MICRA's caps on pain and suffering damages have not reduced insurance rates for doctors in my state. MICRA was signed into law in 1975, but stability in medical malpractice insurance rates did not occur after MICRA was passed. Between 1975 and 1993, in fact, health care costs in California rose 343 percent, nearly twice the rate of inflation. Not only that, but the California costs exceeded the national average each year during that period by an average of 9 percent per year.

Any rate stabilization that has occurred in California is not due to caps, but to Proposition 103, which went into effect in 1990. Proposition 103 was an insurance reform initiative that changed California's insurance laws from a so-called ''open competition'' to a ''prior approval'' regulatory system. Prop. 103 requires insurers to obtain approval of rate increases. But even with enactment of Proposition 103, rates in California have stayed close to national premium trends.

Medical malpractice insurance rate hikes are cyclical. They tend to be at their highest when insurance companies' investment income is at its lowest. Tort caps have not and do not eliminate this cyclical pattern.

I'm not the only one who has said that tort caps alone will not lower insurance rates. I would like to quote just a few other individuals who have made similar statements:

''Insurers never promised that tort reform would achieve specific savings.''—American Insurance Association

''We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.''—Sherman Joyce, president of the American Tort Reform Association

''Many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years.''—Victor Schwartz, general counsel to the American Tort Reform Association

Insurance companies are reluctant to look at any role they may play in the increasing liability insurance rates. Yet, their investment practices have made it nearly impossible for them to balance paid claims with premiums. Capping damages for plaintiffs is only one part of the stabilization equation. In order to bring about true stabilization, we must reform the insurance industry.

H.R. 5, without insurance reform is meaningless. H.R. 5 simply re-injures the legitimate victims of medical malpractice.

Had we been given the opportunity, Democrats would have offered a substitute crafted by Representative DINGELL and CONYERS. That substitute takes concrete steps to eliminating frivolous lawsuits. It requires insurance companies to share their savings with doctors and patients. It evaluates the causes of insurance rate increases and proposes solutions. In short, it seeks to deal with the problem of rising medical malpractice insurance rates by addressing all aspects of the problem—insurance companies, doctors, patients, and the tort system. It would have been the comprehensive and fair way of fighting the real problem. This legislation would have prevented the forest fire before it began.

The Members of this House—and the general American public—deserve the opportunity to consider a real proposal to address the medical malpractice insurance rate crisis. I urge a no vote on this rule.

Mr. UDALL of Colorado. Mr. Speaker, I regret that I cannot support this legislation.

I do think that high premiums for malpractice insurance are a serious problem for doctors in many states. And I agree with the bill's supporters that this is a problem for those who need medical services, because it tends to make health care less available.

I would like to do something about that problem—but I think that if Congress is going to act, it should do so in a way that is both better balanced and better focused than the bill the House is debating today.

The need for balance and focus is all the greater when Congress considers legislation that would apply everywhere and would override a number of different State laws, including laws related to the relations between Health Maintenance Organizations (HMOs) and individual patients.

Over the years, many of our colleagues—particularly those on the other side of the aisle—have been outspoken about the problems associated with that kind of top-down, one-size fits-all approach to a problem that can be addressed by State legislators who are in a better position to respond to the particular circumstances of their constituents.

I haven't always agreed with those criticisms, but in this case I think they are appropriate.

For example, Colorado law places limits on the amounts that can be awarded in some lawsuits against doctors. I do not think the Colorado law is perfect, but I do think that our legislature is in a better position to judge such matters than the Congress—especially when we are forced to act under the kind of restrictive rules the one that applies to this bill.

I hoped the Republican leadership would let the House consider amendments that could have made this bill more effective and better balanced. However, that did not happen, and now we are forced with a take-it-or-leave it choice—a ''my way or the highway'' approach to legislating that is unworthy of this House.

Under those circumstances, and after careful consideration, I have decided I cannot support the bill. I am not persuaded that it will have a significant effect on the premiums doctors have to pay for malpractice insurance—or at least an effect great enough to warrant the reduction in the ability of injured people to win redress of their damages.

We have heard much about ''frivolous'' lawsuits—and I think there really are some. But not every lawsuit is frivolous—some are well-founded, because sometimes people really are hurt by negligence or other improper conduct. If I were persuaded that this bill struck the right balance, reducing the risks of frivolous lawsuits without unduly affecting the others—and if I were persuaded that as a result escalating insurance premiums would be effectively restrained—I would support it.

But as it is, I am not persuaded of those things and so, given the sole choice of a yes or no vote, I must regretfully vote no.

Mr. PAUL. Mr. Speaker, as an OB–GYN with over 30 years in private practice, I understand better than perhaps any other member of Congress the burden imposed on both medical practitioners and patients by excessive malpractice judgments and the corresponding explosion in malpractice insurance premiums. Malpractice insurance has skyrocketed to the point where doctors are unable to practice in some areas or see certain types of patients because they cannot afford the insurance premiums. This crisis has particularly hit my area of practice, leaving some pregnant women unable to find a qualified obstetrician in their city. Therefore, I am pleased to see Congress address this problem.

However this bill raises several questions of constitutionality, as well as whether it treats those victimized by large corporations and medical devices fairly. In addition, it places de facto price controls on the amounts injured parties can receive in a lawsuit and rewrites every contingency fee contract in the country. Yet, among all the new assumptions of federal power, this bill does nothing to address the power of insurance companies over the medical profession. Thus, even if the reforms of H.R. 5 become law, there will be nothing to stop the insurance companies from continuing to charge exorbitant rates.

Of course, I am not suggesting Congress place price controls on the insurance industry. Instead, Congress should reexamine those federal laws such as ERISA and the HMO Act of 1973, which have allowed insurers to achieve such a prominent role in the medical profession. As I will detail below, Congress should also take steps to encourage contractual means of resolving malpractice disputes. Such an approach may not be beneficial to the insurance companies or the trial lawyers, buy will certainly benefit the patients and physicians, which both sides in this debate claim to represent.

H.R. 5 does contain some positive elements. For example, the language limiting joint and several liabilities to the percentage of damage someone actually caused, is a reform I have long championed. However, Mr. Speaker, H.R. 5 exceeds Congress' constitutional authority by preempting state law. Congressional dissatisfaction with the malpractice laws in some states provides no justification for Congress to impose uniform standards on all 50 states. The 10th amendment does not authorize federal action in areas otherwise reserved to the states simply because some members of Congress are unhappy with the way the states have handled the problem. Ironically, H.R. 5 actually increases the risk of frivolous litigation in some states by lengthening the statue of limitations and changing the definition of comparative negligence!

I am also disturbed by the language that limits liability for those harmed by FDA-approved products. This language, in effect, establishes FDA approval as the gold standard for measuring the safety and soundness of medical devices. However, if FDA approval guaranteed safety, then the FDA would not regularly issue recalls of approved products later found to endanger human health and/or safety.

Mr. Speaker, H.R. 5 also punishes victims of government mandates by limiting the ability of those who have suffered adverse reactions from vaccines to collect damages. Many of those affected by these provisions are children forced by federal mandates to receive vaccines. Oftentimes, parents reluctantly submit to these mandates in order to ensure their children can attend public school. H.R. 5 rubs salt in the wounds of those parents whose children may have been harmed by government policies forcing children to receive unsafe vaccines.

Rather than further expanding unconstitutional mandates and harming those with a legitimate claim to collect compensation, Congress should be looking for ways to encourage

physicians and patients to resolve questions of liability via private, binding contracts. The root cause of the malpractice crisis (and all of the problems with the health care system) is the shift away from treating the doctor-patient relationship as a contractual one to viewing it as one governed by regulations imposed by insurance company functionaries, politicians, government bureaucrats, and trial lawyers. There is no reason why questions of the assessment of liability and compensation cannot be determined by a private contractual agreement between physicians and patients.

I have introduced the Freedom from Unnecessary Litigation Act (H.R. 1249). H.R. 1249 provides tax incentives to individuals who agree to purchase malpractice insurance, which will automatically provide coverage for any injuries sustained in treatment. This will insure that those harmed by spiraling medical errors receive timely and full compensation. My plan spares both patients and doctors the costs of a lengthy, drawn-out trial and respects Congress' constitutional limitations.

