spoke. Mr. Dyess was involved in an automobile accident. He had a spinal cord injury, and because there were no neurosurgeons left in southern Mississippi, it took 6 hours to airlift him to a hospital in Louisiana that has some better medical liability laws, and the golden hour for neurosurgery had passed; and as a result Tony Dyess is a quadriplegic simply because malpractice insurance costs chased the neurosurgeons out of southern Mississippi.

This is an issue of access to health care, and we cannot have liability insurance costs force doctors to close their practices and not have access to people who need doctors and need them desperately.

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

Mr. SHUSTER. Mr. Speaker, I rise today in strong support of H.R. 4280. This country's health care system and its providers are currently faced with a crisis in regards to medical liability coverage; and, in fact, my home State of Pennsylvania unfortunately leads the way. Our doctors are leaving or retiring, and currently only 4 percent of physicians practicing in Pennsylvania are under the age of 35. Students graduating from our medical schools are choosing not to stay in Pennsylvania to practice medicine. The largest hospital in my district, the Altoona Hospital, their malpractice insurance has gone from in 2000 $1 million a year to $2.7 million in 2003; $1.7 million, and not a penny of it is going to improve care to the patients and the people of my district.

This real increasing threat to patients' access to quality care cannot be ignored. The medical liability system in this country is in desperate need of reform. So I urge my colleagues to vote ''yes'' on H.R. 4280.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself such time as I may consume.

I will enter into the RECORD an article from the Morning Call newspaper in Pennsylvania, and I will just read the first sentence. April 23, 2004, ''The chairman of the Pennsylvania Medical Society acknowledged Thursday to State lawmakers that the doctors group lacks statistical evidence to support its 3-year claim that doctors are leaving the State in large numbers.''

The whole article will be introduced.

I have the GAO study that was cited June, 2003; and let me just read a couple of points out of it:

''Multiple factors have contributed to the recent increases in medical malpractice premiums in seven States we analyzed. First, since 1998 insurers' losses on medical malpractice claims have increased rapidly in some States,'' and they ''found that the increased losses appeared to be the greatest contributor to increased premium rates, but a lack of comprehensive data at the national and State levels on insurers' medical malpractice claims and the associated losses prevented us from fully analyzing the composition and causes of those losses.

''Second, from 1998 through 2001, medical malpractice insurers experienced decreases in their investment income as interest rates fell on the bonds that generally make up around 80 percent of these insurers' investment portfolios.

'' . . . a decrease in investment income meant that income from insurance premiums had to cover a larger share of insurers' costs. Third, during the 1990s, insurers competed vigorously for medical malpractice business, and several factors, including high investment returns, permitted them to offer prices that in hindsight, for some insurers, did not completely cover their ultimate losses on that business. As a result of this, some companies became insolvent or voluntarily left the market, reducing the downward competitive pressure on premium rates that had existed through the 1990s.''

I say that to say that there are a number of factors that have caused the premiums to go up that have nothing to do with the medical malpractice situation or the laws in medical malpractice and that this bill may or may not have anything to do with future premiums.

[From the Morning Call, April 23, 2004]

DOCTORS CAN'T PROVE THINNING RANKS

(By John M.R. Bull)

HARRISBURG.—The chairman of the Pennsylvania Medical Society acknowledged Thursday to state lawmakers that the doctors group lacks statistical evidence to support its three-year claim that doctors are leaving the state in large numbers.

''Some data sources show an 800-doctor gain,'' internist Daniel Glunk of Williamsport testified before the House Insurance Committee. ''The problem is no one has definitive numbers . . . and that there is conflicting data.''

That number includes 1,000 medical residents. If those aren't counted, he said, there would be a net loss of 200 doctors out of 35,500 since 2002.

''How can the medical society, if you can't agree on the numbers, continue to tout that doctors are leaving'' said Rep. Thomas Tangretti, D–Westmoreland, his voice rising in apparent anger. ''You've run ads saying will the last doctor please turn off the X-ray machine.''

''You've been frightening people, particularly senior citizens, and now we find it was all probably wrong-headed and disingenuous,'' Tangretti said, getting louder. ''Before you continue to frighten people about access to health care, you better get your numbers right. It's an outrage.''

Other lawmakers voiced irritation at his testimony, delivered four days after The Morning Call published new and previously undisclosed figures—some of them from the medical society itself—that make clear doctors are not leaving in large numbers.

For three years, the doctors lobby has insisted that doctors, particularly specialists who perform high-risk procedures, are leaving the state in droves, putting patient care in jeopardy.

Among other tactics, the medical society has promoted a list of 1,700 ''disappearing doctors'' as proof there are fewer physicians in Pennsylvania.

The Morning Call revealed Sunday that new state Insurance Department numbers show doctors have not left the state in waves. There were 35,474 doctors in 2002, as determined by the number who paid their state-mandated supplemental insurance. Now the figure is at least 34,997.

The newest number includes doctors who have applied to the Insurance Department for a piece of $230 million in state tax dollars recently appropriated to offset their rising malpractice premiums, along with a separate list of doctors who had primary insurance coverage at the end of last year but who haven't yet applied for state money.

That total doesn't include doctors who might have moved to Pennsylvania in the last year, might not be in Insurance Department records yet, and who might not know the state has money set aside for them.

In one of several criticisms of The Morning Call's work, the medical society has contended it might be misleading to compare 2002 figures to a list of individual doctors who recently applied for state money and others known to have malpractice insurance at the end of last year. But society officials have not publicly explained why that could be the case.

The new Insurance Department figures show no appreciable reduction in the number of high-risk specialists, a maximum reduction of 56 out of 4,700 since 2002. The medical society has admitted it has separate statistics that show a reduction of only 16 specialists—defined as neurosurgeons, general surgeons, orthopedic surgeons and ob-gyns—during that time frame.

''This a matter of credibility,'' Rep. Nick Micozzie, R-Delaware, chairman of the House Insurance Committee, said after the hearing. ''We've been hearing for three years now that doctors are leaving in large numbers and there is a shortage.''

''I go into my doctor's office and there's a sign that says ''Call Nick Micozzie to Save Our Doctors,'' he said. ''Well, saving our doctors is a different issue than claiming doctors are leaving in large numbers.''

In reference to the three-year campaign, Glunk told the committee that anecdotal evidence indicates there aren't enough of some kind of specialists in some parts of the state, and that not enough young doctors are choosing to move to Pennsylvania.

For three years, the medical society and its associated group, Politically Active Physicians Association, have waged an intensive public relations and lobbying campaign to convince legislators and their constituents that doctors are fleeing the state en masse.

The effort was triggered by medical malpractice premiums that started soaring in 2001 and continue to climb. Rather than pay prices that doubled seemingly overnight, some doctors did indeed depart, others altered their practices to avoid high-risk procedures.

As a result, lawmakers have enacted a series of court reforms sought by doctors as a way to drive down the rising premiums. A new cigarette tax raises roughly $230 million a year to help doctors afford malpractice premiums. Applications for that money are being processed now.

Doctors continue to demand a cap on jury awards on pain and suffering damages in malpractice lawsuits and have threatened to leave the state if they don't get them.

On Thursday, Glunk told the panel of lawmakers that the disappearing doctors list is not actually a list of doctors who disappeared. It is more of a list of doctors who might have been impacted by rising malpractice rates and who might have retired, moved, or curtailed their practices as a result, he explained.

The list makes no mention of doctors who have relocated to Pennsylvania since 2002, lawmakers noted.

''Naturally people leave their profession. You don't count doctors coming in,'' said Rep. Tony DeLuca, D–Pittsburgh told Glunk. ''If you don't have accurate statistics on the number of doctors, how can we tell? How can we make policy like that?''

Lawmakers from both parties say the list—created and maintained by Donna Rovito, the wife of an Allentown physician—has been used extensively as a lobbying tool to support doctor claims.

Democratic House leaders Thursday called for a moratorium on any more medical malpractice reforms until lawmakers ascertain

whether doctors are leaving the sate in large numbers, and whether the medical society deliberately misled lawmakers.

''The data they repeatedly cite, and which served as the basis for legislative action in the last two years, appears to be seriously inaccurate and part of a deceptive campaign,'' said Rep. Mike Veon, D-Beaver, the House Minority Whip. ''We want the real numbers and there should be no further action until the deficiencies of the data are corrected and we know the truth.''

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

The SPEAKER pro tempore. The Chair advises Members that the gentleman from Wisconsin (Mr. SENSENBRENNER) has 9 minutes remaining, the gentleman from Virginia (Mr. SCOTT) has 6 minutes remaining, and the gentleman from Pennsylvania (Mr. GREENWOOD) has 1 minute remaining.

Mr. SENSENBRENNER. Mr. Speaker, I yield 1 minute to the gentleman from Arizona (Mr. SHADEGG).

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

I rise in strong support of the underlying legislation. I want to compliment both the chairman of the Committee on the Judiciary, and the Committee on the Judiciary itself, as well as the chairman of the Committee on Energy and Commerce, and the Committee on Energy and Commerce itself, for bringing this legislation forward. This is critically needed legislation.

We face a crisis in this country in health care because of a runaway tort system. But the specific point I want to make goes to the next step in this process. Under current law, a law called EMTALA, passed by this Congress in 1986, millions of dollars' worth of free health care is provided at our Nation's emergency rooms across the country. It is provided because we have decided that someone who presents himself to an emergency room should not be denied that care, and so they must be screened and they must be initially treated and they must be stabilized. And I think that is a fair and balanced social policy which says that we in this country do not want anyone to go without health care; and clearly that is an important, appropriate policy that we have adopted.

But I think there is an unintended consequence of that law. The law says that this care must be provided by doctors and hospitals for free of these emergency rooms, but it does not provide that they have to provide their own malpractice insurance to cover that, and yet the current law says if they are sued for malpractice in such circumstances, they must pay the damages.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself 30 seconds.

