



S. 22 – The Medical Care Access Protection Act of 2006

Calendar No. 422

Read a second time and placed on the Senate Calendar on May 4, 2006; no written report.

NOTEWORTHY

- A cloture petition on the motion to proceed was filed today. By unanimous consent, a vote on the motion to invoke cloture on the motion to proceed to S. 22 will occur on Monday, May 8, at approximately 5:15 pm. If cloture is not invoked, the Senate will proceed to a similar vote in relation to S. 23, the *Healthy Mothers and Healthy Babies Access to Care Act* (a similar bill that addresses medical liability reform for obstetrical and gynecological services – see RPC Legislative Notice No. 35).
- The bill improves patient access to health care by alleviating the burden that excessive litigation places on the health care delivery system.
- S. 22 was introduced by Senator Ensign. The bill has 16 cosponsors.
- The Congressional Budget Office (CBO) has not yet scored S. 22.
- As of press time, there is no Statement of Administration Policy (SAP) for S. 22. On July 28, 2005, the White House issued a SAP strongly supporting H.R. 5 (similar in scope to S. 22). In addition, the President reiterated his support for medical liability reform during his State of the Union address on January 31, and in a White House fact sheet titled “Making Health Care More Affordable and Accessible for All Americans,” issued May 1.

Highlights

Scope

S. 22 applies to all health care providers and all health care institutions.

Patient Compensation

S. 22 provides an unlimited amount of damages for actual economic losses. In addition, the bill allows up to \$750,000 to be awarded for non-economic damages (commonly referred to as “pain and suffering” damages).

Punitive Damages

The maximum amount of punitive damages that may be awarded in a health care lawsuit is limited to twice the amount of economic damages or \$250,000, whichever is greater.

Attorneys’ Fees

In order to protect against conflicts of interest that may reduce the amount of awarded damages actually paid to the claimant, S. 22 provides a sliding scale for attorneys’ contingency fees.

Periodic Payments

The bill authorizes periodic payments of future damages to claimants for personal injury awards equaling or exceeding \$50,000.

Filing of Claims

The bill requires that a lawsuit be brought within three years of the date of injury or one year after the claimant discovers or should have discovered the injury, whichever occurs first. It establishes exceptions for cases involving minors.

Payment Recovery

The bill allows the court to reduce the amount of damages awarded to a claimant by the amount of any additional payments received from other sources, such as a health insurer. This is commonly referred to as the collateral source rule.

State Flexibility

S. 22 protects states' rights by allowing states to retain medical liability statutes that specify a particular amount of compensatory or punitive damages (or total damages), regardless of whether the amount is greater or less than the amount provided for in this bill. S. 22 also allows future state laws to supersede these provisions.

Background

For years health care providers have faced difficulty obtaining affordable medical liability coverage. The problem is now so great that patients are being deprived access to crucial medical care as hospitals and physicians find it increasingly difficult to continue offering certain services. Premium increases have jumped as much as 81 percent over the last two years, according to some insurers.¹ These cost increases are attributed to an overly expensive litigation system – a system that is slow, unpredictable, largely random, and without standards.²

Liability premium rates are highest for neurosurgery, cardiovascular surgery, and obstetrics and gynecology (ob/gyn). However, many other medical disciplines, such as internal medicine and general surgery, also are reporting significant premium increases. Hospitals, physicians, nurse practitioners, and other providers of care have been calling for liability reform to help reduce these increased costs so they may continue offering vital medical care for patients and their families.

Data from the American Medical Association indicate that 21 states currently face a medical liability “crisis” (up from 19 states in 2004), 22 states show “problem signs,” and 6 states report “okay” status. Texas, which in 2003 implemented a medical liability law that forms the basis for S. 22, has seen its crisis begin to abate as a result of effective reform.³ While the crisis is reminiscent of the 1970s [for details, see the RPC paper, “The Medical Liability Crisis and its Impact on Patients,” issued February 5, 2003], the difference today is the increase in the number and size of jury awards. The amount paid per claim and its unpredictable size brings new challenges for the liability insurance system. A recent PIAA survey demonstrates that jury awards in excess of \$1 million have doubled in the last six years.⁴ The increase in awards and claim payments has, in turn, led to reduced medical underwriting capacity from the marketplace.⁵ Those insurers that have left the medical underwriting market include St. Paul Companies (formerly the

¹Hospitals and Health Networks, April 2002.

²“Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System,” U.S. Department of Health and Human Services, July 24, 2002.

³“State Crisis Map,” American Medical Association, January 2006.

⁴PIAA Data Sharing Project, 2003.

⁵“A New Crisis for the Med Mal Market?” Tillinghast-Towers Perrin, February 11, 2003. A recent report released by Tillinghast-Towers Perrin, an actuarial firm, found similar liability-related losses, leading to a 15-percent reduction of medical underwriting capacity from the marketplace between 2000 and 2003.

largest medical liability carrier in the United States), PHICO, Frontier Insurance Group, Doctors Insurance Reciprocal, and MIXX (except for policies issued in New Jersey).

Given the impact on patient access to medical care, Congress has considered medical liability legislation on several occasions. The issue was debated extensively in the 104th Congress and almost every session thereafter.

Bill Provisions

S. 22 was introduced on May 3 by Senator Ensign. The bill has 16 cosponsors. It was placed on the Senate Calendar under Rule 14.

Section 1 – Short Title.

This Act may be cited as the “Medical Care Access Protection Act of 2006” or the “MCAP Act.”

Section 2 – Findings and Purpose.

Makes several findings related to the core idea that the current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care. Establishes the purpose of the bill to be implementation of reasonable, comprehensive, and effective health care liability reforms.

Section 3 – Definitions.

Establishes a series of definitions, including the term, “Alternative Dispute Resolution (ADR) system” and “health care liability claim.”

Section 4 – Encouraging Speedy Resolution of Claims.

Requires that a lawsuit be brought within three years of the date of injury or one year after the claimant discovers or should have discovered the injury, whichever occurs first. Allows for exceptions upon proof of fraud, intentional concealment, or the presence of a foreign body that has no therapeutic or diagnostic purpose in the injured person. Subsection (c) liberalizes the statute of limitations for children under the age of 6.

Strengthens enforcement of Rule 11 of the Federal Rules of Civil Procedure (and equivalent state laws) governing attorney conduct in the filing of lawsuits. Where such rules are violated, the court shall impose sanctions, which shall include an order to compensate the other party or parties for reasonable expenses incurred as a direct result of the violation. Requires that such sanctions be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated and to compensate the party or parties injured by such conduct.

Section 5 – Compensating Patient Injury.

Provides an unlimited amount of damages for actual economic losses. In addition, the measure allows awards for non-economic damages (commonly referred to as “pain and suffering” damages) as follows:

- Where a final judgment is rendered against a *health care provider*, an award of non-economic damages shall be limited to \$250,000, regardless of the number of separate claims or actions brought against the provider with respect to the same occurrence;
- Where a final judgment is rendered against a *single health care institution*, an award of non-economic damages shall be limited to \$250,000, regardless of the number of separate claims or actions brought against the institution with respect to the same occurrence;
- Where a final judgment is rendered against *more than one health care institution*, the award for non-economic damages shall be limited to \$250,000 for each institution, regardless of the number of separate claims or actions brought against each institution with respect to the same occurrence, with each claimant’s cumulative award against all institutions not to exceed \$500,000; and
- In total, *no claimant may be awarded more than \$750,000 in non-economic damages.*

The section also creates a “fair share rule,” ensuring that each party is responsible for their own share of damages and not for the share of any other defendant, eliminating the incentive for attorneys to pursue “deep pocket” parties.

Section 6 – Maximizing Patient Recovery.

Requires court supervision of payment arrangements to protect against conflicts of interest that may result in a reduction of damages actually paid to the claimant, including establishing attorney contingency fees using the following scale:

- 40 percent of the first \$50,000 recovered by the claimant(s);
- 33 ½ percent of the next \$50,000 recovered by the claimant(s);
- 25 percent of the next \$500,000 recovered by the claimant(s); and
- 15 percent of any amount over \$600,000.

In addition, the section creates an expert witness rule, requiring individuals to be health care professionals who are appropriately credentialed or licensed, have experience in treating the diagnosis under review, and are substantially familiar with the standards of care related to the lawsuit.

Section 7 – Additional Health Benefits.

Allows the court to reduce the amount of damages awarded to a claimant by the amount of any additional payments received from other sources, such as a health insurer.

This is commonly referred to as the collateral source rule. Where a payor of collateral source benefits has a right to reimbursement or subrogation under Federal or state law, the amount of the award shall not be reduced by the collateral source benefits.

Section 8 – Punitive Damages.

Permits punitive damages, if otherwise permitted by applicable state or Federal law, only if it is proven by clear and convincing evidence that the defendant acted with malicious intent to injure the claimant, or that the defendant failed to avoid unnecessary injury to the victim.

Specifies certain factors to be considered when determining punitive damages, including severity, duration or concealment, profitability, number of products sold or medical procedures rendered for compensation, criminal penalties, and any civil fines assessed as a result of the defendant’s conduct.

The amount of punitive damages shall be limited to two times the economic damages or \$250,000, whichever is greater. The section also prohibits the award of punitive damages for medical products unless the claimant demonstrates by clear and convincing evidence that the manufacturer or distributor failed to comply with specific requirements imposed by the Federal Food, Drug and Cosmetic Act. In addition, the section prohibits liability from being assessed against a physician in a product liability lawsuit merely because the doctor prescribed a drug that was approved by the Food and Drug Administration.

Section 9 – Authorization of Payment of Future Damages to Claimants in Health Care Lawsuits.

Allows court judgments, at the request of any party, to pay future damages periodically. Such authorization applies only to future awards equaling or exceeding \$50,000.

Section 10 – Effect on Other Laws.

Excludes suits for vaccine-related death or injury from the requirements of S. 22 if otherwise covered under the National Vaccine Injury Compensation Program and the Smallpox Compensation Fund.

Section 11 – State Flexibility and Protection of States’ Rights.

Permits state liability caps to remain in effect or to be enacted at a future date, often referred to as the “flexicap.”

Section 12 – Applicability; Effective Date.

Specifies that S. 22 shall apply to any health-care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of enactment. Any health-care lawsuit arising from an injury occurring prior to the date of enactment shall be governed by the applicable statute of limitations in effect at the time of injury.

Cost

The Congressional Budget Office (CBO) has not yet conducted an estimate of the cost of S. 22; however, past estimates of equivalent bills indicated that the bill's provisions would reduce providers' medical liability insurance premiums to a significant degree and would result in measurable savings to taxpayers.

Administration Position

As of press time, no Statement of Administration Policy (SAP) has been issued; however, a SAP was issued for H.R. 5 (similar in scope to S. 22) on July, 28, 2005, which reads:

The Administration strongly supports House passage of H.R. 5, legislation to reform the Nation's badly broken medical liability system. The bill would improve access to quality care, reduce health care costs, and ensure a more timely, predictable, and fair liability system.

The President strongly believes patients who are hurt due to the negligence of a doctor should be able to collect full damages for current and future medical care, therapy, rehabilitation, lost wages, and other economic losses. In cases of egregious misconduct, doctors may be responsible for reasonable punitive damages. Victims of malpractice should also be able to collect non-economic damages, such as for pain and suffering, but within a reasonable limit.

Consistent standards for liability reform will prevent excessive awards that drive up health care costs, encourage frivolous lawsuits, and promote time-consuming legal proceedings. The Administration is pleased that H.R. 5 includes many of the President's reforms which are needed to create a medical liability system that will compensate patients fairly, hold the appropriate individuals accountable without driving responsible caregivers out of medicine, and reduce health care costs.

Urgent Congressional action is needed because the medical liability crisis has forced some doctors to close their practices and made it more difficult for patients to access affordable, quality health care in certain parts of the country where the liability crisis is particularly acute. In many States that have not enacted meaningful reforms like those contained in H.R. 5, health care providers are facing enormous increases in their medical liability insurance premiums or are unable to obtain coverage at all. Physicians have been forced to quit their practice and leave patients with no access to trauma care, childbirth care, and other critical

and even basic medical services. Hospitals have been forced to curtail some of their care. Patients and employers have seen health care costs rise sharply as rising insurance rates and costly procedures adopted as part of a defensive practice of medicine have added to the financial burden of health care. The liability crisis has also imposed costs on the Federal Government and the American taxpayer, adding an estimated \$28 billion a year for defensive medicine and other expenses and impeding efforts to improve access to affordable care.

The Administration looks forward to working with Congress to enact legislation that meets the President's goal of reasonable medical liability reforms. Combined with patient safety legislation, this will result in safer and more affordable health care for all.

Possible Amendments

No amendments were known at press time.