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STATEMENT OF JOANNE DOROSHOW
EXECUTIVE DIRECTOR, CENTER FOR JUSTICE & DEMOCRACY

BEFORE THE HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

Hearing on The Cost of the Medical Liability System Proposals for Reform, including H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011.

April 6, 2011

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Mr. Chairman, members of the Committee, I am Joanne Doroshow, President and Executive Director of the Center for Justice & Democracy, a national public interest organization that is dedicated to educating the public about the importance of the civil justice system.

In addition to our normal work, CJ&D has two projects that are relevant to this discussion today: Americans for Insurance Reform, a coalition of nearly 100 public interest groups from around the country that seeks better regulation of the property casualty insurance industry; and the Civil Justice Resource Group, a group of more than 20 prominent scholars from 14 states formed to respond to the widespread disinformation campaign by critics of the civil justice system.

In addition, I served on the New York State Governor's Medical Malpractice Task Force in 2007 and 2008, which among other things, discussed ways to reform New York's insurance system and improve patient safety.

The topic of this hearing is H.R. 5, which is billed as legislation dealing with medical liability issues. However, H.R. 5 also fantastically overreaches, providing immunities for drug and device companies that have no relation whatsoever to medical malpractice issues. My testimony will focus primarily on medical malpractice issues, however, since these issues clearly are the driver for this anti-patient legislation. And specifically, the driver seems to be health care cost savings so I will tackle that issue head on.

In October 2009, the Congressional Budget Office (CBO) presented an analysis (in the form of a 7-page letter to Senator Hatch) on "the effects of proposals to limit costs related to medical malpractice ('tort reform')" finding that "tort reform could affect costs for health care." It based

its new analysis on a small handful of studies, several of which are noted to contradict each other, and did not consider the costs of errors themselves. Even so, CBO found that even if the country enacted the entire menu of extreme tort restrictions listed,[1] which are very similar to those in H.R. 5, it could go no further than to find an extremely small percentage of health care savings, "about 0.5% or $11 billion a year at the current level -- far lower than advocates have estimated."[2] Of this, 0.3% was attributed to "slightly less utilization of health care services" (i.e., so-called "defensive medicine") and 0.2% was ascribed to reduced insurance premiums for doctors. (These issues will be more fully explored below.)

On March 10, 2011, CBO provided a new analysis of H.R. 5 and reduced even this low estimate. CBO now says that enacting H.R. 5 would reduce total health care spending 0.4%, and that would have to be realized over a period of four years. This is less than $10 billion over five years (2011-2016).

However, in its calculations, CBO ignored factors that would not only lower this figure but also likely *increase* the deficit:

- CBO acknowledges but does not consider in its cost calculations the fact that these kinds of extreme "tort reforms" would weaken the deterrent potential of the tort system, with accompanying increases in cost and physician utilization inherent in caring for newly maimed patients and for care.

- There will be new burdens on Medicaid because if someone is brain damaged, mutilated or rendered paraplegic as a result of the medical negligence but cannot obtain compensation from the culpable party through the tort system (which is the impact of capping even non-economic damages), he or she may be forced to turn elsewhere for compensation, particularly Medicaid. None of these increased Medicaid costs are considered.

- Whenever there is a successful medical malpractice lawsuit, Medicare and Medicaid can both claim either liens or subrogation interests in whatever the patient recovers, reimbursing the government for some of the patients' health care expenditures. Without the lawsuit, Medicare and Medicaid will lose funds that the government would otherwise be able to recoup. Again, none of these lost funds are factored in by the CBO.

After CBO issued its original October 9, 2009 letter, members of the CBO staff agreed to meet with me and a panel of experts to discuss these issues. Among the things I learned at this meeting were:

- It may be true that liability restrictions will create new burdens on state and federal deficits since the costs of injuries are not eliminated by enacting "tort reform," but merely shifted onto someone else – including the government. However, no good study had yet been done on this phenomenon and according to CBO, if a study doesn't exist about a problem, it need not consider it even though savings could be significantly lower than what they say.

- While acknowledging in its report the obvious - that more people will be injured and die when accountability is reduced – again CBO would not factor this result into its "savings"

total because, again, there are too few studies on the topic. This is despite the fact that one of the three studies CBO does mention in its October 9, 2009 letter found that to achieve these "savings," there would be a .2 percent increase in the nation's overall death rate. How could this possibly be an acceptable trade off?

- CBO arrived at these numbers by plugging selective studies into CBO's internal econometric models that no one ever sees. When, for example, I raised this transparency issue and specifically asked how CBO could find a 0.2 percent savings due to lower medical malpractice insurance rates for doctors, when years of historical experience show this to be untrue, my comments were met with glares, not data. When Senator Jay Rockefeller (D-WV) asked CBO for a "complete empirical analysis of the cost savings associated with medical malpractice reforms," CBO's response was another seven-page letter.[3] No empirical analysis, no econometric models, no data.

So to begin, clearly these cost savings, low as they are, are still inflated. Besides this issue, there are enormous policy problems with H.R. 5, which will be fully discussed below.

For many years, we have assisted families from around the nation who have traveled to Washington, D.C. to voice their strong opposition to bills like this. These families are the forgotten faces in the debate over how to reduce health care and insurance costs, and I hope that at some point, this Committee decides to hear from them.

In the meantime, please heed the words of Dr. Lora Ellenson, a pathologist at NY Presbyterian Hospital-Weill Cornell Medical Center, whose now 13-year old son, Thomas, was brain-damaged from a birth injury due to negligence. Last month, she told the *New York Daily News*[4]:

> "My son cannot walk or talk. He is not able to carry out activities of daily living - eating, dressing, toileting, bathing - without constant assistance from an adult. He also needs a motorized wheelchair, a speech output device and a wheelchair-accessible van, just to name a few."
>
> Had the Ellenson's not won a malpractice award well above the proposed $250,000 she would have had to quit her job to stay home with her son every day.
>
> "Even with all the support, my son will face huge challenges throughout his life including his ability to move freely in the everyday world, to have a profession, to build friendships. Many of the things created for nondisabled individuals will never be available to him - climbing simple stairs, eating with utensils, swimming at a beach, rearranging the covers on his bed.…
>
> "As a physician, I have also had to grapple with the implications for my profession. I have had to come face-to-face with the knowledge that mistakes are made. Like most physicians, I live with the reality that we might one day make an error and be sued. When that day comes, I will be grief-stricken, not because of the process - although I am sure that won't be pleasant - but due to the fact that I may have caused someone irreparable damage.

"My only hope is that the damaged person can get what they need to live in the best way that they are able. As a physician, I want to know that there will be compensation to rebuild a life that has been diminished. Yet, as a mother, I also know that no typical physician, nor the system within which they operate, can possibly understand the true depth of these mistakes."

OVERVIEW: THE STATE OF MEDICAL LIABILITY, MALPRACTICE INSURANCE AND HEALTH CARE

THE MEDICAL MALPRACTICE EPIDEMIC

- **The amount of malpractice in U.S. hospitals has grown at alarming rates.**
  - It has been over a decade since the Institute of Medicine's seminal study "To Err is Human"[5] was published, which found that between 44,000 and 98,000 patients are killed in hospitals each year due to medical errors. The studies discussed in the report examine *preventable* "adverse events." Adverse events are injuries caused by treatment itself and not an underlying condition. The IOM used stringent criteria in choosing which adverse events to consider. The report notes, "Some maintain these extrapolations likely underestimate the occurrence of preventable adverse events because these studies: 1) considered only those patients whose injuries resulted in a specified level of harm; 2) imposed a high threshold to determine whether an adverse event was preventable or negligent (concurrence of two reviewers); and 3) included only errors that are documented in patient records." In other words, the authors of the IOM study made special care to ensure that only incidents that were preventable or negligent were examined.
  - According to a November 2010 study by the Office of Inspector General of the U.S. Department of Health and Human Services about 1 in 7 hospital patients experience a medical error, 44 percent of which are *preventable*.[6] The study concludes, "Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events."[7]
  - Also in November 2010, a statewide study of 10 North Carolina hospitals, published in the New England Journal of Medicine, found that harm resulting from medical care was common, with little evidence that the rate of harm had decreased substantially over a 6-year period ending in December 2007. This is considered significant nationally because North Carolina is touted as a leader in efforts to improve safety.[8]
  - The situation is probably even worse because 23 states have no medical-error detection program, and even those with mandatory programs miss a majority of the harm."[9] "Most medical centers continue to depend on voluntary reporting to track institutional safety, despite repeated studies showing the inadequacy of such reporting."[10]
  - Texas is a good example. According to a 2009 investigative series by Hearst

newspapers and the *Houston Chronicle* called "Dead By Mistake", [11] after Texas enacted its cap on non-economic damages, the number of complaints against Texas doctors to the Medical Board rose from 2,942 to 6,000 in one year. More than half of those complaints were about the quality of medical care." Yet, "Texas has fumbled attempts to establish a medical error reporting system, often leaving patients to discover errors the hard way — when a mistake costs them their livelihood or the life of a loved one. … In 2003, Texas hospitals were asked to report just nine broadly defined error categories. The Texas data kept from 2003 to 2007 kept hospital names secret. Only error totals were made available to the public." The data on the Texas Department of State Health Services' Web site is minimal and suspiciously low and "[f]amilies of patients found the general nature of the reporting infuriating." What's more, in 2003, "the Texas lawmakers established the fledgling Office of Patient Protection, designed to respond to complaints from the public not handled by the Medical Board." But, "it never got the chance to work. The Legislature eliminated the agency in 2005 and, without resistance from the hospital lobby, eliminated the error reporting system in 2007."