During the debate, we have talked about how much debate is going on. I just point out that this debate is on a closed rule so that we cannot offer amendments to the bill. We have to take it or leave it. There are a lot of improvements that could be made if we have a full and open debate. That is not happening today because the majority passed a closed rule prohibiting any amendments to the bill.

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

The SPEAKER pro tempore. The Chair will advise Members that the order of closure will be the gentleman from Pennsylvania (Mr. GREENWOOD) followed by the gentleman from Virginia (Mr. SCOTT) followed by the gentleman from Wisconsin (Mr. SENSENBRENNER).

Mr. SENSENBRENNER. Mr. Speaker, I yield 1 minute to the gentleman from Illinois (Mr. CRANE).

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

Health care providers in my district need relief. Doctors, nurses, and hospitals all are struggling to shoulder the burden of the escalating cost of medical malpractice insurance.

Many regions of the country have been hit especially hard by this medical liability crisis, and doctors are leaving my district in suburban Chicago and moving to Wisconsin or Indiana to practice where medical malpractice insurance costs significantly less.

I certainly do not want them to go, but I understand why they are leaving or why some are choosing to retire early. The price of medical malpractice insurance has made it cost prohibitive for physicians to practice. It is not just doctors either. Hospitals, many of which struggle every year to keep solvent, have been hit especially hard. I am confident that the House will pass H.R. 4280, and I encourage all of my colleagues to support it; but it is time for the other body to act and pass this bill. Congress's inaction to address the medical liability crisis is driving doctors out of all of our districts.

The time has come to address this problem and pass the HEALTH Act.

□ 1700

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

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

Mr. GREENWOOD. I yield to the gentleman from Arizona.

Mr. SHADEGG. Mr. Speaker, I thank the gentleman for yielding. I apologize for the rather disjointed nature of this presentation.

Mr. Speaker, the point I wanted to make is we under EMTALA require doctors and hospitals to provide free health care in our emergency rooms. That may be appropriate as public policy, but the unfair context is that while forcing them to provide this free care, if they in fact are alleged to have committed malpractice, either the hospital or the doctor while providing free health care, they are on the hook for that alleged malpractice.

It seems to me only fair that if we are going to force doctors and hospitals to provide free health care to anyone who presents at an emergency room, then we should either cover the cost of their medical liability arising out of that, which I have proposed in an amendment and in separate legislation, providing that free EMTALA care would come under the Federal Torts Claims Act or we should grant immunity.

It seems to me to add insult to injury to say to a doctor at a hospital, you must provide free health care to anyone who presents at your emergency room and you must pay for the substantive cost of that health care, but that in addition to that, you must cover the medical liability that arises out of it.

That is in fact driving doctors away from emergency rooms and imposing unfair costs on both emergency rooms and emergency room doctors, and I hope the Congress will consider that legislation in the near future.

Mr. SCOTT of Virginia. Mr. Speaker, I yield the balance of my time to the gentlewoman from Texas (Ms. JACKSON-LEE).

The SPEAKER pro tempore (Mr. SWEENEY). The gentlewoman from Texas is recognized for 5½ minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, to the distinguished gentleman from Virginia and to my ranking member and colleagues on the floor, this reminds me of deja vu and here we go again.

I am reminded that we were here on the floor of the House not very long ago dealing with the catastrophe of medical malpractice insurance and the desire to deny access to the courthouse. I am reminded as well that we had the good conscience, if you will, to have a vigorous debate.

Now we are on the floor of the House with exactly 1 hour, no opportunity for a substitute, it is my understanding, in combined time between the Committee on Energy and Commerce and the Committee on the Judiciary, two very important committees as it relates to dealing with the medical malpractice question.

We also seemingly are not confronted by the reality of life. More and more Americans are uninsured, some 44 million. Today we have spent time trying to address the question of whether or not we can insure those Americans. Yet we come today with an overall one-shoe-fits-all Federal legislative initiative rather than allowing, first of all, the possibility that each State address their own concerns.

This bill, in essence, is a bill that will take away the rights. For example, parents who lose a child due to a tragedy like the one in North Carolina recently, where the wrong heart and lung were placed in a young girl, they do not lose any money, they lose part of their souls. But now we are going to tell them that their child was only worth $250,000 in noneconomic damages for all of their pain and suffering. We are being told we are going to do this

to such devastated families in order to enable our doctors to keep treating patients.

Well, let me say this: I would rather stand on the side of those who access the courthouse.

H.R. 4280 calls for a protracted statute of limitations in which a plaintiff may file a claim. Such a restrictive statute of limitations cuts off legitimate claims. A reduced statute of limitations shortens the time that injured patients and their families have to file claims.

This provision is ultimately designed to eliminate claims for diseases with long incubation periods. That means, for example, that if a patient contracted HIV-AIDS from tainted blood but the symptoms of HIV did not present itself for at least 5 years, which is often the case, there would be no remedy that this Congress would allow because this enacted 2-year statute of limitations.

The gentleman from Michigan (Mr. CONYERS) and the gentleman from Michigan (Mr. DINGELL) had an alternative that speaks more to the accrual of a right of action. Therefore, a person who upon reasonable knowledge would not know that they had contracted a condition such as HIV, would still have a right to action.

The bill before us today also provides arbitrary and discriminatory caps on noneconomic damages that will hurt those patients with the most serious injuries. Proponents of medical malpractice reform want to limit noneconomic damages to $250,000 in the aggregate, regardless of the number of parties responsible for a patient's injury and regardless of the number of parties against whom an action is brought.

Noneconomic damages compensate injured patients for very real injuries such as the loss of a limb, loss of sight, permanent infertility or even the loss of a child. Damage caps have a tremendously negative impact on the permanently or catastrophically injured person who is more in need of financial protection, for only the most seriously injured receive damage awards greater than the cap. Even the AMA has testified that caps affect only those cases involving severe injury where the victim faces the greatest need for compensation.

I include those remarks in the RECORD so that I can speak to the physicians who are listening today, hopefully to understand that this is not a battle with you. This is not a battle between patients and physicians. This is not a battle between those of us who oppose caps on noneconomic damages and statutory limitations and what is a bad medical malpractice bill. This is not a battle.

What it is to say is, frankly, this. We all have a part in contributing to good health care. This medical malpractice legislation does not contribute to good health care. What it simply says is those who have the least will get the least, primarily when it comes to dealing with catastrophic illnesses which may ruin their life forever, which provide an economic burden on their caretakers forever, which in essence does not provide the necessary punitive measures for those who have done wrong.

We realize that there are good doctors, and we support that. My question is, let me have a full study again of all the insurance companies who can tell me that their premiums will go down because of this legislation.

We have passed a legislative initiative in Texas, and to defend themselves for such a horrible bill, we have had a number of editorials saying how things have gotten better. We still have uninsured children in Texas, we still have people injured in Texas without the proper benefits, and we have not seen a decrease in insurance premiums as well.

This is a bad medical initiative, if that is what it is supposed to be. To doctors, we promote all of the legislative initiatives to help you be good doctors. We are supportive of decreasing the insurance premiums that put you out of business, better Medicaid and Medicare regulations, but we are not supportive of a legislative initiative that does nothing but tear up the Constitution, undermine our values, and does not save lives.

I ask my colleagues to vote against this.

Mr. Speaker, I was enormously disappointed with the rule that was issued on this bill and call on my colleagues to defeat the underlying bill as well. We have a health care crisis on our hands. We need to work together in a democratic fashion to address it: to improve access to care, to protect patients, to ensure that good physicians can afford to continue treating those patients, and to decrease frivolous lawsuits. Last year in March we fought to defeat a bill, H.R. 5, which sought to reform tort law to the detriment of patients, physicians, patients, and injured plaintiffs. The underlying identical bill is before us today and it seeks to do the same thing. The Ranking Member of the House Judiciary Mr. CONYERS and Mr. DINGELL offered a substitute during the Rules Committee hearing that would have ensured that these concerns were addressed. Not a single one of those excellent ideas will be even considered today.

What in the name of God and Country is our Democracy coming to when on the Floor of the House of Representatives, there is not a single chance to debate and vote on one of many ideas that could save lives and rescue our floundering health care system?

I hate the idea of putting a price tag on human life, or a value on pain and suffering. However, we all know that malpractice premiums are outrageously high in some regions and for some specialties of medicine. I understand that some physicians are actually going out of business because the cost of practicing is too high and that we run the risk of decreasing access to healthcare if we do not find a way to decrease malpractice insurance premiums.

However, it would be doubly tragic if we did compromise the ability of patients suffering from medical negligence from seeking recourse in our courts, and did not achieve any meaningful decrease in malpractice premiums. Therefore, I considered offering three amendments yesterday that would require that all malpractice insurance companies make a reasonable estimate each year of the amount of money they save each year through the reduction in claims brought about by this Act. Then they would need to ensure that at least 50 percent of those savings be passed down in the form of decreased premiums for the doctors they serve.

I shared this concept with doctors and medical associations down in Texas, and they were very enthusiastic, because this amendment would ensure that we do what, I am being told, this bill is supposed to do—lower premiums for doctors.

Without my provision, this bill could easily end up being nothing more than heartbreak for those dealing with loss, and a giant gift to insurance companies. Parents who lose a child due to a tragedy like the one in North Carolina recently where the wrong heart and lung were placed in a young girl—they don't lose any money—they lose a part of their souls. We are going to tell them that their child was only worth $25,000 in non-economic damages for all of their pain and suffering. We are being told that we are going to do this to such devastated families, in order to enable our doctors to keep treating patients.

H.R. 4280 calls for a protracted statute of limitations in which a plaintiff may file a claim. Such a restrictive statute of limitations cuts off legitimate claims. A reduced statute of limitations shortens the time that injured patients and their families have to file claims. This provision is ultimately designed to eliminate claims for diseases with long incubation periods. That means, for example, that if a patient contracted HIV from tainted blood, but the symptoms of HIV did not present for at least five years—which often is the case—there would be no remedy if Congress enacted a two-year statute of limitations.