Congress could also help physicians lower insurance rates by passing legislation, such as my Quality Health Care Coalition Act (H.R. 1247), that removes the antitrust restrictions preventing physicians from forming professional organizations for the purpose of negotiating contracts with insurance companies and HMOs. These laws give insurance companies and HMOs, who are often protected from excessive malpractice claims by ERISA, the ability to force doctors to sign contracts exposing them to excessive insurance premiums and limiting their exercise of professional judgment. The lack of a level playing field also enables insurance companies to raise premiums at will. In fact, it seems odd that malpractice premiums have skyrocketed at a time when insurance companies need to find other sources of revenue to compensate for their losses in the stock market.

In conclusion, Mr. Speaker, while I support the efforts of the sponsors of H.R. 5 to address the crisis in health care caused by excessive malpractice litigation and insurance premiums, I cannot support this bill. H.R. 5 exceeds Congress' constitutional limitations and denies full compensation to those harmed by the unintentional effects of federal vaccine mandates. Instead of furthering unconstitutional authority, my colleagues should focus on addressing the root causes of the malpractice crisis by supporting efforts to restore the primacy of contract to the doctor-patient relationships.

Mr. STRICKLAND. Mr. Speaker, I speak on the floor today in opposition to H.R. 5 and in opposition to the closed rule under which we are debating the bill.

I have heard from doctors and hospitals throughout my district that they are struggling with high malpractice rates. I think we all recognize that this is a big problem in many regions of the country, and I believe we must take action to ensure patients can continue to access quality and timely health care. In my rural Ohio district, access to care is a constant problem for many of my constituents. I hear the voices of the family practice physicians who tell me they no longer may be able to afford to deliver babies. In some cases in Ohio, pregnant women must travel long distances for prenatal care and delivery services because there is only one doctor providing these services throughout a county. Something must be done, but I do not think H.R. 5 gets it done.

These are the reasons I have cosponsored H.R. 1124, which has been introduced by Rep. DINGELL. H.R. 1124 would address high malpractice rates through moderate tort reforms, requiring attorneys to submit a certificate of merit declaring a case to be meritorious, and requiring medical malpractice insurance companies to dedicate at least 50 percent of the savings from these tort reforms to reducing the insurance premiums paid by physicians and other health professionals. In addition, H.R. 1124 attempts to look at the broad issues that may have contributed to the high malpractice rates doctors across the country are facing by establishing an independent advisory commission on medical malpractice insurance. I wish Congress had acted quickly and in a bipartisan fashion last year—had we done so, we may already have more answers about why rates are now as high as they are. And finally, H.R. 1124 would create a grants program through the Department of Health and Human Services to ensure that areas affected by high malpractice rates do not suffer a shortage of providers. However, we will not even hear debate about these provisions or others because the Leadership passed a closed rule that limits debate to the base bill. This does a disservice to the American people, to the House, and to the health care providers we want to help.

I believe H.R. 5 will not address the high malpractice rates our doctors are confronting. H.R. 5 fails to address or even acknowledge the complicated nature of this problem: my colleagues who have introduced H.R. 5 haven't considered how the insurance industry may have contributed to the high rates or considered how individual states' systems have affected malpractice rates.

Throughout the Energy and Commerce Committee's consideration of H.R. 5, I spoke about two provisions in H.R. 5 that I strongly oppose.

First, H.R. 5 would limit the liability of HMO's, drug companies, and nursing homes. These companies have never come to me to explain why their liability should be limited; in fact, I strongly believe consumers should have the right to use every tool possible to collect damages if they are injured by a drug or device company whose product is defective. My constituents have access to prescription drugs—the drugs are there in the pharmacy, ready to be purchased, and the drug companies aren't going out of business. Unfortunately, many of my constituents, especially seniors, can't afford to pay the prices these companies are charging. Since the drug companies are doing quite well, I think it's safe to say that they don't need the further protections H.R. 5 would afford them.

Second, I cannot support H.R. 5 because of its $250,000 limit on noneconomic damages. Noneconomic damages are awarded by a jury to compensate a victim for intangible pain and suffering. These noneconomic damages compensate for real, permanent harms that are not easily measured in terms of money, including blindness, physical disfigurement, loss of fertility, loss of limb, loss of mobility, and the loss of a child.

Noneconomic damages are often very important to low income adults, women, and children who often would not recover a large economic damage award when they are injured. In addition, someone whose injury is purely cosmetic may not have economic damages because the injury doesn't directly affect his or her ability to work. For example, the facial disfiguration 17-year-old Heather Lewinski has had to live with for the past 9 years because when she was 8 years old a plastic surgeon committed clear malpractice and scarred her for life. The years of pain and suffering Heather has lived with and testified to before the Energy and Commerce Committee two weeks ago are real. Heather's lawsuit against the plastic surgeon who injured her resulted in zero economic damages, but she did receive compensation in the form of noneconomic damages. H.R. 5 would have limited her award to $250,000. I cannot vote for legislation that would arbitrarily limit the damages that might be so important to the average American who finds themselves injured through medical malpractice. Although proponents of H.R. 5 contend that the bill will limit frivolous lawsuits, I believe it will not do so; instead, this provision would arbitrarily cap meritorious claims of malpractice.

I ask my colleagues: if we trust our jury system to make decisions about life and death, I believe we must be able to trust that jury system to make decisions about money.

The increase in malpractice rates is a huge problem for doctors and hospitals, and that is why I wish this bill had been crafted with input from the leaders of both parties. At the least, I wish we had the benefit of an open rule that would allow real debate here on the floor. I will not support this bill because I think it fails to prevent frivolous lawsuits, fails to address the problems with the insurance industry, and fails to provide direct relief to communities that are struggling with access problems resulting from high malpractice rates.

Mr. SHAYS. Mr. Speaker, I rise in support of the medical malpractice reforms contained in H.R. 5, the HEALTH Act. This legislation will help prevent frivolous litigation and significantly limit the practice of ''defensive medicine,'' which has contributed to spiraling health care costs.

H.R. 5 caps noneconomic at $250,000, but doesn't place any limit on the economic damages which plaintiffs can recover. Excessive jury awards have driven the cost of health care up for everyone, so in my mind, there has to be a limit on how much juries can award victims in non-economic and punitive damages. The HEALTH Act is critical to retarding the explosion in health costs and making insurance more affordable to the 41 million Americans who lack it.

The dramatic increases in insurance rates which many physicians have experienced over the past year also prevent them from actually practicing medicine. Many physicians I have spoken to are at wits' end trying to figure out how to maintain their practice and pay these exorbitant costs.

On March 4, the American Medical Association added Connecticut to the list of states facing crises in their medical malpractice insurance rates. The organization also cited Connecticut as a state where a large number of physicians have ended their practices because of the high medical malpractice insurance rates.

These malpractice reforms, which are based on a proven California law, will make much-needed changes to the federal civil justice system without denying the legal rights of legitimate plaintiffs. It is imperative we move forward on this reform to discourage abuse of

our legal system and curb the unsustainable growth of medical costs in our country.

Mr. Speaker, I strongly support the HEALTH Act because it will bring meaningful reform to a flawed system. I urge my colleagues to vote for this legislation.

Ms. KILPATRICK. Mr. Speaker, H.R. 5 is the Republican's quick fix to the health care crisis across the nation. They address the problem of increased insurance cost for medical malpractice, but have proposed a contorted theory for fixing it. An in-depth look at H.R. 5 shows that it does absolutely nothing to implement ways to decrease insurance premium costs, and furthermore, it does initiate means to increase the availability of medical malpractice insurance. For the foregoing reasons, I voted ''no'' on this passage.

H.R. 5 will limit the amount of non-economic damages that a patient can recover in a malpractice suit and it sets a bar for punitive damage recovery that is nearly impossible to reach. Overall, this bill limits the amount of recovery for all patients by providing a one-size-fits-all solution. How can we limit what a jury can award to an individual who has lost her/his right to reproduce because of a doctor's or medical manufacturer's negligence? How can we limit damage awards to an individual who has been paralyzed as a result of their negligence? How can we set a standard that is so difficult to meet that it will reduce the opportunity that plaintiffs will have to punish these defendants for their malicious acts? H.R. 5 is moving away from fixing the crisis in our health care industry and leaning towards making it worse by essentially punishing the victims.

Mr. Speaker, we need a bill that acts fast to help doctors and the medical industry sustain themselves financially. Right now, as we debate H.R. 5, thousands of doctors are leaving their respective states because they cannot afford the high insurance premiums. Doctors are now taking on much heavier loads of patients, much more than some of them can handle. To such as extent, some say that their situation is ripe for potential negligence cases, as they are not able to devote the attention necessary for the patient. They need our help now, Mr. Speaker, and we cannot change their situation by selling unfounded limits on non-economic damages.

Additionally, we must work to curb rogues from bringing fraudulent malpractice claims that flood our courtrooms, which are factored into the issue of high insurance premiums. For example, we should not prohibit a justified victim from receiving $750,000 in non-economic damages, but rather, we should aim to deter those rogues from each bringing fraudulent claims for non-economic damages worth $250,000. H.R. 5 does not provide for any differentiation between legitimate claims and the many unwarranted claims that bring a halt to judicial economy every day.

The Democratic substitute is superior because it would have sought and punished rogues for bringing fraudulent cases. It would not have capped non-economic damages or punitive damages. The substitute commissioned a study to assess the medical malpractice issue and determine how we can better address and then eliminate the problem. As for the current crisis, the substitute would authorize the Department of Health and Human Services (HHS) to provide grants to geographic areas that experienced extreme shortages of health providers due to the high premiums.

Although the Democratic substitute was superior for this crisis situation, the Republicans used their control of the House to prevent the substitute from being brought to the floor for a debate, along with any amendments that Democrats would have offered. This is undemocratic and an irresponsible use of leadership. The House floor is where all members should have the opportunity to discuss various ideas, views or bills from both sides of the aisle. To preclude that possibility is undemocratic. Mr. Speaker, I do not agree with the Republicans regulation of this very important issue and I also vehemently disagree with H.R. 5.

Mr. COSTELLO. Mr. Speaker, I rise today in opposition to H.R. 5, the HEALTH Act. There is no question that medical liability insurance rates are out of control. These high insurance costs are threatening to put many doctors and other health care professionals out of business and limit access to health care. However, I cannot in good faith support legislation that limits the rights of patients, victims, and their families while protecting the health insurance industry. HMOs and big health insurers should not receive special treatment; they are not above the law and should not be exempt from responsibility through this legislation.

Under H.R. 5, insurance carriers can still raise rates any amount, at anytime. The Republican Leadership refused to allow free and fair debate by not allowing a substitute or any amendments to be debated and voted upon by the House of Representatives. The substitute would reform malpractice insurance carriers, which is essential in solving the medical liability crisis. It would also weed out frivolous lawsuits without restricting the rights of legitimate claims.

H.R. 5 is a one-size-fits-all approach that places caps on non-economic and punitive damages and does not address the issue of frivolous lawsuits. When a stay-at-home mother, child, or senior citizen dies or suffers irreversible harm, there is no economic loss because it is impossible to prove damages from loss of income. H.R. 5 takes away the rights of parents who lose children, husbands who lose wives, children who lose parents, and patients who have very real losses that are not easily measured in terms of money. These caps imposed in H.R. 5 unfairly take away the rights of victims of medical malpractice to receive compensation for their injuries.

H.R. 5 is modeled after the state of California's 1975 reform laws; however, my Republican colleagues give a false impression of the ramifications of that law. For more than a decade after California passed the 1975 law limiting damages in medical malpractice lawsuits, doctors' premiums continued to rise faster, overall, than the national rate of inflation. Once voters enacted Proposition 103, a measure to cap all insurance rates in California, premiums leveled off. The ballot initiative curbed the premiums, not the law implementing caps.

Physicians in Illinois and across the country are facing skyrocketing medical liability premiums, and for many providers, medical liability insurance is either unaffordable or completely unavailable. I believe something needs to be done to derail frivolous lawsuits and reform the insurance industry. Insurers' business practices for accounting and pricing have contributed sharply to the current problem. H.R. 5 does not reform the insurance industry, places unfair, restrictive caps on victims, and does not address frivolous lawsuits. For these reasons, I oppose H.R. 5.

Mr. GARRETT of New Jersey. Mr. Speaker, it's always easier to fix blame than to find a solution. That's certainly true when it comes to the health care accessibility crisis we have right now in America.

In state after state, including my home state of New Jersey, doctors are closing down or limiting their practices. Trauma centers are shutting their doors, and overall health care costs are rising dramatically because of medical liability problems. Who suffers? Thousands upon thousands of individual patients who need care—some who need critical care.

Rather than solve this problem, some people want to distort the facts and point fingers to serve a large political agenda. They'd sacrifice access to medical care as part of their effort to prevent tort reform of any kind.

Today, I have heard allegations that the real culprit is the lack of regulation over insurance company investment practices and pricing. As the former chairman of the New Jersey Assembly Insurance Committee, I can assure you that this is simply not the case. Insurance is a highly-regulated industry, where state insurance departments oversee nearly every aspect of the marketplace, including product pricing and insurer investment practices.

To be more specific, state insurance laws do not allow insurance companies to raise rates to make up for past investment losses. As Steve Roddenberry, a top Florida insurance official, said recently, and I quote, ''We cannot permit it.'' Furthermore, the stock market has very little influence on companies who write medical malpractice insurance. In 2001, stock market investments made up just 9 percent of the industry's portfolio. Just 9 percent.

So it's simply not true that the lack of insurance regulation is causing premium increases. But what is causing those increases?

In large part, it's because the insurers are paying out more than they're taking in. That's right—insurance is an income-and-expense business just like any other. And in today's medical malpractice marketplace, companies are being forced to spend more on claims than they can collect in premiums.

The bottom line? The average medical malpractice insurance company is paying out $1.50 for every dollar it collects. That's not a recipe for success in the business world.

And that's why we have this crisis.

As long as insurance companies, many of which, by the way, are owned directly by their insured doctors, are faced with these losing scenarios, pressures on rates will continue unless something is done about what causes those companies to lose money.

This leads me back to my original point. If the doctors and nurses and hospitals who care for our children, our seniors, and the neediest among us cannot afford to deliver that care, we have a much bigger problem than who's making some money in the stock market. And rather than point fingers, it's time we address the real issue of lawsuit abuse, so we can solve the problem and let the health care system start working again.

Mr. Speaker, patient access to care in jeopardized. Physicians are being forced to limit services and practice defensive medicine and patients are bearing the burden, often being

forced to travel hundreds of miles to the next available doctor in order to receive life-saving care.

I strongly encourage my follow members to pass the HEALTH Act, providing a much-needed, common sense solution toward reforming America's medical justice crisis. Together, let's ensure that patients get quality care first rather than gong to court.

Mr. DEFAZIO. Mr. Speaker, I attempted to offer three of the thirty-one amendments to H.R. 5, the HEALTH Act, last night. Inexplicably, these were disallowed out of hand.

This rule is an abuse of the process. Yes, it might be payback to the Democrats based on some revisionist history, but more importantly, it's a payoff to the Republicans' generous benefactors in the insurance industry, and through this bill, a payoff to the pharmaceutical industry.

The Republicans claim that the underlying bill, H.R. 5, will control insurance costs through so-called "tort reform." This bill won't do that. In fact, in 1999, a senior executive at the American Tort Reform Association conceded that "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."

This is the third crisis in medical malpractice in 25 years. Each of these "crises" happens to coincide with recessions, stock market downturns, and insurance industry investment losses.

The insurance industry is an equal opportunity market abuser. They legally can and regularly do collude to raise rates and limit availability of all lines of insurance. If this "crisis" in medical malpractice insurance is due to a malpractice crisis then why also is there a crisis in health insurance, homeowners' insurance, auto insurance, and general liability insurance? Health insurance costs are up 13 percent, homeowners insurance, 8 percent, and auto insurance, 8.5 percent. Maybe it's time the insurance industry was subject to the same laws as other industries.

Mr. Speaker, the solution that will bring relief and improve access to our nation's physicians will start with a repeal of the antitrust exemption of the insurance industry. Legislation like H.R. 5 simply allows the insurance industry to profit off the backs of both doctors and patients.

Mr. KIND. Mr. Speaker, I rise today in opposition to the HEALTH Act, H.R. 5. Although I support the concept of sensible medical malpractice laws, this bill goes too far in defending negligence and not far enough in protecting patients.

In my home state of Wisconsin, we have medical malpractice laws that work. The components of this successful law include a cap on non-economic damages of $442,000, which is indexed annually for inflation; a requirement that all providers carry malpractice insurance; and a victims' compensation fund.

The victims' compensation fund is a unique entity that has served both patients and health care providers well. The fund operates by collecting contributions from Wisconsin health care providers and paying the victims once an award has been determined. The physicians are liable only for the first $1 million in an award. If the award exceeds $1 million, the compensation fund will pay the remainder of the award.

A major problem with H.R. 5 is that it goes beyond medical malpractice law by including the provisions regarding pharmaceutical and medical devices. The bill completely exempts from liability medical device makers and distributors as well as pharmaceutical companies, as long as the product complies with FDA standards. These provisions would have no effect on medical malpractice insurance rates. Instead, they would leave victims with little recourse and render them unable to hold pharmaceutical companies and the makers of defective medical products accountable for faulty or unsafe products.

Another problem with H.R. 5 is that it overrides some state laws. While the bill would not override Wisconsin's own cap on non-economic damages, it would supersede our state laws regarding statute of limitations, attorneys' fees, and the criteria for punitive damages. This bill is a one-size fits all solution that is not right for Wisconsin.

Although I oppose H.R. 5, I agree that medical malpractice issues must be addressed. Unfortunately, H.R. 5 is modeled after California's law, not Wisconsin's statutes. The successful components of Wisconsin's medical malpractice laws could be the basis for a much better bill. I urge my colleagues to go back to the drawing board to craft a consensus piece of legislation that both protects patients and keeps physicians in business. In Wisconsin, we are proud to have laws that effectively accomplish both of these goals. These laws are threatened, however, by the current proposal. Therefore, I oppose H.R. 5.

Mr. SHAW. Mr. Speaker, I rise today in strong support of H.R. 5, the HEALTH Act. America's doctors are facing a full blown crisis. What's at stake is nothing less than the survival of the profession. What's to blame is astronomical medical liability insurance rates.

Patients have watched helplessly as physicians have had to limit services or close their doors altogether and flee the state in search of more business friendly environments. Even worse, many young people who dreamed of studying medicine are choosing not to, realizing they won't be able to reconcile their dream with the reality of making a living.

In my state of Florida, the situation is among the worst in the nation. The American Medical Association has labeled Florida as one of 19 "in crisis" regarding medical liability which can reach sums of over $200,000 annually. When it's easier to sue a doctor than to see a doctor, something has to be done.

We know that the reforms in the HEALTH Act will actually lower the overall cost of healthcare. Doctors, laboring under a constant fear of being sued, have a natural tendency to practice defensive medicine—ordering tests that may not be needed or refusing to perform more risky procedures. The direct cost of malpractice insurance and the indirect cost from defensive medicine raise the federal government's health care cost by at least $28 billion a year.

It is clear that the current system of dispute resolution is not working. The entire industry suffers for the few bad eggs out there. Only 5% of doctors account for more than half of all the money paid out in malpractice suits, but all doctors pay the costs in their premiums. I believe it will take reform on the federal level to get the country's health system back on course and out of the courtroom and I therefore, support the HEALTH Act. I urge a "yes" vote on H.R. 5.

Mr. BISHOP. Mr. Speaker, I rise today to oppose H.R. 5.

Mr. Speaker, this bill is dangerous because it proposes a one-size-fits-all limit, regardless of the circumstances. It supersedes the laws of all fifty states and will not solve the problem of high insurance costs.

The real culprit is the insurance industry. All insurance premiums—including medical malpractice, automobile and homeowner policies—have seen a drastic increase in the past few years. These increases are not unique to medical malpractice. When the stock market returns and interest rates are high, malpractice premiums go down. When investment income goes down insurance companies increase premiums and reduce coverage. This is a fabricated "liability insurance crisis." What we actually have is an "insurance malpractice crisis."

Those who support restrictions on medical malpractice awards must explain these arbitrary limits to the parents of Jessica Santillan, the young girl who died after receiving the wrong organs from a heart and lung transplant operation at Duke University Hospital.

Because of cases like this, Congress must expand, not limit patient's rights.

This bill does not address the high cost of insurance. Instead it limits meritorious cases and valid judgments. An exhaustive study of the court system by the University of Georgia concluded that "there is no evidence of an explosion in tort filings, and there are few signs of run-a-way juries." In contrast, this bill will hurt real people with real losses. I urge my colleagues to vote against this bill and defeat this fraud on the public.

Mr. CROWLEY. Mr. Speaker, a lot of people on the other side have one crucial fact wrong—capping medical malpractice awards does not mean insurance rates will fall.

I have charts here that compare the average insurance premium for states with damage caps versus the average insurance premium for states with no caps.

For OB/GYN doctors, supposedly a group especially hard hit by medical malpractice awards—we find that OB/GYNs in states without caps on damages pay $44,485 in insurance. OB/GYNs in states with caps on damages pay $43,010—a "whopping" 3.4 percent difference.

For general surgery doctors, they pay $26,144 in premiums if they are in a state with no caps on damages. They pay $602 more—not less—if their state caps malpractice awards.

Look, if we want to decrease medical malpractice insurance costs for doctors, then let's talk about that.

Let's talk about investigating insurance company pricing practices.

Or, if we want to cap something, then let's cap the actual problem, insurance rates.

But to put the blame for rising insurance costs on victims—that's not only cruel, it's completely false.

Mrs. MCCARTHY of New York. Mr. Speaker, I rise today in strong opposition to H.R. 5, the HEALTH Act. As a nurse, I understand all too well the high cost of malpractice insurance and I recognize the crisis this is creating in our healthcare system, particularly in areas of high-risk procedures. I want a solution to fix this problem, but H.R. 5 is not the solution to helping this crisis.

H.R. 5 will only make this crisis worse. H.R. 5 exempts HMOs, pharmaceutical companies, and the FDA from punitive damage awards.

This means that HMOs will continue to make medical decisions for patients based on what's best for their bottom line and not what is best medicine for the patients they serve. Under this legislation, a pharmaceutical company manufactures a drug or the FDA approves a product that proves to be harmful or deadly, a patient's family is limited in their recourse. After last year's Congressional debate, on the need to hold HMOs accountable for their actions I am shocked that anyone who supported the Patient's Bill of Rights can vote for this legislation.

In addition, by capping the punitive damages to $250,000, this bill unfairly penalizes children, the elderly, and mothers who stay at home since it is impossible to prove economic damages from lost wages. The only compensation these patients have is non-economic or punitive damages.

Mr. Speaker, I am appalled at the arrogance of the Republican leadership, for prohibiting Members from offering any amendments to improve this legislation in any way shape or form.

Mr. Speaker, had I been allowed to offer an amendment, I would have offered the following to improve this legislation:

Reducing frivolous lawsuits.—We need to limit the amount of time during which a patient can file a medical malpractice action to no later than three years from the date of injury, or three years from the date the patient discovers the injury. And require an affidavit by a qualified specialist before any medical malpractice action may be filed. This ''Qualified Specialist'' would be a health care professional with knowledge of the relevant facts of the case, expertise in the specific area of practice, and board certification in a specialty relating to the area of practice.

Reducing premiums.—We should require medical malpractice insurance companies to annually project the savings that will result from the anti-price fixing mechanisms required by the Democrat substitute. Insurance companies must also develop and implement a plan to annually dedicate at least 50 percent of those savings to reduce the insurance premiums that medical professionals pay.

Solving healthcare professionals shortage.—We need to provide grants or contracts through the Health Resources and Services Administration (HRSA) to geographic areas that have a shortage of one or more types of health providers as a result of dramatic increases in malpractice insurance premiums.

Mr. Speaker, I urge all my colleagues to vote against H.R. 5.

Mr. WYNN. Mr. Speaker, the issue of high premiums for medical malpractice insurance is an important issue to doctors and patients. It is important that we lower insurance premiums, giving patients greater access to care. However, I am opposed to H.R. 5, the HEALTH Act.

First, tort reform has historically been the province of the States. All but 14 States, have some form of caps on medical malpractice suits. Thus, there is no need for Federal intervention.

However, I am not convinced that medical malpractice litigation alone has caused the increase in medical malpractice premiums. There is convincing evidence that suggests that the rise in medical malpractice liability premiums stems from poor business practices by many insurance companies. Insurance carriers in several cases appear to have relied on the investments in the booming stock market of the 1990s to price premiums at levels below the market price. Today's premiums seem designed to offset losses suffered when the market soured.

Meanwhile, it is unclear that even capping noneconomic damages in medical malpractice cases would lower premiums. Since California passed MICRA and capped noneconomic damages in the 1970s, their premiums have risen at rates above inflation.

Lastly, it took the 1985 passage of Proposition 103, which imposed price controls on premiums, to control the rising costs of premiums in California. Even with caps, California premiums are eight percent higher than in States without caps.

When considering this issue, we should not just consider tort reform, but examine the business and accounting practices of medical malpractice insurance carriers.

In committee, I introduced a substitute amendment to the underlying bill. The amendment would have created a medical malpractice commission to study the rising costs of medical malpractice insurance.

Last year, the Health Subcommittee held a hearing on the rising premiums. However, the committee never adequately considered the impact of the business practices employed by carriers on the rising cost of medical malpractice insurance. That is the real issue.

To date, the government has not fully examined all of the possible root causes for the rise in medical malpractice insurance.

My amendment in committee would have stripped the underlying bill and created a Federal bipartisan commission of eight members to study the cause of rising medical malpractice premiums during the last 20 years.

Specfically, the commission would look at the investment, accounting, and pricing practices of carriers, as well as jury awards in medical malpractice cases to determine what is causing the rise in premiums.

We all deserve our day in court; the case for caps on noneconomic damages has not yet been made. Before placing an unreasonably low cap on noneconomic damages in medical malpractice suits, let's sufficiently study the issue and determine the root cause for the rising premiums.

Mr. PITTS. Mr. Speaker, I rise today in support of H.R. 5.

Medical liability reform is one issue on which we cannot afford to waste time. In my home State of Pennsylvania, medical liability is not just a problem; it's a crisis. Medical liability rates are up 81 percent in Pennsylvania, and higher for some specialties. Every year, $22 billion is sucked out of the American economy due to excessive medical liability claims. In Pennsylvania alone, there are $1.2 billion in payouts each year. That's $1,000 for every man, woman, and child in the Commonwealth. As a result, insurance companies are fleeing and many doctors cannot afford—financially nor professionally—to continue to practice medicine in the State.

Last year, Chester County Hospital, in my district, came very close to taking the drastic step of closing its maternity ward when insurance for the obstetricians skyrocketed. The doctors reported that they would have to discontinue offering care at that hospital. Thankfully, the hospital stepped in at the last minute with a temporary solution and actually put these independent physicians on their payroll in order to provide coverage for them through the hospital captive insurance company. Since Chester County Hospital does twenty-one hundred or so deliveries a year, this load was too big for other providers in the area to pick up. Women would have had to leave Chester County to have their babies.

Lancaster General Hospital, also in my district, had to abandon plans to open a new clinic to serve the poor in Lancaster City when it learned that it would have to pay $1.5 million more for malpractice insurance. This is unacceptable. We cannot wait any longer to address this crisis.

Pennsylvania is not alone. In fact, most States face this same crisis. Patient access to health care is on the decline. It is alarming. Unless we can reign in the costs of medical liability, men, women, and children across the country will suffer from lack of access to health care. Our health care system cannot support nor afford the big payouts of medical liability lawsuits.

H.R. 5 is not simply an important bill, but a critical one. It will inject predictability and fairness into the medical liability process.

The bottom line is this: If you care about patient access to health care and are concerned about the rampant increase in the cost of health care, vote for this bill that is before us today.

Vote for H.R. 5.

Mr. NEY. Mr. Speaker, I rise today to express my support for H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2003. Our healthcare system is currently in a crisis. Medical malpractice insurance rates have risen to epidemic levels in many areas of the country—so much so that it is a national problem, not just a state or local issue. For many physicians, their rates have risen at factors of over four times the level that they experienced when they began practicing medicine.

Mr. Speaker, imagine having to pay upwards of $130,000 to $150,000 out of your own pocket to do business. This is what our doctors are experiencing.

Statistics such as these have far reaching implications and effects on our Nation's healthcare system. As insurance rates rise, the costs to do business rise, and the costs to consumers and patients rise. The end result is that hardworking Americans are paying the tab for unwieldy lawsuits. The HEALTH Act will help to lessen the medical liability of healthcare professionals and will thus lower the costs of healthcare to all Americans. It will reduce these lottery style lawsuits and will improve the protections for victims of malpractice.

This bill allocates damages fairly by holding a party liable only for his or her degree of fault. It also requires that a jury be informed of any payments already made, allowing for consideration of payment by other tortfeasors. The act does provide for full compensation of economic damages, such as future medical expenses and loss of future earnings, and it does not limit damages recoverable for physical injuries resulting from a provider's care nor does it cap punitive damages.

Instead, it places reasonable limits on punitive damages. They would be limited to the greater of: Two times a patient's economic damages, or $250,000. The HEALTH Act does limit unquantifiable, noneconomic damages,

such as pain and suffering, to $250,000. Patients will also be ensured that there will be funds to cover future medical expenses, and that a damage award will not risk bankrupting the defendants. The bill achieves this by allowing payments for future medical expenses to be made periodically, rather than in a single lump sum.

In conclusion, Mr. Speaker, for the sake of America's patients and healthcare system, I urge my colleagues to put partisanship aside and to pass this important piece of legislation.

Mr. Baca. Mr. Speaker, I come to the floor today in opposition to H.R. 5. I oppose this legislation because it will do nothing to change the current liability rates for doctors and it will punish America's senior, children, and poor people.

People must realize that if this bill is passed, patients will be limited to actual damages only. That means a child or senior citizen who doesn't have income would receive only $250,000 for their injuries but a CEO with the same injury could be compensated millions simply because his income is higher.

I just don't see the difference. Under this bill if a homemaker or a waitress from my district who works just as hard as a CEO goes into the hospital and is permanently disabled, she would receive $250,000. But if Bill Gates or Donald Trump goes into the hospital and experiences the same injury, a jury can award them millions.

Why don't the Republicans believe that the waitress or the homemaker deserve just compensation? Why do Republican's believe that a CEO's injury is worth more than our daughter's, son's, parent's, or grandparent's? Once again, we are seeing legislation from the Republicans that benefits only the wealthy.

Insurances companies are currently gouging our Nation's doctors and it needs to stop. But, capping punitive damages at $250,000 will not help doctors—it will only hurt patients.

I am horrified that my colleagues on the other side of the aisle want to trump the decisions made by juries and tell an injured patient who has just lost their eyesight or a limb due to gross negligence that their injury is worth only $250,000.

The patient could be in pain for the rest of their life. The Republicans want to take the power to decide away from the jury and tell everyone that their pain and suffering is only worth a mere $250,000—no matter how painful the injury, no matter how permanent the damage.

And the Republicans think that once medical malpractice claims are capped at $250,000 that insurances rates will drop. I hate to break it to the Republicans, but we tried that system in California. Over a 12-year-period rates rose 190 percent. It wasn't until we passed sensible insurance reform that doctors experienced relief from staggering insurances rates.

We need to get a grip on insurance rates to help the doctors, but not at the expense of injured patients. H.R. 5 does not make sense, we need to stop further punishing injured patients and pass sensible legislation that really helps doctors.

Mr. MOORE of Kansas. Mr. Speaker, I rise in opposition to H.R. 5.

Last year, when the House approved legislation virtually identical to H.R. 5, I expressed my strong belief that Congress should address the medical malpractice insurance system as a whole. My calls went unheeded.

I believed last year, as I believe now, that a solution to the problem of rapidly rising medical malpractice insurance premiums must address all of the factors that contribute to premium cost. I have spoken with many physicians in my congressional district about this problem, and almost to a person, they agree with my assessment that Congress should look at the entire health care system for a solution to this very complex problem. Neither this legislation nor the hearings held in House committees addressed the pricing and accounting practices of medical malpractice insurance companies. The legislation before us addresses neither the responsibilities of the medical profession, through state medical boards, to police itself, nor the barriers that exist in some states to keep the profession from doing so. This legislation does not provide solutions to address the problem of medical errors nor does it provide one dollar to help hospitals and physicians purchase existing technology that could dramatically reduce those errors. It is also clear that Congress has not clearly thought through the consequences of preempting the traditionally state-regulated and state-monitored field of health care professions.

I truly share the concern of many of my colleagues and those in the medical profession about the rising rate of medial malpractice premiums. Last week, in my office, representatives of the Kansas Medical Society expressed their concern that this legislation is overreaching and a threat to state laws in states like Kansas, where they believe that a delicate balance has been achieved between the interests of injured patients and the medical profession. Notably, many States, including those considered to be in "crisis," have acted or are now acting to get their own houses in order.

Mr. Speaker, I call on my colleagues to reject spurious, ill-conceived and overtly political solutions, and join with me in an effort to attain a comprehensive understanding of our Nation's health care system. Then we can truly find a solution to this very real crisis.

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

The bill does nothing to reduce the staggering number of medical errors that kill so many thousands of Americans each year.

It does nothing to weed out the five percent of the medical profession who are responsible for 54 percent of the claims.

It does nothing to regulate the rates that insurance companies charge for their policies.

Instead of adopting any of these measures, the Republican majority has chosen to blame the victims—capping jury awards at artificially low levels that are insufficient to meet their needs, and that makes it difficult for them to find a qualified attorney who is willing to take their case.

The cap on non-economic damages is cruelest to the most vulnerable: children and mothers who stay at home. They have no econimic damages. No loss of employment. No loss of past and future earnings. No loss of business opportunities. Apart from their medical bills, all of their losses are non-economic—for pain and suffering. Physical impairment. Disfigurement.

It's unconscionable for Congress to deprive these victims of the right to have a jury decide what their pain and suffering is worth.

Stephen Olson was left blind and brain-damaged after an HMO refused to give him an $800 CAT scan when he was two years old. He'll need round-the-clock supervision for the rest of his life. The jury awarded him $7.1 million for his pain and suffering. But California has a cap of non-economic damages, so the judge was forced to reduce the award to $250,000. Is that really all he is owed for the irreversible damage that was done to him?

Linda McDougal receive an unnecessary double mastectomy after doctors mixed up her lab results and erroneously told her that she had breast cancer. Under this bill, would receive a maximum of $250,000 for her lifetime of pain and disfigurement. Is that really all she is owed? Is that really all the compensation we would wish for our own mothers, sisters, and wives?

The irony is that despite the claims of the bill's supporters, there is no reason to believe that the cap on non-economic damages will have a serious impact on insurance premiums. A report by the New Jersey Medical Society estimated that a state cap of $250,000 on non-economic damages might result in reductions of, at most, five-to-seven percent. Other studies suggest that insurance rates are affected less by the level of non-economic damages than by the amounts paid out for economic losses.

And in California, whose 1975 Medical Injury Compensation Reform Act, known as MICRA, was the model for many of the provisions of this bill, there is little persuasive evidence that the law has brought about any reduction in premiums. Indeed, a 1995 study concluded that premiums increased dramatically during the decade following enactment of MICRA, and only stabilized once the voters imposed rate regulation under a 1988 ballot measure known as Proposition 103.

The sponsors of the bill are unwilling to take that step. Far be it from them to impose regulation on the insurance industry! Yet when it comes to litigation, these apostles of free markets opt for wage and price controls. They are horrified at the though that Congress would cap the amount of assets that wealthy bankrupts can shelter from their creditors, but have no compunction about capping the amount that malpractice victims can recover from their injuries.

I suppose it's all a question of priorities. If medical care were really a priority for the majority, we'd be talking about increasing reimbursement rates. Improving the quality of medical training. Providing incentives for doctors to practice in underserved communities. Reducing the paperwork burden that drives dedicated physicians out of the profession. But we can't talk about any of these things. They cost money. And with new tax cuts promised and deficits mounting, investments in the health care system are simply not a priority.

That's why we're debating a bill like this one instead. A bill that does nothing to address the legitimate concerns of physicians, while inflicting further harm on patients who have suffered enough.

Mr. SHUSTER. Mr. Speaker, the rising costs of medical liability insurance in Pennsylvania are among the worst in the country. In fact, Pennsylvania physicians faced a 50 percent increase in insurance costs in 2002, with

an additional 50 percent hike expected this year. Physicians have moved from my district to other States to continue practicing medicine. Recently, one of the most efficient hospitals in my district was literally within an hour of closing its doors when its pathology department could not secure medical liability insurance the 11th hour. The threat of rising medical liability costs to quality patient care in central Pennsylvania is beyond a crisis situation. The time for the House to act is now.

H.R. 5 is common-sense legislation aimed at reducing the skyrocketing medical liability costs that are threatening the availability of quality patient care in Pennsylvania and throughout the country. In addition, H.R. 5 protects the rights of patients with legitimate claims to receive compensation for economic losses, medicals costs, and lost wages.

Mr. Speaker, the threat of frivolous medical liability litigation is endangering the ability of physicians in my district to provide quality patient care. Congress must do its part to ensure access to care is not jeopardized at the expense of lining the pockets of trial lawyers.

I urge my colleagues to vote in favor of H.R. 5.

Ms. MALONEY. Mr. Speaker, I rise today in opposition to H.R. 5, the Medical Liability Limitation Act.

I represent many of the nation's premier health care and biomedical research institutions in the nation. As such, I have worked diligently to represent the interests of my district on health matters.

On this issue in particular, I have met with numerous doctors and I agree, they need relief from the high cost of insurance premiums. Rising health costs are not just impacting doctors. High health costs are hurting consumers, hospitals, employers and the economy, in general.

But H.R. 5 is not the right prescription!

Because of the strict caps for pain and suffering, H.R. 5 will especially harm women, children, the elderly and disabled individuals who may not have significant economic losses to recover. Stay-at-home moms and caregivers for children or the elderly, in particular, will be denied the ability to seek adequate compensation for damages inflicted upon them. H.R. 5 also will be especially punitive to women because many kinds of injuries that happen mostly to females—like those that affect the reproductive system, that cause a loss of fertility, or that are inflicted through sexual assault—are largely compensated through pain-and-suffering awards and other non-economic loss damages.

I met recently with a constituent who was a victim both of medical malpractice and pharmaceutical negligence. When she was in her mother's womb, her mother was prescribed DES at a time when reports about its ineffectiveness and its potential harmful effects on the fetus had already been circulated. Almost two decades later, she developed an adenocarcinoma, an aggressive cancer affecting her reproductive organs. Not only was she then misdiagnosed, her doctor prescribed treatments that were contraindicated and that hastened the growth of her cancer. The misdiagnosis resulted in extensive surgery and reconstruction resulting in her infertility and a lifetime of intense emotional and physical suffering. The pharmaceutical negligence, which was not accurately diagnosed for years—long after the statute of limitations would have expired under the terms of H.R. 5—has resulted in a lifetime of pain and a mountain of bills for follow-up medical care. If H.R. 5 had been the law when her mother had been prescribed DES, she would never have been awarded enough even to pay her extensive medical bills, let alone compensate her for years of pain and suffering.

For several Congresses, we have worked to pass a patient's bill of rights, to make sure that doctors and patients make medical decisions, not bureaucrats. H.R. 5 is an anti-patient's bill of rights.

H.R. 5 is too broad. Beyond the issue of medical malpractice, H.R. 5 includes severe liability limitations for pharmaceutical companies, medical device manufacturers, nursing homes and assisted living facilities, and insurance companies.

Unlike the Conyers/Dingell alternative which I strongly support, H.R. 5 promises no relief from the high malpractice insurance rates paid by doctors and hospitals and serves as nothing more than a bailout for insurance companies who are passing on their investment losses to doctors.

Vote "no" on H.R. 5.

Ms. DEGETTE. Mr. Speaker, I think we all agree that there is a crisis in medical malpractice insurance rates. Unfortunately, this bill does not mention insurance rates or offer solutions for the doctors who are feeling the burden of high premiums.

H.R. 5 relies on the misconception that savings from malpractice litigation reforms will relieve high insurance premiums. However, litigation is not the cause of high malpractice insurance rates. There has been no increase in the rate of malpractice claims filed in recent years and the average payout has remained steady over the past decade. In fact, the one state that proponents of malpractice litigation reform continually cite as a success is California. What they don't say is that California's malpractice insurance rates only stabilized after the state reformed its insurance system.

Despite this evidence, proponents of H.R. 5 have continued to represent this bill as a relief for physicians, rather than what it really is—a bill that will add additional injury to patients who have suffered from medical malpractice.

H.R. 5 would cap non-economic damages at an arbitrary amount of $250,000 for people who have been injured by malpractice. Non-economic damages compensate people for injuries that are very real, like permanent disfigurement, loss of sight or a limb, loss of fertility, and wrongful death. The cap on non-economic damages is unfair and should not become law.

This bill tells people like Heather Lewinski, a 17 year old girl who suffered permanent facial disfigurement at the hands of a plastic surgeon who lied to her and her family, that the severe pain, trauma, and suffering that she went through is worth $250,000. The bill tells people like Linda McDougal, whose breasts were amputated after she had been misdiagnosed with cancer, that the loss of her breasts and dignity is only worth $250,000. And it tells the family of Jesica Santillan, the little girl who died because the hospital failed to ensure that the heart and lungs she was about to receive would be compatible with her blood type, that their little girl's life was only worth $250,000.

Some advocates of H.R. 5 say that the bill only caps non-economic damages, not economic damages and that a person can receive full economic compensation for their injuries. Yet, this is unfair to the millions of Americans who do not work—retirees, stay-at-home moms, children, and seniors because they do not have economic damages. For example, Heather Lewinski, who underwent surgery when she was only 8 years old, did not have any economic damages. Linda McDougal's medical bills were already paid for and her loss would not directly affect her future earning potential. Yet, she suffered emotional trauma and a loss of dignity. Is her loss worth an arbitrary amount that was determined by a group of politicians? I certainly don't think so.

By adopting strict monetary caps on damages, Congress is creating a solution for a problem that does not exist. Medical malpractice claims are not increasing and juries are not making outrageous awards. According to the National Center for State Courts, there was no increase in the volume of medical malpractice claims between 1997 and 2001. Additionally, of the 16,676 medical malpractice cases with awards in 2001, only 5 percent were for $1 million or more. Clearly, this represents an extraordinarily small number of cases. I do not believe we should be restricting the rights of patients to receive fair and adequate compensation for their losses because of this very small number of large awards.

If we truly want to fix the real crisis that is plaguing our nation's doctors, we need to take a good look at the insurance industry. According to a study using the insurance industry's own data and conducted by Americans for Insurance Reform, while the total amount paid out over the past decade by malpractice insurers directly tracks the rate of medical inflation, the premiums that insurance companies charge doctors increase or decrease depending on the economy. In my state of Colorado, which has certain caps on damages, insurance companies took in over $119 million in premiums in 2001. Yet, they only paid out $36 million.

We should be taking a comprehensive approach to this crisis instead of placing unfair burdens on patients. We should be looking at the insurance cycle, how insurers manage investments and reserves, and financial pressures that health care payers place on providers and how that affects the way care is delivered.

Instead, we are considering a bill that is akin to curing a headache by amputating an arm. Arbitrarily limiting patients' rights is not fair and it will not solve the problem.

Stand up for the rights of patients and oppose this bill.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise today in opposition to the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act. Tens of thousands of people die each year from preventable medical errors. But rather than reform the medical system to prevent needless deaths and injuries, doctors and big insurance companies are lobbying to limit the rights of injured patients to seek full recovery in the courts. This measure unfairly impacts women and low income patients.

The HEALTH Act (H.R. 5) attempts to address the problem of high insurance costs for doctors by limiting punitive damages in medical malpractice cases to $250,000 and caps attorneys' fees under the guise of addressing

the rising cost of medical malpractice insurance. H.R. 5 caps non-economic damages in the aggregate—regardless of the number of parties involved in the dispute.

Despite its claim, H.R. 5 does nothing to directly address the problem of rising medical malpractice insurance rates for doctors. Malpractice insurance companies can expect a huge windfall from this legislation because it limits how much they have to pay out in claims, but does not address how much these insurance companies charge in premiums to doctors. The insurance industry has said that there is no guarantee of any specific savings from passage of this type of legislation.

The major malpractice problem facing Texans is the unreliable quality of medical care being delivered, which is a result of frequent medical mistakes and a lack of doctor oversight by the state medical board.

Government data show that "repeat offender" doctors are responsible for the bulk of malpractice payments. Between September 1990 and September 2002, 6.5 percent of Texas' doctors made two or more malpractice payouts worth a total of more than $1 billion. These represented 51.3 percent of all payments, according to information obtained from the federal government's National Practitioner Data Bank. Just 2.2 percent of the doctors made three or more payments, representing about a quarter of all payouts.

For every $100 spent on health care in America, only $.66 has been spent on malpractice insurance. As patients are most often victimized by repeat offending doctors (a mere six percent of doctors in Texas are responsible for 46 percent of all malpractice), this bill does nothing to reduce negligence by doctors and hospitals, but decreases incentive to improve patient safety.

Medical errors cause 3,260 to 7,261 preventable deaths in Texas each year. These errors cost families and communities $1.3 billion to $2.2 billion annually in lost wages, lost productivity and increased health care costs. In contrast, medical malpractice insurance costs Texas's doctors less than $421.2 million annually.

One more time the patient (consumer) gets the lump for being victimized. Vote against this rule and this bill under consideration..

It is for these reasons that I will vote against the rule and the bill, H.R. 5, and I urge my Colleagues to vote against H.R. 5.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 139, the previous question is ordered.

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

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

MOTION TO RECOMMIT OFFERED BY MR. CONYERS

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

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

Mr. CONYERS. I am, Mr. Speaker.

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

The Clerk read as follows:

Mr. CONYERS moves to recommit the bill H.R. 5 to the Committee on the Judiciary and the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendments:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medical Malpractice and Insurance Reform Act of 2003".

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

Sec. 1. Short title; table of contents.

TITLE I—LIMITING FRIVOLOUS MEDICAL MALPRACTICE LAWSUITS

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

TITLE II—INDEPENDENT ADVISORY COMMISSION ON MEDICAL MALPRACTICE INSURANCE

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

TITLE I—LIMITING FRIVOLOUS MEDICAL MALPRACTICE LAWSUITS

SEC. 101. STATUTE OF LIMITATIONS.

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

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

(1) The date of the injury.

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

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

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

SEC. 102. HEALTH CARE SPECIALIST AFFIDAVIT.

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

(b) EXTENSION IN CERTAIN INSTANCES.—

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

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

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

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

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

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

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

SEC. 103. SANCTIONS FOR FRIVOLOUS ACTIONS AND PLEADINGS.

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

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

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

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

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

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

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

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

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

(c) MANDATORY SANCTIONS.—

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

violation, or upon both such person and such person's attorney or client (as the case may be).

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

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

SEC. 104. MANDATORY MEDIATION.

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

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

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

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

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

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

(A) is affordable for the parties involved;

(B) encourages timely resolution of claims;

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

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

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

SEC. 105. LIMITATION ON PUNITIVE DAMAGES.

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

(1) gross negligence;

(2) reckless indifference to life; or

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

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

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

(d) TRUST FUND.—

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

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

(3) USE.—

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

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

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

(4) INVESTMENT.—

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

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

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

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

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

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

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

SEC. 107. DEFINITIONS.

In this title, the following definitions apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico,

American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Virgin Islands, and any other territory or possession of the United States.

SEC. 108. APPLICABILITY.

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

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

TITLE II—INDEPENDENT ADVISORY COMMISSION ON MEDICAL MALPRACTICE INSURANCE

SEC. 201. ESTABLISHMENT.

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

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

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

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

SEC. 202. DUTIES.

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

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

(A) improve the availability of health care services;

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

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

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

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

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

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

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

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

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

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

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

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

(8) The effect of State policies under which—

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

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

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

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

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

SEC. 203. REPORT.

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

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

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

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

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

SEC. 204. MEMBERSHIP.

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

(b) MEMBERSHIP.—

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

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

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

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

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

(D) An individual representing physicians.

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

(F) Two individuals representing patient interests.

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

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

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

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

(c) TERMS.—

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

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

(3) COMPENSATION.—Members of the Commission shall be compensated in accordance with section 1805(c)(4) of the Social Security Act.

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

(5) MEETINGS.—

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

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

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

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

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

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

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

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

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

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

SEC. 206. POWERS.

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

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

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

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

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

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

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

SEC. 207. AUTHORIZATION OF APPROPRIATIONS.

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

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

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

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

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

There was no objection.

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

Mr. CONYERS. Mr. Speaker, this is the Conyers-Dingell motion to recommit. It started out originally as the Conyers-Dingell substitute motion which, in the wisdom of the Committee on Rules and the chair of the Committee on Energy and Commerce, was determined not to be necessary. We did not need to waste this much time worrying or going over the same matter twice. So let us just have a 5-minute discussion on each side about a multibillion-dollar measure that affects every man, woman, and child in the United States of America. So I will take a couple of minutes and ask the dean of the House to spend the rest of the time making sure that we all understand what it does.

First of all, we do something about the problem that has been complained of grievously by every Member that has taken to the floor today. We do something about it. That is, we limit frivolous lawsuits by requiring that there is mandatory mediation for every malpractice lawsuit filed in the United States of America and that we require that attorneys' certificates of merit and mandatory sanctions occur. We require that affidavits of merit be provided from qualified medical specialists. We attempt to, in short, weed out frivolous lawsuits that will not restrict the rights of those with legitimate claims. Of course, finally, it is very important to realize that we reexamine the antitrust exemption that has been enjoyed by the insurance industry all of these years.

Mr. Speaker, I am delighted now to yield the balance of the time to the dean of the House, the gentleman from Michigan (Mr. DINGELL).

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

Mr. DINGELL. Mr. Speaker, the bill before us is a bad bill. The motion to recommit is forced upon us by the recalcitrance of the Republican leadership which has not permitted us to offer a substitute. This is the package that we could go home and talk with pride of to our people and to our doctors. It weeds out frivolous lawsuits. It does not restrict the rights of legitimate claimants. It establishes an equitable, 3-year statute of limitation that protects children, the aged, the poor.

It requires affidavits of merit from qualified medical specialists and attorneys' certificates of merit with mandatory sanctions. It requires mandatory mediation. It also allows health care providers to challenge malpractice premium increases. It provides direct assistance to physicians in crisis areas through Federal grants, and it provides direct assistance to medical centers in danger of closing. It repeals the antitrust exemption for malpractice insurance, and it establishes Federal malpractice insurance and a reinsurance program. This is a program that will work.

Under a House in which we had a decent opportunity to debate and amend, Members of this body would understand that this is the package for which they want to vote. They would understand that this is a package which their people wish them to vote for, and I include in that the health care providers. It is a bill, or rather an amendment, which would assure that health care providers would receive the help that they need while, at the same time, not providing unnecessary shelters for HMOs and other undeserving persons who have contrived to leap aboard a vehicle which they think is going out and a situation which permits the doctors to be used as frontmen for a bunch of iniquitous rascals who do not deserve relief.

Mr. CONYERS. Mr. Speaker, we yield back any time that may be remaining.

The SPEAKER pro tempore. Does the gentleman from Louisiana (Mr. TAUZIN) seek time in opposition to the motion?

Mr. TAUZIN. I do, Mr. Speaker.

I first yield to the gentleman from Nevada (Mr. GIBBONS) for a colloquy.

Mr. GIBBONS. Mr. Speaker, I would like to ask the gentleman from Louisiana (Mr. TAUZIN) a question which concerns the relationship of Nevada law and H.R. 5.

In my State of Nevada, we have recently passed a law that sets forth a $350,000 cap for noneconomic damages, but it has some exceptions. I would like to know how this legislation applies in this circumstance.

Mr. TAUZIN. Mr. Speaker, I thank the gentleman. Subparagraph 11(c)(1) says: ''Any State law, whether effective before, on, or after the dates of the enactment of this Act that specifies a particular monetary amount of compensatory or punitive damages, or the total amount of damages, that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided under this Act.''

Nevada's $350,000 cap generally fits the terms of this subparagraph and would generally apply. The handling of the exceptions is not specifically stated in the legislation. I would be prepared to work with the gentleman to discuss these exceptions as we move further in the process of this legislation.

Mr. GIBBONS. Mr. Speaker, I thank the gentleman for his response, and I look forward to working with him on this matter.

Mr. TAUZIN. Mr. Speaker, the Dingell motion offers us a different solution than H.R. 5. Interestingly enough, not a single one of the 175 health care organizations and associations, doctors across America, endorses that solution.

□ 1445

But they have all endorsed H.R. 5. And let me explain to you why the doctors and the health care organizations have not endorsed the Dingell solution and have endorsed H.R. 5. By the way, the Committee on Energy and Commerce took a vote on the general substance of this motion to recommit and voted 30 to 20 against it and it was not a party line vote. Let me tell you why it was defeated, why so many organizations opposed it. Because what it generally offers is not insurance reform but a Federal commission, another bureaucracy to study the problem and to make recommendations one day to us.

We have studied this problem ad infinitum. We have held numerous hearings. The States have experienced this problem going back 25 years and they

have offered us a solution. We are following their lead after 25 years of experience. Do we really need another Federal commission? No insurance reform, just a commission? And then to solve the problem of high malpractice liability coverage, this is the Dingell motion to recommit solution, not a single limitation at all on recoveries, unlimited recoveries as in current law, not a single cap on any kind of damages. Instead we get an attorney's certificate of merit. An attorney's certificate of merit. We get the trial lawyer to say, I think I have got a good lawsuit, and that is the solution.

Mr. Speaker, when an attorney signs a petition, when he signs the most egregiously incorrect, horribly drafted, when he signs the most inappropriate false petition, when he signs his name on it he is attesting to the validity of that petition. It may be a bad petition. It may be the most horrible lawsuit ever filed. It may get dismissed on the first motion to have it dismissed, but when he signed his name on it, he said it was a good petition.

So what does the Democratic motion to recommit tell us? We are going to solve this problem in America by having the same attorney sign a certificate that he has got a good suit, that he has got a good petition. Wow, that will really solve the problem.

I think you see why now that solution has been rejected by 175 organizations representing the doctors, the nurses, all the organizations across America who are crying to us for relief, who are telling us we are tired of petitions signed by lawyers that have no merit, that drive up medical malpractice suits, that drive us out of business and deprive the citizens of our country needed medical care when their loved ones need it the most. They are crying to us for help and the victims that came to us in our committee room and said, for God's sake, it is horrible when somebody commits a medical error, but it is also terrible when the doctor is not there when my child is sick, when my husband has been horribly mutilated in an automobile accident, when my daughter is trying to deliver her first child and there is no doctor there willing to do it because the cost of liability insurance is too high. They are crying to us to do something today. The motion to recommit tells us, well, let us just trust the lawyers and create a Federal commission. Whoopie-ding.

What do we tell those victims when we said all we did was trust the lawyers and created another Federal commission? I did not come here to create new Federal commissions to tell us what the problems were and what the solutions were. I came here like the rest of you, to figure out what the problems were and to solve them. H.R. 5 solves this program and deserves to be passed. This motion to recommit needs to go down.

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

There was no objection.

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

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

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

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

The Sergeant at Arms will notify absent Members.

Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for any electronic vote on the question of passage.

The vote was taken by electronic device, and there were—yeas 191, nays 234, not voting 9, as follows:

[Roll No. 63]

YEAS—191

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

NAYS—234

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

NOT VOTING—9

Clyburn
Combest
DeGette
Doyle
Gilchrest
Hyde
Istook
Johnson (IL)
Snyder

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. REHBERG) (during the vote). There are 2 minutes left in this vote.

□ 1508

Messrs. MCHUGH, QUINN, BURGESS, HOUGHTON, TANCREDO, BRADY of Texas and SAXTON changed their vote from ''yea'' to ''nay.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

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

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

RECORDED VOTE

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

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 229, noes 196, answered ''present'' 1, not voting 8, as follows:

[Roll No. 64]

AYES—229

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

NOES—196

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

ANSWERED ''PRESENT''—1

Bachus

NOT VOTING—8

Combest
DeGette
Doyle
Gilchrest
Hyde
Johnson (IL)
Shuster
Snyder

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

□ 1516

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed a bill of the following title in which the concurrence of the House is requested:

S. 3. An act to prohibit the procedure commonly known as partial-birth abortion.

The message also announced that pursuant to section 276d–276g of title 22, United States Code, as amended, the Chair, on behalf of the Vice President, appoints the Senator from Idaho (Mr. CRAPO) as Chairman of the Senate Delegation to the Canada-United States Interparliamentary Group conference during the One Hundred Eighth Congress.

The message also announced that in accordance with section 1928a–1928d of title 22, United States Code, as amended, the Chair, on behalf of the Vice President, appoints the Senator from Delaware (Mr. BIDEN) as Vice Chairman of the Senate Delegation to the North Atlantic Treaty Organization Parliamentary Assembly during the One Hundred Eighth Congress.

ANNOUNCEMENT BY COMMITTEE ON RULES REGARDING H.R. 975, BANKRUPTCY ABUSE PREVENTION AND CONSUMER PROTECTION ACT OF 2003

Mr. DREIER. Mr. Speaker, the Committee on Rules may meet the week of March 17 to grant a rule which could limit the amendment process for floor consideration of H.R. 975, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2003. Any Member wishing to offer an amendment should submit 55 copies of the amendment and one copy of a brief explanation to the Committee on Rules up in room H–312 of the Capitol by noon on Tuesday, March 18. Members should draft their amendments to the bill as reported by the Committee on the Judiciary on March 12, 2003. Members are advised that the text should be available for their review on the Web sites of the Committee on the Judiciary and the Committee on Rules by Friday, March 14.

Members should use the Office of Legislative Counsel to ensure that their amendments are properly drafted and should check with the Office of the Parliamentarian to be sure their amendments comply with the rules of the House.

ANNOUNCEMENT BY COMMITTEE ON RULES REGARDING CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2004

Mr. DREIER. Mr. Speaker, the Committee on Rules may meet the week of March 17 to grant a rule which could limit the amendment process for the concurrent resolution on the budget for fiscal year 2004. Any Member who wishes to offer an amendment should submit 55 copies of the amendment and one copy of a brief explanation of the