



CENTER FOR JUSTICE & DEMOCRACY
185 WEST BROADWAY
NEW YORK, NY 10013
TEL: 212.431.2882
centerjd@centerjd.org
<http://centerjd.org>

A “RETORT” TO THE WHITE HOUSE BUDGET’S MEDICAL MALPRACTICE PROPOSALS

February 2018

The White House Fiscal Year 2019 budget proposal recommends imposing private-sector mandates on patients involved in local health care disputes.¹ The White House believes that in order to save a mere 0.4 to 0.5 percent in national health care costs, the federal government should impose nationwide mandates on patients, which strip them of their rights, radically preempt state laws, and restrict the power and authority of local courts in medical malpractice cases. Specifically,

The Budget proposal includes: a cap on non-economic damage awards of \$250,000 (increasing with inflation over time); a three-year statute of limitations; allowing courts to modify attorney’s fee arrangements; allowing evidence of a claimant’s payments from other sources (e.g., workers’ compensation, auto insurance) to be introduced at trial; creating a safe harbor for clinicians following evidence-based clinical practice guidelines; and authorizing the Secretary to provide guidance to States to create expert panels and administrative health care tribunals to review medical liability cases.²

The White House alleges that these measures would save \$52 billion in health care costs over 10 years. This figure is based on a Congressional Budget Office (CBO) analysis, now almost a decade old,³ suggesting that an extreme set of federal tort limits would lower health care costs by \$54 billion, or 0.5 percent of health care costs.⁴ (CBO now says savings would be less than \$50 billion over 10 years, or 0.4 percent.⁵) Adding to the uncertainty of these numbers, the menu of

¹ White House, *An American Budget: Major Savings and Reforms* (February 2018), <https://www.whitehouse.gov/wp-content/uploads/2018/02/msar-fy2019.pdf>

² *Id.* at 116.

³ Congressional Budget Office, “CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (‘Tort Reform’),” October 9, 2009, <http://www.cbo.gov/publication/41334>

⁴ *See also*, 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

⁵ *See* Congressional Budget Office, “Congressional Budget Office Cost Estimate, H.R. 1215 Protecting Access to Care Act of 2017,” March 22, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1215.pdf>. *See also*, Chad Terhune, “Top Republicans say there’s a medical malpractice crisis.

state tort restrictions considered by CBO has varied over time and differ in ways from the White House proposal. State tort laws that would be overturned are constantly changing, as well. In other words, there is no consistency in the data or process used by the CBO or the White House to arrive at any of these figures.

Coincidentally, many of these measures can be found in an unpopular congressional bill, H.R. 1215, which narrowly passed the U.S. House of Representatives in March 2017 by a vote of 218-210 "with few votes to spare," since "19 GOP lawmakers from both the centrist and most conservative wings of the party voted against the bill, as did all House Democrats."⁶ The House Liberty Caucus also opposed the bill.⁷ So did Dean Clancy, former senior budget official in the George W. Bush administration, who called such proposals, "half-baked ideas, and unconstitutional to boot (Congress has no authority to regulate local civil justice rules)... Caps [on damages awards] don't save money, don't increase physician supply, and don't reduce health care costs" and may "actually increase costs."⁸

Indeed, there are many problems with these proposals. This paper focuses on one: their cost. More specifically, this report addresses the impact of these proposals on the federal deficit, finding that contrary to the White House position, such measures would make the deficit worse.

CONGRESSIONAL BUDGET OFFICE DATA ARE INACCURATE AND LONG OUT-OF-DATE

The White House deficit-reduction theory is based on a 2009 CBO analysis, which has been regularly reissued since then.⁹ CBO arrives at its numbers by plugging selective studies into CBO's internal econometric models that no one ever sees, including U.S. Senators who have asked for explanations.¹⁰

CBO's original analysis suggested that an extreme set of tort limits imposed nationwide would lower health care costs by \$54 billion over 10 years due to savings in two specific areas: so-called "defensive medicine" (the ordering of unnecessary tests and procedures solely to protect from liability) and malpractice premiums. (More specifically, CBO said there would be 0.3