Mr. CONYERS and Mr. DINGELL had an alternative that speaks more to the accrual of a right of action. Therefore, a person who, upon reasonable knowledge, would not know that they had contracted a condition such as HIV, would still have a right of action.

The bill before us today also provides arbitrary and discriminatory caps on non-economic damages that will hurt those patients with the most serious injuries. Proponents of medical malpractice reform want to limit non-economic damages to $250,000 in the aggregate, regardless of the number of parties responsible for a patient's injury and regardless of the number of parties against whom an action is brought. Non-economic damages compensate injured patients for very real injuries—such as the loss of a limb, the loss of sight, permanent infertility or even the loss of a child. Damage caps have a tremendously negative impact on the permanently or catastrophically injured who are most in need of financial protection for only the most seriously injured receive damage awards greater than the cap. Even the AMA has testified that caps affect only those cases involving severe injury where the victim faces the greatest need for compensation. When damages caps leave such victims unable to meet the costs associated with their injuries, the government is often left footing the bill with taxpayer dollars.

Non-economic damage caps are unfair to women. Capping non-economic damages, while at the same time preserving full compensation for economic loss, such as lost wages and lost salary, shamefully devalues the worth of homemakers and stay-at-home moms. Moreover, by protecting medical device manufacturers specifically, the bill favors the makers of those very products—such as the Dalkon Shield and Copper 7 intrauterine devices—that have caused devastating harm to women.

Medical malpractice in the United States is a very real problem with devastating consequences. We hear about countless medical horror stories, whether involving a botched surgery, a mix-up in the medical records, an unnecessary amputation, or the discovery of medical objects inside patients.

I offer a few case studies to illustrate the terrible downward trend that we can expect with the passage of this ill-crafted bill:

Sandra Katada of McKinney, Texas: During the birth of Sandra's daughter Alexandra, the doctor contorted and stretched Alexandra's spine, destroying her nerves and leaving her partially paralyzed. The doctor applied so much force that, in addition to the spinal injury, which would prove fatal, the baby's elbow was broken and pulled from its socket. Some of the damaged spinal nerves were responsible for stimulating the growth of her rib cage. But because the nerves were damaged, her ribs did not expand, and when the rest of her body grew over the next several months she suffocated inside her small rib cage. Alexandra died on Valentine's Day, 1994, at age 8-months-old. The Katadas's settled the case against the doctor for the insurance company's policy limits, $1 million.

A Dallas Morning News investigation found that two other babies in this doctor's care had died in the 3 years before the Katada's and another died after their baby died. In one of those cases, by the time the parents found out that this doctor had caused their baby's injuries, it was too late to go to court because the 2-year statute of limitations had run out. All the families complained to the Texas Medical Board about this doctor but he is still practicing.

Dylan Malone of Everett, WA: Dylan's son Ian suffered severe brain damage at birth after a doctor used a drug to induce labor that the manufacturer explicitly warned should not be used for that purpose. Ian cannot hold his head up, suck, swallow or gag properly and requires 16 hours of nursing care per day. He eats through a feeding tube in his abdomen, breathes with a ventilator, takes medication daily to prevent seizures and needs a sedative to sleep. The family sued the doctor, who already had a number of medical malpractice cases filed against him. The Malone case is still pending.

I will not vote for H.R. 4280, because as it is, it does nothing to decrease the premiums our nation's physicians are burdened with. It does nothing to decrease the number of frivolous lawsuits. It does nothing to decrease the amount of malpractice being inflicted upon the American people, by bad doctors who are jeopardizing the lives of their patients, and driving up the insurance costs of their colleagues. And it does nothing to protect the rights of those suffering in the wake of an act of medical negligence. H.R. 4280 does nothing to respond to these problems of rampant medical malpractice. I reiterate that the substitute offered by Mr. CONYERS and Mr. DINGELL at the hearing before the Rules Committee was a more prudent alternative. Our colleagues on the other side of the aisle wish to shove this bill down the feeding tubes of the helpless and sickly patients who sit and suffer from a health care system that seeks to pad the pockets of insurance companies.

I strongly oppose H.R. 4280 and I urge my colleagues to join me.

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

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

Mr. Speaker, the gentlewoman from Texas is right. We did do a similar bill statewide in Texas and it passed last September, and it really has provided physicians in the State of Texas a significant amount of relief from the high cost of liability premiums.

My last year in active practice was 2002, and I paid $19,000 a year in obstetrics and gynecology for that privilege. If I had bought that insurance in 2003, it would have increased to $45,000. This year, had I purchased that same insurance policy, it would have been back down to $25,000, obviously a significant increase.

But we really are not talking about the cost of a liability premium for a doctor, we are talking about the embedded cost of an unfair medical justice system on our entire medical system, and we can no longer afford to pay that price.

A study done at Stanford University in 1996 showed that if you remove the cost of defensive medicine from Medicare, you would save $50 billion a year. That would pay for our prescription drug benefit, whether the CBO or the OMB does the figures.

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

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

The SPEAKER pro tempore. The gentleman from Pennsylvania is recognized for 2 minutes.

Mr. GREENWOOD. Mr. Speaker, I would like to read from two letters. The first is from Engel, Smith & Associates, an obstetrics and gynecology practice, a letter written to their patients.

''It is with great sadness that we are writing to inform you of the plan to close in its present configuration the Engle, Smith & Associates obstetrics and gynecology practice. We have diligently tried over the past several months to find an alternative solution as we struggle with this decision. Unfortunately, the practice environment for physicians in our specialty has become so difficult that we have no choice but to dramatically change the way in which we provide care.

''We, like many of our colleagues in high-risk specialties such as obstetrics, have a crisis situation because our malpractice insurance premiums have more than doubled in the past 2 years. These increases are being driven primarily by skyrocketing jury awards in Pennsylvania, which have been forcing both insurance companies and physicians out of business.''

Here is the impact on patients, a letter to me.

''I am a Pennsylvania native. I was born and raised in the Philadelphia area, an area that used to be known for excellent medical care. Eight months ago, I again found a wonderful OB–GYN office. The doctors are wonderful, respectful and well-educated and overall just great. They delivered my beautiful baby girl for me, and I could not have been happier with their care. I referred my sister, who is currently pregnant and due in a few short weeks. She too, is satisfied with them.

''Two weeks ago we were outraged to discover that they were closing the doors at the end of May 2002. My sister, who has been going to their office for all her prenatal care visits, cannot even have her after-delivery exam by the doctor who delivers her first child. I will not be able to return to them for subsequent health care or even normal GYN care.

''This is an outrage. It is also the second physician's office I have been to in the last couple of years that has been forced to close due to medical liability costs. Another office that I was aware of closed as well for the same reason. I cannot even switch to see them, because they no longer exist within our State. I do not know who I can go to even now. No other OB–GYN physicians practice in my area anymore.''

Mr. Speaker, this is the face of the medical malpractice crisis. This is the bill that will resolve that crisis. We believe that this legislation will solve the crisis in the near term for malpractice insurers, for doctors and for patients, and, in the long run, for 3.9 million Americans, give them health care that they do not have today.

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

The SPEAKER pro tempore. The gentleman from Wisconsin is recognized for 4 minutes.

Mr. SENSENBRENNER. Mr. Speaker, during the course of the debate we have heard a string of red herrings from people who do not wish this bill to pass. I would like to rebut those from the study that the General Accounting Office made on the whole topic of our medical liability crisis.

First, as the gentleman from Pennsylvania (Mr. GREENWOOD) has eloquently stated, patient access to care is being harmed. He recounted the case of a pregnant woman who went to at least two OB/GYN practices to get a doctor to deliver her baby and was told that as a result of the medical liability crisis, they were shutting down the doors to their practice.

The GAO confirmed instances in the five States selected for study where actions taken by physicians in response to malpractice pressures have reduced

access to services affecting emergency surgery and newborn deliveries. When the baby comes, you cannot wait. When someone has an accident and needs emergency surgery, you cannot wait. And if the malpractice insurance crisis closes down those practices, people are going to be harmed, and they will die, and this bill will stop that.

Secondly, doctors do practice defensive medicine. The GAO report found that in response to rising premiums, ''the fear of litigation research indicates that physicians practice defensive medicine in certain clinical situations, thereby contributing to health care costs.''

The gentleman from Texas (Mr. BURGESS) said that if unnecessary defensive medicine does not have to be practiced by reforming our liability laws, Medicare alone will save $50 billion a year, which is more than enough to pay for the prescription drug benefit, whether it is by the GAO study or the OMB study.

Third, insurers are not to blame for skyrocketing premiums. The gentleman from Ohio (Mr. BROWN) seemed to think they are.

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But the GAO found that insurers are not to blame. The report states that insurer ''profits are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates,'' and that ''in most States the insurance regulators have the authority to deny premium rate increases they deem excessive.''

Fourth, rising litigation awards are the problem, not insurer investments. What did the GAO say? The GAO found that losses on medical malpractice claims which make up the largest part of insurers' costs appear to be the primary driver of rate increases in the long run.

''Since 1998, insurers' losses on medical malpractice claims have increased rapidly in some States. However, none of the studied companies experienced a net loss on investments, at least through 2001, the most recent year such data were available. Additionally, almost no medical malpractice insurers overall experienced net investment losses from 1997 to 2001.'' So much for that red herring.

Finally, liability reform does have a real impact. The GAO concludes that data indicate that rates of growth in malpractice premiums and claims payments have been slower on average in States that enacted certain caps on damages for pain and suffering, referred to as noneconomic damage caps, than in States with more limited reforms and that average per capita payments for malpractice claims against all physicians tended to be lower on average in States with noneconomic damage caps than in States with limited reforms.

This bill is a good one, and it ought to be passed.