- **The costs of these errors is enormous.**

    - The Institute of Medicine put the total national costs of the preventable adverse events (lost income, lost household production, disability and health care costs) at between $17 billion and $29 billion each year.[12]
    - In its November 2010 study the Office of Inspector General of the U.S. Department of Health and Human Services said preventable errors cost Medicare $4.4 billion a year. [13] Moreover, it noted, "These Medicare cost estimates do not include additional costs required for follow-up care after the sample hospitalizations."[14]

- **State medical boards fail to protect patients from the small number of doctors responsible for most malpractice payments.**

    - According to Public Citizen's 2007 analysis of National Practitioner Data Bank (NPDB) files, "The vast majority of doctors – 82 percent – have never had a medical malpractice payment since the NPDB was created in 1990. Just 5.9 percent of doctors have been responsible for 57.8 percent of all malpractice payments since 1991, according to data from September 1990 through 2005. Each of these doctors made at least two payments. Just 2.3 percent of doctors, having three or more malpractice payments, were responsible for 32.8 percent of all payments. Only 1.1 percent of doctors, having four or more malpractice payments, were responsible for 20.2 percent of all payments."[15]
    - However, "only 8.61 percent of doctors who made two or more malpractice payments were disciplined by their state board. Only 11.71 percent of doctors who made three or more malpractice payments were disciplined by their state board. Only 14.75 percent of doctors who made four or more malpractice payments were disciplined by their state board. Only 33.26 percent of doctors who made 10 or more malpractice payments were disciplined by their state board – meaning two-thirds of doctors in this group of egregious repeat offenders were not disciplined at all."[16]

- A March 2011 Public Citizen analysis of National Practitioner Data Bank data shows that "[s]tate medical boards have failed to discipline 55 percent of the nation's doctors who either lost their clinical privileges or had them restricted by the hospitals where they worked."
- According to the study, given that a physician must exhibit serious deviations of behavior or performance to warrant hospital disciplinary action (e.g., incompetence, negligence, malpractice, immediate threat to health or safety), the failure of state medical boards to take subsequent action has serious public safety implications. "One of two things is happening, and either is alarming," said Dr. Sidney Wolfe, director of Public Citizen's Health Research Group and overseer of the study. "Either state medical boards are receiving this disturbing information from hospitals but not acting upon it, or much less likely, they are not receiving the information at all. Something is broken and needs to be fixed."[17]

MEDICAL MALPRACTICE AND HEALTH CARE COSTS

I noted earlier the finding of the CBO in its October 2009, analysis (in the form of a 7-page letter to Senator Hatch) on "the effects of proposals to limit costs related to medical malpractice ('tort reform')" finding that "tort reform could affect costs for health care." CBO found that even if the country enacted the entire menu of extreme tort restrictions listed,[18] it could go no farther than to find an extremely small percentage of health care savings, "about 0.5% or $11 billion a year at the current level -- far lower than advocates have estimated."[19] On March 10, 2011, CBO reduced this estimate to 0.4% with regard to the impact of H.R. 5, which would be realized over a period of four years. Because the earlier CBO letter more specifically discussed the source of these numbers, we will focus on the earlier letter even though those figures are higher than the H.R. 5 estimate.

- Of the 0.5% savings found in 2009, CBO found tiny health care savings – "0.3 % from slightly less utilization of health care services," or "defensive medicine."
    - Columbia University's Mailman School of Public Health Professor Fred Hyde, M.D. defined defensive medicine as follows: "The implicit hypothesis would appear to be the following: 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."[20]
    - According to the CBO, if there is any problem at all in the area, it's with Medicare, specifically its emphasis on "fee-for-service" spending, whereas private managed care "limit[s] the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as 'defensive medicine')." In other words, CBO virtually admits that to the extent "defensive medicine" exists at all, it can be controlled through simply managing care correctly as

opposed to taking away patients' rights and possibly killing and injuring more people.

(See more discussion of defensive medicine, below)

- Of the 0.5% savings found in 2009, CBO found 0.2% would be due to a drop in liability premiums as a result of a 10 percent drop in medical malpractice. Given that CBO's assertions about the direct connection between tort laws to premiums contradicts 30 years of liability premium insurance history and experience,[21] (explained below), this calculation is troublesome, at best.

Each of these two areas are discussed in more detail below.

CLAIMS AND LAWSUITS

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 lawmakers succumbed to political pressure and enacted hundreds of state laws that weaken the rights of patients injured by medical negligence, make it more difficult for them to obtain fair compensation, or make it harder to hold accountable those responsible – so-called "tort reform." The medical profession now has more legal protection for their negligence than any other profession in the country. As a result, according to insurance industry analysts at A.M. Best, the number of injured patients bringing medical malpractice claims (i.e., claims frequency) has reached "historic lows."[22]

- **While the U.S. population and the number of doctors are steadily increasing[23], medical malpractice claims and lawsuits are dropping significantly.**
    - According to the National Center for State Courts, medical malpractice claims are in steep decline, down 15 percent from 1999 to 2008. The NCSC says rarely does a medical malpractice caseload exceed a few hundred cases in any one state in one year.
    - 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, called "*True Risk: Medical Liability, Malpractice Insurance and Health Care,*"[24] 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.…"[25]

- In Texas, the non-economic damages cap passed after a 2003 ballot initiative has had a disproportionate impact on the filing of legitimate cases involving children, the elderly and the poor.[26] In a Fall 2008 research paper published by professors Charles Silver of the University of Texas School of Law, David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law and Bernard S. Black of the Northwestern University School of Law, estimated that "if the same cases were brought, the cap would result in an 18-25% drop in per-case payouts in settled cases, and a 27% drop in tried cases. We also find that a cap on non-economic damages will have different effects on different groups of plaintiffs, with larger effects on the unemployed and deceased, and likely on the elderly as well. … [O]ne would expect the cap to dissuade some plaintiffs from suing at all, especially those in the more severely affected groups.[27] As one Texas attorney put it, since the law passed, "We're taking one out of 300 cases."[28]
- Cases involving medical malpractice in emergency rooms have been knocked out almost completely, making Texas ER's some of the most dangerous in the country. "'What Texans don't know is that their Legislature has mandated a very low standard of care — almost no care,' says Brant Mittler, a Duke University-educated cardiologist in San Antonio who added malpractice law to his resume in 2001.'"[29]
- A June 1, 2009, *New Yorker* magazine article by Dr. Atul Gawande, called "The Cost Conundrum; What a Texas town can teach us about health care," 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.*
>
> "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.

(See more about defensive medicine, below).

- As the above article seems to confirm, doctors' fear of lawsuits is "out of proportion to the actual risk of being sued" and enacting "tort reforms" have no impact on this phenomenon, according to an article in the September 2010 edition of *Health Affairs* by David Katz, M.D., associate professor of medicine with University of Iowa Health Care (and several other authors)."[30] Several explanations are suggested for this undue fear. One squarely blames the medical societies, which continuously hype the risk of lawsuits to generate a lobbying force to help them advocate for doctors' liability

limits. A second possible explanation is that doctors will "exaggerate their concern about being sued, using it as a justification for high-spending behavior that is rewarded by fee-for-service payment systems." A third explanation relates to well-documented human tendencies to overestimate the risk of unfamiliar and uncommon events, such as a fear of plane crashes compared to much more common car crashes. They write, "Lawsuits are rare events in a physician's career, but physicians tend to overestimate the likelihood of experiencing them."

- **According to the Harvard School of Public Health, "portraits of a malpractice system that is stricken with frivolous litigation are overblown."**
  - In May, 2006, the Harvard School of Public Health published a study in the *New England Journal of Medicine* about the medical malpractice system. Lead author, David Studdert, associate professor of law and public health at HSPH, said, "Some critics have suggested that the malpractice system is inundated with groundless lawsuits, and that whether a plaintiff recovers money is like a random 'lottery,' virtually unrelated to whether the claim has merit. These findings cast doubt on that view by showing that most malpractice claims involve medical error and serious injury, and that claims with merit are far more likely to be paid than claims without merit."[31] The authors found:
    - Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.
    - Eighty percent of claims involved injuries that caused significant or major disability or death.
    - "The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our 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."
    - "Disputing and paying for errors account for the lion's share of malpractice costs."
    - "Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. … [F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims."

MEDICAL MALPRACTICE INSURANCE

The insurance industry and the medical industry argue that "capping" compensation for injured patients will lead to reduced medical malpractice rates, or simply slower growth for doctors.

Despite the enormous hardships on innocent patients caused by "caps," or the fact that they shift compensation burdens onto others, insurers argue that caps are therefore worth enacting. However, this argument is based entirely upon a false predicate – that the U.S. civil justice system is to blame for insurance price-gouging. History repeatedly shows that capping damages 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 and remedies that do not specifically address this phenomenon will fail to stop these wild price gyrations in the future. Indeed, H.R. 5 entirely ignores the insurance industry's major role in the pricing of medical malpractice insurance premiums – an industry that is exempt from anti-trust laws under the McCarran-Ferguson Act. Repealing this act is critical to stabilizing the medical malpractice insurance market.