Experts say there isn't," *Kaiser Health News/Washington Post*, December 30, 2016,

https://www.washingtonpost.com/news/to-your-health/wp/2016/12/30/top-republicans-say-theres-a-medical-malpractice-crisis-experts-say-there-isnt/?utm_term=.3632e745bbf9

⁶ Cristina Marcos, "House Votes to Limit Damages from Medical Malpractice Lawsuits," *The Hill*, June 28, 2017, <http://thehill.com/blogs/floor-action/house/339947-house-votes-to-limit-medical-malpractice-lawsuits>

⁷ House Liberty Caucus, "House Liberty Caucus Statement on H.R. 1215, Protecting Access to Care Act of 2017," June 27, 2017, <https://www.facebook.com/libertycaucus/posts/1429927993738790:0>

⁸ Dean Clancy, "Replacing ObamaCare: Sorry Republicans, 'med-mal' reforms don't lower costs," *The Hill*, January 4, 2017, <http://thehill.com/blogs/congress-blog/healthcare/312599-replacing-obamacare-sorry-republicans-med-mal-reforms-dont>

⁹ The original analysis was released in October 2009, in the form of a seven-page letter to U.S. Senator Orin Hatch (R-UT). See <https://www.cbo.gov/publication/41334?index=10641>

¹⁰ When former U.S. 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, with no empirical analysis, no econometric models, and no raw data. <https://www.cbo.gov/publication/41812?index=10802>

percent savings from reduced “defensive medicine” costs, and 0.2 percent savings from lower malpractice premiums.)

“Defensive medicine”

It should first be noted that even in its original analysis, CBO found little evidence of “defensive medicine” in private managed care systems.¹¹ According to CBO, the problem of ordering too many tests and procedures was really due to Medicare’s 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 admitted that to the extent defensive medicine existed at all, it could be controlled through simply managing care correctly as opposed to taking away patients’ rights and possibly killing and injuring more people.

Recent studies have now completely undermined common notions about the existence of “defensive medicine” or the impact of tort system changes on it. For example:

- The most recent study on this topic, conducted by researchers who have studied medical malpractice for years, said, “A core policy argument used to support adoption of damage caps, is that caps will reduce defensive medicine and thus reduce healthcare spending... we find evidence [in states with damages caps] pointing, instead, toward *higher* Medicare Part B spending.”¹²
- Another recent study on imaging tests – often described as “overused” or unnecessary – found, “Imaging costs did not drop in states with med mal non-economic damages (NED) caps” and “imaging costs in some of the states that cap NED payouts were among the highest in the nation.”¹³

¹¹ 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. 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. According to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit.” General Accounting Office, *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (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.”)

¹² Bernard S. Black, David A. Hyman and Myungho Paik, “Damage Caps and Defensive Medicine, Revisited,” *J. Health Econ.* (January 2017) at 16, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2110656 [emphasis in original].

¹³ Debra Beachy, “Imaging costs not cut in states with tort reform,” *Health Imaging*, August 18, 2014, <http://www.healthimaging.com/topics/healthcare-economics/imaging-costs-not-cut-states-tort-reform>, discussing Seth I. Stein et al. “Are chargemaster rates for imaging studies lower in States that cap noneconomic damages (tort reform)?” 11 *J. Am. Coll. Radiol.* 808 (August 2014), <http://www.ncbi.nlm.nih.gov/pubmed/25087989>

- Researchers for another recent study concluded that “[s]tate-based medical legal environment is not a significant driver of increased defensive medicine associated with neurosurgical spine procedures.”¹⁴
- Another recent “analysis of empirical studies on defensive medicine . . . indicate[s] that the empirical evidence [of its existence] is weak and that, if there is a concern about defensive practices, it seems to exist primarily in physicians’ minds.”¹⁵

Similar studies can be found in the Center for Justice & Democracy’s *Briefing Book – Medical Malpractice: By the Numbers*.¹⁶

Medical malpractice premiums

Recent studies that have examined the insurance industry’s actual data (unlike CBO) found that state limits on patients’ legal rights have no impact whatsoever on insurance rates for doctors, and that in any event, medical malpractice premiums and claims per doctor are now at the lowest level in four decades.¹⁷ In fact, they have been steadily dropping since CBO issued its 2009 analysis without any of these anti-patient proposals being enacted into federal law.

Indeed, 40 years of liability premium insurance history and experience show that there is no correlation between enactment of tort laws and medical malpractice rate hikes. The well-known insurance cycle is primarily responsible for medical malpractice cost increases or decreases, and that has nothing to do with the tort system.¹⁸

THE BUDGET PROPOSAL WOULD WEAKEN PATIENT SAFETY, INCREASING COSTS

It has been almost two decades since the Institute of Medicine’s (IOM) seminal study *To Err is Human* was published, which found that between 44,000 and 98,000 patients are killed (and many more are injured) in hospitals each year due to medical errors, costing the nation between \$17 billion and \$29 billion each year.¹⁹ Today, researchers consider those numbers to

¹⁴ Timothy R. Smith et al., “Defensive Medicine in U.S. Spine Neurosurgery,” 42 *Spine* 177 (February 2017), http://journals.lww.com/spinejournal/Abstract/2017/02010/Defensive_Medicine_in_U_S_Spine_Neurosurgery.13.aspx

¹⁵ Gijs van Dijck, “Should Physicians Be Afraid of Tort Claims? Reviewing the Empirical Evidence,” *Journal of European Tort Law* (January 2016), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2716627

¹⁶ <https://centerjd.org/content/briefing-book-medical-malpractice-numbers>

¹⁷ Americans for Insurance Reform, *Premium Deceit 2016* (November 2016), <http://centerjd.org/system/files/MasterPremiumDeceit2016F3.pdf>; Americans for Insurance Reform, *Stable Losses/Unstable Rates 2016* (November 2016), <http://centerjd.org/system/files/MasterStableLosses2016F9.pdf>

¹⁸ *Ibid.* See also, Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press; Chicago (2005) at 45 et al.

¹⁹ Linda T. Kohn et al., Eds., *To Err Is Human; Building a Safer Health System*, Institute of Medicine, National Academies Press: Washington, D.C. (1999), http://books.nap.edu/openbook.php?record_id=9728

significantly underestimate the problem, with preventable errors causing as many as 440,000 patient deaths annually.²⁰

It is also now known that “reduced risk of med mal litigation, due to state adoption of damage caps, leads to higher rates of preventable adverse patient safety events in hospitals.”²¹ In fact, even in 2009, CBO acknowledged that “imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes.”²² Yet CBO has never taken account of associated health care costs that would result from the maiming and hospitalization of additional patients due to an increase in errors. This is even though it cites a study, which found that tort restrictions would lead to a 0.2 percent increase in the nation’s overall death rate.²³ If true, that would be an additional 5,253 Americans killed every year by medical malpractice, or 52,530 Americans over the 10-year period covered by the White House budget estimates.²⁴

Based on these same numbers, another 500,000 or more patients could be injured during those 10 years (given that one in 10 injured patients dies²⁵). The costs of errors, which the Institute of Medicine put conservatively between “\$17 billion and \$29 billion, of which health care costs represent over one-half,” would clearly increase.²⁶ Today, the average cost per hospital stay is \$10,400.²⁷ Consider those costs in addition to physician utilization inherent in caring for these new patients. Yet those costs do not even consider lost contributions to the workforce and tax revenues for the most seriously injured who cannot work, or for those who have died.²⁸

Now, however, there are actual studies by esteemed academics in the field of medical malpractice research confirming the health and safety repercussions of limiting patients’ rights. Recently, researchers examined five states that enacted compensation caps during the last “hard” insurance market (2003 to 2005)²⁹ where standard Patient Safety Indicators (PSIs)³⁰ were also

²⁰ John T. James, “A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care,” *Patient of Journal Safety* (September 2013), <https://www.documentcloud.org/documents/781687-john-james-a-new-evidence-based-estimate-of.html#document/p1/a117333>

²¹ Bernard S. Black and Zenon Zabinski, “The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform,” Northwestern University Law & Economics Research Paper No. 13-09 (May 2015), <http://ssrn.com/abstract=2161362>

²² Congressional Budget Office, “CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (‘Tort Reform’),” October 9, 2009, <http://www.cbo.gov/publication/41334>

²³ Ibid. (“Lakdawalla and Seabury (2009) found that a 10 percent reduction in costs related to medical malpractice liability would increase the nation’s overall mortality rate by 0.2 percent.”)

²⁴ Based on 2,426,264 deaths according to Center for Disease Control and Prevention, “Deaths and Mortality,” <http://www.cdc.gov/nchs/FASTATS/deaths.htm> (data as of May 3, 2017).

²⁵ Study of California hospitals cited in Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press: Chicago (2005).

²⁶ Linda T. Kohn et al., Eds., *To Err Is Human; Building a Safer Health System*, Institute of Medicine, National Academies Press: Washington, D.C. (1999), http://books.nap.edu/openbook.php?record_id=9728

²⁷ Healthcare Cost and Utilization Project (HCUP), *Overview of Hospital Stays in the United States* (October 2014), <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb180-Hospitalizations-United-States-2012.pdf>

²⁸ The U.S. workforce is 161.1 million including unemployed workers generating a gross national product of \$17.35 trillion. As such, each worker, including the unemployed, is responsible for \$107,697 of the GNP.

²⁹ Florida, Georgia, Illinois, South Carolina and Texas. Illinois’ and Georgia’s caps were found unconstitutional in 2010, but that is the last year examined by the authors and so had no impact on their results.

³⁰ PSIs are the “standard measures of often preventable adverse events, developed by the Agency for Healthcare Research and Quality (AHRQ).” They include operative and post-operative errors, infections, birth-related errors and cases at risk, like hospital-acquired pneumonia.

available for at least two years before caps passed (to allow for comparison).³¹ They then compared these data to other “control” states. They found “consistent evidence that patient safety generally falls” after caps are passed. Specifically:

- “We find a gradual rise in rates for most PSIs after [caps were passed], consistent with a gradual relaxation of care, or failure to reinforce care standards over time.”
- “The decline is widespread, and applies both to aspects of care that are relatively likely to lead to a malpractice suit (e.g., ... foreign body left in during surgery), and aspects that are unlikely to do so (e.g., ... central-line associated bloodstream infection).”
- “The broad relaxation of care suggests that med mal liability provides ‘general deterrence’ – an incentive to be careful in general – in addition to any ‘specific deterrence’ it may provide for particular actions....”
- “We find evidence that reduced risk of med mal litigation, due to state adoption of damage caps, leads to higher rates of preventable adverse patient safety events in hospitals.”

THESE MEASURES WOULD RESULT IN OTHER COSTS IGNORED BY THE WHITE HOUSE AND CBO

- **New burdens on Medicaid.** If someone is brain-damaged, mutilated or rendered paraplegic as a result of medical negligence but cannot obtain compensation from the culpable party through the tort system, he or she may be forced to turn elsewhere for compensation, particularly Medicaid. None of these increased Medicaid costs are considered by the White House or CBO.
- **Liens and subrogation.** 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 White House or CBO.

SPECIFIC MEASURES AND THEIR IMPACT ON THE DEFICIT

The 2019 budget recommends new federal laws that would constitute a major interference with the work of state court judges and juries in civil cases and amount to a massive and

³¹ Bernard S. Black and Zenon Zabinski, “The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform,” Northwestern University Law & Economics Research Paper No. 13-09 (May 2015), <http://ssrn.com/abstract=2161362>

unprecedented federal preemption of traditional state common law. Numerous states have specifically rejected many of these ideas. Other states have found them unconstitutional. In spite of this, the White House recommends the following:

- **Caps on non-economic damages.** If worded to reflect the current congressional bill, H.R. 1215, this proposal would mandate an across-the-board \$250,000 cap on compensation for “non-economic” injuries (like paralysis, trauma and reproductive harm). Caps would be mandated in states even where such caps are unconstitutional.

New studies now confirm that such “caps” will lead to *higher* health care costs. In the most recent study evaluating the cost of caps, researchers examined health care spending trends in nine states that enacted caps during the last “hard” insurance market (2002 to 2005)³² and compared these data to other “control” states.³³ They found that “damage caps have no significant impact on Medicare Part A (hospital) spending. However, caps predict 4-5% *higher* Part B [physician reimbursement and outpatient services] spending....”³⁴

The reasons may have to do with physicians practicing riskier medicine in “cap” states, such as performing “high-risk services or procedures,” which they avoid in states where the tort system’s “general deterrence” function (noted above) works properly. The authors note:

A core policy argument used to support adoption of damage caps, is that caps will reduce defensive medicine and thus reduce healthcare spending. For the third-wave cap adoptions, we find evidence pointing, instead, toward *higher* Medicare Part B spending. This result could arise if the effect of caps in reducing assurance behavior are, on average, outweighed by their effect in reducing avoidance behavior. Overall, we estimate a 4-5% post-cap rise in Medicare Part B spending. Our estimates for the effect of damage caps on Part A spending are small and not statistically significant. Total Medicare spending appears to rise as well – our point estimates are 2-3% and are sometimes statistically significant. There is, at the least, no evidence that caps *reduce* healthcare spending.³⁵

- **Statute of limitations.** If worded to reflect the current congressional bill, H.R. 1215, the White House proposal would establish a three-year statute of limitations for injured patients to bring a lawsuit after an injury, or one year after the patient discovers or should have discovered the injury, *whichever comes first*. For all intents and purposes then, this is a one-year statute of limitation, which is more restrictive than what currently exists in almost every state.

³² Florida, Georgia, Illinois, Mississippi, Nevada, Ohio, Oklahoma, South Carolina and Texas.

³³ Bernard S. Black, David A. Hyman and Myung-ho Paik, “Damage Caps and Defensive Medicine, Revisited,” *J. Health Econ.* (January 2017), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2110656.

³⁴ *Ibid* [emphasis in original].

³⁵ *Ibid* [emphasis in original].

This recommendation lacks logic from a deficit reduction angle. Its only impact would be to cut off meritorious claims, especially those involving diseases with longer incubation periods. If a patient is brain-damaged, mutilated or rendered paraplegic 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. In other words, unreasonably reducing a state statute of limitations would cause deficit increases, not decreases.

- **Attorney fee limits.** If worded to reflect the current congressional bill, H.R. 1215, this White House proposal would mandate limits on fees for patients' attorneys, making it more difficult for patients to hire competent counsel. Laws like this essentially turn a free-market approach to providing legal representation into a system of government-imposed wage and price controls, and interfere directly with the contractual arrangements between people and their own attorneys.

CBO's original analysis never evaluated this proposal although it was subsequently dropped in. It clearly lacks logic from a deficit reduction standpoint, since limiting an attorney's income will limit the federal taxes they pay. Indeed, CBO acknowledges that "the limitation on attorney's fees would slightly reduce taxable income, causing a loss of revenue." But for baffling reasons, CBO claims this would only be an issue "in the first year." After that, says CBO, the "net effect" would be to "increase revenues."³⁶ This is unexplained and doubtful.

- **Federal repeal of state collateral source rules.** Under this provision, a wrongdoer would be able to reduce their obligation to compensate a patient by the amount of workers' compensation or insurance received, to which a patient has a right.

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 for which the injured party has already paid premiums or taxes. Representatives from the conservative American Enterprise Institute found in 2003 that modifying the collateral source rule has patient safety implications, specifically that it could endanger infant safety³⁷ (with accompanying related costs).

Notably, the White House contradicts itself as it considers this measure while simultaneously recommending proposals that would specifically prevent Medicare from recovering money from jury awards. As noted earlier, following a successful medical malpractice lawsuit, Medicare and Medicaid can both claim either liens or subrogation

³⁶ See Congressional Budget Office, "Congressional Budget Office Cost Estimate, H.R. 1215 Protecting Access to Care Act of 2017," March 22, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1215.pdf>

³⁷ Jonathan Klick and Thomas Stratmann, "Does Medical Malpractice Reform Help States Retain Physicians and Does It Matter?" (March 8, 2004), presented at American Enterprise Institute forum, "Is Medical Malpractice Reform Good for Your Health?" September 24, 2003, http://www.aei.org/events/eventID.614/event_detail.asp

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.

- **“Safe harbor” immunity for providers who follow best practices of care.** Patient safety can benefit from clinical practice guidelines when triggered by the desire to reduce unwarranted variation in practice and provide patients with benchmark quality care rooted in science. In fact, both sides in malpractice litigation currently make limited use of clinical practice guidelines in settlement negotiations, or even to help lawyers decide whether or not to file suits. However, the White House suggestion, which would establish government-approved guidelines as legal standards, has been rejected by the medical communities in states that have tried it. And in those states, this type of measure saw no impact on claims costs or premiums.

For example, in the 1990s, Maine established a program that allowed doctors in four specialties – anesthesiology, obstetrics and gynecology, emergency medicine and radiology – to participate in a program allowing use of guidelines as exculpatory evidence in lawsuits. Other specialties were encouraged to take advantage of this program but did not. The program expired, and the Maine Bureau of Insurance concluded that “the medical demonstration project had no measurable effect on medical professional liability claims, claims settlement costs, or malpractice premiums.”³⁸

- **State-created expert panels and administrative health care tribunals to review medical liability cases.** This proposal envisions dismissal of the jury system, and the creation of entirely new state governmental agencies to handle what are a relatively small percentage of cases in our court system. No one believes these kinds of “health courts” would save money. In fact, they would significantly increase costs.

In their book *Medical Injustice: The Case Against Health Courts* (2007), Case Western Reserve Professors Maxwell J. Mehlman and Dale A. Nance note the following³⁹:

- Health courts “would entail some huge potential increases in total system costs.... If we take health care proponents at their word, their goal is to bring ... currently non-claiming people into the process.” This, however “would multiply the number of claims involving negligence by a factor between 33 and 50.”⁴⁰
- “[C]laims involving error account for at least 84 percent of total system costs ... so that, even if we assume that only claims involving error are brought into the system,

³⁸ Linda L. LaCraw, “Use of Clinical Practice Guidelines in Medical Malpractice Litigation,” *J. Oncol. Pract.* (September 2007) at 254, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2793844/>. (In 1996, Florida also began a demonstration project for cesarean deliveries, but it reportedly “garnered relatively little support among physicians – only 20% of physicians eligible to participate chose to do so. The project ended in 1998. Three other states (Kentucky, Maryland, and Minnesota) adopted test projects in the 1990s, though none of the projects is fully operational today (the Maryland and Minnesota projects have fully expired.)” [citations omitted].)

³⁹ Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 74.

⁴⁰ *Id.* at 72.

the system costs should increase by a factor of at least 28, all other things (like system efficiency) being equal.”⁴¹

- “[E]ven if we assume that the average per patient damages under a new system embracing all potential claimants (including those who claim under the existing system) would be only 30 percent of the average damages for claims now paid, that still leaves total direct system costs multiplied by a factor of about 8.5, again as a low end estimate.”⁴²
- Health courts involve the creation of a new judicial or administrative bureaucracy. Costs “would certainly be substantial, vastly more than the public (taxpayer borne) judicial costs currently associated with the adjudication of malpractice claims.”⁴³

CONCLUSION

Of all the reasons voters may have sent politicians to Washington, D.C., usurping state laws and eliminating constitutional rights via the White House budget isn’t one of them. Yet that is what this White House is proposing to do.

What’s more, these measures will cost money while resulting in more injuries and deaths. If someone is brain-damaged, burned or rendered paraplegic as a result of health care system negligence but cannot obtain adequate compensation through the state legal system, they will have to turn elsewhere for help, and it’s likely taxpayers will be picking up the tab.

Indeed, this proposal may be one of the most flawed aspects of the very misguided White House budget.

⁴¹ Ibid.

⁴² Ibid.

⁴³ *Id.* at 73.