Ms. SCHAKOWSKY. Mr. Speaker, I rise today in opposition to out-of-control medical malpractice premiums but also in opposition to H.R. 4280. Once again, we are being asked to vote on a bill that claims to be a solution to a very real problem but which will simply not do the job of lowering premiums. Once again, we are being asked to vote on legislation that ignores the major component in the medical malpractice insurance crisis—insurance.

A study of the medical malpractice situation in my State of Illinois found last year that there was little, if any, correlation between medical sea -HMOOsmalpractice payments and medical malpractice premiums. The Americans for Insurance Reform report found that the amount of jury awards and settlements has actually declined since 1991, below the rate of medical inflation. In constant dollars, the amount of medical malpractice jury awards and settlements per doctor has decreased over the past decade in Illinois.

As providers in my State know all too well, their medical malpractice premiums are going in the opposite direction. Instead of tracking payouts, they are tracking economic conditions and insurance company investment decisions. Imposing arbitrary caps on non-economic damages—which would especially limit potential payments to injured infants and senior citizens—is not the answer when the problem is poor investment choices by insurance companies and economic conditions.

As a member of the Energy and Commerce Committee, I had the opportunity to participate in hearings on H.R. 5, last year's medical malpractice bill. We never heard a medical malpractice insurer testify that passage of that bill would lower premiums or that the Federal government should even be allowed to track the effects on medical malpractice premiums if H.R. 5 were to pass. That failure was no surprise given multiple statements made by medical malpractice insurance company officials before State legislatures around the country, that tort reform will not lower rates. Even Sherman Joyce, president of the American Tort Reform Association, has said that ''We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.'' Victor Schwartz, general counsel of ATRA, has said, ''(M)any tort reform advocates do not contend that restricting litigation will lower insurance rates, and ''I've never said that in 30 years.''

Caps won't make medical malpractice premiums affordable but there are other proposals that would make a real difference in providing affordable coverage. As a member of the House Medical Malpractice Crisis Task Force, I had hoped that we would take the opportunity to explore those opportunities instead of being presented with the same bill that we voted on last year, the same bill that the insurance industry itself says won't lower premiums.

Here are many ideas that I believe are worthy of consideration but that, unfortunately, are not included in H.R. 4280. We know that insurance reform in California requiring a premium rollback and improving review had a positive impact in lowering medical malpractice premiums—after tort reform did not. We could have created a Commission on Medical Malpractice Insurance to investigate the real causes for premium increases and consider solutions such as mandatory loss-ratio requirements, experience rating, and a Federal reinsurance mechanism. We could have established a certification mechanism to make sure that cases are meritorious, expand Rule 11 sanctions for anyone who falsifies information as part of that process, and encourage arbitration while requiring that savings are passed through by insurers in the form of lower premiums. We could have repealed the McCarran-Ferguson Act that shields medical malpractice insurers from Federal antitrust laws. We could have provided a tax deduction to help health care providers and professionals faced with sharp premium increases.

Instead of considering those initiatives, we are being asked to once again pass legislation that restricts the rights of injured patients and their families to seek legal remedies, not just against doctors, but against HMOs and other insurers, nursing homes, medical labs, drug companies, medical device manufacturers and others. For the first time, the Federal government would intrude on what has always been a State authority to take away consumer rights. Yet, the insurance industry itself refuses to say whether doing so will have the effect of lowering rates. It is the wrong answer to a very real problem.

In the future, I hope that we will be given the chance to look at ways to address insurances industry practices and reduce the incidences of medial malpractice by improving health care quality. In the meantime, we should reject this bill.

Mr. STARK. Mr. Speaker, I rise in strong opposition to H.R. 4280, legislation that would undermine the right of patients and their families to seek appropriate compensation and penalties when they, or a loved one, are harmed or even killed by an incompetent health care provider.

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

The most ludicrous aspect of this debate today is the fact that it is completely unnecessary. The House already passed this exact same legislation last March and there is no need for us to be here debating it again.

The only reason that Republicans are bringing up this bill today is that it is ''Cover the Uninsured Week'' and they have no real proposals to help cover the uninsured. So, they are trotting out medical malpractice reform so they can have another vote that doctors appreciate and they can again blame the Senate for not taking action on the legislation. It is political showmanship pure and simple—it has no other meaning.

This bill is identical to H.R. 5 which was passed last year, so if my comments look familiar, it is because I am raising the exact same points in opposition.

The Republican Leadership has once again brought forth a bill that favors their special interests at the expense of patients and quality health care. Doctors, hospitals, HMOs, health insurance companies, nursing homes, and other health care providers would all love to see their liability risk reduced. Unfortunately, this bill attempts to achieve that goal solely on the backs of America's patients. I said, ''attempts to achieve that goal'' intentionally.

Despite the rhetoric from the other side, there is absolutely nothing in H.R. 4280 that guarantees a reduction in medical malpractice premiums. There is not one line to require that

the medical malpractice insurance industry—in exchange for capping their liability—return those savings to doctors and other providers they insure through lower malpractice premiums. To quote one of many economists on this matter, Frank A. Sloan, an economics professor from Duke, recently said, ''If anyone thinks caps on pain and suffering are going to work miracles overnight, they're wrong.'' In fact, the outcome of this bill could have zero impact on lowering malpractice premiums and instead go into the pocketbooks of the for-profit medical malpractice industry. Of course, the bill's proponents avoid mentioning that very real possibility.

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

Supporters of this bill would have you believe that medical malpractice lawsuits are driving health care costs through the roof. In fact, for every $100 spent on medical care in 2000, only 56 cents can be attributed to medical malpractice costs—that's one half of one percent. In addition, a recent report by the Congressional Budget Office highlights the same fact. Specifically the report states, ''Malpractice costs amounted to an estimated $24 billion in 2002, but that figure represents less than 2 percent of overall health care spending. Thus, even a reduction of 25 percent to 30 percent in malpractice costs would lower health care costs by only about 0.4 top 0.5 percent, and the likely effect on health insurance premiums would be comparably small.'' So, supporters are spreading false hope that capping medical malpractice awards will reduce the costs of health care in our country by any measurable amount. It won't.

What supporters of this bill really do not want you to understand is how bad this bill would be for consumers. The provisions of this bill would prohibit juries and courts from providing awards they believe reasonably compensate victims for the harm that has been done to them.

H.R. 4280 caps non-economic damages. By setting an arbitrary $250,000 cap on this portion of an award, the table is tilted against seniors, women, children, and people with disabilities. Medical malpractice awards break down into several categories. Economic damages are awarded based on how one's future income is impacted by the harm caused by medical malpractice. There are no caps on this part of the award. But, by capping non-economic damages, this bill would artificially and arbitrarily lower awards for those without tremendous earning potential. This means that a housewife or a senior would get less than a young, successful businessman for identical injuries. Is that fair? I don't think so.

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

The issue of rising malpractice insurance costs is a real concern. I support efforts by Congress to address that problem. That is why I would have voted for the Democratic alternative legislation that Reps. CONYERS and DINGELL brought to the Rules Committee last night. Unlike H.R. 4280, the Dingell/Conyers alternative would not benefit the malpractice insurance industry at the expense of America's patients. Instead, it addresses the need for medical malpractice insurance reform—learning from the experience of California—to rein in increasing medical malpractice premiums. Rather than enforcing an arbitrary $250,000 cap, the bill makes reasonable tort reforms that address the problems in the malpractice arena—penalties for frivolous lawsuits and enacting mandatory mediation to attempt to resolve cases before they go to court. It also requires the insurance industry to project the savings from these reforms and to dedicate these savings to reduced medical malpractice premiums for providers. The Dingell/Conyers bill (H.R. 1219) is a real medical malpractice reform bill that works for doctors and patients alike.

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

Medical malpractice costs are an easy target. My Republican colleagues like to simplify it as a fight between America's doctors and our Nation's trial lawyers. That is a false portrayal. Our medical malpractice system provides vital patient protection.

The bill before us drastically weakens the effectiveness of our Nation's medical malpractice laws. I urge my colleagues to join me in voting against this wrong-headed and harmful approach to reducing the cost of malpractice premiums. It is the wrong solution for America's patients and their families.

Mr. KIND. Mr. Speaker, my home State of Wisconsin has sensible medical malpractice laws that make the State attractive to doctors and safe for patients. The components of this successful law include a cap on non-economic damages of $442,000, which is indexed annually for inflation; a requirement that all providers carry malpractice insurance; and a victims' compensation fund.

The victims' compensation fund is a unique entity that has served both patients and health care providers well. The fund operates by collecting contributions from Wisconsin health care providers and paying the victims once an award has been determined. The physicians are liable only for the first $1 million in an award. If the award exceeds $1 million, the compensation fund will pay the remainder of the award. For several years now, this system has served the State well. Like many of my colleagues, I believe that we need sensible malpractice reform, and were the bill before us today similar to Wisconsin's system, I would be proud to support it.

Unfortunately, H.R. 4280 is vastly different from Wisconsin law and goes too far in defending negligence and not far enough in protecting patients. The legislation goes beyond medical malpractice law by including provisions regarding pharmaceutical and medical devices and completely exempts from liability medical device makers and distributors as well as pharmaceutical companies, as long as the product complies with FDA standards. These provisions would have no effect on medical malpractice insurance rates. Instead, they would leave victims with little recourse and render them unable to hold pharmaceutical companies and the makers of defective medical products accountable for faulty or unsafe products.

Another problem with H.R. 4280 is that it overrides some State laws. While the bill would not override Wisconsin's own cap on non-economic damages, it would supersede our State laws regarding statute of limitations, attorney's fees, and the criteria for punitive damages. This bill is a one-size-fits-all solution that is not right for Wisconsin.

The successful components of Wisconsin's medical malpractice laws could be the basis for a much better bill. Wisconsin law protects patients and keeps physicians in business. These laws are threatened, however, by the current proposal. Therefore, I oppose H.R. 4280 and ask my colleagues to defeat the bill, revisit the issue, and create a more sensible plan that will protect patients and help doctors.

