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**STATEMENT OF JOANNE DOROSHOW
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AT NEW YORK LAW SCHOOL**

BEFORE THE HOUSE JUDICIARY COMMITTEE

**S.B. 406 – AN ACT ESTABLISHING AN EARLY OFFER ALTERNATIVE IN
MEDICAL INJURY CLAIMS**

April 26, 2012

Thank you for the opportunity to address the committee about S.B. 406. I am Joanne Doroshow, President and Executive Director of the Center for Justice & Democracy at New York Law School, a national public interest organization that is dedicated to educating the public about the importance of the civil justice system. I also co-founded Americans for Insurance Reform, a coalition of over 100 public interest groups that works for better oversight of the insurance industry. I also served on a New York State Medical Malpractice Task Force in 2007 and 2008.

The idea behind S.B. 406 is not new to me, as I have testified in Congress six times on medical malpractice issues, including once in 2006, sharing a panel with Professor Jeffrey O’Connell. At that time, Professor O’Connell was attempting to pitch the merits of a similar proposal to Congress. Congress is an institution with many members seeking to change our nation’s medical liability system. I think it’s fair to say that following that 2006 hearing, we never heard another word about Professor O’Connell’s proposal. An idea that is so dismissive of our constitutional rights and potentially calamitous for injured patients had no audience there. Nor has it in any other state in the nation. It shocks me that New Hampshire is going down this road. Because what is proposed is such a radical departure from anything implemented anywhere in this country, for the purpose of this testimony I will identify S.B. 406 as “the experiment,” since that is exactly what it is.

This experiment, as proposed, is unethical. It violates the legal rights of patients. It flouts basic notions of fairness. It will increase medical errors. The cited support for it, as articulated in the bill’s findings, is riddled with inaccuracies, so many that we are concerned that New Hampshire lawmakers have been significantly misled by those who are lobbying for it.

Before exploring the details of this experiment, I would first just like to note the irony of the criticism made by providers and insurers who say this experiment is needed for the citizens of

New Hampshire because the malpractice system delivers compensation too slowly. Obviously, the burdensome medical screening panel process that they support, which forces patients to bear extra time and expense just to get to court, is clearly a large reason for this. Moreover, despite the delays created by the screening process, malpractice cases in New Hampshire still resolve within two years as indicated in a letter to the Committee from one of the state's largest insurers, as well as in testimony from counsel.

But it's more than that. As others have written,¹ "This argument strikes us as an example of the 'chutzpah defense,' best exemplified by the individual who killed his parents, and then threw himself on the mercy of the court because he was an orphan." Nothing prevents providers or liability carriers *right now* from settling claims with patients before they file a court case, or from paying valid claims expeditiously. In fact, CJ&D and the malpractice victims with whom we work all agree that informal pre-trial settlements, where both parties voluntarily agree to take a case out of the civil justice system, are not only appropriate but currently resolve the vast majority of legitimate medical malpractice claims today. However, we strongly object to statutory schemes like this, which tilt the legal playing field so dramatically in favor of insurers as to essentially eviscerate patients' rights to adequate compensation. Expediency is clearly not the goal of this experiment. The goal is to interfere with a process that ensures at least some semblance of fairness for patients, allowing insurers to take money from the hands of victims and put it into their own pockets.

THIS EXPERIMENT IS BOTH UNFAIR AND UNETHICAL

PATIENTS FORFEIT SIGNIFICANT RIGHTS TO COMPENSATION

1. Economic damages, including medical costs and lost income. No matter what a patient's actual medical losses and lost wages total, which a patient would be entitled to prove in a court case, this experiment allows a medical provider to choose its own doctor to decide these damages. While these physicians may not be "affiliated" with the provider, they are chosen by and paid for by the provider, for whom the chief motivation is to cut costs. It should be obvious to anyone that this presents a conflict of interest that is highly unfair to the patient. In fact, this kind of conflict infects every single step of the patient's process to obtain economic damages under this experiment.

Then, in order to receive any future medical expenses, the patient or his/her family is forced to undergo a burdensome and humiliating struggle to get bills paid from the medical provider, which has a financial incentive to deny claims or cut costs. It is entirely within the provider's discretion to decide what is "reasonable proof" for a claim. And if the patient disagrees with any of this, he or she has no right to argue their case before an unbiased panel, but is stuck having to present their case before an appointee of the insurance commissioner, an individual likely influenced by (1) the commissioner's support of the bill as reflected on the web site of the

¹ David A. Hyman and Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 *Vand. L. Rev.* 1085, 1122 (2006).

proponents and (2), the provider's decision to already deny compensation. Rules of evidence are thrown out the window.

What's more, even this hearing right is chilled, since if the insurance commissioner's appointee decides that the patient's claim is "frivolous," the patient, who likely has no legal representation since few patients could afford an attorney of their choosing, may be forced to pay a \$1,000 penalty. The provider, on the other hand, has high-priced attorneys fighting the patient every step of the way.

In sum, this experiment contemplates condemning patients – or their injured children – to a lifetime of fighting medical providers just to get their bills paid. Any notion that this experiment contemplates fairness when it comes to compensating a patient for economic damages is absurd.

2. Non-economic loss. Under this experiment, patients lose all ability to be compensated for non-economic loss. Such a provision should offend every New Hampshire citizen. Non-economic injuries range from mutilation to blindness to loss of a woman's reproductive ability to permanent male sterility and beyond. In fact, when a person is seriously injured, the greatest loss is non-economic – the loss of the enjoyment of life, the pleasure, the satisfaction or the utility that human beings derive from life, separate and apart from earnings. People are not chattel or property. What is truly valuable to us as human beings is our ability to live life on a daily basis free of debilitating physical or emotional problems that diminish our capacity to enjoy life and compromise our sense of self-worth, dignity and integrity. The pleasure of living lies in our ability to participate fully in the give and take of family and career. It lies in our experience of the ordinary day – waking up without pain; drinking a cup of coffee without someone's help; dressing a child in mismatched clothes that she insists on wearing, rather than have that child dress you; walking to the bus stop or subway in the brisk air, rather than being wheeled to a lift van; deciding what to make for dinner and preparing it. These and thousands of everyday things are what we live for. Such injuries go to the very essence of our quality of life as human beings. Defining these kinds of injuries as worth nothing is not only heartless but goes against our nation's very definitions of individualized justice, a cornerstone of our democratic system.

What's more, eliminating compensation for these kinds of injuries is discriminatory. When President Bill Clinton vetoed a products liability bill in 1996, he explained, "The legislation would make it impossible for some people to recover fully for non-economic damages. This is especially unfair to senior citizens, women, children, who have few economic damages, and poor people, who may suffer grievously but, because their incomes are low, have few economic damages."

For women, the discrimination is even broader than this. In a 2004 law review article, University of Buffalo Law Professor Lucinda Finley wrote about empirical research she conducted of jury verdicts, which found "certain injuries that happen primarily to women are compensated predominantly or almost exclusively through noneconomic loss damages. These injuries include sexual or reproductive harm, pregnancy loss, and sexual assault injuries." Also, "juries consistently award women more in noneconomic loss damages than men.... [A]ny cap on noneconomic loss damages will deprive women of a much greater proportion and amount of a jury award than men. Noneconomic loss damage caps therefore amount to a form of

discrimination against women and contribute to unequal access to justice or fair compensation for women.”²

Of course, this experiment proposes not just capping non-economic damages for patients under this program but eliminating them altogether.

It should be noted that the “schedule of benefits” included in the bill is not a replacement for non-economic damages, even if they were at adequate levels. Schedules like this eliminate any room for consideration of circumstances for these types of injuries, which judges and juries – not politicians or insurers – are uniquely suited to evaluate after hearing all the evidence in a case. As pointed out in 2006 congressional testimony by Duke Law Professor Neil Vidmar, “Even when some leeway is built into compensation schedules, they cannot take into account the number of factors and extreme variability of pain and suffering, physical impairment, mental anguish, loss of society and companionship, and other elements of damages that fall under the rubric of non-economic damages. That is why these matters have been entrusted to juries. They provide justice on an individualized basis.”³

3. Penalizing patients who have been low-balled by the provider. Because the medical provider has so much discretion and cost-cutting motivation to reject portions of a patient’s claim, the patient may have no option but to go to court at that point. However, the patient is then penalized by having to prove their case under a burden that is almost impossible to meet (gross negligence by clear and convincing evidence). Their other option is to request a hearing, which as explained above, guarantees them nothing more than a utterly biased process controlled by the state insurance department, for which there is no right to appeal and may involve hitting the patient with a \$1,000 penalty. Both of these options violate basic notions of fairness and justice.

It is particularly striking that in March 15, 2012 testimony before the Senate Judiciary Committee, ProSelect Insurance Company condemned this new standard as well, noting that it “could work against claimant by encouraging providers to make low offers, knowing that a rejection significantly raises the standard of proof.”

THE EXPERIMENT IS UNETHICAL

This experiment has never been tried before. And since human subjects are involved in the New Hampshire experiment, all of the issues that pertain to any kind of clinical trial should be of concern here. Legal and ethical rules must be followed to protect the rights of any prospective participant. Yet this experiment contemplates following none of those protective rules.

While its proponents argue that participation in this experiment is voluntary, the actual “consent” process violates even the most basic precepts of what constitutes a voluntary program. Informed consent requires a clearly articulated, strictly enforced process (exceedingly clear and

² Lucinda Finley, “The Hidden Victims of Tort Reform: Women, Children, and the Elderly,” 53 *Emory L.J.* 1263, 1266 (2004).

³ Testimony of Neil Vidmar, Russell M. Robinson II Professor of Law, Duke Law School, before the U.S. Senate Committee on Health, Education, Labor and Pensions, “Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients,” June 22, 2006 at 18 (citations omitted).

understandable disclosure of potential risks and problems) and should have full Institutional Review Board (IRB) review and approval. At a minimum, patients who “opt in” must be able to “opt out” without prejudice. They must be able to discontinue participation at any point, without penalty or loss of benefits to which they are entitled. Such a scenario is obviously not contemplated here, as “opting in” requires patients to sign a waiver of their rights before the patient even knows specifically what compensation and courtroom rights they are relinquishing. This is highly unethical.

The waiver document itself violates basic ethical notions and cannot be a basis of informed consent. A waiver of rights, to be ethical and voluntary, cannot be written in legalese. It must be written in understandable, lay language, loudly explaining exactly what harm could come to a patient who participates in this program – for example, that every single decision-maker is heavily weighted toward the provider or insurer with conflicting financial motives to reject or reduce compensation for individual claims; that this experiment contemplates that after an incident of possible malpractice, the hospital’s lawyer, insurer and doctor decide if malpractice occurred and what the compensation should be; that the victim will have to fight to get bills paid for the rest of their lives – in other words, that the injured patient is rendered virtually powerless in this process and is at the mercy of the hospital and their insurer and, should they get to court, their rights have been stripped away to such an extent that they are almost guaranteed to lose their case.

But even if a waiver form could be written correctly, for this experiment to be ethical, people who are expected to participate in it must be shielded from any harm that could result from it. There is little doubt that an uninformed patient, particularly one who is catastrophically injured or has a child in this situation, will be pressured by the hospital to accept a fraction of what they need or deserve, particularly when it comes to future medical expenses. When there is an injury with serious complications that might not be known for some time, no lay person will ever be capable of making a reasoned decision as to what they may need, such as in the case of a brain-injured newborn, without the assistance of counsel or their own expert. These patients could be extremely harmed by this experiment. It is unethical for any of those cases to be put into New Hampshire’s proposed early offer process.

If the provider’s offer is so low that the patient then has no choice but to file a lawsuit, the burden of proof on the patient becomes untenable. This is clearly designed to intimidate the unprotected patient from exercising his or her right to go to court. All of these issues raise serious ethical concerns.

THE FINDINGS AND CONCLUSIONS ARE RIDDLED WITH INACCURACIES AND MYTHS

The point of departure for this entire experiment is that, “[S]ignificant resources are diverted from health care and spent on litigation costs and defensive medicine. The result is a system that has higher than necessary health care costs, higher liability insurance premiums, higher health insurance premiums, and ultimately reduced access to care.” We absolutely disagree with every element of this premise.

MYTH: SIGNIFICANT RESOURCES ARE SPENT ON LITIGATION COSTS.

Underlying this finding is the notion that because providers and their insurers spend inordinate amounts of money fighting patients with legitimate claims, causing the system's transaction costs to spiral *because* providers refuse to take responsibility for their negligence and drag out lawsuits, we should strip patients of their legal rights. This is offensive.

Just as disturbing is S.B. 406's finding II(b) supporting this experiment, namely that "medical injury cases are highly complex, requiring specialized medical evidence and testimony. This complex medical evidence and testimony requires additional discovery and case preparation that results in a particularly lengthy process for resolving cases." Again, whose fault is that? The provider is sitting on the medical records. The patient needs to find out what happened. As Michelle Mello and her colleagues at the Harvard School of Public Health reported, "[O]ur findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information *that litigation triggers*."⁴ Access to legal representation and experts *helps the patient*. Every patient who pursues a claim deserves a level legal playing field, their own lawyer and experts, and the opportunity to litigate their case as they see fit, and should not be punished because insurers drive up the system's costs.

MYTH: SIGNIFICANT RESOURCES ARE SPENT ON DEFENSIVE MEDICINE.

In over 30 years, premiums and claims have never been greater than 1% of our nation's health care costs.⁵ Despite this, the claim is often made that these figures do not include the costs of so-called "defensive medicine," or the ordering of tests or procedures to avoid litigation and not because they are "medically indicated and necessary for the health of the patient," as required by Medicare.⁶

However, the Congressional Budget Office (CBO), in its October 2009 analysis (in the form of a 7-page letter to Senator Orin Hatch), found that even if the country enacted an entire menu of extreme tort restrictions, it could go no farther than to find an extremely small percentage of

⁴ David M. Studdert, Michelle Mello et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, May 11, 2006.

⁵ See, Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), found at <http://insurance-reform.org/pr/090722.html>.

⁶ The Medicare law states: "It shall be the obligation of any health care practitioner and any other person...who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act...will be provided economically and only when, and to the extent, medically necessary." 42 U.S.C. § 1320c-5(a)(1). Also, "[N]o payment may be made under part A or part B for any expenses incurred for items or services...which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A). The Medicare claim form (Form 1500) requires providers to expressly certify that "the services shown on the form were medically indicated and necessary for the health of the patient."

health care savings, about 0.5%, “far lower than advocates have estimated.”⁷ Of the 0.5% savings, CBO found tiny health care savings – “0.3 % from slightly less utilization of health care services” or “defensive medicine.”

Let’s assume for a minute that the CBO statistics are wrong, that “defensive medicine” is a significant problem driving up the cost of health care – or, as Professor Fred Hyde, M.D., Clinical Professor in the Department of Health Policy and Management at Columbia University’s Mailman School of Public Health, defined it:

That, in contravention of good medical judgment, the basic rules of Medicare (payment only for services that are medically necessary), threats of the potential for False Claim Act (prescribing, referring, where medically unnecessary), physicians will, as a group, act in ways which are possibly contrary to the interests of their patients, certainly contrary to reimbursement and related rules, under a theory that excessive or unnecessary prescribing and referring will insulate them from medical liability.⁸

Even assuming defensive medicine exists, we know that stripping away patients’ rights does absolutely nothing to stop doctors from complaining about “defensive medicine,” and enacting S.B. 406 will not either. In fact, no researcher has ever found that limiting litigation has any impact whatsoever on the ordering of tests. Texas is a good example.

On June 1, 2009, Dr. Atul Gawande published an article in the *New Yorker* magazine called “The Cost Conundrum; What a Texas town can teach us about health care,” which explored why the town of McAllen, Texas, “was the country’s most expensive place for health care.” The following exchange took place with a group of doctors and Dr. Gawande:

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

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

⁷ Alexander C. Hart, “Medical malpractice reform savings would be small, report says,” *Los Angeles Times*, October 10, 2009, found at <http://articles.latimes.com/2009/oct/10/nation/na-malpractice10>.

⁸ Fred Hyde, M.D., Clinical Professor in the Department of Health Policy and Management at Columbia University’s Mailman School of Public Health, “Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and ‘Health Reform’ in ‘Tort Reform.’” (2010). Dr. Hyde holds both medical and law degrees from Yale and an MBA from Columbia, consults for hospitals, physicians, medical schools and others “interested in the health of hospitals,” has served twice as chief executive of a non-profit hospital and as vice president of a major university teaching hospital. The article was funded by a grant from CJ&D and has been submitted for publication.

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

In his 2010 article, “Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussion,” Columbia University’s Dr. Hyde found as follows:

- “The import of the phrase ‘defensive medicine’ is in its ‘political’ or strategic use: ‘Defensive medicine has mainly been invoked as an argument for tort reform in the years between malpractice crises when other pressures for legal change have ebbed.’ The methods used to study the existence, prevalence and impact of defensive medicine have been, primarily, survey of those (practicing physicians) who may be perceived as having a position or stance in the political discussion, in addition to having access to information necessary to answer the questions posed above.”
- “Survey-type findings led to a conclusion that defensive medicine was significant among physicians in Pennsylvania who pay the most for liability insurance. In later studies (Mello [footnote omitted]), however, some of the same authors have cast doubt on the survey as an objectively verifiable means of establishing the presence, quantity or scope of defensive medicine.”
- “If most claims result from errors, and most errors result in injuries, and most injuries resulting from such errors result in compensation (73%), what is at stake in limiting access to the courts? If access is limited, it would be in recognition that the basic principle of civil justice, having a remedy available to enforce a right, is void.”

As Professor Hyde notes, studies of defensive medicine frequently use anonymous physician “surveys” to establish its widespread existence. These are usually conceived by organized medicine, whose purpose it is to give the impression of a scientifically conducted poll, yet they are not. In fact, in 2003, the General Accountability Office (GAO) condemned the use of “defensive medicine” physician surveys, noting everything from low response rates (10 and 15 percent) to the general failure of surveys to indicate whether physicians engaged in “defensive behaviors on a daily basis or only rarely, or whether they practice them with every patient or only with certain types of patients.”⁹ The GAO also noted that those who produced and cited such surveys “could not provide additional data demonstrating the extent and costs associated with defensive medicine.” And, “some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can mitigate defensive practices.” Moreover, “according to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit.”

⁹ General Accounting Office, *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836, released August 29, 2003, found at <http://www.gao.gov/new.items/d03836.pdf>.

In 1994, the congressional Office of Technology Assessment (OTA) found that less than 8 percent of all diagnostic procedures were likely to be caused primarily by liability concerns. OTA found that most physicians who “order aggressive diagnostic procedures...do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability.” The effects of “tort reform” on defensive medicine “are likely to be small.”¹⁰

We do wish to also point out that we do not believe that most physicians are submitting false claims to Medicare and Medicaid. We believe most physicians are good doctors who order tests and procedures for the very reasons that they certify to Medicare and Medicaid – because they are medically indicated and necessary for the health of the patient. But the law is clear in this area: a doctor who bills Medicare or Medicaid for tests and procedures done for a personal purpose – e.g., possible lawsuit protection – as opposed to what is medically necessary for a patient, is committing fraud under federal and state Medicare/Medicaid programs.

- The Medicare law states: “It shall be the obligation of any health care practitioner and any other person...who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act...will be provided economically and only when, and to the extent, medically necessary.”¹¹ “[N]o payment may be made under part A or part B for any expenses incurred for items or services...which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”¹²
- Providers cannot be paid and/or participate in the Medicare program unless they comply with these provisions, and they impliedly certify compliance with these provisions when they file claims. Thus, if they are not in compliance, the certifications and the claims are false. Providers who do not comply and/or file false claims can be excluded from the Medicare program.¹³

Perhaps more importantly, the Medicare claim form (Form 1500) requires providers to expressly certify that “the services shown on the form were medically indicated and necessary for the health of the patient.”¹⁴ If the services are not, to the doctor’s knowledge, medically unnecessary, the claim is false.

¹⁰ Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H-602 (1994).

¹¹ 42 U.S.C. § 1320c-5(a)(1).

¹² 42 U.S.C. § 1395y(a)(1)(A).

¹³ See also, *Mikes v. Strauss*, 274 F. 3d 687, 700-1 (2d Cir. 2001) and cases cited therein (holding that compliance with § 1320c-5(a)(1) is a condition of participation in the Medicare program but not a condition of payment; other courts do not make that distinction, e.g., *United States ex rel. Kneepkins v. Gambro Healthcare, Inc.*, 115 F. Supp. 2d 35, 41 (D. Mass. 2000) (holding that compliance with § 1320c-5(a)(1) is a condition of payment).

¹⁴ See, <http://www.cms.gov/cmsforms/downloads/CMS1500805.pdf>.

MYTH: THESE COSTS RESULT IN HIGHER THAN NECESSARY HEALTH CARE COSTS.

As noted above, in over 30 years, premiums and claims have never been greater than 1% of our nation's health care costs.¹⁵ And the CBO, in its October 2009 analysis (in the form of a 7-page letter to Senator Orin Hatch), found that even if the country enacted an entire menu of extreme tort restrictions, it could go no farther than to find an extremely small percentage of health care savings, about 0.5%, "far lower than advocates have estimated."¹⁶

Similarly, in his April 2012 article, Cornell Law School Professor Theodore Eisenberg, a leading authority on the use of empirical analysis in legal scholarship, published a new article entitled, "The Empirical Effects of Tort Reform."¹⁷ He found that "tort reform" provides little in the way of health care savings, noting, "One recent summary concludes that the 'accumulation of recent evidence finding zero or small effects suggests that it is time for policymakers to abandon the hope that tort reform can be a major element in healthcare cost control' (Paik 2012, 175)."

On the other hand, what happens to health care costs when patients' rights are stripped, as S.B. 406 would do? Nothing. According to the consumer group Texas Watch, in Texas where patients' legal rights have been decimated, "Medicare spending has risen 16% faster than the national average since Texas restricted the legal rights of patients. Four of the nation's 15 most expensive health markets as measured by Medicare spending per enrollee are in Texas.¹⁸ Texas Watch shows that growth in Medicare spending per enrollee in the three years before patients lost their rights was 3.80% in Texas compared to 3.36% for the national average. In the three years following so-called "tort reform," average Medicare spending increased 7.43% in Texas compared to 6.03% for the national average.

What's more, according to Families USA and Texas Watch, family health insurance premiums for Texas families are up 92% – more than 4.5 times faster than income.¹⁹ Texas has the nation's highest rate of uninsured, with 24.5% of Texans lacking health insurance.²⁰

MYTH: THESE COSTS RESULT IN HIGHER INSURANCE PREMIUMS.

For more than 30 years, the state medical and insurance lobbies have argued that establishing legal roadblocks in the way of injured patients was the only way to reduce periodically high malpractice insurance rates and keep doctors practicing. As a result of this lobbying, many state

¹⁵ See, Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), found at <http://insurance-reform.org/pr/090722.html>.

¹⁶ Alexander C. Hart, "Medical malpractice reform savings would be small, report says," *Los Angeles Times*, October 10, 2009, found at <http://articles.latimes.com/2009/oct/10/nation/na-malpractice10>.

¹⁷ Theodore Eisenberg, "The Empirical Effects of Tort Reform," April 1, 2012. *Research Handbook on the Economics of Torts*, forthcoming, found at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740.

¹⁸ See, Texas Watch, "Restricting Patient Rights Does Not Lower Health Costs," <http://www.texaswatch.org/wordpress/wp-content/uploads/2010/10/MedicareSpending-HealthCosts.pdf>.

¹⁹ Texas Watch, "Texas-Style 'Reform' Fails Patients; Costs Up, Access Down" (2010), found at www.texaswatch.org/wordpress/wp-content/uploads/2011/07/MedMal-Fact-Sheet-2010.pdf.

²⁰ See, http://pubdb3.census.gov/macro/032007/health/h06_000.htm.

lawmakers succumbed to political pressure and enacted hundreds of state laws that weaken the rights of patients injured by medical negligence, making it more difficult for them to obtain fair compensation, or make it harder to hold accountable those responsible – so-called “tort reform.” As a result, nationally the number of injured patients bringing medical malpractice claims (*i.e.*, claims frequency) has reached “historic lows.”²¹ New Hampshire is no different. The medical profession here has many legal protections for negligence, and both the frequency and severity of claims are down.

In 2009, our project, Americans for Insurance Reform, took a look at medical malpractice insurance claims, premiums and profits in the country at that time and for 30 years prior. In this report, *True Risk: Medical Liability, Malpractice Insurance and Health Care*,²² we found that according to the insurance industry’s own data, medical malpractice claims, inflation-adjusted, are dropping like a rock, down 45 percent since 2000. Inflation-adjusted per doctor claims have dropped since 2002 from \$8,676.21 that year to \$5,217.49 in 2007 to \$4,896.05 in 2008. In fact, at no time during this decade did claims spike or “explode.” As A.M. Best put it, “Overall, the most significant trend in [medical professional liability insurance] results over the five years through 2008 is the ongoing downward slope in the frequency of claims...”²³

Despite this drop in claims, the insurance and medical industries argue that limiting compensation for injured patients will lead to reduced medical malpractice rates, or simply slower growth for doctors. However, this argument is based entirely upon a false predicate – that the civil justice system is to blame for insurance price-gouging. History repeatedly shows that limiting damages for patients will not lead to lower rates, because what drives rate hikes has nothing to do with a state’s tort law. It is driven by the insurance underwriting cycle. Indeed, S.B. 406 entirely ignores the insurance industry’s major role in the pricing of medical malpractice insurance premiums.

Medical liability insurance is part of the property/casualty sector of the insurance industry. This industry’s profit levels are cyclical, with insurance premium growth fluctuating during hard and soft market conditions. This is because insurance companies make most of their profits, or return on net worth, from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return, particularly in “long-tail” lines – where the insurers hold premiums for years before paying claims – like medical malpractice. Due to this intense competition, insurers may actually underprice their policies (with premiums growing below inflation) in order to get premium dollars to invest. This period of intense competition and stable or dropping insurance rates is known as the “soft” insurance market.

When interest rates drop or the economy turns, causing investment decreases, or the cumulative price cuts during the soft market years make profits unbearably low, the industry responds by sharply increasing premiums and reducing coverage, creating a “hard” insurance market. This

²¹ A.M. Best, “Solid Underwriting Undercut by MPLI’s Investment Losses,” *Best’s Special Report*, April 27, 2009.

²² Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), found at <http://insurance-reform.org/pr/090722.html>.

²³ A.M. Best, “Solid Underwriting Undercut by MPLI’s Investment Losses,” *Best’s Special Report*, April 27, 2009.

usually degenerates into a “liability insurance crisis” often with sudden high rate hikes that may last for a few years. Hard markets are followed by soft markets, when rates stabilize once again.

The country experienced a hard insurance market in the mid-1970s, particularly in the medical malpractice and product liability lines of insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. From the late 1980s through about 2001, doctors and hospitals nationwide experienced a relatively stable medical malpractice insurance market. Insurance was available and affordable. Rate increases were modest, often far below medical inflation. Meanwhile, profits for medical malpractice insurers soared, generated by high investment income. During this period, doctors benefited from an extended “soft market” period. That changed AGAIN after 2001.

After dropping interest rates and an economic downturn, compounded by years of cumulative price cuts during the prolonged soft market, insurers suddenly began raising premiums and canceling some coverage for doctors, or at least threatening to do so, in virtually every state in the country. This was an industry-wide insurance phenomenon, not just a medical malpractice phenomenon. It was not a state-specific phenomenon either. It was not even a country-specific phenomenon. It was even happening in countries like Australia and Canada that do not have jury trials in civil cases. And it was even though claims and payouts were stable. This was a classic “hard market.”

Like all hard markets, it did not last. In fact, the entire country has been in a “soft” insurance market for several years now, stabilizing rates everywhere in the country.²⁴ Premiums have dropped or stabilized irrespective of whether “tort reforms” were enacted in any particular state.²⁵ States with little or no restrictions on patients’ legal rights have experienced the same level of liability insurance rate changes as those states that enacted severe restrictions on patients’ rights.²⁶ Among states that had pure premium increases of more than 5% in the last five years were states with significant medical malpractice limits like Florida, Nevada and Utah, and states with fewer restrictions like Vermont, Wyoming – and New Hampshire. Enactment of limits on medical malpractice patients’ rights has made no difference at all.

But then, look at profits. According to the National Association of Insurance Commissioners (NAIC), in 2007 the medical malpractice insurance industry had an overall return on net worth of 15.6%, which was *well over* the 12.5% overall profit for the entire property/casualty industry.²⁷ But in New Hampshire, the return on net worth was 36.8% – more than double the national average!

²⁴ See, data from the Council of Insurance Agents & Brokers cited in Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), found at <http://insurance-reform.org/pr/090722.html>. See also, Joanne Doroshow, “Here’s Really Why Your Insurance Rates Go Up – and Then Don’t,” *Huffington Post*, October 27, 2010, found at http://www.huffingtonpost.com/joanne-doroshow/heres-really-why-your-ins_b_775077.html.

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ National Association of Insurance Commissioners, *Report on Profitability by Line by State in 2007* (2008) at 38.

Some of this must clearly be due to decreasing payouts to New Hampshire patients, which I understand is confirmed by Department of Insurance data that show a substantial drop over the last few years. Clearly, this industry does not need more help. It needs to be reigned in.

MYTH: THESE COSTS RESULT IN REDUCED ACCESS TO CARE.

There are years of studies showing no correlation between where physicians decide to practice, their choice of specialty and liability laws. As Professor Ted Eisenberg found in his April 2012 article.²⁸

If increasing premiums drive exit decisions, then programs alleviating premiums should have effects. But Smits et al. (2009) surveyed all obstetrical care providers in Oregon in 2002 and 2006. Cost of malpractice premiums was the most frequently cited reason for stopping maternity care. An Oregon subsidy program for rural physicians pays 80 percent of the professional liability premium for an ob/gyn and 60 percent of the premium for a family or general practitioner. Receiving a malpractice subsidy was not associated with continuing maternity services by rural physicians. Subsidized physicians were as likely as nonsubsidized physicians to report plans to stop providing maternity care services. And physician concerns in Oregon should be interpreted in light of the NCSC finding, described above, that this was a period of substantial decline of Oregon medical malpractice lawsuit filings.

Texas is another good example. In 2003, injured Texans relinquished their legal rights because the insurance and medical lobbies told them this was the only way to prevent a doctor shortage in Texas. Yet doctor shortages still loom in Texas today. This is apparently due to “caps and cuts in Medicare and Medicaid funding, which help pay for residencies. Those have forced many healthcare agencies to freeze or scale back residency programs.”²⁹ Specifically, with a ratio of 158 doctors per 100,000 residents, Texas ranks 42nd among the 50 states and District of Columbia, according to the Texas Medical Association. “We are at a shortage of physicians of all types in Texas, both primary care and specialty care,” said Dr. Gary Floyd, JPS Health Network chief medical officer said. “We would love to see this addressed in our new healthcare reform. How do we train more physicians?”³⁰

According to Texas Watch, nearly half of all Texas counties do not meet the national standard of having 114 doctors for every 3,500 people.³¹ In December 2009, the *Fort Worth Star-Telegram* reported,³²

The number of new doctors in family practice, the area most in demand, has increased by

²⁸ Theodore Eisenberg, “The Empirical Effects of Tort Reform,” April 1, 2012. *Research Handbook on the Economics of Torts*, forthcoming, found at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740.

²⁹ Alex Branch, “JPS official warns Texas legislators of doctor shortage,” *Fort Worth Star-Telegram*, October 19, 2010.

³⁰ *Id.*

³¹ <http://www.tafp.org/news/stories/attachments/090601releaseHB2154.pdf>.

³² Diana Hunter, “Tort law brought more doctors, but its effect on patients is unclear,” *Fort Worth Star-Telegram*, December 20, 2009.

only about 200, about 16 percent, and more than 130 counties still did not have an obstetrician or gynecologist as of October, according to a *Star-Telegram* analysis of licensing data from the Texas Medical Board.

At the same time, the number of specialists in Texas has increased sharply, with 425 psychiatrists, more than 900 anesthesiologists and five hair transplant physicians among the more than 13,000 new doctors in Texas in the five years after the Legislature's approval of the liability caps, the analysis found.

More than half the new doctors settled in the state's largest urban areas, not in rural areas, where the shortage has been most apparent.

Healthcare costs, meanwhile, have continued to rise in Texas. Proponents of malpractice caps predicted that costs would drop along with lawsuits and malpractice insurance rates.

"Consumers are much worse off today," said Alex Winslow, executive director of Texas Watch, a consumer advocacy group in Austin. "Not only have they not seen the benefits they were promised in healthcare, but now they've lost the ability to hold someone accountable. I think that puts patients at greater risk."

And according to a Fall 2009 study by Professors Charles Silver of the University of Texas School of Law, David A. Hyman of the University of Illinois College of Law and Bernard S. Black of the Northwestern University School of Law, when it comes to physicians engaged in patient care (in other words, considering physicians who retire, leave the state or stop seeing patients), the data show that the per capital number has not grown.³³ In fact, the number grew steadily through 2003 and then leveled off. They write, "This is not the pattern one would expect if the [2003 tort reform law] HB 4 had dramatically improved the working climate for [direct patient care] physicians."³⁴

On August 29, 2003, the U.S. General Accountability Office released a study³⁵ ostensibly to find support for the AMA's assertions that a widespread health care access "crisis" existed in this country caused by doctors' medical malpractice insurance problems. The GAO found that the AMA and doctor groups had based their claims on information GAO determined to be "inaccurate" and "not substantiated," and that to the extent there are a few access problems, many other explanations can be established "unrelated to malpractice," that problems "did not widely affect access to health care," and/or "involved relatively few physicians." The health care access problems that GAO could confirm were isolated and the result of numerous factors having nothing at all to do with the legal system. Specifically, GAO found that these pockets of problems "were limited to scattered, often rural, locations and in most cases providers identified

³³ Charles Silver, David A. Hyman and Bernard S. Black, "The Impact of the 2003 Texas Medical Malpractice Damages Cap on Physician Supply and Insurer Payouts: Separating Facts from Rhetoric," *Texas Advocate* (Fall 2008).

³⁴ *Id.* at 26.

³⁵ General Accounting Office, *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836, released August 29, 2003, found at <http://www.gao.gov/new.items/d03836.pdf>.

long-standing factors in addition to malpractice pressures that affected the availability of services.”

Other studies have also rejected the notion that there has been any legitimate access problem due to doctors’ malpractice insurance problems. In August 2004, the National Bureau of Economic Research researchers found: “The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt. The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings.”³⁶

Other state-specific studies draw the same conclusion. In April 2007, Michelle Mello of the Harvard School of Public Health published a study of physician supply in Pennsylvania in the peer-reviewed journal, *Health Affairs*. The authors “looked at the behavior of physicians in ‘high-risk’ specialties – practice areas such as obstetrics/gynecology and cardiology for which malpractice premiums tend to be relatively high – over the years from 1993 through 2002. They found that contrary to predictions based on the findings of earlier physician surveys, only a small percentage of these high-risk specialists reduced their scope of practice (for example, by eliminating high-risk procedures) in the crisis period, 1999-2002, when malpractice insurance premiums rose sharply.... What’s more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion who did so during 1993-1998, before premiums spiked. ‘It doesn’t appear that the restrictions we did observe after 1999 were a reaction to the change in the malpractice environment,’ said Mello, the C. Boyden Gray Professor of Health Policy and Law at the Harvard School of Public Health.”³⁷

Similarly, the *Cincinnati Enquirer* reviewed public records in Ohio in the midst of that state’s medical malpractice insurance crisis. The investigation found “more doctors in the state today than there were three years ago ... ‘[T]he data just doesn’t translate into doctors leaving the state,’ says Larry Savage, president and chief executive of Humana Health Plan of Ohio.”³⁸

Past studies have also shown there to be no correlation between where physicians decide to practice and state liability laws. One study found that, “despite anecdotal reports that favorable state tort environments with strict ... tort and insurance reforms attract and retain physicians, no evidence suggests that states with strong ... reforms have done so.”³⁹ A 1995 study of the impact of Indiana’s medical malpractice “tort reforms,” which were enacted with the promise

³⁶ Katherine Baicker and Amitabh Chandra, “The Effect of Malpractice Liability on the Delivery of Health Care,” *NBER Working Paper Series* (August 2004), found at <http://www.dartmouth.edu/~kbaicker/BaickerChandraMedMal.pdf>.

³⁷ “Malpractice Premium Spike In Pennsylvania Did Not Decrease Physician Supply,” *Health Affairs*, April 24, 2007, found at <http://www.healthaffairs.org/press/marapr0707.htm>.

³⁸ Tim Bonfield, “Region Gains Doctors Despite Malpractice Bills,” *Cincinnati Enquirer*, October 11, 2004.

³⁹ Eleanor D. Kinney, “Malpractice Reform in the 1990s, Past Disappointment, Future Success?” 20 *J. Health Pol. Pol’y & L.* 99, 120 (1996), cited in Marc Galanter, “Real World Torts,” 55 *Maryland L. Rev.* 1093, 1152 (1996).

that the number of physicians would increase, found that “data indicate that Indiana’s population continues to have considerably lower per capita access to physicians than the national average.”⁴⁰

In sum, doctors’ malpractice insurance problems should not be solved on the backs of injured patients. The solutions lie with the insurance industry itself.

THE EXPERIMENT WILL HARM PATIENT SAFETY

One of the precepts of conservative economic theory is that the tort system’s economic function is deterrence of non cost-justified accidents, and that the tort system creates economic incentives for “allocation of resources to safety.”⁴¹ Indeed, as Professor Eisenberg noted in his recent article, “One possible factor contributing to the continued high rate of errors is that doctors do not expect to bear the full cost of harms caused by their negligence. . . .and [h]ospitals do not bear the full costs of the harms caused in them even though hospitals directly and indirectly influence patients’ risk of medical error (Mello et al. (2007)).”⁴² In other words, further weakening the system’s deterrent potential will only lead to more errors.

In its October 9, 2009 letter to Senator Orin Hatch on medical malpractice issues, the Congressional Budget Office noted, “The [medical malpractice] system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses. . . .” CBO wrote that “imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes.” Of the three studies that address the issue of mortality that it examined, CBO noted that one study found tort system restrictions would lead to a .2 percent increase in the nation’s overall death rate.⁴³ If true, that would be an additional 4,853 Americans killed every year by medical malpractice, or 48,250 Americans over the 10-year period CBO examines.⁴⁴ Moreover, based on these same numbers, another 400,000 or more patients could be injured during the 10 years that CBO examined (given that one in 10 injured patients die⁴⁵). The costs of errors, which the Institute of Medicine put between “\$17 billion and \$29 billion, of which health care costs represent over one-half,” would clearly increase⁴⁶ as would the costs of caring for these new patients.

⁴⁰ Eleanor D. Kinney & William P. Gronfein, “Indiana’s Malpractice System: No-Fault by Accident,” 54 *Law & Contemp. Probs.* 169, 188 (1991), cited in Marc Galanter, “Real World Torts,” 55 *Maryland L. Rev.* 1093, 1152-1153 (1996).

⁴¹ See, e.g., William M. Landes, Richard A. Posner, *The Economic Structure of Tort Law* (1987).

⁴² Theodore Eisenberg, “The Empirical Effects of Tort Reform,” April 1, 2012. *Research Handbook on the Economics of Torts*, forthcoming, found at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740.

⁴³ CBO says “[t]here is less evidence about the effects of tort reform on people’s health, however, than about the effects on health care spending – because many studies of malpractice costs do not examine health outcomes.”

⁴⁴ Based on 2,426,264 deaths according to the Center for Disease Control and Prevention, found at <http://www.cdc.gov/nchs/FASTATS/deaths.htm>.

⁴⁵ Study of California hospitals cited in Tom Baker, *The Medical Malpractice Myth*. University of Chicago Press (2005).

⁴⁶ Institute of Medicine, *To Err Is Human, Building a Safer Health System* (1999).

Law Professors David A. Hyman and Charles Silver have researched and written extensively about medical malpractice.⁴⁷ They also confirm, “The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. ...[T]wo major factors forced their hand: malpractice claims and negative publicity.... Anesthesiology [malpractice] premiums were...among the very highest – in many areas, two to three times the average cost for all physicians. By the early 1980s, anesthesiologists recognized that something drastic had to be done if they were going to be able to continue to be insured.... Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it.”⁴⁸ In other words, “[a]s Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious. As the title of their most recent article says, ‘it’s the incentives, stupid’: Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients..... In short, the notion that errors would decline if tort liability [and payouts, as contemplated by this experiment] are diminished is ridiculous.”⁴⁹

Numerous medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. In addition to anesthesia procedures, these include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.⁵⁰ The *New England Journal of Medicine* published a 2006 article confirming this point: that litigation against hospitals improves the quality of care for patients, and that “more liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously.”⁵¹

In sum, this experiment calls into serious question the continuation of hospital accountability mechanisms that are currently in place to deter errors, with the possibility of significant deleterious effects on patient safety.

DISRESPECT FOR THE CONSTITUTION

Finally, this experiment infringes directly on the third branch of government, which is not represented anywhere in the development or implementation of this process. This is of tremendous concern because of the fundamental nature of the right to trial by jury that would be severely limited by this experiment. Even assuming such a law is constitutional, which we doubt, these rights are priceless and should not be casually eliminated. There are fundamental democratic principles at stake with legislation like this. As Justice Rehnquist has stated:

⁴⁷ David A Hyman and Charles Silver, “The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?,” 90 *Cornell L. Rev.* 893, 917 (2005).

⁴⁸ *Id.* at 920, 921.

⁴⁹ Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid*, 59 *Vand. L. Rev.* 1085, 1131 (2006).

⁵⁰ Meghan Mulligan & Emily Gottlieb, “Hospital and Medical Procedures,” *Lifesavers: CJ&D’s Guide to Lawsuits that Protect Us All*. Center for Justice & Democracy (2002) at A-36 *et seq.*, B-12 *et seq.*

⁵¹ George J. Annas, J.D., M.P.H., “The Patient’s Right to Safety – Improving the Quality of Care through Litigation against Hospitals,” *New England Journal of Medicine*, May 11, 2006.

The guarantees of the Seventh Amendment [right to trial by jury in civil cases] will prove burdensome in some instances; the civil jury surely was a burden to the English governors who, in its stead, substituted the vice-admiralty court. But, as with other provisions of the Bill of Rights, the onerous nature of the protection is no license for contracting the rights secured by the Amendment.⁵²

Over the years, mostly under pressure from insurers, states and Congress have occasionally considered proposals that require or pressure wrongly injured persons to have their disputes resolved outside the court system and/or force them to obtain compensation from an administrative system. It would be one thing if any of these systems succeeded and could be considered appropriate models. But none has. This is due not to poor legislative construction or elements that can be fixed. Rather, it is because of one inherent flaw that infects all such systems; namely, once an area of law is removed from the civil justice system and is codified by statute, it is immediately and forever vulnerable to manipulation by political forces and turns into a nightmare for those it was originally meant to help.

Moreover, as Penn law professor Tom Baker wrote while he was a law professor Director of the Insurance Law Center at the University of Connecticut School of Law:

Lawsuits make people work *through* the system, not against it. Lawsuits take place in the open. Lawsuits provide procedural protections for everyone involved. To win a lawsuit you have to be right. It is not enough just to be angry.

...

Responsibility lies at the heart of tort law. A tort lawsuit is a public statement that a defendant has not accepted responsibility, coupled with the demand to do so. Malpractice lawsuits ask doctors and hospitals to take responsibility for their mistakes, not just prevent future mistakes or to compensate the patient, but also because taking responsibility is the morally proper thing to do.⁵³

Thank you, and I would be happy to answer any questions.

⁵² *Parklane Hosiery Co. Inc. v. Shore*, 439 U.S. 322 (1979) (Rehnquist dissenting).

⁵³ Tom Baker, *The Medical Malpractice Myth* (2005) at 112, 113.