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 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 – irrespective of whether a state enacted tort restrictions.[32]

- **The country has been in a soft insurance market since 2006; medical malpractice premiums, inflation-adjusted, are nearly the lowest they have been in over 30 years and they may go even lower.**

  - According to A.M. Best, after reaching a high of 14.2% in 2003 during the last hard market, medical malpractice premium growth has been dropping, decreasing by 6.6% nationally in 2007, and an additional 5.3% in 2008.[33]
  - The insurance pure premium[34] or loss costs,[35] is particularly important to examine. This is the one component of an insurance rate that should be affected by verdicts, settlements, payouts, or so-called "tort reform." It is the largest part of the premium dollar for most lines of insurance. The Insurance Services Office (ISO)[36] shows the same cyclical pattern with the biggest increases during the hard market of 2002-2005, and dropping steadily since then with 2008 seeing an astonishing 11% decrease. This data confirms that we are experiencing a very soft market. Moreover, this decrease might have been even greater had 17 states not limited the decrease to 20%, likely because ISO wanted to control this drop. Most likely, this result was due to the recognition that, with profits as high as they were, medical malpractice insurance for doctors was greatly overpriced in prior years.[37]
  - Premiums have dropped irrespective of whether "tort reforms" were enacted in any particular state, such as Texas.[38] 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.[39] Compare, for example, Missouri and Iowa, two neighboring Midwest states. Missouri has had a cap since the mid-1980s, as well as other "tort reform" in medical malpractice cases. Iowa has never had a cap. In the last five years, Missouri's pure premium increased 1%. Iowa's dropped 6%. Among states that had pure premium increases of more than 5% in the last five years were states with significant medical malpractice limits like FL, NV, and UT, and states with fewer restrictions like NH, VT and WY.
  - As mentioned above, rates are expected to drop even further! According to a December 2010 ISO publication, which examined reserves at year-end 2009, reserves are still redundant (i.e., excessive) for medical malpractice policies: 15% to 35% for occurrence policies and by 41% to 61% for claims made policies. *This means rates still have much further to fall.*

"CAPS" DO *NOT* LOWER INSURANCE PREMIUMS FOR DOCTORS

Because insurance rate fluctuations have nothing to do with a state's legal system, history proves that enacting "caps" on non-economic damages will not lower insurance rates.

- **Maryland and Missouri are both examples of states that enacted severe caps on damages in the mid-1980s, only to be hit with huge rate hikes during the last hard market.**

    - **Maryland.** In the mid-2000's, Maryland was called an American Medical Association (AMA) "problem state"[40] and a "crisis state" according to the American College of Obstetricians and Gynecologists because insurance rates had suddenly jumped.[41] Yet Maryland had had a cap on non-economic damages since 1986, originally $350,000 but later increased somewhat.[42] Despite the cap, the state experienced premiums that "rose by more than 70 percent in the last two years."[43] This caused lawmakers to push for, once again, even more restrictions on patients' rights in a special session called by the Governor in 2004 ostensibly "to combat the high cost of malpractice insurance."[44]
    - **Missouri** was also identified by the AMA as a so-called "crisis state,"[45] yet had had a cap on non-economic damages since 1986. The cap started at $350,000 and was adjusted annually for inflation, reaching $557,000 in 2003.[46] "New medical malpractice claims dropped 14 percent in 2003 to what the [Missouri Department of Insurance] said was a record low, and total payouts to medical malpractice plaintiffs fell to $93.5 million in 2003, a drop of about 21 percent from the previous year." And "the National Practitioner Data Bank, a federally mandated database of malpractice claims against physicians, found that the number of paid claims in Missouri fell by about 30 percent since 1991. The insurance department's database found that paid claims against physicians fell 42.3 percent during the same time period." *Yet doctors' malpractice insurance premiums rose by 121 percent between 2000 and 2003*.[47]

- **Florida:** "When Gov. Jeb Bush and House Speaker Johnnie Byrd pushed through a sweeping medical malpractice overhaul bill … the two Republican leaders vowed in a joint statement that the bill would 'reduce ever-increasing insurance premiums for Florida's physicians . . . and increase physicians' access to affordable insurance coverage.'" But, insurers soon followed up with requests to increase premiums by as much as 45 percent.[48]

- **Ohio:** Almost immediately after "tort reform" passed, all five major medical malpractice insurance companies in Ohio announced they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.[49]

- **Oklahoma:** After "caps" passed in 2003, the third-largest medical malpractice insurer in the state raised its premiums 20 percent, followed by an outrageous 105 percent rate hike in 2004.[50] The largest insurance company, which is owned by the state medical association, requested an astounding 83 percent rate hike just after "tort reform" passed (which was approved on the condition it be phased in over three years).[51]

- **Mississippi:** Four months after "caps" passed, investigative news articles reported that surgeons still could not find affordable insurance and that many Mississippi doctors were still limiting their practice or walking off the job in protest.[52]

- **Nevada:** Within weeks of enactment of "caps" in the summer of 2002, two major insurance companies proclaimed that they would not reduce insurance rates for at least another year to two, if ever. The Doctor's Company, a nationwide medical malpractice insurer, then filed for a 16.9 percent rate increase. Two other companies filed for 25 percent and 93 percent rate increases.[53]

- **Texas:** During the 2003 campaign for Prop. 12 – the "tort reform" referendum that passed – ads promised rate cuts if caps were passed. Right after the referendum passed, major insurers requested rate hikes as high as 35 percent for doctors and 65 percent for hospitals.[54] In April 2004, after one insurer's rate hike request was denied, it announced it was using a legal loophole to avoid state regulation and increase premiums 10 percent without approval.[55] In a 2004 filing to the Texas Department of Insurance, GE Medical Protective revealed that the state's non-economic damage cap would be responsible for no more than a 1 percent drop in losses.[56]

INDUSTRY INSIDERS HAVE REPEATEDLY ADMITTED THAT CAPPING DAMAGES WILL NOT LOWER INSURANCE RATES

- **American Insurance Association:** "[T]he insurance industry never promised that tort reform would achieve specific premium savings." (American Insurance Association Press Release, March 13, 2002)

- **Sherman Joyce, President, American Tort Reform Association:** "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." (*Liability Week*, July 19, 1999)

- **Victor Schwartz, General Counsel, American Tort Reform Association:** "[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'" (*Business Insurance*, July 19, 1999)

- **Connecticut State Lawmaker:** "[T]he insurance industry now says [tort reform] measures will have no effect on insurance rates. We have been disappointed by the response of the insurance industry. The reforms we passed should have led to rate reductions because we made it more difficult to recover, or set limits on recovery. But this hasn't happened." (*UPI*, March 9, 1987)

- **State Farm Insurance Company (Kansas):** "[W]e believe the effect of tort reform on our book of business would be small. … [T]he loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses.…." (Letter from Robert J. Nagel, Assistant Vice President, State Filings Division, to Ray Rather, Kansas Insurance Department, Oct. 21, 1986, at 1-2.)

- **Aetna Casualty and Surety Co. (Florida):** After Florida enacted what Aetna Casualty and Surety Co. characterized as "full-fledged tort reform," including a $450,000 cap on non-economic damages, Aetna did a study of cases it had recently closed and concluded that

Florida's tort reforms would not effect Aetna's rates. Aetna explained that "the review of the actual data submitted on these cases indicated no reduction of cost." (Aetna Casualty & Sur. Co., Commercial Ins. Div., Bodily Injury Claim Cost Impact of Florida Tort Law Change, at 2, Aug. 8, 1986)

- **Allstate Insurance Company (Washington State):** In asking for a 22% rate increase following passage of tort reform in Washington State, including a cap on all damage awards, the company said, "our proposed rate would not be measurably affected by the tort reform legislation." (*The Seattle Times,* July 1, 1986)

- **Great American West Insurance Company (Washington State):** After the 1986 Washington tort reforms, the Great American West Insurance Company said that on the basis of its own study, "it does not appear that the 'tort reform' law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the 'tort reform' law." (Letter from Kevin J. Kelley, Director of Actuarial, to Norman Figon, Rate Analyst, Washington Insurance Department, April 23, 1986, at 1)

- **Vanderbilt University:** A regression analysis conducted by Vanderbilt University economics professor Frank Sloan found that caps on economic damages enacted after the mid 1970's insurance crisis had no effect on insurance premiums. (Sloan, "State Responses to Malpractice Insurance Crisis of the 1970's: An Empirical Assessment," 9 *Journal of Health Politics, Policy & Law* 629-46 (1985))

STRONG INSURANCE REGULATORY LAWS ARE THE ONLY WAY TO CONTROL INSURANCE RATES FOR DOCTORS AND HOSPITALS.

There are only two states in the nation where it is possible to compare the impact on insurance rates of both "caps" on non-economic damages and strong insurance rate regulation (which New York State lacks): California and Illinois. The following describes the experience of both states. It is clear – caps do not solve doctors' insurance problems. Rather, strong insurance regulatory laws are the only effective and fair way to control insurance rates for doctors and hospitals.

California

- **In 1975, California enacted a severe $250,000 cap on non-economic damages, the first in the nation. This cap has greatly reduced the number of genuine malpractice cases brought in California.**

    - Caps on non-economic damages make many legitimate cases economically impossible for attorneys to bring: those involving seniors, low wage earners (including women who work inside the home), children and the poor, who are more likely to receive a greater percentage of their compensation in the form of non-economic damages. Insurance defense attorney Robert Baker, who had defended malpractice suits for more than 20 years, told Congress in 1994, "As a

result of the caps on damages, most of the exceedingly competent plaintiff's lawyers in California simply will not handle a malpractice case … There are entire categories of cases that have been eliminated since malpractice reform was implemented in California."[57]

  - Despite the reduction of legitimate cases, between 1975 and 1988, doctors' premiums in California increased by 450 percent, rising faster than the national average.[58]
  - Today, as a result of the cap, California's medical malpractice insurance industry has become so bloated that "as little as 2 or 3 percent of premiums are used to pay claims" and "the state's biggest medical malpractice insurer, Napa-based The Doctors Company, spent only 10 percent of the $179 million collected in premiums on claims in 2009." Insurance Commissioner Dave Jones said that "insurers should reduce rates paid by doctors, surgeons, clinics and health providers while his staff scrutinizes the numbers."[59]

- **In 1988, California voters passed a stringent insurance regulatory law, Proposition 103, which ordered a 20% rate rollback, forced companies to open their books and get approval for any rate change before it takes effect, and allowed the public to intervene and challenge excessive rate increases.**

  - In the twelve years after Prop. 103 (1988-2000), malpractice premiums dropped 8 percent in California, while nationally they were up 25 percent.[60]
  - During the period when every other state was experiencing skyrocketing medical malpractice rate hikes in the mid-2000s, California's regulatory law led to public hearings on rate requests by medical malpractice insurers in California, which resulted in rate hikes being lowered three times in two years,[61] saving doctors $66 million.
  - Today, if the California medical malpractice insurance industry does not lower rates on its own, as the Insurance Commissioner has requested, Prop. 103 will allow the Commissioner to take action and do so.

Illinois

In 2005, Illinois enacted a non-economic damages cap on compensation for injured patients ($500,000 for doctors and $1,000,000 for hospitals) and a very strong insurance regulatory law. In February 2010, the Illinois Supreme Court struck down this cap as unconstitutional.[62] Because of a non-severability clause, the insurance regulatory law was struck down, as well. In the five years these laws were in place, the following occurred:

- **The cap never really affected settlements or insurance rates in Illinois during the five years it existed.**

  This was acknowledged in a May 2010 webinar sponsored by A.M. Best, where a Chicago-based insurance attorney said:

> It may be headlines in other places but here in Cook County [Illinois] I think that the Supreme Court's decision in *Lebron* was fully anticipated and discounted. None of the settlements that I've been involved in for the last couple of years paid the slightest attention to the caps anymore. There was almost a universal acceptance that it would be overturned by the Supreme Court. In fact it was overturned in Cook County two years ago. Lebron was a Cook County case going up, so the caps haven't been law here for quite some time.[63]

- **The strong insurance regulatory reforms *did* take effect and had an impact.**

In October 2006, the Illinois Division of Insurance announced that an Illinois malpractice insurer, Berkshire Hathaway's MedPro, would be expanding its coverage and cutting premiums for doctors by more than 30 percent. According to state officials and the company itself, this was made possible because of new insurance regulatory law enacted by Illinois lawmakers in 2005, and expressly not the cap on compensation for patients.[64] The new law required malpractice insurers to disclose data on how to set their rates. This, according to Michael McRaith, director of the state's Division of Insurance, allowed MedPro to "set rates that are more competitive than they could have set before."

In February 2010, the Illinois Division of Insurance released data showing that insurance regulation had greatly improved the medical malpractice insurance environment with expanded coverage and lower premiums for doctors[65]. Specifically, the insurance division said:

> "The 2005 Reform Laws imposed changes to the Illinois Insurance Code that improved insurer reporting and transparency requirements and enhanced the Department's rate oversight authority. Since 2005, the Department has observed improvements in the medical malpractice insurance market. In particular, the Department observed:
>
> > **A decrease in medical malpractice premiums.** Gross premium paid to medical malpractice insurers has declined from $606,355,892 in 2005 to $541,278,548 in 2008;
> >
> > **An increase in competition among companies offering medical malpractice insurance.** In 2008, 19 companies offering coverage to physicians/surgeons each collected more than $500,000 in premiums, an increase from 14 such companies in 2005; and
> >
> > **The entry into Illinois of new companies offering medical malpractice insurance.** In 2008, five companies collected more than $22,000,000 in combined physicians/surgeons premiums – and at least $1,000,000 each in premiums – that did not offer medical malpractice insurance in 2005."

HIGH INSURER PROFITS

- **Medical malpractice insurers have been incredibly profitable in recent years.**
  - In the 2009 report *True Risk*, Americans for Insurance Reform found that no matter how profits were measured, medical malpractice insurers were doing incredibly well, especially when compared to every other sector in the economy.[66] Medical malpractice insurers admitted that they had "a very good" 2008.[67] This came "after posting record profits in 2007."[68] A.M. Best predicted that their "operating profits will continue through 2009."[69] And a quick look at the most recent data shows this to be true.
  - We reported in *True Risk* that in 2007 – the last year data was available - the medical malpractice insurance industry had an overall return on net worth of 15.6%, *well over* the 12.5% overall profit for the entire property/casualty industry.[70] According to the National Association of Insurance Commissioners most recent data, overall return on net worth for the medical malpractice insurers for 2009 remains high at 15.3 %.
  - Profitability can also be measured by the loss ratio, which compares the premiums that insurers take in and the money expected to be paid in claims. The lower the loss ratio, the less the insurer expects to pay for claims and the more profitable the insurer likely is (assuming all other things are equal.) According to A.M. Best, the loss ratio for medical malpractice insurers has been declining for at least five years.[71] In 2008, it was remarkably low, at 61.1%. Put another way, medical malpractice insurers believe they will pay out in claims only 61.1 cents for each premium dollar they take in. The rest goes towards overhead and profit, in addition to the profit the insurer makes by investing premiums.
  - Another way to illustrate how well insurers have been doing in recent years is by examining "reserves" – the money set aside for future claims. Reserves are often manipulated by insurers for reasons having little to do with actual claims. Indeed, according to A.M. Best, reserves were "redundant" (i.e. excessive) during the last hard market - 2002 to 2004.[72] In those years, insurers told lawmakers that they needed dramatically to raise rates for doctors in order to pay future claims. It wasn't true. As reserves went up, so did rates.[73]
  - Reserves are now dropping at a substantial rate, with a whopping 13.6% drop in the last two years examined by AIR.[74] Yet they have even further to go! According to a December 2010 ISO publication, which examined reserves at year-end 2009, reserves are still redundant (i.e., excessive) for medical malpractice policies: 15% to 35% for occurrence policies and by 41% to 61% for claims made policies. *This means rates still have much further to fall!*
  - In Texas, an Austin-based medical malpractice insurer– American Physicians Service Group Inc. - agreed in September to be acquired by Alabama's ProAssurance Corp. for about $250 million in cash. The company earned $6.2 million on $20.7 million in revenue in the second quarter that ended June 30. … ProAssurance CEO W. Stancil Starnes said APS' strength in Texas made it an attractive acquisition candidate. ProAssurance currently writes about $10 million in premiums in Texas."[75]

"DEFENSIVE MEDICINE" AND HEALTH CARE COSTS

In over 30 years, premiums and claims have never been greater than 1% of our nation's health care costs.[76] 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.[77] However:

- CBO found no evidence of pervasive "defensive medicine."[78] It found tiny health care savings – "0.3 percent from slightly less utilization of health care services" -- if severe tort reform were passed nationally.

- In February, the Center for Justice & Democracy released excerpts from a working draft of a groundbreaking new article, "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.'" The article was written by Fred Hyde, M.D., Clinical Professor in the Department of Health Policy and Management at Columbia University's Mailman School of Public Health. Dr. Hyde, who 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. The following are excerpts from this article:
    - "'Defensive medicine' by all accounts has become such a myth, a combination of surveys of interested parties and the 'imagination' that those parties are avoiding--or believe they are avoiding—liability through alteration of their medical practices."
    - "The cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care."
    - Medical liability "acts as a guardian against under treatment, the primary concern which should now be facing policy-makers."
    - "If tort reform reduces or even eliminates sanctions associated with negligent care and activity, adverse events themselves may increase, and by a number far greater than .2, .3 or .7% of the American health care bill."
    - "The implicit hypothesis would appear to be the following: 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. There are many more cases concerning incompetence in credentialing and privileging, negligent referral, unnecessary radiation, etc., to provide at least a counter hypothesis.
    - "[A]s reaffirmed in the CBO studies, and as reflected in the literature generally, all estimates of the 'indirect' costs of professional liability, including, for example, the cost, if any, of defensive medicine, are trivial, in comparison to the cost of health

care. Controversies involving Senators, the CBO in 2009 appear entirely to reflect the difference between .2 and .5% of health costs.

  - "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.
  - "The fee for service system both empowers and encourages physicians to practice very low risk medicine. Health care reform may change financial incentives toward doing fewer rather than more tests and procedures. If that happens, concerns about malpractice liability may act to check potential tendencies to provide too few services.
  - "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."

- **AAOS Survey.** In a widely-reported recent "survey" of 56 (according to American Academy of Orthopaedic Surgeons' on-line summary of presentations) or 72 (according to the Academy's news release) Pennsylvania orthopedic surgeons, these surgeons claim that 19.7 percent of the imaging tests that they ordered were for defensive purposes – i.e. to avoid being sued. This supposedly amounts to 34.8 percent of total imaging costs because "the most common test was an MRI, which costs more than an X-ray." This information was presented at the Academy's annual meeting in San Diego on February 16, 2011. CJ&D requested Fred Hyde, M.D., Clinical Professor in the Department of Health Policy and Management at Columbia University's Mailman School of Public Health, to review this study. Dr. Hyde found:
  - In searching for the actual paper containing these findings, it turns out that there is no paper, much less one peer reviewed prior to publication. Instead, this was a podium presentation by a medical student, accompanied by a faculty supervisor.
  - The methodology, according to news and public relations reports, was this: to ask the ordering doctor whether or not he or she was ordering a test for reasons having to do with "defensive medicine."
  - However, the issues are not straightforward. For example, a moderator of the presentation suggested other possible explanations for the MRI exams. He noted that MRIs and other imaging studies are frequently ordered "unnecessarily" for reasons *other than malpractice avoidance*.
    - The moderator noted that many MRIs are required by insurers before those insurers will authorize an arthroscopy (a minimally invasive surgical

procedure in which an examination and treatment of damage of the interior of a joint is performed using an arthroscope, an endoscope inserted into the joint through a small incision).
    - The insurers require the imaging study in an attempt to protect against fraud. Orthopedic surgeons believe the MRI study prior to arthroscopy to be unnecessary; this was affirmed by a show of hands in the audience for the San Diego presentation.
  - No mention was made of the potential for fraudulent billing if the MRI studies ordered were not for the benefit of the patient. If the box checked "defensive" were accompanied by a box that indicated "no bill to be rendered" or "bill referring physician" this would undoubtedly have been included in the report. It would be a reasonable assumption that, to the contrary, a bill was rendered to the patient or to the insurance company for the MRIs as ordered. Were the physicians really uninterested in the results of the MRI tests, and willing to risk sanction? Or did they "check the box" to "show support" without realizing that it might indicate a potentially fraudulent act?
  - Finally, appearing in Pennsylvania especially,[79] this study should be regarded primarily as an advocacy position. This advocacy presentation has received disproportionate attention due to its timing in the context of current proposals before the Congress, not because of the credibility of the survey. The difficulty facing physicians especially in Pennsylvania concerning the cost and availability of malpractice insurance are well known, but are due to insurance issues, and not to causes directly related to tort law.

- **GAO.** 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 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."[80] 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."

- **OTA.** 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."[81]

- **Wellmark Blue Cross and Blue Shield.** Much has been written about how the problem of "self-referral" contributes to overutilization. Not too long ago, the *Washington Post* obtained some Wellmark Blue Cross and Blue Shield documents, which showed that in 2005, doctors at a medical clinic on the Iowa-Illinois border were ordering eight or nine CT scans a month in August and September of 2005. But after those doctors bought their own CT scanner, within seven months, those numbers ballooned by 700 percent. The *Post* did a similar analysis of the Wellmark data for doctors in the region and found that after CT scanners were purchased, the number of scans they ordered was triple that of other area doctors who hadn't purchased such equipment. The *Post* also cited consistent data from the GAO and MedPac. Jean M. Mitchell, a professor for public policy and a health economist at Georgetown University suggested, getting rid of profit-driven medicine like this "could reduce the nation's health care bill by as much as a quarter."[82]

- **California.** Many other factors contribute to overutilization. For example, an investigative team recently took a look at C-Section rates in California, which has had a $250,000 cap since 1975. It found, "[W]omen were at least 17 percent more likely to have a cesarean section at a for-profit hospital than at a nonprofit or public hospital from 2005 to 2007. A surgical birth can bring in twice the revenue of a vaginal delivery.… In addition, some hospitals appear to be performing more C-sections for nonmedical reasons -- including an individual doctor's level of patience and the staffing schedules in maternity wards, according to interviews with health professionals. ... In California, hospitals can increase their revenues by 82 percent on average by performing a C-section instead of a vaginal birth."[83]

- **The "False Claims" Issue.** We do not believe that most physicians in the country 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."[84] "[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."[85]
    - 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.[86]

- o 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."[87] If the services are, to the doctor's knowledge, medically unnecessary, the claim is false.

THE IMPACT OF TEXAS "TORT REFORM" ON "DEFENSIVE MEDICINE" AND HEALTH CARE COSTS.

- According to the consumer group Texas Watch, "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.[88]

- 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.

- 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.[89] Texas has the nation's highest rate of uninsured with 24.5% of Texans without health insurance."[90]

- The Texas experience shows that removing litigation as a factor will not change the extent of tests and procedures that will be ordered. I noted earlier a June 1, 2009, *New Yorker* magazine article by Dr. Atul Gawande, 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." It is worth repeating 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.*
>
> "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.

ACCESS TO CARE

- **There is no correlation between where physicians decide to practice, their choice of specialty, and liability laws.**
  - On August 29, 2003, the U.S. General Accountability Office released a study[91] 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 doctors 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 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."[92]
  - 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."[93]
  - 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."[94]

- 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."[95] A 1995 study of the impact of Indiana's medical malpractice "tort reforms," which were enacted with the promise 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."[96]
- It is well-documented that lifestyle considerations are the most important factor for determining not only a doctor's choice of location, but also his or her choice of specialty - far more important than income and expenses. As reported in the *New York Times*, "Today's medical residents, half of them women, are choosing specialties with what experts call a 'controllable lifestyle.'… What young doctors say they want is that 'when they finish their shift, they don't carry a beeper; they're done,' said Dr. Gregory W. Rutecki, chairman of medical education at Evanston Northwestern Healthcare, a community hospital affiliated with the Feinberg School of Medicine at Northwestern University.… Lifestyle considerations accounted for 55 percent of a doctor's choice of specialty in 2002, according to a paper in the Journal of the American Medical Association in September by Dr. [Gregory W.] Rutecki and two co-authors. That factor far outweighs income, which accounted for only 9 percent of the weight prospective residents gave in selecting a specialty."[97] For example, compared to dermatology, which is becoming a more competitive specialty, "'The surgery lifestyle is so much worse,'' said Dr. [Jennifer C.] Boldrick, who rejected a career in plastic surgery. 'I want to have a family. And when you work 80 or 90 hours a week, you can't even take care of yourself.'"
- Another key factor is age. University of California-San Francisco study of New York doctors found that the main reason doctors cease providing obstetrics care is advancing age. The UCSF study, of New York State physicians during the mid-1980s insurance crisis, found no association between malpractice premiums and doctors' decisions to quit. The study did find that the decrease in doctors practicing obstetrics was associated with the *length of time* since receiving a medical license in New York. This relationship "very likely represents the phenomenon of physician retiring from practice or curtailing obstetrics as they age."[98]
- Finally, we asked David Goodman, M.D., M.S., Professor of Pediatrics and Health Policy at Dartmouth Medical School, about his views on the subject. Goodman is co-investigator of the highly respected Dartmouth Atlas, which analyzes and ranks health care spending and has been the basis of a lot of discussion about why certain areas of the country are so costly. His email to us said: "We haven't explicitly analyzed this, but I agree with the impression that physician supply in general bears no relationship to state tort reform, or lack thereof."

- **Texas still suffers from the same doctor shortages, especially in rural areas, as before caps were passed.**

- 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 doctors' shortages still loom in Texas today. This is apparently due to "[C]aps 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." 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?"[99]
- 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.[100]
- In December 2009, the *Ft. Worth Star-Telegram* reported,[101]

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

- According to a Fall 2009 study by professors Charles Silver of the University of Texas School of Law, David A. Hyman, Professor of Law and Medicine at 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 step seeing patients), the data shows that the per capital number has not grown. In fact, the number grew steadily through 2003 and then leveled off. They write, "This is not the pattern you would expect a 2003 tort reform law was responsible."[102]

IMPACT OF RESTRICTIONS ON THE RIGHTS OF INJURED PATIENTS

H.R. 5 would unfairly increase the obstacles that sick and injured patients face in the already difficult process of seeking compensation and prevailing in court. They will also reduce the financial incentive of institutions, such as hospitals and HMOs, to operate safely, which will lead to more costly errors.

DETERRENCE

- **Weakening the tort system will increase errors, injuries and deaths**
  - In its October 9, 2009 letter to Senator Orin Hatch on medical malpractice issues, the CBO noted, "The system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses …" CBO wrote, "imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes," yet it brushed aside its significance, not because it is untrue, but because it says there are too few studies on the topic. However, of the three studies that address the issue of mortality, CBO notes that one study finds such tort restrictions would lead to a .2 percent increase in the nation's overall death rate.[103] 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.[104]
  - 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 die.[105]) 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 increase.[106] Consider, for example, that the average length of stay per hospitalization is around 4.4 days[107] and the average cost in the hospital is approximately $2,000 per day per injury.[108] Consider those costs in addition to physician utilization inherent in caring for these new patients.
  - David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law, and Charles Silver of the University of Texas at Austin School of Law, have researched and written extensively about medical malpractice.[109] They 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."[110] "As 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 diminished is ridiculous."[111]

- Numerous other 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.[112] As a result of such lawsuits, the lives of countless other patients have been saved.
- "The authors of the Harvard [Medical Practice Study] study acknowledged, as well: '[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.'"[113]
- 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."[114]
- No one said this better than Dr. Wayne Cohen, then-medical director of the Bronx Municipal Hospital, who said, "The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing."[115]

- **Removing the undue "fear" of litigation - even if you could - would not change the culture of secrecy at hospitals.**

  - Fear of litigation is not the reason hospitals and doctors do not report errors or communicate with their patients. David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law and Charles Silver of the University of Texas School of Law, who have studied this problem, write, "[e]xhaustive chronicles of malpractice litigation's impact on physicians never once assert that physicians freely and candidly disclosed errors to patients once upon a time, but stopped doing so when fear of malpractice liability increased. Instead, the historical evidence indicates that there was never much *ex post* communication with patients, even when liability risk was low."[116]
  - In his book on medical malpractice, Tom Baker, then Connecticut Mutual Professor of Law and Director of the Insurance Law Center at the University of Connecticut School of Law, confirmed, "to prove that lawsuits drive medical mistakes underground, you first have to prove that mistakes would be out in the open if there were no medical malpractice lawsuits. That is clearly not the case."[117]
  - A May 11, 2006 article in the *New England Journal of Medicine* noted that only one quarter of doctors disclosed errors to their patients, but "the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance" [i.e., no litigation against doctors] for decades. In other words, "There are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges."[118]
  - According to a recent study by Dr. Thomas Gallagher, a University of Washington internal-medicine physician and co-author of two studies published in the *Archives of*

Internal Medicine, "Comparisons of how Canadian and U.S. doctors disclose mistakes point to a 'culture of medicine,' not lawyers, for their behavior."[119] In Canada, there are no juries, non-economic awards are severely capped and "if patients lose their lawsuits, they have to pay the doctors' legal bills… yet "doctors are just as reluctant to fess up to mistakes." Moreover, "doctors' thoughts on how likely they were to be sued didn't affect their decisions to disclose errors." The authors believe "the main culprit is a 'culture of medicine,' which starts in medical school and instills a 'culture of perfectionism' that doesn't train doctors to talk about mistakes."[120]

- Another example is in Massachusetts, where nearly all hospitals fall under the state's charitable immunity laws that cap their liability at $20,000. Yet hospitals are still "vastly underreporting their mistakes to regulators and the public." According to *Boston Magazine,* "The biggest challenge is finding a way to break the culture of silence in hospital corridors that has long crippled efforts to cut medical errors, just as the blue wall of silence has stifled police investigations.[121]
- Hyman and Silver offer a number of explanations for physicians failure to report errors: a culture of perfectionism within the medical profession that shames, blames, and even humiliates doctors and nurses who make mistakes; fragmented delivery systems requiring the coordination of multiple independent providers; the prevalence of third-party payment systems and administered prices; overwork, stress, and burnout; information overload; doctors' status as independent contractors and their desire for professional independence; the Health Insurance Portability and Accountability Act (HIPAA); a shortage of nurses; and underinvestment in technology that can reduce errors.[122] They write, "It is naive to think that error reporting and health care quality would improve automatically by removing the threat of liability."[123]

H.R. 5 SPECIFIC PROPOSALS

- **Preemption and Seventh Amendment issues.**

H.R. 5 would overturn traditional state common law and would be an unprecedented interference with the work of state court judges and juries in civil cases. Its one-way preemption of state law provisions that protect patients (there are some exceptions for caps) makes clear that the intent of this legislation is not to make laws uniform in the 50 states. Rather, it is a carefully crafted bill to provide relief and protections for the insurance, medical and drug industries. Every provision places a ceiling on patient recovery in tort litigation, but allows state laws to survive where those laws place more restrictions on patients' rights. There is nothing in this bill to protect patients.

What's more, it is ironic that in this era of celebrating the U.S. Constitution, we should be considering measures that directly interfere with the rights protected by the Seventh Amendment since without that Amendment, we would not have had Constitution at all. Our founding fathers secured the right to jury trial in criminal cases by incorporating it directly into the main body of the Constitution. However, they did not secure the right to civil jury trial in the main body.

Thomas Jefferson denounced this. States were so upset at that they began resisting ratification. They fixed the problem with the Seventh Amendment.

H.R. 5 would interfere directly with this right by limiting the power and authority of jurors to decide cases based on the facts presented to them. As the late Chief Justice William Rehnquist stated:

> The guarantees of the Seventh Amendment [right to civil jury trial] 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.[124]

Moreover, many states have found such tort restrictions unconstitutional in their state based on their own state law. For example, caps have been held unconstitutional by the high courts of many states, including most recently Georgia (*Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 691 S.E.2d 218 (Ga. 2010) (violates State constitution's guarantee that "[t]he right to trial by jury shall remain inviolate") and Illinois (*Lebron, a Minor v. Gottlieb Memorial Hospital*, 930 N.E.2d 895 (Ill. 2010) (violates constitutional separation of powers).

- **$250,000 Aggregate Cap on Non-Economic Damages**

This proposal would establish a permanent across-the-board $250,000 "cap" on compensation for "non-economic damages" in medical malpractice cases. Non-economic damages compensate for injuries like permanent disability, disfigurement, blindness, loss of a limb, paralysis, trauma, or physical pain and suffering. This cap would apply across the board to all medical malpractice jury verdicts that exceed the level of the cap. It applies no matter how much merit a case has, or the extent of the misconduct of a hospital, doctor or health care provider. It applies regardless of the severity of an injury. In most cases, lost earnings make up the largest part of the economic damages that go directly to the injured victim. Essentially, then, limiting non-economic damages results in valuing the destruction of an individual's life based on what that person would have earned in the marketplace but for the injury. The lives of low wage earners, children, seniors, and women who do not work outside the home, are thus deemed worth less than the life of a corporate executive.

University of Buffalo Law Professor Lucinda Finley noted in a recent study, "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."[125] Also, "[J]uries 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*."[126]

The state of California has had a 35-year track record with a similar $250,000 non-economic damages cap in medical malpractice cases. The results offer a guide for what can be expected by

this provision. According to an analysis by the Rand Institute for Civil Justice,[127] plaintiffs less than one year of age had awards capped 71 percent of the time, compared with 41 percent for all plaintiffs with identifiable non-fatal injuries. Injury cases with reductions of $2.5 million or more usually involved newborns and young children with very critical injuries. In effect, such a cap comes from reductions in payments to the most seriously injured and those with the longest lifespan after the injury.

Caps on non-economic damages also make cases economically impossible for attorneys to bring. In fact, this problem has already happened in states with non-economic damages caps, like California. Insurance defense attorney Robert Baker, who defended malpractice suits for more than 20 years, told Congress in 1994, "As a result of the caps on damages, most of the exceedingly competent plaintiff's lawyers in California simply will not handle a malpractice case … There are entire categories of cases that have been eliminated since malpractice reform was implemented in California."[128] So, for example, care for injured senior citizens will fall to Medicare and Medicaid instead of the culpable hospital's insurance company, adding to deficit, not decreasing it..

- **Imposing a statute of limitations - perhaps one to three years - on medical malpractice lawsuits.**

The provision reduces the amount of time an injured patient has to file a lawsuit to one year from the date the injury was discovered or should have been discovered, but not later than three years after the date of injury. This statute of limitations, which is much more restrictive than a majority of state laws, would cut off meritorious claims involving diseases with long incubation periods. Thus, a person who contracted HIV through a negligent transfusion but learned of the disease more than five years after the transfusion would be barred from filing a claim.

This idea lacks complete logic from a deficit reduction angle since its only impact would be to cut off meritorious claims. If a patient is harmed as a result of the medical negligence but unable to sue due to an unreasonably unfair statute of limitations period, he or she (or a child's family) would be forced to turn elsewhere for compensation, such as Medicaid. None of these increased costs are considered by CBO in its analysis, for example. In other words, unreasonably reducing a state statute of limitations would cause deficit increases, not decreases.

- **Contingency Fee Limits**

H.R. 5 gives the court power to restrict plaintiff's attorney fees regardless of whether recovery is by judgment, settlement, or any form of alternative dispute resolution. The bill specifies that contingent fees, regardless of the number of plaintiffs, may not exceed: (1) 40 percent of the first $50,000 recovered; (2) 33 percent of the next $50,000 recovered; (3) 25 percent of the next $500,000 recovered; and (4) 15 percent of any recovery in excess of $600,000. In other words, H.R. 5 would impose national wage caps on an injured patient's attorney, preventing the patient from getting decent legal assistance. On the other hand, insurance companies will continue being able to hire the best defense attorneys, who bill for every minute that they work, and are paid every dollar that they charge, whether they win or lose.

Contingency fee arrangements are tantamount to an injured patient's "key to the courthouse door." Under a contingency fee system, a lawyer takes a case without expecting any money up front—which is important, as injured patients may be in pain, unable to work, or lack funds to pay next month's mortgage or rent, let alone an hourly attorney's fee. Fees are paid only if the attorney wins. If the case is lost, the attorney is paid nothing. That is a huge risk. The impact of capping fees way below one-third, as H.R. 5 would do, would make it is far less likely that attorneys could afford to risk bringing the more costly and complex malpractice cases, providing practical immunity for many wrongdoers.

From a conservative viewpoint, this provision makes no sense at all. Many conservatives have written in praise of contingency fees because they screen out frivolous lawsuits and do not have any impact on increasing awards.[129]

- **Modifying the "collateral source" rule to allow outside sources of income collected as a result of an injury (for example workers' compensation benefits or insurance benefits) to be considered in deciding awards.**

The collateral source rule prevents a wrongdoer, such as a negligent hospital, from reducing its financial responsibility for the injuries it causes by the amount an injured party receives (or could later receive) from outside sources. Payments from outside sources are those unrelated to the wrongdoer, like health or disability insurance, for which the injured party has already paid premiums or taxes. The collateral source rule is one of fairness and reason. The rule's premise is that the wrongdoer's liability and obligation to compensate should be measured by the harm done and the extent of the injuries inflicted. In this way, the rule helps promote deterrence.

In fact, representatives from the conservative American Enterprise Institute found that modifying the collateral source rule could endanger infant safety. They wrote:

> [C]ollateral source reform leads to a statistically significant increase in infant mortality.... For whites, the increase is estimated to be between 10.3 and 14.6 additional deaths per 100,000 births. This represents an increase of about 3 percent. For blacks, the collateral source reversal leads to between 47.6 and 72.6 additional deaths per 100,000 births, a percentage increase between 5 and 8 percent. These results suggest that the level of care provided decreases with the passage of collateral source reform.…The relationships we estimate between reform measures and infant mortality rates appear to be causal.... In summary, these results show that collateral source reform leads to increased infant mortality."[130]

- **Limits on Punitive Damages.**

H.R. 5 provides that punitive damages may only be awarded if the plaintiff proves by an impossibly heightened standard of clear and convincing evidence that: (1) the defendant acted with malicious intent to injure the plaintiff; or (2) the defendant understood the plaintiff was substantially certain to suffer unnecessary injury, yet deliberately failed to avoid such injury. The bill further limits punitive damages to two times the amount of economic damages or $250,000, whichever is greater. Moreover, the bill completely immunizes manufacturers of

drugs and devices that are approved by the FDA from punitive damages and extends immunity to the manufacturers of drugs and devices that are not FDA-approved, yet are "generally recognized as safe and effective." Finally, the bill immunizes the manufacturer or seller of drugs from punitive damages for packaging or labeling defects.

Punitive damages are assessed against defendants by judges or juries to punish particularly outrageous, deliberate or harmful misconduct, and to deter the defendant and others from engaging in similar misconduct in the future. There is no need for Congress to interfere with state law in this area. According to the Bureau of Justice Statistics, only 1 percent of medical malpractice plaintiffs and 1 percent of product liability plaintiffs who prevailed at trial were awarded punitive damages in the most recent year studied - 2005.[131] Although rare, the prospect of having to pay punitive damages in a lawsuit by an injured patient causes large institutions and the drug industry to operate more safely.[132] When a court requires a wrongdoer to pay punitive damages, it calls upon the wrongdoer to pay more than the amount required to compensate a person for the impact of a specific injury. Punitive damages are designed to be a deterrent against future serious misconduct. In other words, legislating the "FDA defense" idea could make it impossible for a consumer to ask a court to require a drug manufacturer to pay punitive damages even if the manufacturer had information that the drug was harmful, and even if the FDA knew the drug was harmful and refused to act.

Linking punitive damages to the economic loss of the injured party would effectively would punish wrongdoing based on the harm done to the victim, not the culpability of the conduct. This would mean that cruel and unconscionable harm to low-wage earners, such as non-working women and elderly individuals, would be punished less than harm to corporate CEO. Punitive damages are imposed by judges and juries to punish egregious misconduct and to hold corporations accountable for their most reckless or deliberately harmful acts. The size of the punitive award, under long-held standards, should be based on the egregiousness of the actions, the extent to which the company acted with malice and awareness of the harm that would result, and the financial size of the company.

- **Eliminating joint-and-several liability.**

Again, this provision would burden the most seriously injured patients. The doctrine of joint and several liability has been a part of the common law for centuries. It is a rule that applies to allocating damages when more than one defendant is found *fully responsible* for causing an entire injury. If one of them is insolvent or cannot pay compensation, the other defendants must pick up the tab so the innocent victim is fully compensated. Courts have always held that it applies only to injuries for which the defendant is fully responsible. That means that their negligent or reckless behavior must be an "actual and proximate" cause of the entire injury, a high standard.[133] Having said that, joint and several liability limits have already been enacted in over 40 states, so the proposal is not only superfluous, but would expressly interfere with the decisions of many state legislatures.[134]

What's more, according to CBO, this change could increase costs, not lower costs. Specifically, CBO said that modifying joint and several liability "may increase the volume and intensity of physician services." In other words, this change could cause a deficit increase, not decrease.

- **Structured Settlements.**

Allowing all future damages over $50,000 to be paid periodically, as does H.R. 5, would leave those injured by malpractice and unsafe products vulnerable and undercompensated while large insurance companies reap the interest benefits of a plaintiff's jury award. Moreover, this provision increases the hardships of the most seriously injured patients who are hit soon after an injury with large medical costs and must make adjustments in transportation and housing.

ONE THING CONGRESS CAN DO: REPEAL THE ANTI-TRUST EXEMPTION

Congress must take responsible, remedial steps to reign in the power and control the abuses of insurance companies. Otherwise, we will never be able to deal systematically with the tactics of this industry, which consistently looks for scapegoats to cover up its own instability and mismanagement.

One thing Congress could do is repeal the insurance industry's federal anti-trust exemption. Since 1944, the McCarran-Ferguson Act has allowed insurance companies to fix prices. A law repealing the federal anti-trust exemption would ensure that all domestic and foreign insurers and reinsurers that do business in the United States are subject to federal anti-trust prohibitions applicable to other industries. Such legislation would prohibit the insurance industry from acting in concert to raise prices and would prohibit tying arrangements, market allocation among competitors and monopolization.

If the McCarran-Ferguson Act were repealed, the industry-owned and controlled, for-profit Insurance Services Office, Inc. (ISO) and other rating bureaus could still jointly collect, compile and disseminate past data relating to premiums and claims. However, price-fixing agreements would be illegal. Moreover, ISO would be forced to disclose to insurance buyers the documents it prepares for insurance sellers, listing both current prices major insurers charge and the ISO advisory rates.

IMPROVING PATIENT SAFETY, INCLUDING FOR HIGH-COST OBSTETRICAL INJURIES

- **NY Presbyterian Hospital-Weill Cornell Medical Center Obstetric Safety Initiative**

    - In the February 2011 *American Journal of Obstetrics & Gynecology*, three physicians published an article about a comprehensive obstetric patient safety program that was implemented in the labor and delivery unit at NY Presbyterian Hospital-Weill Cornell Medical Center, beginning in 2002.[135] This program initially came at the recommendation of the hospital's insurance carrier, MCIC Vermont. The authors wrote, "Our experience supports the recommendation that: '. . . Malpractice loss is

best avoided by reduction in adverse outcomes and the development of unambiguous practice guidelines.'" Specifically, they say,

> After an external review of our obstetric service, we undertook comprehensive system changes beginning in 2003, to improve patient safety on our service. Among these patient safety changes were significant eliminations in practice variations as well as significant improvements in communication methods between staff. The main goal of these changes was to improve patient safety and decrease adverse outcomes.

For example, they used team training and other methods to improve communication, electronic medical record charting, improved on call scheduling, established new drug protocols, premixed and color coded solutions, hired full time patient safety obstetric nurses funded by the carrier, made better use of physicians assistants and put a laborist on staff, required certification in electronic fetal monitoring and held obstetric emergency drills.

They found that "that implementing a comprehensive obstetric patient safety program not only decreases severe adverse outcomes but can also have an immediate impact on compensation payments." For example, they reported that "2009 compensation payment total constituted a 99.1% drop from the average 2003-2006 payments (from $27,591,610 to $ 250,000). The average yearly compensation payment in the 3 years from 2007 to 2009 was $2,550,136 as compared with an average of $27,591,610 in the previous 4 years (2003-2006), a yearly saving of $25,041,475 (total: $75,124,424) during the last 3 years."

- **Beth Israel Deaconess Medical Center**
  - I served on a New York State medical malpractice task force in 2007 and 2008, which among other things, discussed ways to improve patient safety as the best way to reduce injuries, claims, lawsuits and costs to the system. The presentation by Dr. Ronald Marcus Director of Clinical Operations, Department of OB/GYN at Beth Israel Deaconess Medical Center and Assistant Professor of the Harvard Medical School, was instructive. His presentation not only acknowledged the extent of birth injuries caused by OB error, but discussed the reasons for this and proven methods to correct the situation.
  - As did the NY Presbyterian Hospital-Weill Cornell Medical Center authors, Dr. Marcus also specifically discussed the concept of team training or crew resource management that was developed by NASA to deal with pilot error. Dr. Marcus found that with crisis management training in OB emergencies, patient outcomes dramatically improved, with a 50 percent decrease in low Apgars, neonatal encephalopathy. With crew resource management in place, there was a 23 percent decrease in frequency and 13 percent decrease in severity of adverse events, and a 50 percent decrease in OB malpractice cases. It should be noted that if medical errors were not the cause of a certain birth-related injuries, as some doctors insist, clearly these kinds of statistics would not exist.[136]

- **Rand Institute for Civil Justice**

    - In 2010, the Rand Institute for Civil Justice released a new report funded, in part, by insurance companies, which examined whether successful patient safety efforts leads to reductions in medical malpractice claims, since apparently no study had yet looked at this issue.[137] Rand looked at California hospitals from 2001 to 2005, and found that indeed, it does. Specifically, the authors found,
        - [There is a] highly significant correlation between the frequency of adverse events and malpractice claims: On average, a county that shows a decrease of 10 adverse events in a given year would also see a decrease of 3.7 malpractice claims.
        - We also found that the correlation held true when we conducted similar analyses for medical specialties—specifically, surgeons, nonsurgical physicians, and obstetrician/gynecologists (OB-GYNs). Nearly two-thirds of the variation in malpractice claiming against surgeons and nonsurgeons can be explained by changes in safety. The association is weaker for OB-GYNs, but still significant.
        - These findings are consistent with the basic hypothesis that iatrogenic harms are a precursor to malpractice claims, such that modifying the frequency of medical injuries has an impact on the volume of litigation that spills out of them. Although this is an intuitive relationship, it is not one that has been well validated previously. It suggests that safety interventions that improve patient outcomes have the potential to reduce malpractice claiming, and in turn, malpractice pressure on providers.
        - [N]ew safety interventions potentially can have positive effects on the volume of malpractice litigation—a desirable result to seek out, even beyond the immediate impact of medical injuries avoided.
        - Presumably, the one thing that all parties to the debate can agree on is that reducing malpractice activity by reducing the number of iatrogenic injuries is a good idea. Arguments about the merits of statutory tort intervention will surely continue in the future, but to the extent that improved safety performance can be shown to have a demonstrable impact on malpractice claims, that offers another focal point for policymakers in seeking to address the malpractice crisis. Based on the results of the current study, we would suggest that that focal point may be more immediately relevant than has previously been recognized.

CONCLUSION

History is clear on this matter: taking away the rights of the most seriously injured in our society has been and continues to be a failed public policy. Laws and proposals that increase the obstacles sick and injured patients face in the already difficult process of prevailing in court are certainly the wrong way to respond to the important economic problems that face this country. Tort restrictions will add to the deficit and will reduce the financial incentive of institutions like

hospitals and HMOs to operate safely, when our objectives should be deterring unsafe and substandard medical practices while safeguarding patients' rights. Indeed, our goal must be to reduce medical negligence. Moreover, effective insurance reforms, like repealing the McCarran-Ferguson Act, are the only way to stop the insurance industry from abusing its enormous economic influence, which it uses to promote a legislative agenda that bilks taxpayers and severely hurts the American public.

NOTES

[1] A $250,000 cap on non-economic damages, a punitive damages cap of $500,000 or two times the amount of economic damages, repeal of the collateral source rule, one-year date of discovery statute of limitations (3 years for children), and repeal of joint and several liability.
[2] Alexander C. Hart, "Medical malpractice reform savings would be small, report says," *Los Angeles Times,* October 10, 2009; http://www.latimes.com/news/nationworld/nation/la-na-malpractice10-2009oct10,0,4877440.story
[3] See, http://wonkroom.thinkprogress.org/2009/10/23/rockefeller-malpractice/
[4] Denis Hamill, "Doctor with disabled son is no fan of governor's plan to cap malpractice suits," New York Daily News, March 13th 2011.
[5] *To Err Is Human, Building a Safer Health System,* Institute of Medicine, 1999.
[6] U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), pp. i-ii, found at http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.
[7] *Id* at iii.
[8] Christopher P. Landrigan et al., "Temporal Trends in Rates of Patient Harm Resulting from Medical Care," *N Engl J Med* 2010; 363:2124-2134, 2130 (November 2010)(citations omitted), found at http://www.nejm.org/doi/full/10.1056/NEJMsa1004404#t=articleTop.
[9] Cathleen F. Crowley and Eric Nalder, "Year after report, patients still face risks," *Times Union*, September 20, 2010, found at http://www.timesunion.com/local/article/Year-after-report-patients-still-face-risks-665059.php#page-1.
[10] Christopher P. Landrigan et al., "Temporal Trends in Rates of Patient Harm Resulting from Medical Care," *N Engl J Med* 2010; 363:2124-2134, 2130-2131(November 2010)(citations omitted), found at http://www.nejm.org/doi/full/10.1056/NEJMsa1004404#t=articleTop.
[11] See, http://www.chron.com/deadbymistake/; Terri Langford, "Texas laws are vague, abandoned or unfunded," *Houston Chronicle,* July 30, 2009.
[12] Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).
[13] U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), pp. i-ii, found at http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.
[14] *Id* at ii-iii (emphasis in original).
[15] Public Citizen, Congress Watch, *The Great Medical Malpractice Hoax: NPDB Data Continue to Show Medical Liability System Produces Rational Outcomes,* (January 2007). http://www.citizen.org/publications/publicationredirect.cfm?ID=7497#14
[16] *Ibid.*
[17] Public Citizen, "New Public Citizen Study Questions Ability of State Medical Boards to Protect Patients From Dangerous Doctors," March 15, 2011, found at http://www.commondreams.org/newswire/2011/03/15-8.
[18] A $250,000 cap on non-economic damages, punitive damages cap of $500,000 or two times the amount of economic damages, repeal of the collateral source rule, one-year date of discovery statute of limitations (3 years for children), and repeal of joint and several liability.
[19] Alexander C. Hart, "Medical malpractice reform savings would be small, report says," *Los Angeles Times,* October 10, 2009; http://www.latimes.com/news/nationworld/nation/la-na-malpractice10-2009oct10,0,4877440.story

[20] Forthcoming article, Hyde, Fred. M.D., Clinical Professor, Department of Health Policy and Management, 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'" (2011)

[21] See, Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. http://insurance-reform.org/pr/090722.html

[22] "Solid Underwriting Undercut by MPLI's Investment Losses," *Best's Special Report*, A.M. Best, April 27, 2009.

[23] *Physician Characteristics and Distribution in the U.S.,* American Medical Association. It should be noted that there continues to be physician shortages, but medical malpractice cases have nothing to do with this. For example, according to a recent investigation by the *New York Times* less than one month ago, "More than 42,000 students apply to medical schools in the United States every year, and only about 18,600 matriculate, leaving some of those who are rejected to look to foreign schools. Graduates of foreign medical schools in the Caribbean and elsewhere constitute more than a quarter of the residents in United States hospitals. The New York medical school deans say that they want to expand their own enrollment to fill the looming shortage, but that their ability to do so is impeded by competition with the Caribbean schools for clinical training slots in New York hospitals. The big Caribbean schools, which are profit-making institutions, are essentially bribing New York hospitals by paying them millions of dollars to take their students. "These are designed to be for-profit education mills to train students to pass the boards, which is all they need to get a license," said Dr. Michael J. Reichgott, a professor at the Albert Einstein College of Medicine in the Bronx. Anemona Hartocollis, Medical Schools in Region Fight Caribbean Flow, *New York Times*, December 22, 2010.

[24] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html

[25] "Solid Underwriting Undercut by MPLI's Investment Losses," *Best's Special Report*, A.M. Best, April 27, 2009.

[26] In most cases, lost earnings make up the largest part of the economic damages that go directly to the injured victim. Essentially, then, limiting non-economic damages results in valuing the destruction of an individual's life based on what that person would have earned in the marketplace but for the injury. The lives of low wage earners, children, seniors, and women who do not work outside the home, are thus deemed worth less than the life of businessmen. Capping non-economic damages promotes a kind of caste system by branding entire classes of low- or non-earners in our society as worth less than their wealthier counterparts. It also makes it far less likely that an attorney can afford to bring these cases, providing practical immunity for many wrongdoers.

[27] "The Impact of the 2003 Texas Medical Malpractice Damages Cap on Physician Supply and Insurer Payouts: Separating Facts from Rhetoric," *Texas Advocate*, pp. 25-34, Fall 2008.

[28] Terri Langford, "Texas laws are vague, abandoned or unfunded," *Houston Chronicle,* July 30, 2009.

[29] "ER Patients Can't Find Attorneys, Blame Tort Reform," *Texas Tribune,* December 12-20, 2010

[30] "Physicians still fear malpractice lawsuits, despite tort reforms," *Health Affairs*, September 2010; Volume 29, Issue 9, http://content.healthaffairs.org/content/29/9.toc

[31] Press Release, Study Casts Doubt on Claims That the Medical Malpractice System Is Plagued By Frivolous Lawsuits, Harvard School of Public Health, May 10, 2006. http://www.hsph.harvard.edu/news/press-releases/2006-releases/press05102006.html; David M. Studdert, Michelle Mello, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," New England Journal of Medicine, May 11, 2006.

[32] 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; http://insurance-reform.org/pr/090722.html. See also, Joanne Doroshow, "Here's Really Why Your Insurance Rates Go Up - and Then Don't," http://www.huffingtonpost.com/joanne-doroshow/heres-really-why-your-ins_b_775077.html

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[34] "Pure premium" is a term used interchangeably with "loss costs." It is the part of the premium used to pay claims and the cost of adjusting and settling claims, including adjuster and legal expenses.

[35] "Loss cost" is the term for the portion of each premium dollar taken in, that insurance companies use to pay for claims and for the adjustment of claims. Insurers use other parts of the premium dollar to pay for: their profit, commissions, other acquisition expenses, general expenses and taxes. Loss costs include both paid and outstanding claims (reserves are included through an actuarial process known as "loss development") but also include trends into

the future since rates based on ISO loss costs are for a future period. Thus, loss costs include ISO's adjustments to make sure that everything is included in the price, even such factors as future inflation.

[36] The ISO has the largest database of audited, unit transaction insurance data of any entity in the United States.

[37] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. http://insurance-reform.org/pr/090722.html.

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[77] 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."

[78] This is consistent with other studies. When the GAO tried to find evidence of "defensive medicine," they found instead, "Some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, General Accounting Office, GAO-03-836, Released August 29, 2003. See also, Dr. Atul Gawande, "The Cost Conundrum; What a Texas town can teach us about health care," New Yorker, June 1, 2009 ("'Come on,' the general surgeon finally said. 'We all know these arguments [about defensive medicine] are bulls**t. There is overutilization here, pure and simple.' Doctors, he said, were racking up charges with extra tests, services, and procedures.")

[79] Malpractice insurance has been an extremely difficult issue for Pennsylvania physicians and hospitals in the time period (1994 to present) since the Office of Technology Assessment dismissed "defensive medicine" as a minor, even illusory issue. That is, in part, because physicians and hospitals indulged in the self-insurance business, through the now insolvent MIIX and Hospital Association of Pennsylvania misadventures. Commercial insurers often avoid markets where "home grown" and "provider owned" insurance is their competitor. As a result of these insurance problems, Pennsylvania has compelled a variety of taxes and insurance surcharge premiums for purposes of providing affordable malpractice insurance coverage. Quite aside from the limitations of studies in this area, the controversies stemming from insurance problems facing Pennsylvania physicians and hospitals--some self-inflicted--would color and may overshadow any attempt to generalize findings from that state.

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[84] 42 U.S.C. § 1320c-5(a)(1).
[85] 42 U.S.C. § 1395y(a)(1)(A).
[86] *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).
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