Mrs. BIGGERT. Mr. Speaker, I rise today in strong support of H.R. 4280, the HEALTH Act.

My home State of Illinois is in the midst of a crisis. Will County, part of which I represent, no longer has any practicing neurosurgeons. A recent survey found that 11 percent of OB/GYNs no longer practice obstetrics in Illinois. And more than half of OB/GYNs in the State are considering dropping their obstetrics practice entirely in the next two years due to medical liability concerns.

Women and children are the first to suffer in a crisis like this. As a mother and a grandmother, I don't want to see pregnant women driving to another State because they can't find an OB-GYN in their own area. I don't want to see injured children transported miles away from their homes because there are no pediatric neurosurgeons left to treat head injuries. And I don't want to see health insurance premiums climb so high that employers can no longer afford to provide benefits to their workers. We need reform and we need it now.

Mr. STENHOLM. Mr. Speaker, I rise in strong support of H.R. 4280. Health care costs have been increasing dramatically over the past decade, while insurance has become prohibitively expensive for over 40 million Americans.

There are a number of factors which have contributed to the skyrocketing cost of health care, and the costs associated with medical malpractice are one factor.

This Country's tort system encourages litigation and large awards in medical malpractice suits, which has led to high malpractice insurance rates and increased health care costs through the practice of defensive medicine.

Last year, my state of Texas enacted reforms of our medical malpractice system in order to avert a growing health crisis in the Texas health-care system. Too many lawsuits against health-care providers were driving up the cost of practicing medicine, resulting in reduced access to affordable health care.

There are early signs that the reforms enacted in Texas have helped improve access to

affordable health care. Essentially, every doctor in Texas is either paying less malpractice premiums today or avoiding scheduled increase in premiums.

The bill before us today contains the same proven reforms that will translate directly into increased access to affordable health care for all Americans.

Without Federal legislation, the exodus of physicians from the practice of medicine will continue, especially in high-risk specialties, and patients across the country will find it increasingly difficult to obtain affordable health care.

In rural areas, we are particularly sensitive to the impact malpractice insurance costs have in discouraging physicians from locating in rural communities, leaving residents without health care.

Here in Washington, if an obstetrician decides to stop delivering babies because the malpractice insurance costs are too great, the yellow pages will still list hundreds of other choices of physician care for expectant parents. In rural communities, the same physician decision may well mean that young couples must entirely uproot and relocate to urban centers just so they can have a family.

The ultimate result of this legislation will be greater protections for quality health care, keeping precious health care dollars in direct care rather than feeding our legal system, and buttressing access to care for all Americans.

Medical malpractice reform isn't a magic bullet that will solve the problems of skyrocketing health care costs by itself, but it is one part of the larger process of reforming our health care system to control costs and improve access to health care.

Ms. HARMAN. Mr. Speaker, I am a strong supporter of California's Medical Injury Compensation Reform Act—or MICRA. With it, California charted a bold and creative course toward responsible medical malpractice reform.

In my view, the entire country would do well to follow California's lead, and it makes sense to have Federal legislation on the subject. But this particular bill includes the very same flaws contained in legislation I opposed last year—and I cannot support it.

H.R. 4280 is overly broad, and the cap on punitive and noneconomic awards is not indexed and does not reflect its current value.

While H.R. 4280 adopts the structure of MICRA, it is weighed down by restrictions on certain causes of action against HMOs, nursing homes, and insurance companies—areas in which California has enacted significant protections for patients. And the $250,000 cap on punitive and noneconomic awards must be adjusted upward.

In the past, I voted for other medical liability legislation. I did so with the hope and expectation that improvements would be made in conference with the Senate to narrow its egregious provisions or that, in re-introducing the bill, these changes would be made.

Mr. Speaker, once again the closed process by which we are considering medical malpractice reform belies any desire by the majority to make the improvements I and many others believe are necessary.

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

But I cannot support H.R. 4280 in its present form, and I urge the leadership to postpone a vote on this legislation to open up what has thus far been a closed process and incorporate the ideas of members like myself who support common-sense medical liability reform.

Medical professionals should be able to practice in a climate of certainty, and patients should be charged reasonable rates for quality care. This is what I support for every community in the country. This is not what H.R. 4280, in its present form, delivers.

Mr. DINGELL. Mr. Speaker, what we are witnessing today is a sorry spectacle. We are voting on the same bill the House already voted on a little over a year ago. The one difference is that there is a new bill number. And, in those 14 months that have passed, our Republican colleagues have not changed one line in their bill to respond to the problems of increasing insurance costs to the doctors while protecting injured patients.

Instead, they are sticking with the same legislation, legislation they know will not pass the Senate. A bill they know will trample on the rights of legitimate patients, and will provide unprecedented protections to HMOs, the real beneficiaries of this legislation. This legislation is the exact opposite of the Patients' Bill of Rights, which would have provided real protections to doctors and patients alike in the struggle against cookie-cutter medicine foisted upon them by HMOs, if the Republicans had not successfully defeated it.

Let's be clear, this Republican bill does nothing to end frivolous lawsuits, just responsible ones. The bill limits awards for honest claims. It imposes new hurdles on aggrieved patients. And the bill does nothing to address the real problem—skyrocketing insurance premiums sending profits directly into the coffers of those companies.

I would like to point out that this bill is brought up during "Cover the Uninsured Week." To say that shielding HMOs from lawsuits will help cover the uninsured is a huge stretch for even the most vivid imagination.

If the Republican leadership was really interested in helping those without healthcare insurance, they would take up legislation like the bills democrats introduced today—the FamilyCare Act and the Medicare Early Buy-in—and build upon existing successful insurance programs to give families dependable, affordable coverage. And they would take up the Small Business Health Insurance Promotion Act which targets small businesses with real subsidies to purchase solid insurance products.

Democratic proposals take us forward, providing meaningful coverage without trampling the rights of consumers, eroding protections, or causing millions to lose their existing coverage. The Republican bill, and the other bills we will see this week, pay lip service to helping consumers, while richly rewarding the health insurance company allies.

Mr. SANDLIN. Mr. Speaker, I rise today just as I did almost exactly 14 months ago in strong opposition to the so-called HEALTH Act. Of course, today, we are spending the valuable time and limited resources of the American people debating the HEALTH Act of 2004, which, ironically, is precisely the same—virtually word-for-word—as the HEALTH Act of 2003, legislation this House already passed.

Mr. Speaker, it is as if the leadership of this House is being guided by the wisdom of that great American philosopher, Yogi Berra, who once said, "It's déjà vu all over again." Apparently, the Republican leadership of the House is at a loss as to how to fix the very real problems our nation is facing, so we find ourselves here in the People's House deliberating legislation that we have already considered and passed.

I don't know about the rest of the Members of this House, but I am pretty confident that my constituents in East Texas would consider our action on this flawed legislation to be a profound waste of time and money even in the best of times.

However, Mr. Speaker, these are not the best of times for our Nation. The fact is the United States is facing difficult times at home and abroad. Today, as a Nation, we have 135,000 military personnel on the ground in Iraq fighting a shadowy and lethal insurgency and struggling to bring stability to a troubled part of the globe. The United States remains in serious danger of terrorist attacks at home with vulnerabilities in our ports and other infrastructure in desperate need of improved security. Many of our first responders—the very front line of defense for our hometowns—lack interoperable communications and other resources critical to their success.

Mr. Speaker, today, almost 9 million Americans are unemployed, including almost 3 million manufacturing jobs that have been lost during the past three years. Our Nation has accumulated a national debt of over $7 trillion—more and more of which is owned to foreign nations, including China. Despite our burgeoning debt, the House Republican leadership refuses even to acknowledge a problem, refuses to adopt sensible "pay-as-you-go" rules that recognize the very real cost of both spending increases and tax cuts, and insists on budgets with larger and larger deficits, including a deficit in excess of $360 billion in FY 2005 alone.

Mr. Speaker, as we complete our work during "Cover the Uninsured Week," almost 44 million Americans—15 percent of all Americans—have no health insurance. That number includes almost 8 million children. Almost 44 million Americans have no health insurance, despite the fact that the vast majority of them have full-time jobs.

So, Mr. Speaker, we have a health care crisis in this country that demands a solution. Nevertheless, to paraphrase President Reagan, "here we go again." Instead of working on real solutions to cover the uninsured and to solve the many other very real and immediate problems the country faces, today, we are spending the People's time and money to consider again legislation we have already passed.

Mr. Speaker, our nation's health care providers—our doctors, our nurses, our hospitals and nursing homes—are confronting skyrocketing medical malpractice insurance premiums. They need relief now. What they don't need is the warmed over illusory promise of relief that the HEALTH Act represents.

The HEALTH Act will not provide the relief American physicians, hospitals and other health care providers need. It didn't do anything to reduce escalating medical liability insurance premiums when we passed it last March; legislation like it has not done anything to reduce premiums in the many states that already have enacted damage caps; and it will not magically result in reduced premiums if it passes the House again today.

The simple fact is that claims from the Republican leadership that limiting liability for medical negligence will cure the healthcare cost crisis are without merit. Focusing solely on limiting malpractice liability, without insurance reform, does nothing to reduce the ever increasing costs of medical malpractice insurance. Damage caps such as those in H.R. 4280 do accomplish one thing: they boost insurers' profits. With damage caps, malpractice insurers win at the expense of physicians, nurses, hospitals and other health care providers.

Mr. Speaker, last year, after we last considered the HEALTH Act, my home state of Texas enacted comprehensive tort ''reform'' legislation strikingly similar to the HEALTH Act we considered and passed in March 2003 and that we consider again today. During the long debate on that legislation, proponents of the damage cap legislation repeatedly assured opponents that imposition of liability limitations would lead to dramatic medical liability insurance premium decreases.

Not surprisingly, however, the imposition of damage caps did not have the predicted effect. To the contrary, all but one medical malpractice insurance carriers in Texas proposed increases in physician premiums. Consequently, malpractice insurance premiums for physicians are reported to have risen an average of 12 percent statewide despite the damage caps. For Texas hospitals and nursing homes, the news was even worse—an average proposed increase of 20 percent. Moreover, the only carrier reported to offer reduced premiums provided a rate reduction that fell far short of even recapturing the dramatic premium increases it imposed on physicians during the past three years.

In Texas, as in other states with caps, the evidence does not support the rhetoric; those who suggest the HEALTH Act or its ilk as a panacea simply fail to make their case. Clearly, old line thinking and the ''reform'' embodied in the HEALTH Act will not cure what ails the system and will not reduce premiums.

Mr. Speaker, 14 months ago, I stood on the floor of this House and called on my colleagues to stand up for the doctors and stand up for the hospitals. Because the House Republican leadership has seen fit to conduct debate on that same legislation, I suppose I am on solid ground reiterating what I said then.

Mr. Speaker, malpractice premiums are choking America's physicians, and H.R. 4280 is nothing but a sham because H.R. 4280 does not mention one time, from front to back, soup to nuts, does not ever even mention malpractice premiums. We need to do something about those premiums for the doctors. We need to do it now. We need to do it today. H.R. 4280 will not do it.

And how about frivolous lawsuits? Frivolous lawsuits need to be stopped. If a suit is filed with no basis in law or in fact, it should be dismissed at the cost of the plaintiff, and he plaintiff should be sanctioned. But what does H.R. 4280 say about frivolous lawsuits? It does not say one thing. That is a shame. That is outrageous.

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

H.R. 4280 is not good for doctors; it is not good for hospitals; it is not good for patients. Let us stand up for them. Let us do the right thing.

Mr. Speaker, the HEALTH Act was not progress in March 2003, and it's not progress now.

Apparently, the House Republican leadership wants to prove that Yogi Berra was wrong when he said, ''The future ain't what it used to be.'' In the U.S. House of Representatives, the future appears to be exactly what it used to be. And that's a real shame and a tragic disservice to the People who sent us to this great House.

I urge my colleagues to vote ''no'' on H.R. 4280.

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

The SPEAKER pro tempore (Mr. SWEENEY). All time for debate has expired.

Pursuant to House Resolution 638, the bill is considered read for amendment and the previous question is ordered.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. CONYERS

Mr. CONYERS. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. CONYERS. Yes, I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Conyers moves to recommit the bill H.R. 4280 to the Committee on the Judiciary and the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendments:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medical Malpractice and Insurance Reform Act of 2004''.

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

Sec. 1. Short title; table of contents.

TITLE I—LIMITING FRIVOLOUS MEDICAL MALPRACTICE LAWSUITS

Sec. 101. Statute of limitations.
Sec. 102. Health care specialist affidavit.
Sec. 103. Sanctions for frivolous actions and pleadings.
Sec. 104. Mandatory mediation.
Sec. 105. Limitation on punitive damages.
Sec. 106. Use of savings to benefit providers through reduced premiums.
Sec. 107. Definitions.
Sec. 108. Applicability.

TITLE II—INDEPENDENT ADVISORY COMMISSION ON MEDICAL MALPRACTICE INSURANCE

Sec. 201. Establishment.
Sec. 202. Duties.
Sec. 203. Report.
Sec. 204. Membership.
Sec. 205. Director and staff; experts and consultants.
Sec. 206. Powers.
Sec. 207. Authorization of appropriations.

TITLE I—LIMITING FRIVOLOUS MEDICAL MALPRACTICE LAWSUITS

SEC. 101. STATUTE OF LIMITATIONS.

(a) IN GENERAL.—A medical malpractice action shall be barred unless the complaint is filed within 3 years after the right of action accrues.

(b) ACCRUAL.—A right of action referred to in subsection (a) accrues upon the last to occur of the following dates:

(1) The date of the injury.

(2) The date on which the claimant discovers, or through the use of reasonable diligence should have discovered, the injury.

(3) The date on which the claimant becomes 18 years of age.

(c) APPLICABILITY.—This section shall apply to any injury occurring after the date of the enactment of this Act.

SEC. 102. HEALTH CARE SPECIALIST AFFIDAVIT.

(a) REQUIRING SUBMISSION WITH COMPLAINT.—No medical malpractice action may be brought by any individual unless, at the time the individual brings the action (except as provided in subsection (b)(1)), it is accompanied by the affidavit of a qualified specialist that includes the specialist's statement of belief that, based on a review of the available medical record and other relevant material, there is a reasonable and meritorious cause for the filing of the action against the defendant.

(b) EXTENSION IN CERTAIN INSTANCES.—

(1) IN GENERAL.—Subject to paragraph (2), subsection (a) shall not apply with respect to an individual who brings a medical malpractice action without submitting an affidavit described in such subsection if, as of the time the individual brings the action, the individual has been unable to obtain adequate medical records or other information necessary to prepare the affidavit.

(2) DEADLINE FOR SUBMISSION WHERE EXTENSION APPLIES.—In the case of an individual who brings an action for which paragraph (1) applies, the action shall be dismissed unless the individual (or the individual's attorney) submits the affidavit described in subsection (a) not later than 90 days after obtaining the information described in such paragraph.

(c) QUALIFIED SPECIALIST DEFINED.—In subsection (a), a ''qualified specialist'' means, with respect to a medical malpractice action, a health care professional who is reasonably believed by the individual bringing the action (or the individual's attorney)—

(1) to be knowledgeable in the relevant issues involved in the action;

(2) to practice (or to have practiced) or to teach (or to have taught) in the same area of health care or medicine that is at issue in the action; and

(3) in the case of an action against a physician, to be board certified in a specialty relating to that area of medicine.

(d) CONFIDENTIALITY OF SPECIALIST.—Upon a showing of good cause by a defendant, the court may ascertain the identity of a specialist referred to in subsection (a) while preserving confidentiality.

SEC. 103. SANCTIONS FOR FRIVOLOUS ACTIONS AND PLEADINGS.

(a) SIGNATURE REQUIRED.—Every pleading, written motion, and other paper in any medical malpractice action shall be signed by at least 1 attorney of record in the attorney's individual name, or, if the party is not represented by an attorney, shall be signed by the party. Each paper shall state the signer's address and telephone number, if any. An unsigned paper shall be stricken unless omission of the signature is corrected promptly after being called to the attention of the attorney or party.

(b) CERTIFICATE OF MERIT.—(1) A medical malpractice action shall be dismissed unless the attorney or unrepresented party presenting the complaint certifies that, to the best of the person's knowledge, information, and belief, formed after an inquiry reasonable under the circumstances,—

(A) it is not being presented for any improper purpose, such as to harass or to cause

unnecessary delay or needless increase in the cost of litigation;

(B) the claims and other legal contentions therein are warranted by existing law or by a nonfrivolous argument for the extension, modification, or reversal of existing law or the establishment of new law; and

(C) the allegations and other factual contentions have evidentiary support or, if specifically so identified, are likely to have evidentiary support after a reasonable opportunity for further investigation and discovery.

(2) By presenting to the court (whether by signing, filing, submitting, or later advocating) a pleading, written motion, or other paper, an attorney or unrepresented party is certifying that to the best of the person's knowledge, information and belief, formed after an inquiry reasonable under the circumstances—

(A) it is not being presented for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation;

(B) the claims, defenses, and other legal contentions therein are warranted by existing law or by a nonfrivolous argument for the extension, modification, or reversal of existing law or the establishment of new law; and

(C) the allegations and other factual contentions have evidentiary support or, if specifically so identified, are reasonable based on a lack of information or belief.

(c) MANDATORY SANCTIONS.—

(1) FIRST VIOLATION.—If, after notice and a reasonable opportunity to respond, a court, upon motion or upon its own initiative, determines that subsection (b) has been violated, the court shall find each attorney or party in violation in contempt of court and shall require the payment of costs and attorneys fees. The court may also impose additional appropriate sanctions, such as striking the pleadings, dismissing the suit, and sanctions plus interest, upon the person in violation, or upon both such person and such person's attorney or client (as the case may be).

(2) SECOND VIOLATION.—If, after notice and a reasonable opportunity to respond, a court, upon motion or upon its own initiative, determines that subsection (b) has been violated and that the attorney or party with respect to which the determination was made has committed one previous violation of subsection (b) before this or any other court, the court shall find each such attorney or party in contempt of court and shall require the payment of costs and attorneys fees, and require such person in violation (or both such person and such person's attorney or client (as the case may be)) to pay a monetary fine. The court may also impose additional appropriate sanctions, such as striking the pleadings, dismissing the suit and sanctions plus interest, upon such person in violation, or upon both such person and such person's attorney or client (as the case may be).

(3) THIRD VIOLATION.—If, after notice and a reasonable opportunity to respond, a court, upon motion or upon its own initiative, determines that subsection (b) has been violated and that the attorney or party with respect to which the determination was made has committed more than one previous violation of subsection (b) before this or any other court, the court shall find each such attorney or party in contempt of court, refer each such attorney to one or more appropriate State bar associations for disciplinary proceedings, require the payment of costs and attorneys fees, and require such person in violation (or both such person and such person's attorney or client (as the case may be)) to pay a monetary fine. The court may also impose additional appropriate sanctions, such as striking the pleadings, dismissing the suit, and sanctions plus interest, upon such person in violation, or upon both such person and such person's attorney or client (as the case may be).

SEC. 104. MANDATORY MEDIATION.

(a) IN GENERAL.—In any medical malpractice action, before such action comes to trial, mediation shall be required. Such mediation shall be conducted by one or more mediators who are selected by agreement of the parties or, if the parties do not agree, who are qualified under applicable State law and selected by the court.

(b) REQUIREMENTS.—Mediation under subsection (a) shall be made available by a State subject to the following requirements:

(1) Participation in such mediation shall be in lieu of any alternative dispute resolution method required by any other law or by any contractual arrangement made by or on behalf of the parties before the commencement of the action.

(2) Each State shall disclose to residents of the State the availability and procedures for resolution of consumer grievances regarding the provision of (or failure to provide) health care services, including such mediation.

(3) Each State shall provide that such mediation may begin before or after, at the option of the claimant, the commencement of a medical malpractice action.

(4) The Attorney General, in consultation with the Secretary of Health and Human Services, shall, by regulation, develop requirements with respect to such mediation to ensure that it is carried out in a manner that—

(A) is affordable for the parties involved;

(B) encourages timely resolution of claims;

(C) encourages the consistent and fair resolution of claims; and

(D) provides for reasonably convenient access to dispute resolution.

(c) FURTHER REDRESS AND ADMISSIBILITY.—Any party dissatisfied with a determination reached with respect to a medical malpractice claim as a result of an alternative dispute resolution method applied under this section shall not be bound by such determination. The results of any alternative dispute resolution method applied under this section, and all statements, offers, and communications made during the application of such method, shall be inadmissible for purposes of adjudicating the claim.

SEC. 105. LIMITATION ON PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may not be awarded in a medical malpractice action, except upon proof of—

(1) gross negligence;

(2) reckless indifference to life; or

(3) an intentional act, such as voluntary intoxication or impairment by a physician, sexual abuse or misconduct, assault and battery, or falsification of records.

(b) ALLOCATION.—In such a case, the award of punitive damages shall be allocated 50 percent to the claimant and 50 percent to a trustee appointed by the court, to be used by such trustee in the manner specified in subsection (d). The court shall appoint the Secretary of Health and Human Services as such trustee.

(c) EXCEPTION.—This section shall not apply with respect to an action if the applicable State law provides (or has been construed to provide) for damages in such an action that are only punitive or exemplary in nature.

(d) TRUST FUND.—

(1) IN GENERAL.—This subsection applies to amounts allocated to the Secretary of Health and Human Services as trustee under subsection (b).

(2) AVAILABILITY.—Such amounts shall, to the extent provided in advance in appropriations Acts, be available for use by the Secretary of Health and Human Services under paragraph (3) and shall remain so available until expended.

(3) USE.—

(A) Subject to subparagraph (B), the Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, shall use the amounts to which this subsection applies for activities to reduce medical errors and improve patient safety.

(B) The Secretary of Health and Human Services may not use any part of such amounts to establish or maintain any system that requires mandatory reporting of medical errors.

(C) The Secretary of Health and Human Services shall promulgate regulations to establish programs and procedures for carrying out this paragraph.

(4) INVESTMENT.—

(A) The Secretary of Health and Human Services shall invest the amounts to which this subsection applies in such amounts as such Secretary determines are not required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

(B) Any obligation acquired by the Secretary in such Secretary's capacity as trustee of such amounts may be sold by the Secretary at the market price.

SEC. 106. USE OF SAVINGS TO BENEFIT PROVIDERS THROUGH REDUCED PREMIUMS.

(a) IN GENERAL.—Notwithstanding any other provision of this title, a provision of this title may be applied by a court to the benefit of a party insured by a medical malpractice liability insurance company only if the court—

(1) determines the amount of savings realized by the company as a result; and

(2) requires the company to pay an amount equal to the amount of such savings to a trustee appointed by the court, to be distributed by such trustee in a manner that has the effect of benefiting health care providers insured by the company through reduced premiums for medical malpractice liability insurance.

(b) DEFINITION.—For purposes of this section, the term ''medical malpractice liability insurance company'' means an entity in the business of providing an insurance policy under which the entity makes payment in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim.

SEC. 107. DEFINITIONS.

In this title, the following definitions apply:

(1) ALTERNATIVE DISPUTE RESOLUTION METHOD.—The term ''alternative dispute resolution method'' means a method that provides for the resolution of medical malpractice claims in a manner other than through medical malpractice actions.

(2) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice claim, and any person on whose behalf such a claim is alleged, including the decedent in the case of an action brought through or on behalf of an estate.

(3) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by the laws or regulations of the State to be licensed or certified by the State to provide such services in the State.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(5) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice action or a medical malpractice claim.

(6) MANDATORY.—The term ''mandatory'' means required to be used by the parties to attempt to resolve a medical malpractice claim notwithstanding any other provision of an agreement, State law, or Federal law.

(7) MEDIATION.—The term ''mediation'' means a settlement process coordinated by a neutral third party and without the ultimate rendering of a formal opinion as to factual or legal findings.

(8) MEDICAL MALPRACTICE ACTION.—The term ''medical malpractice action'' means an action in any State or Federal court against a physician, or other health professional, who is licensed in accordance with the requirements of the State involved that—

(A) arises under the law of the State involved;

(B) alleges the failure of such physician or other health professional to adhere to the relevant professional standard of care for the service and specialty involved;

(C) alleges death or injury proximately caused by such failure; and

(D) seeks monetary damages, whether compensatory or punitive, as relief for such death or injury.

(9) MEDICAL MALPRACTICE CLAIM.—The term ''medical malpractice claim'' means a claim forming the basis of a medical malpractice action.

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

SEC. 108. APPLICABILITY.

(a) IN GENERAL.—Except as provided in section 104, this title shall apply with respect to any medical malpractice action brought on or after the date of the enactment of this Act.

(b) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over medical malpractice actions on the basis of section 1331 or 1337 of title 28, United States Code.

TITLE II—INDEPENDENT ADVISORY COMMISSION ON MEDICAL MALPRACTICE INSURANCE

SEC. 201. ESTABLISHMENT.

(a) FINDINGS.—The Congress finds as follows:

(1) The sudden rise in medical malpractice premiums in regions of the United States can threaten patient access to doctors and other health providers.

(2) Improving patient access to doctors and other health providers is a national priority.

(b) ESTABLISHMENT.—There is established a national commission to be known as the ''Independent Advisory Commission on Medical Malpractice Insurance'' (in this title referred to as the ''Commission'').

SEC. 202. DUTIES.

(a) IN GENERAL.—(1) The Commission shall evaluate the effectiveness of health care liability reforms in achieving the purposes specified in paragraph (2) in comparison to the effectiveness of other legislative proposals to achieve the same purposes.

(2) The purposes referred to in paragraph (1) are to—

(A) improve the availability of health care services;

(B) reduce the incidence of ''defensive medicine'';

(C) lower the cost of health care liability insurance;

(D) ensure that persons with meritorious health care injury claims receive fair and adequate compensation; and

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

(b) CONSIDERATIONS.—In formulating proposals on the effectiveness of health care liability reform in comparison to these alternatives, the Commission shall, at a minimum, consider the following:

(1) Alternatives to the current medical malpractice tort system that would ensure adequate compensation for patients, preserve access to providers, and improve health care safety and quality.

(2) Modifications of, and alternatives to, the existing State and Federal regulations and oversight that affect, or could affect, medical malpractice lines of insurance.

(3) State and Federal reforms that would distribute the risk of medical malpractice more equitably among health care providers.

(4) State and Federal reforms that would more evenly distribute the risk of medical malpractice across various categories of providers.

(5) The effect of a Federal medical malpractice reinsurance program administered by the Department of Health and Human Services.

(6) The effect of a Federal medical malpractice insurance program, administered by the Department of Health and Human Services, to provide medical malpractice insurance based on customary coverage terms and liability amounts in States where such insurance is unavailable or is unavailable at reasonable and customary terms.

(7) Programs that would reduce medical errors and increase patient safety, including new innovations in technology and management.

(8) The effect of State policies under which—

(A) any health care professional licensed by the State has standing in any State administrative proceeding to challenge a proposed rate increase in medical malpractice insurance; and

(B) a provider of medical malpractice insurance in the State may not implement a rate increase in such insurance unless the provider, at minimum, first submits to the appropriate State agency a description of the rate increase and a substantial justification for the rate increase.

(9) The effect of reforming antitrust law to prohibit anticompetitive activities by medical malpractice insurers.

(10) Programs to facilitate price comparison of medical malpractice insurance by enabling any health care provider to obtain a quote from each medical malpractice insurer to write the type of coverage sought by the provider.

(11) The effect of providing Federal grants for geographic areas that have a shortage of one or more types of health providers as a result of the providers making the decision to cease or curtail providing health services in the geographic areas because of the costs of maintaining malpractice insurance.

SEC. 203. REPORT.

(a) IN GENERAL.—The Commission shall transmit to Congress—

(1) an initial report not later than 180 days after the date of the initial meeting of the Commission; and

(2) a report not less than each year thereafter until the Commission terminates.

(b) CONTENTS.—Each report transmitted under this section shall contain a detailed statement of the findings and conclusions of the Commission.

(c) VOTING AND REPORTING REQUIREMENTS.—With respect to each proposal or recommendation contained in the report submitted under subsection (a), each member of the Commission shall vote on the proposal or recommendation, and the Commission shall include, by member, the results of that vote in the report.

SEC. 204. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General of the United States.

(b) MEMBERSHIP.—

(1) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, medical malpractice insurance, insurance regulation, health care law, health care policy, health care access, allopathic and osteopathic physicians, other providers of health care services, patient advocacy, and other related fields, who provide a mix of different professionals, broad geographic representations, and a balance between urban and rural representatives.

(2) INCLUSION.—The membership of the Commission shall include the following:

(A) Two individuals with expertise in health finance and economics, including one with expertise in consumer protections in the area of health finance and economics.

(B) Two individuals with expertise in medical malpractice insurance, representing both commercial insurance carriers and physician-sponsored insurance carriers.

(C) An individual with expertise in State insurance regulation and State insurance markets.

(D) An individual representing physicians.

(E) An individual with expertise in issues affecting hospitals, nursing homes, nurses, and other providers.

(F) Two individuals representing patient interests.

(G) Two individuals with expertise in health care law or health care policy.

(H) An individual with expertise in representing patients in malpractice lawsuits.

(3) MAJORITY.—The total number of individuals who are directly involved with the provision or management of malpractice insurance, representing physicians or other providers, or representing physicians or other providers in malpractice lawsuits, shall not constitute a majority of the membership of the Commission.

(4) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of the Commission of financial or other potential conflicts of interest relating to such members.

(c) TERMS.—

(1) IN GENERAL.—The terms of the members of the Commission shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(2) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(3) COMPENSATION.—Members of the Commission shall be compensated in accordance

with section 1805(c)(4) of the Social Security Act.

(4) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate at the time of appointment a member of the Commission as Chairman and a member as Vice Chairman. In the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

(5) MEETINGS.—

(A) IN GENERAL.—The Commission shall meet at the call of the Chairman.

(B) INITIAL MEETING.—The Commission shall hold an initial meeting not later than the date that is 1 year after the date of the enactment of this title, or the date that is 3 months after the appointment of all the members of the Commission, whichever occurs earlier.

SEC. 205. DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.

Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties;

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission;

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

SEC. 206. POWERS.

(a) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

(b) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

(1) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(2) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(3) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

(c) ACCESS OF GENERAL ACCOUNTING OFFICE TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

(d) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General of the United States.

SEC. 207. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this title for each of fiscal years 2004 through 2008.

(b) REQUESTS FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

Amend the title so as to read: ''A bill to limit frivolous medical malpractice lawsuits, to reform the medical malpractice insurance business in order to reduce the cost of medical malpractice insurance, to enhance patient access to medical care, and for other purposes.''.

Mr. CONYERS (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

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

There was no objection.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Michigan (Mr. CONYERS) is recognized for 5 minutes in support of his motion.

Mr. CONYERS. Mr. Speaker, this motion is being offered by me and the dean of the Congress, the gentleman from Michigan (Mr. DINGELL). We are offering this motion to recommit to attack the heart of the medical malpractice crisis. Rather than limiting the rights of legitimate malpractice victims, as the bill before us would do, our motion would logically and directly address the problems of frivolous lawsuits and insurance industry abuses.

Title I addresses the problem of frivolous lawsuits. It would require that both an attorney and a health care specialist submit an affidavit that the claim is warranted before malpractice action can be brought and imposes strict sanctions for attorneys who make frivolous pleadings. But it provides also for mandatory mediation, a uniform statute of limitations, and a narrowing of the requirements for punitive damage claims. Finally, insurers would be required to dedicate at least 50 percent of any savings resulting from the litigation reforms to reduce the premiums that medical professionals pay.

Unlike the majority's bill before us, this motion is limited to licensed physicians and health professionals for malpractice cases only. It does not include lawsuits against HMOs, insurance companies, nursing homes, and drug and device manufacturers.

The second part of this motion to recommit, title II, establishes a national commission to evaluate the rising insurance premiums and the causes for why that is occurring. The commission would consider, among other things, whether the McCarran-Ferguson Antitrust exemption for medical malpractice insurers should be reconsidered and possibly repealed and study the potential benefits of providing a Federal medical malpractice insurance program where insurance was unavailable or unaffordable.

This same commission, 15-person commission appointed by the Comptroller General, would also consider government-sponsored grant programs to give direct assistance to areas facing a shortage of health care providers, as well as to send physicians to trauma centers that are in danger of closing because of rising premiums. Finally, it would consider alternative means of reducing medical errors and increasing patient safety.

So support this motion to recommit. It is good policy. It changes the whole line of unbelievably reactionary legislation that has come out of this House on this subject before now. It is time for a change. We want to limit frivolous lawsuits, and this would give us an opportunity to examine the real causes of the medical malpractice insurance crisis.

The SPEAKER pro tempore. Does the gentleman from Wisconsin (Mr. SENSENBRENNER) rise in opposition to the motion?

Mr. SENSENBRENNER. I do, Mr. Speaker.

The SPEAKER pro tempore. The gentleman from Wisconsin (Mr. SENSENBRENNER) is recognized for 5 minutes.

Mr. SENSENBRENNER. Mr. Speaker, yes, it is time for a change, and it is time for a real change. This motion to recommit does not provide a real change, and it should be defeated. It should be defeated because it contains zero legal protections for doctors beyond current law.

Legal reforms are essential to solving the current crisis in the medical professional liability insurance area and increasing access of health care to all. Here is what the president of the National Association of Insurance Commissioners said: ''To date, insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price-fixing, bid-rigging, or market allocation. The evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice rates.''

The underlying bill, and not the motion to recommit, is the only proven legislative solution to the current crisis. According to the CBO, under H.R. 4280 ''premiums for medical malpractice insurance ultimately would be an average of 25 to 30 percent below what they would be under current law.''

The motion to recommit, on the other hand, besides including zero legal protections for doctors beyond current law, sets up an advisory commission to study a problem that is already patently obvious to the most casual observer and to report back sometime in the future when even more patients will have lost access to essential medical care.

Opponents of the bill claim there is no enforcement mechanism to make sure that medical professional liability rates go down. That is completely false. An enforcement mechanism already exists throughout all 50 States, namely, State insurance commissioners who are required by State law

to turn down rates that are excessive, unfairly discriminatory, or otherwise unjustified. On the other hand, the motion to recommit creates a system of price controls linked to savings that without the legal protections in this bill will be nonexistent. Without legal reforms, there will be no cost savings, and the motion to recommit contains zero legal protections beyond the current law.

Along with creating a commission to further study a problem that is obvious, the motion simply throws more Federal money at it. H.R. 4280, on the other hand, contains solid legal reforms that have been proven successful over 28 years in California and will save billions of dollars in taxpayers' funds, according to the CBO. The choice is clear: oppose the motion to recommit, support H.R. 4280, and let us make sure that doctors are there to care for the 287 million Americans.

Mr. Speaker, I urge defeat of this motion and passage of the bill.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

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

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

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

The Sergeant at Arms will notify absent Members.

Pursuant to clauses 8 and 9 of rule XX, this 15-minute vote on the motion to recommit will be followed by 5-minute votes, if ordered, on passage of H.R. 4280, adoption of H. Con. Res. 378, and adoption of H. Con. Res. 409.

The vote was taken by electronic device, and there were—yeas 193, nays 231, not voting 9, as follows:

[Roll No. 165]

YEAS—193

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

NAYS—231

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Berkley
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Cramer
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis (FL)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Holden
Hostettler
Houghton
Hulshof
Hunter
Isakson
Issa
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Larson (CT)
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
Matheson
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Mollohan
Moran (KS)
Murphy
Murtha
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOT VOTING—9

Brown-Waite, Ginny
DeMint
Hyde
Istook
Lantos
Lowey
Reyes
Scott (GA)
Tauzin

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SWEENEY) (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 1748

Ms. McCOLLUM changed her vote from ''nay'' to ''yea.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

Stated against:

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, on rollcall No. 165, I was unavoidably detained. Had I been present, I would have voted "no."

The SPEAKER pro tempore (Mr. SWEENEY). The question is on the passage of the bill.

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

RECORDED VOTE

Mr. GREENWOOD. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 229, noes 197, not voting 7, as follows:

[Roll No. 166]

AYES—229

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Cardoza
Carter
Castle
Chabot
Chocola
Cole
Collins
Cox
Cramer
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, M.
Dooley (CA)
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Foley
Forbes
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Gordon

Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Holden
Hostettler
Houghton
Hulshof
Hunter
Isakson
Issa
Johnson (CT)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
Matheson
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Murtha
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Stenholm
Sullivan
Sweeney
Tancredo
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOES—197

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Case
Chandler
Clay
Clyburn
Coble
Conyers
Cooper
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Diaz-Balart, L.
Dicks
Dingell
Doggett
Doolittle
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Flake
Ford
Frost
Gephardt
Gonzalez
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Istook
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Jenkins
John
Johnson (IL)
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (NY)
Kleczka
Kucinich
Lampson
Langevin
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lynch
Majette
Maloney
Markey
Marshall
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Price (NC)
Rahall
Rangel
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Strickland
Stupak
Tanner
Tauscher
Terry
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—7

DeMint
Hyde
Lantos
Lowey
Reyes
Scott (GA)
Tauzin

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 1800

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MAKING IN ORDER AT ANY TIME CONSIDERATION OF H. CON. RES. 414, EXPRESSING SENSE OF CONGRESS THAT ALL AMERICANS OBSERVE THE 50TH ANNIVERSARY OF BROWN V. BOARD OF EDUCATION WITH A COMMITMENT TO CONTINUING AND BUILDING ON THE LEGACY OF BROWN

Mr. SENSENBRENNER. Mr. Speaker, I ask unanimous consent that it shall be in order at any time without intervention of any point of order to consider House Concurrent Resolution 414;

The concurrent resolution shall be considered as read for amendment; and the previous question shall be considered as ordered on the concurrent resolution to final adoption without intervening motion or demand for a division of the question excepted: (1) 30 minutes of debate on the concurrent resolution equally divided and controlled by the chairman and ranking minority member of the Committee on the Judiciary; and (2) one motion to recommit.

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

There was no objection.

□ 1800

CALLING ON THE GOVERNMENT OF SOCIALIST REPUBLIC OF VIETNAM TO RELEASE FATHER THADDEUS NGUYEN VAN LY

The SPEAKER pro tempore (Mr. SWEENEY). The unfinished business is the question of suspending the rules and agreeing to the concurrent resolution, H. Con. Res. 378, as amended.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 378, as amended, on which the yeas and nays are ordered.

Without objection, the remaining two votes in this series will be 5-minute votes.

There was no objection.

The vote was taken by electronic device, and there were—yeas 424, nays 1, not voting 8, as follows:

[Roll No. 167]

YEAS—424

Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chandler
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gephardt
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski