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STATEMENT OF JOANNE DOROSHOW
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BEFORE THE HOUSE SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW

OVERSIGHT HEARING ON HEALTH CARE LITIGATION REFORM: "DOES LIMITLESS LITIGATION RESTRICT ACCESS TO HEALTH CARE?"

June 12, 2002

Mr. Chairman, members of the Subcommittee, 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. I appreciate the opportunity to address the issue of health care litigation. I might respectfully disagree with the premise of the hearing, however, in that health care litigation is certainly not limitless in this country today.

Following the conclusion of this written testimony, you will find a list of major tort restrictions in medical malpractice cases that state lawmakers have enacted since the mid-1980s. They enacted these laws after medical and insurance lobbyists told them that legislation was needed to reduce medical malpractice insurance rates, just as they are telling you today. It should be noted that this extensive list does not include every state restriction on patients' right to sue, such as laws found in many states requiring patients to present affidavits or "certificates of merits" before cases can even be brought.

Today, I would like to discuss why these laws have had terrible consequences for patients while doing nothing to improve the affordability or availability of insurance.

For the last 17 years, doctors and hospitals nationwide have experienced a relatively stable medical malpractice insurance market. Insurance was available and affordable. Rate increases were modest. In fact, over the last 10 years, average premiums increased by only 1.9 percent nationwide, far below medical inflation. Meanwhile, profits for medical malpractice insurers soared, generated by high investment income.

Medical malpractice insurance companies are now experiencing a downturn and they are raising premiums and canceling coverage for doctors, or at least threatening to do so, in virtually every state in the country. One insurance insider, Richard G.M. Marko, senior Vice President of National Markets at Liberty Mutual Insurance Co. in Boston, recently told an insurance audience that from 1994 to 1999, insurance rates decreased by about 50 percent and that now, after two straight years of increasing rates, only about half of that decrease has been made up. This is not a state-specific phenomenon. It is not even a country-specific phenomenon. It is even happening in countries like Australia and Canada that do not have jury trials in civil cases.

This so-called insurance "crisis" is an exact repeat of the last insurance "crisis" that hit the United States in the mid-1980s and an earlier one in the mid-1970s. As its predecessors, today's insurance "crisis" has absolutely nothing to do with the U.S. legal system, tort laws, lawyers or juries. 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.

One solution that Congress has proposed to respond to these problems, H.R. 4600, would be as egregious for patients and the quality of health care in America, as it would be ineffective in bringing insurance rates under control. It is based entirely upon a false predicate – that the U.S. civil justice system is to blame for insurance price-gouging. Moreover, this particular bill fantastically overreaches, providing immunities for drug companies that have no relation whatsoever to medical malpractice issues.

To summarize:

- **Contrary to insurance company claims that medical malpractice verdicts are "exploding," the current average medical malpractice insurance payout is about $30,000 and has been virtually unchanged for the last decade.** In fact, total insurance payouts to *all claimants* have hovered between $2.5 billion and $4 billion per year. By comparison, Americans spend twice that much – about $8 billion – on dog food each year. Moreover, medical malpractice costs, as a percentage of national health care expenditures, are at an all time low, 0.55 percent. In light of the fact that medical malpractice is the eighth leading cause of death in the United States, killing more people than breast cancer, AIDS and traffic deaths, medical malpractice insurance is an amazing value, covering all medical injuries for about one-half of one percent of health system costs. On the other hand, the cost of medical errors is huge. Total national costs (lost income, lost household production, disability and health care costs) are estimated to be between $17 billion and $29 billion each year.[1] The problem here is the degree of malpractice itself.

- **Volcanic eruptions in insurance premiums for doctors have occurred three times in the last 30 years.** The cause is always the same: a severe drop in investment income for insurers compounded by severe underpricing in prior years. Each time, insurers have tried to cover up their mismanaged underwriting by blaming lawyers and the legal system. Under this theory, one would have to believe that jury verdicts or trial lawyers have timed their "aggression" to precisely coincide with the insurance industry's economic cycle, so that the aggression impacts just when the market turns hard. In other

words, one would have to accept the notion that they were aggressive in the mid 1970s, then non-aggressive for a decade, then aggressive in the mid-1980s, non-aggressive for 17 years and are now aggressive again. This is ludicrous.

- **In the midst of the last insurance "crisis" in the mid-1980s, state lawmakers enacted often severe tort restrictions on patients' rights in this country, to reduce insurance rates. These laws had absolutely no impact on insurance rates.** Some states that resisted enacting any "tort reform" experienced low increases in insurance rates or loss costs relative to the national trends, and some states that enacted major "tort reform" packages saw very high rate or loss cost increases relative to the national trends. In other words, there was no correlation between "tort reform" and insurance rates.[2] Indeed, a few years after the mid-1980s insurance "crisis," the insurance cycle flattened out, rates stabilized and availability improved everywhere – until now, over a decade later. The flattening of rates had nothing to do with tort law restrictions enacted in particular states, but rather to modulations in the insurance cycle everywhere. In 1991, Washington's insurance commissioner Dick Marquardt concluded in a report that it was "impossible to attribute stable insurance rates to tort-law changes or the damages cap," since rates also improved in states that did not pass tort reform. The American Insurance Association (AIA) and the American Tort Reform Association (ATRA) have admitted in published statements that lawmakers who enact "tort reforms" should not expect insurance rates to drop, most recently with the AIA's March 13, 2002 statement, "[T]he insurance industry never promised that tort reform would achieve specific premium savings."

- **H.R. 4600 is a cruel bill that would reduce the protections and rights of citizens in every state in this country.** The bill directly interferes with the independence of our nation's civil justice system, tying the hands of judges and juries who hear the evidence in a case, and undermining our country's uniquely individualized system of justice. H.R. 4600 would make it more difficult or impossible for injured patients to hold accountable those who have injured them. Adding to the already existing barriers that prevent injured patients from turning to the courts, H.R. 4600 presents a peril to both family safety and democracy in our country.

History is clear on this matter: legislative attempts to reduce insurance rates by taking away the rights of the most seriously injured in our society has been and continues to be a failed public policy.

California Is A Failed Model For Proposed National Restrictions On Patients' Rights

In the mid-1970s, California enacted severe tort restrictions for patients who have been injured by malpractice (MICRA). Among other things, this law allows patients to recover no more than $250,000 in non-economic compensation no matter how egregious the malpractice or serious the injury; prohibits patients from receiving damages in a lump sum; repeals the collateral source rule; and imposes restrictions on the attorneys' fees of patients. The medical establishment is campaigning to spread this law, one of the most draconian in the nation, not only to other states, but also to the entire nation in H.R. 4600, arguing falsely that this cap has kept premiums down dramatically.

The Center for Justice & Democracy (CJ&D) and the California-based Foundation for Taxpayer and Consumer Rights submit to the Subcommittee today data that show California's MICRA law has failed to slow premium increases for doctors and hospitals. In fact, over the last decade, the average malpractice premium in California has grown *more quickly* than it has in the nation overall.

This actuarial analysis was done by nationally recognized actuary J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator under Presidents Ford and Carter, who compared national malpractice premium trends to those in California. Hunter found that from 1991 to 2000, malpractice premiums in California stayed close to national premium trends. The 2000 average premium per doctor in California was only 8.2 percent below that of the nation ($7,200.61 vs. $7,843.75) while the average malpractice premium in California between 1991 and 2000 actually grew more quickly (3.5 percent) than it did in the nation overall (1.9 percent.) According to Hunter, "There is not much difference in the rates or the rate of change between California and the nation based on the latest decade of experience."

This analysis has, for the first time, exposed as an insidious public relations scam the notion that California's cruel law has controlled the growth of malpractice insurance premiums. This law has had terrible consequences for many innocent people, while doing nothing to improve the affordability of liability insurance for doctors. Jamie Court, Executive Director of the Foundation for Taxpayer and Consumer Rights, says, "California is a failed model for the national restrictions being proposed on patients. California patients have been denied adequate compensation and representation for their injuries, and California doctors have seen almost no premium savings. Only the insurers have gotten rich in the good times." These data are found in the following table:

YEAR	CALIFORNIA NUMBER OF DOCTORS IN STATE	U.S.A. NUMBER OF DOCTORS	CALIFORNIA MEDICAL MALPRACTICE PREM EARNED (in thousands)	U.S.A. MEDICAL MALPRACTICE PREM EARNED (in thousands)	AVERAGE MED MAL PREMIUM PER DOCTOR CALIFORNIA	AVERAGE MED MAL PREMIUM PER DOCTOR U.S.A.
1991	76043	631400	529056	4862170	6957.33	7700.62
1992	76367	652100	526496	5138395	6894.29	7879.77
1993	76411	670300	563004	5174055	7368.10	7719.01
1994	77311	684400	576771	5931898	7460.40	8667.30
1995	78169	720300	597660	6080639	7645.74	8441.81
1996	79048	737800	610003	5992394	7716.87	8121.98
1997	80341	756700	628858	5917038	7827.36	7819.53
1998	81762	777900	652601	6195047	7981.72	7963.81
1999	82872	797600	611785	6155241	7382.29	7717.20
2000	84675	812800	609712	6375401	7200.61	7843.75
			1991 to 1999 percent change		3.5	1.9
		1991 to 1999 % change		(annualized)	0.4	0.2

Sources: Doctors USA: Statistical Abstract of the United States;
Doctors CA: California Department of Consumer Affairs;
Earned Premiums: NAIC Report On Profit By Line By State

The consequences for patients of California MICRA law has been, quite simply, unfathomable. In his upcoming book *Corporateering: How the Invisible Hand Steals the Individual's Freedom,* Jamie Court of the Foundation for Taxpayer and Consumer Rights, writes:

> Twelve years old Steven Olsen is blind and brain damaged because, as a jury ruled, he was a victim of medical negligence when he was two years old. He fell on a stick in the woods while hiking. Under the family's HMO plan, the hospital pumped Steven up with steroids and sent him away with a brain tumor, although his parents had asked for a CAT scan because they knew Steven was not well. Steven Olsen came back to the hospital comatose. At trial, medical experts testified that had he received the $800 CAT scan, which would have detected a growing brain mass, he would have his sight and be healthy today.
>
> The jury awarded $7.1 million in non-economic damages for Steven's avoidable life of darkness and suffering. However, the jury was not told of a two-decade-old restriction on non-economic damages in the state. The judge was forced to reduce the amount to $250,000. The jurors only found out that their verdict had been reduced by reading about it in the newspaper. Jury foreman Thomas Kearns expressed his dismay in a letter published in the San Diego Union Tribune:
>
> > "We viewed video of Steven, age 2, shortly before the accident. This beautiful child talked and shrieked with laughter as any other child at play. Later, Steven was brought to the court and we watched as he groped, stumbled and felt his way along the front of the jury box. There was no chatter or happy laughter. Steven is doomed to a life of darkness, loneliness and pain. He is blind, brain damaged and physically retarded. He will never play sports, work, or enjoy normal relationships with his peers. His will be a lifetime of treatment, therapy, prosthesis fitting and supervision around the clock."
>
> Our medical-care system has failed Steven Olsen, through inattention or pressure to avoid costly but necessary tests. Our legislative system has failed Steven, bowing to lobbyists of the powerful American Medical Association (AMA) and the insurance industry, by the Legislature enacting an ill-conceived and wrongful law. Our judicial system has failed Steven, by acceding to this tilting of the scales of justice by the Legislature for the benefit of two special-interest groups. I think the people of California place a higher value on life than this.
>
> In 2001, Steven had 74 doctor visits, 164 physical and speech therapy appointments, and three trips to the emergency room. And his parents say that was a good year because Steven was not hospitalized. Steven's mother Kathy had to leave her job because caring

> for Steven is a full time job. She has to struggle constantly with the school district for Steven to receive special education classes. One day, Steven ate a light bulb, not an uncommon problem for children with brain injuries. He has to be watched constantly. Corporate executives that seek to limit jury awards for the individual's pain and suffering claim society must do so to save money. Yet these executives typically make millions every year without any of Steven Olsen's pain and suffering. Limiting their responsibility for the pain of individuals reduces not only the corporation's accountability, but the worth of the individual to that of a mere object.

A New Insurance "Crisis" Takes Hold

Three times in the last 30 years, the insurance industry has created liability insurance "crises," making insurance unaffordable or, in some cases, unavailable at any price for many businesses and professions. A crisis happened in the mid-1970s, precipitating the first wave of "tort reform" in medical malpractice insurance and product liability insurance, particularly.

A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. At that time, manufacturers, municipalities, doctors, nurse-midwives, day-care centers, non-profit groups and many other commercial customers of liability insurance were faced with insurance rate increases of 300 percent or more. Many could not find coverage at any price. Now, once again, in 2002, the country is experiencing what has become known as the "hard market" part of the cycle, this time impacting property as well as liability coverages, with medical malpractice lines of insurance seeing rates going up 100% or more in some states.

What precipitates these crises is always the same. Insurers make their money from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premiums dollars to invest for maximum return. More specifically, insurers engage in severe underpricing and insure very poor risks just to get premium dollars to invest. But when investment income decreases because interest rates drop, the stock market plummets and/or cumulative price cuts make profits become unbearably low, the industry responds by sharply increasing premiums and reducing coverage, creating a "liability insurance crisis."

Here's how one insurance expert recently described the problem:

> A quick examination of the medical malpractice insurance marketplace in the second half of 2001 might lead a dispassionate observer to conclude this segment of the insurance industry is confused, in disarray, and generally in a state of disorder. Premiums are doubling, hospital deductibles are tripling, claims-free physicians are being nonrenewed, insurers are leaving territories en masse. Simply put, the market is in chaos. … Yet, in a perverse way, the condition of the medical malpractice market is actually quite rationale and not at all surprising.
>
> What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is,

> they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income.
>
> In a perfect world, investment income would cover any deficiencies that might exist in underwriting results and the insurers' aggressive marketing and pricing strategy would prove to be successful. Alas, we do not live in a perfect insurance world and, as competition intensified, underwriting results deteriorated. Regardless of the level of risk management intervention, proactive claims management, or tort reform, the fact remains that if insurance policies are consistently underpriced, the insurer will lose money.
>
> Clearly a business cannot continue operating in this fashion indefinitely. Indeed, this has been the case for such long time writers of professional liability insurance as Frontier, Reliance, and P.I.E Mutual. These companies, who suffered through several years of weakening performance, have been liquidated or are otherwise inactive.
> …
>
> In August 2001, the list of impaired medical malpractice insurers got longer as the Pennsylvania Department of Insurance placed PHICO under state rehabilitation. PHICO, one of the ten largest writers of medical malpractice insurance, has been one of the more aggressive underwriters during the late 1990s. The company has seen its surplus decrease dramatically over the past year and half from almost $200 million to under $10 million. Regulatory intervention was necessary as it became obvious PHICO's premiums had been inadequate to cover losses.[3]

Each time in the last 30 years when the market has turned "hard," the insurance industry has tried to cover up its pricing errors by blaming lawyers and the legal system for the liability insurance price jump. Like clockwork, there are frenetic calls for legislative limits on victims' rights to sue.

Terrorizing States – Circa 1980s

The liability insurance crisis of the mid-1980s, which led many states to enact "tort reform," was acute. Small businesses, doctors, non-profit groups and others were hit with dramatic increases in insurance premiums, reduced coverage and arbitrary policy cancellations. The situation received extensive media attention, such as *Time Magazine*'s 1986 cover story entitled, "Sorry, Your Policy is Cancelled."[4]

It was in the midst of this crisis – January 17, 1986 – that a number of business, professional and insurance trade organizations announced the formation of the American Tort Reform Association (ATRA). ATRA and its member organizations, the insurance industry and other large corporations blamed the crisis on the legal system and lobbied extensively for "tort reform," claiming that enactment of "tort reform" would cause insurance rates to stabilize and even fall. Indeed, great pressure was brought to bear on state legislatures around the country to restrict the rights of innocent victims to recover for their injuries in order to bring down insurance rates.

This was despite the fact that numerous studies at the time, including those conducted by the National Association of Attorneys General[5] and state commissions in New Mexico, Michigan and Pennsylvania[6], confirmed that the crisis was not caused by the legal system but rather by the insurance cycle and mismanaged underwriting by the insurance industry. Even the insurance industry admitted this internally. In 1986, Maurice R. Greenberg of American International Group told an insurance audience in Boston that the industry's problems were due to price cuts taken "to the point of absurdity" in the early 1980s. Had it not been for these cuts, Greenberg said, "[T]here would not be 'all this hullabaloo' about the tort system."[7]

As *Business Week* magazine also explained a January 1987 editorial:

> Even while the industry was blaming its troubles on the tort system, many experts pointed out that its problems were largely self-made. In previous years the industry had slashed prices competitively to the point that it incurred enormous losses. That, rather than excessive jury awards, explained most of the industry's financial difficulties.[8]

Threats and intimidation by reinsurers were an additional driving force behind the liability insurance crisis of the mid-1980s. Evidence gathered by over a dozen state attorneys general for an anti-trust class action filed in 1988, and settled in 1995, found that a number of insurance companies had helped cause the insurance crisis by restricting coverage to commercial customers and raising prices, creating an atmosphere intended to coax states into enacting "tort reform."[9] As John J. Byrne, Chairman and Chief Executive Officer of Geico Corp., put it, "[T]he goal is to withdraw [from the market] and let the pressure for reform build in the courts and in the state legislatures."[10]

Reinsurers were in the middle of it. In fact, according to the anti-trust complaint, Lloyd's of London became the locus of meetings and discussions for a coordinated industry effort to raise commercial insurance rates, abandon certain lines of coverage, change the standard terms of coverage used by the majority of the industry and enact "tort reforms."[11] To reach these goals, reinsurers misled U.S. public officials about reasons for rate hikes and policy cancellations and their commitment to the U.S. market.

Some of the threats directed at lawmakers were quite brash. In 1985, attorney Jeff Johnson of the U.S. law firm LeBoeuf, Lamb, Leiby and MacCrae[12] – Lloyd's U.S. counsel – told Alaska state legislators:

> If you change your tort laws in Alaska, you will have a market here when the rest of the United States will not. Lloyd's is pulling out of the United States as a reinsurer – they have already pulled out of Connecticut, New York and New Jersey – and they're continuing to pull out of more states.[13]

As a result, Alaska's Director of Insurance, John George, proceeded to tell Alaska's Defense Council, "Lloyd's is threatening to pull out of the United States, in fact they are pulling out of the States one by one, but they will stay in Alaska if we enact tort reform. If we all work

together we might be able to steam roller this legislation."[14] (Alaska responded by enacting a broad "tort reform" bill.)

Despite its threats, Lloyd's never pulled out of the United States. And, within two years, desperately in need of U.S. business, Lloyd's representatives began attempting to smooth over any evidence of withdrawal and minimize their earlier intimidation of U.S. companies and public officials.[15]

Medical Malpractice – Then and Now

In the mid-1980s, lawmakers in many states passed tort restrictions in medical malpractice cases after being told by insurance companies and others that this was the only way to reduce skyrocketing insurance rates for doctors. Lawmakers were responding to news reports like these, virtually identical to the reports of today:

- "An American Medical Association official says escalating costs of medical malpractice insurance are increasing health-care costs for the public and forcing doctors to curtail some services." *Baton Rouge Morning Advocate,* **May 31, 1986.**

- "Doctors are threatening to quit practicing some specialties or move out of the state while South Florida hospitals and trauma centers have threatened to shut down or have curtailed services." *St. Petersburg Times,* **May 7, 1987.**

- "Busloads of physicians from around [New York] state will travel to Albany on Wednesday, May 21, to rally for legislative reform of the state's medical liability system." *PR Newswire,* **May 19, 1986.**

- "Doctors and hospitals in [West Virginia] have been saying for weeks that they would have to close their doors at the end of this month when three major insurance companies planned to cancel malpractice insurance coverage for most of the state's medical providers." *Washington Post,* **May 24, 1986.**

- "Hundreds of doctors, especially those in high-risk specialties like obstetrics and orthopedics, refused to accept new patients last February when a state Insurance Division decision opened them up to massive retroactive premium increases." *The Record (New Jersey),* **July 24, 1986.**

Medical malpractice is one line of insurance that reinsurers historically have targeted for rate hikes. According to Director of Insurance for the Consumer Federation of America J. Robert Hunter, when he was Federal Insurance Administrator in the 1970s, a group of insurance companies in the medical malpractice line told him that Lloyd's had just doubled its reinsurance rates while supplying no data to justify this increase.[16]

The influence of reinsurers over rates has been particularly effective even over doctor-owned mutual insurance companies, which account for more than half the medical liability insurance in

this country and should be independent of the profit considerations that motivate pricing decisions by the rest of the industry.

For example, in 1985 testimony before the Maryland Governor's Task Force on Maryland Mutual Society's request for a 70 percent rate increase for OB/GYNs (when a 10 percent reduction was justified), the company's president stated, "In order to keep [reinsurers'] participation on cover we had to accede to some strong suggestions from the reinsurers to beef up the rate charged to the OB's and it might be relevant to point out Med Mutual is...the only company in the state writing OB's."[17]

In 1987, after heavy lobbying by the Medical Mutual Society, Maryland's legislature passed a bill to limit collateral source payments in medical malpractice cases. According to Maryland Delegate Lawrence Wiser, in early August 1987, John Spinella, then of Medical Mutual, was asked why there was little rate reduction as a result of the new collateral source law. Spinella replied that there would not be much rate impact because Medical Mutual still had to pay the same premiums to their London reinsurers.[18]

In Arizona in April 1987, the Mutual Insurance Company of Arizona (MICA) announced medical malpractice rate increases averaging 36 percent across the board, with some as high as 50 percent, despite a whopping $38 million surplus, up 23 percent from 1985. MICA said the surplus was needed to maintain a 1:1 premium/surplus ratio, which it claimed was required by the Arizona Department of Insurance (DOI). DOI Director Dave Childers, however, denied that his department had ever required such a premium/surplus ratio.[19]

Six months later, during a subcommittee hearing of the Governor's Committee in Medical Malpractice Insurance in Arizona, Woody Beckman, MICA's actuary, implicated the reinsurance industry as responsible for both the high surplus and the premium increases. According to task force member Jim Roush, Staff Director of Fairness and Accountability in Insurance Reform, "There were...several legislators in attendance who remember, as I do, that it was a whole new defense of the surplus and certainly the first time any of us had heard of any linkage to the reinsurance market…."[20]

A few years after the mid-1980s insurance crisis, the insurance cycle flattened out, rates stabilized and availability improved everywhere. This had nothing to do with tort law restrictions enacted in particular states, but rather with modulations in the insurance cycle everywhere. However, now that the market has again turned "hard," particularly as medical malpractice insurers are once again sharply increasing medical malpractice premiums around the country, there are renewed calls for "tort reform" reflecting an intensity not seen since the mid-1980s.

It should be noted that other factors are making the medical malpractice situation even worse this year. A major medical malpractice insurer, St. Paul Cos., has withdrawn from the medical malpractice insurance market, creating a major "supply and demand" problem in some states. St. Paul has had a history of problems. For example, some reports indicate that the company lost a large amount of money in the Enron fiasco. One thing is certain, however. This company has had so many other management problems that even after eliminating its medical malpractice

business, Standard & Poor's said on May 16, 2002 that it still was placing its ratings of the company on "CreditWatch with negative implications" for reasons having nothing to do with medical malpractice.

In addition, price increases in general were sped up by the September 11th terrorist attacks, collapsing two years of anticipated increases into a few months. However, the bulk of the increases are not related to pricing for terrorism, *per se.* This is a classic economic cycle.

Therefore, it should come as no surprise that a 1999 Center for Justice & Democracy study, *Premium Deceit – the Failure of "Tort Reform" to Cut Insurance Prices*, found that enactment of laws that restrict injured patients' rights to go to court has not succeeded in lowering insurance costs or rates.

Premium Deceit is the first-ever look at 14 years of property/casualty insurance price trends nationwide. Its actuarial analysis was again conducted by J. Robert Hunter, who called *Premium Deceit* "the most extensive review of insurance rate activity in the wake of the 'liability insurance crisis' of the mid-1980s ever undertaken. It was designed to test the impact on liability insurance rates of 'tort reforms' enacted in reaction to the liability insurance crisis of the mid-1980s, and in the years since."

Hunter said, "Despite years of claims by insurance companies that rates would go down following enactment of tort reform, we found that tort law limits enacted since the mid-1980s have not lowered insurance rates in the ensuing years. States with little or no tort law restrictions have experienced approximately the same changes in insurance rates as those states that have enacted severe restrictions on victims' rights." In other words, laws that restrict the rights of injured consumers to go to court do not produce lower insurance costs or rates and insurance companies that claim they do are severely misleading this country's lawmakers.

Moreover, spokespeople for national "tort reform" organizations admitted in published statements following the release of *Premium Deceit* that lawmakers who enact "tort reforms" should not expect insurance rates to drop. Specifically, when asked to respond to *Premium Deceit*, Sherman Joyce, president of the American Tort Reform Association (ATRA), told the publication *Liability Week*, "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."[21] Victor Schwartz, ATRA's General Counsel and one of the principal "tort reform" lobbyists in Washington on behalf of business interests, told *Business Insurance* that while he thought some severe "tort reform" measures could reduce insurance rates, he said when pressed that, "more importantly … many tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'"[22]

And in a startling March 13, 2002 admission, the American Insurance Association (AIA), a major insurance industry trade group, said lawmakers who enact "tort reform" should not expect insurance rates to drop. Specifically, an AIA press release, evidently issued to critique *Premium Deceit*, led with an astounding face-saving pronouncement: "[T]he insurance industry never promised that tort reform would achieve specific premium savings."

The insurers' strategy is evidently to make rates so high or coverage so unavailable that doctors threaten to leave the state or give up medicine entirely, jeopardizing the health care of citizens. Trade and business associations are conveying this message to lawmakers and the public everywhere.

But are these threats real, or are they industry tactics meant to terrorize lawmakers into delivering whatever the insurers want? In their landmark series, "The Price of Practice," *Charleston Gazette* reporters Lawrence Messina and Martha Leonard found that despite claims from the West Virginia Medical Association that the lack of "tort reform" had caused a mass exodus of doctors from the state, the number of doctors in West Virginia had increased yearly, with the state seeing a 14.3 percent increase in its number of doctors between 1990 and 2000. This increase is at a rate about 20 times greater than the population.[23] The paper said in a March 1, 2001 editorial:

> The Medical Association has made much of the fact that Wheeling has lost all three of its neurosurgeons in the past year. But two of those neurosurgeons are near the top of the list for the number of malpractice suits brought against them. In all but one of the 19 lawsuits brought against those two doctors, the insurance company representing them settled out of court, apparently paying damages. The third neurosurgeon left town shortly after being sued for malpractice. That neurosurgeon admitted drilling into the wrong side of his patient's head during an operation, possibly leaving her permanently scarred. The same neurosurgeon lost a jury trial for $1.8 million for botching a surgery that caused multiple cerebral aneurysms and cardiac arrest. Is Wheeling really worse off for losing these doctors?[24]

Similar findings have recently been made of Pennsylvania doctors. According to a recent census conducted by the Pennsylvania Medical Professional Liability Catastrophe Loss Fund (CAT fund), the state agency that provided backup malpractice coverage for doctors and hospitals, the number of Pennsylvania doctors increased by 13.5 percent between 1990 and 2000, a period the population grew just 3.4 percent.[25] The head of the CAT fund, John H. Reed, reported not only that there was no evidence of "any major departure of physicians from the state" but also that Pennsylvania had "more doctors [in 2001] than we did five years ago or ten years ago."[26] Moreover, *Morning Call* reporter Ann Wlazelek found in her investigational series, "Examining Medical Malpractice," that in the year 2000 "Pennsylvania ranked ninth-highest nationally for physician concentration, a top-10 position it has held since 1992. There were 318 doctors for every 100,000 residents in 2000, according to the American Medical Association."[27]

In New York, where OB/GYN's say they are leaving the state, the New York Public Interest Research Group (NYPIRG) released figures showing that New York State is third in the nation in its number of obstetricians and gynecologists per capita, well ahead of California (ranked 27th). When compared to the region, only Connecticut (ranked 2nd) is ahead of New York State in the number of ob gyns per capita. Moreover, the number of physicians practicing in New York State has skyrocketed and is increasing at a rate faster than the national average. The number of physicians in New York State has risen dramatically over the past twenty years. New York had 280 doctors per 100,000 people in 1980; it had 414 physicians per 100,000 population in 1998. The nation's ratio of physicians per capita rose by 43.6% compared with the 47.9%

increase in New York during that same period. New York State is now ranked second to Massachusetts in the number of doctors per capita.

Other analyses have come to similar conclusions. One recent 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."[28] 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."[29]

Medical Malpractice, "Tort Reform" and Insurance Rates

During past and current liability insurance crises, the insurance industry has tried to cover up its pricing errors by blaming "aggressive" lawyers and the legal system for the liability insurance price jump. Under this theory, one would have to believe that trial lawyers have timed their "aggression" to precisely coincide with the insurance industry's economic cycle, so that the aggression impacts just when the market turns hard. Thus, one would have to accept the notion that lawyers were aggressive in the mid 1970s, then non-aggressive for a decade, then aggressive in the mid-1980s, non-aggressive for 17 years and are now aggressive again. This is ludicrous.

Yet it has been a surprisingly easy message for the media to accept, or at least misunderstand. Certainly, the media's willingness to accept the notion that big jury awards have caused the recent rise in insurance rates fits with their typical over-coverage of big-dollar jury verdicts.[30] In one study, for example, researchers discovered that the mean personal injury verdict reported in the *New York Times* over a six-year period was almost 16.5 times larger than the mean award recorded in the *New York Jury Reports* for New York State and 15.4 times larger than the awards recorded in the metro New York area.[31] This kind of reporting paints a grossly erroneous picture of a tort system spiraling out of control.

Recent reporting of the medical malpractice crisis has followed the same pattern. For example, *ABC News* reported on March 5, 2002 that "[m]ost doctors need malpractice insurance in order to practice. But jury awards in malpractice lawsuits are climbing from a median of $370,000 in 1994 to, as you can see, $800,000 in 1999."[32]

Similarly, a March 22, 2002 *New York Times* article reported, "The [AMA] and the insurers say the crux of the problem is the ballooning cost of awards to victims of medical errors. Between 1995 and 2000, for example, the average jury award jumped more than 70 percent to $3.5 million, and a few claims in 2000 even ran to more than $40 million, according to Jury Verdict Research in Horsham, Pa."[33]

Reality tells a completely different story, however. Insurance companies are paying victims of medical negligence on average *under $32,000* and have been for the last decade.[34] Even assuming a 15 percent increase over the next few years, the averages would stay below $35,000 per claimant. In fact, total insurance payouts to *all claimants* have hovered between $2.5 billion and $4 billion per year. By comparison, Americans spend at least twice that much – about $8

billion – on dog food each year. Moreover, medical malpractice costs, as a percentage of national health care expenditures, are now at an all time low, 0.55 percent.

The above analysis, conducted for the Center for Justice & Democracy by actuary J. Robert Hunter, Director of Insurance for the Consumer Federation of America, examined year 2000 insurance data, the most recent available from the National Association of Insurance Commissioners and A.M. Best and Co. Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator, concludes, "Medical malpractice insurance is amazing value, considering that it covers all medical injuries for about one-half of one percent of health system costs."

And let there be no doubt that deaths and injuries due to medical malpractice are substantial. In late 1999, the National Academy of Sciences Institute of Medicine (IOM) published *To Err is Human; Building a Safer Health System.* The study makes some striking findings about the poor safety record of U.S. hospitals due to medical errors.[35] For example:

- Between 44,000 and 98,000 deaths occur each year in U.S. hospitals due to medical errors, the higher figure extrapolated from the 1990 Harvard Medical Practice study of New York hospitals. Even using the lower figure, more people die due to medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).

- These figures underestimate the magnitude of the medical malpractice problem, since hospital patients represent only a small percentage of the total population at risk. Not included, for example, are errors at outpatient surgical centers, physician offices and clinics.

- The cost of medical errors is huge. Total national costs (lost income, lost household production, disability and health care costs) are estimated to be between $17 billion and $29 billion each year, of which health care costs represent over one-half.

Following the IOM study, several newspapers ran extensive series on the degree and cost of malpractice in their states. For example, in March 2000, a *New York Daily News* week-long investigative series found that "hundreds of New York State doctors, dentists and podiatrists – ranging from modest practitioners to prominent surgeons – have amassed extensive hidden histories of malpractice yet continue to treat patients." Moreover, "making even three malpractice payments is rare – only 1% of the nation's doctors have crossed that line, according to the national database. But those doctors account for 24% – or $5.6 billion – of the money paid to aggrieved patients…. The effect of failing to crackdown on the tiny percentage of doctors with the worst malpractice records is stunning, because they are a powerful driving force behind medical misfeasance nationwide."

These conclusions are similar to those found by Public Citizen's Health Research Group in its book *20,125 Questionable Doctors*.[36] The group found that only one-half of 1 percent of 770,320 licensed medical doctors face any serious state sanctions each year. "Too little discipline is still being done," the report said. "2,696 total serious disciplinary actions a year, the number state medical boards took in 1999, is a pittance compared to the volume of injury and

death of patients caused by negligence of doctors…. Though it has improved during the past 15 years, the nation's system for protecting the public from medical incompetence and malfeasance is still far from adequate."

Despite the amount of medical negligence currently harming patients in this country, very few victims file suit and those who do often have a very difficult time winning their cases. The 1990 Harvard Medical Practice study, which found that medical negligence in New York hospitals results in 27,000 injuries and 7,000 deaths every year, also found that eight times as many patients are injured by medical malpractice as ever file a claim; 16 times as many suffer injuries as receive any compensation.[37] Moreover, defendants now prevail in 76.6 percent of all medical malpractice trials, according to the Bureau of Justice Statistics and the National Center for State Courts.[38]

What may seem like a recent epidemic of medical malpractice is, unfortunately, nothing new. Consider that in 1985 the director of Maternal/Fetal Medicine at Pasadena's Huntington Memorial Hospital told the American College of Obstetrics and Gynecology: "The greatest cause of malpractice is malpractice. You must understand that some of the malpractice out there is so grievous, offensive and implausible as to beggar the imagination."[39] This kind of information led *Business Week* to write in its August 3, 1987 issue, "So what can we do? Start by facing up to what the problem is not. It is not a malpractice insurance crisis. Nor, contrary to popular mythology, is the problem a lawsuit crisis. The real crisis is the degree of malpractice itself."[40]

A Word About Defensive Medicine Costs

There is universal agreement that at most a very small portion of health care costs result from "defensive medicine." In 1994, the Office of Technology Assessment was asked, initially by proponents of sweeping malpractice tort restrictions, to study the issue. This much-anticipated landmark study by the OTA, entitled *Defensive Medicine and Medical Malpractice* (July 1994), completely undermined the credibility of claims that bills like H.R. 4600 will significantly reduce "defensive" medicine. The OTA found that:

- Only "a relatively small proportion of all diagnostic procedures – certainly less than 8 percent – is likely to be caused primarily by conscious concern about malpractice liability risk." The OTA also stressed that this figure actually "overestimates the rate" of "defensive" medicine because it "is based on physicians' responses to hypothetical clinical scenarios that were designed to be malpractice sensitive."

- 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 traditional tort reforms – particularly caps on damages and amendments to the collateral source rule – on defensive medicine "are likely to be small."

- "[P]hysicians consistently overestimate their own and their colleagues' risk of being sued."

- Defensive medicine "may benefit patients."

- "It is impossible to accurately measure the overall level and national cost of defensive medicine."

- "Health care reform may change financial incentives toward doing fewer rather than more tests and procedure. If that happens, concerns about malpractice may act to check potential tendencies to provide too few services."

H.R. 4600 Will Have Terrible Consequences for Patients

- **One-Way Preemption.** Like most recent federal tort reform bills, H.R. 4600 would present a major interference with the traditional authority of state court judges and juries in medical malpractice and products liability cases. It would be a massive federal preemption of state law, pandering to this country's insurance and pharmaceutical companies. Its *one-way* preemption of state law provisions that protect patients makes clear that the intent of this legislation is not to make medical malpractice and products liability laws uniform in the 50 states. Rather, it is a carefully crafted bill to provide relief and protections for the insurance and drug companies. 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.

- **$250,000 Aggregate Cap on Non-Economic Damages,** regardless of the number of parties against whom the action is brought. Non-economic damages compensate injured consumers for the human suffering accompanying injuries caused by wrongful conduct. These are intangible but real injuries, like infertility, permanent disability, disfigurement, pain and suffering, loss of a limb or other physical impairment. Caps on non-economic damages hurt those who suffer most – men, women and children who suffer brain injury, amputation, paralysis, quadriplegia and other devastating injuries. And they have a disproportionate effect on plaintiffs who do not have high wages – like women who work inside the home, children, seniors and the poor, who are thus more likely to receive a greater percentage of their compensation in the form of non-economic damages if they are injured. In recent years, such caps have been found to be unconstitutional in a number of states, violating a right to jury trial and interfering with the proper functioning of the courts.

- **Complete Abolition of Joint and Several Liability for Economic and Non-Economic Damages,** overturning many state laws. Again, this provision would burden the most seriously injured patients. The doctrine of joint and several liability has been 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 much 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 his negligent or reckless behavior must be an "actual and proximate" cause of the entire injury. This is a high standard. (*See, e.g.*, Richard Wright, "The Logic and Fairness of Joint and Several Liability," 23 *Memphis State Law Review* 45 (1992).

Joint and several liability is rarely used. But it has been critical in cases such as those involving the anti-miscarriage drug DES, where it was not possible for a victim to establish which of many manufacturers produced the drug that caused cancer. In one DES case, a court held manufacturers jointly liable for an entire injury, on the basis of "actual analytic cooperation" and "information pooling" by a number of manufacturers and later "conscious parallel activity" in seeking FDA approval of the use of the drug. When joint and several liability is limited or abolished, however, wrongdoers are let off the hook and the innocent victim receives far less compensation for injuries than the judge or jury has determined they deserve.

- **Limits on Punitive Damages.** This bill 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. According to the Bureau of Justice Statistics, only 1.1 percent of medical malpractice plaintiffs who prevailed at trial were awarded punitive damages in 1996. Of these, 1.2 percent of plaintiff winners were awarded punitive damages by juries.[41] Although rare, the prospect of having to pay punitive damages in a lawsuit by an injured patient causes companies and other wrongdoers to operate more safely. In the case of the Dalkon Shield IUD, which killed and injured thousands of women, it took 11 punitive damage awards over a number of years, totaling in excess of $24.8 million, before A.H. Robins finally agreed to urge doctors and women to remove the device and offered to pay for the removal. Robins would not have taken this needed action without "growing concern about the rising tide of punitive damages claims against the company," as reported in the *Wall Street Journal.*[42]

- **Repealing the Collateral Source Rule.** H.R. 4600 would repeal the collateral source rule, which prevents a wrongdoer 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. Government benefits received by the injured victim are entitlements, which lawmakers determined should be available, and should not be manipulated to benefit wrongdoers who produce injury. 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.

- **Contingency Fee Limits.** H.R. 4600 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. Under a contingency fee arrangement, a lawyer agrees to take a case on behalf of an injured patient without obtaining any money up front from the client. This is a risk, because if the case is lost, the lawyer is paid nothing. This system provides injured consumers who could not otherwise afford legal representation with access to the courts. The principal impact of contingency fee limits is to make it less likely attorneys can afford to risk bringing many cases, particularly the more costly and complex ones, providing practical immunity for many wrongdoers.

  In 1986, James Gattuso of the conservative Heritage Foundation, later with the Competitive Enterprise Institute, wrote an article for the *Wall Street Journal* entitled "Don't Rush to Condemn Contingency Fees." He stated the truth about contingency fees -- that the contingency fee system both ensures that injured persons who could not otherwise afford legal representation obtain access to the legal system, and, "rather than encourage baseless lawsuits, the contingent fee actually helps screen them out of the system." On the other hand, defense lawyers are paid by the hour. *They* are the ones motivated to increase their hours by conducting unnecessary discovery, filing frivolous motions or refusing to participate in meaningful settlement negotiations until immediately before trial. It is more than unfair to restrict plaintiff's attorney fees when defendants have no such restrictions.

- **Structured Settlements.** Allowing all future damages over $50,000 to be paid periodically, as does H.R. 4600, leaves 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.

- **Reduced Statute of Limitations.** The legislation 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.

Real Insurance Reforms

For medical malpractice insurers, high-pressure tactics have paid off and will pay off again unless Congress 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.

1. **Meaningful Disclosure.**

With rare exceptions, federal and state laws today do not force even licensed property/casualty insurance companies to disclose meaningful information to U.S. authorities that could substantiate or refute their allegations about the financial health of the industry or the impact of the U.S. judicial system. Nor do we understand today the covert influence that the reinsurance industry may be having on the current medical malpractice insurance "crisis," with doctors being price-gouged around the country.

At the federal level, officials currently have no legal authority to collect data from insurance companies or even to question an insurer effectively when it shuts off the flow of insurance/reinsurance to a specific line of insurance or threatens a specific state. Even at the state level, state reporting laws typically allow insurance companies to conceal such figures as:

- Premium income and payouts for specific sublines of insurance;
- Reserves and the amount of losses "incurred but not reported" (IBNR) – the insurer's guess at the amount for claims that have occurred prior to the end of an accounting period but are not reported until after the end of the reporting period – for each line of insurance;
- How much insurers pay out for different types of damages, *i.e.*, economic damages, non-economic damages and punitive damages;
- How victims actually fare – in other words, how much insurers actually pay in settlements or verdicts that are reduced post-trial compared to victims' injuries and losses; and
- How much insurers pay in cases involving multiple defendants (where joint and several liability may be an issue).

Congress should have information on payouts, losses, income and reserves to determine the true condition of the insurance industry and how victims are faring under the present system. Congress should set minimum disclosure standards for surplus lines and reinsurers operating in the United States and encourage states to set state-specific or stricter disclosure standards if they so choose.

2. **Congress Should Create Alternative Reinsurance Programs.**

During cycle bottoms, reinsurance is often more difficult to find than primary insurance, particularly when reinsurers refuse to cover certain risks. And sharp rate increases by reinsurers may force insurers to drop additional risks to satisfy state premium/surplus ratios. When reinsurers hiked premium rates and reduced coverage in the mid-1980s, U.S. insurers had no effective recourse. Small businesses and other entities that may have wanted to self-insure were unable to find reinsurance.

A federal reinsurance program would ensure that primary companies and entities that self-insure can purchase reinsurance even during cycle bottoms or when other reinsurers abandon certain markets. When rates skyrocket or coverage decreases, a government reinsurance program would exert downward pressure on reinsurance rates. This in turn would enable insurers to maintain reasonable rates.

To supplement a federal reinsurance program, states could establish an interstate compact to create joint reinsurance programs. For example, as a condition of doing business in any member state, the compact could require an insurance company to contribute a small percentage of its premiums to fund a self-sustaining joint program that would write reinsurance in all member states for businesses and others that self-insure in accordance with jointly-established underwriting standards.

If efficiently run, a government reinsurance program can and should make money. Congress established a similar program to reinsure insurers against riot-caused damages when private insurers pulled out of inner-city markets in 1968. The program made a profit of $125 million while keeping insurance available in the inner cities.

3. **Congress Should Repeal the 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. Increased competition would bring lower prices and would increase the availability of insurance for consumers.

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 for auto and homeowner insurance and the ISO advisory rates.

Conclusion

In a March 5, 1995 *New York Times* article, Dr. Wayne Cohen, then-medical director of Bronx Municipal Hospital, 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."[43] In a somewhat obscure way, Dr. Cohen actually heralded one of the most important functions of lawsuits and the civil justice system: deterring unsafe practices. Numerous hospital and medical procedures have been made safer as a result of lawsuits. These include, anesthesia procedures, catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care, all of which are documented in the Center for Justice & Democracy study, *Lifesavers: CJ&D's Guide to Lawsuits that Protect Us All.*

Indeed, our goal must be to reduce medical negligence. Moreover, effective insurance reforms are the only way to stop the industry from abusing its enormous economic influence, which it uses to promote a legislative agenda that bilks taxpayers and severely hurts the American public. 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 any medical malpractice insurance "crisis." Tort restrictions only 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.

Major Tort Restrictions Enacted in Medical Malpractice Cases, 1985-1999

Alabama
Pre-1985: collateral source
87: med mal cap (but declared unconstitutional in 91)
87: punitive cap (but declared unconstitutional in 93)
87: collateral source (but declared unconstitutional in part in 96)

Alaska
86: cap, non-economic
86: joint and several liability
86: collateral source rule
88: joint and several liability (ballot initiative)
97: cap, all damages
97: punitive cap
97: prejudgment interest

Arizona
Pre-1985: med mal collateral source
87: joint and several
89: med mal structured settlements (but declared unconstitutional in 94)

Arkansas
Pre-1985: medical malpractice structured settlements

California
Pre-1985: med mal cap, noneconomic; med mal collateral source; med mal contingency fees; med mal structured settlements
86: joint and several liability (ballot initiative)

Colorado
86: cap, noneconomic
86: joint and several liability
86: punitive cap
86: collateral source
88: med mal cap, all damages
88: med mal statute of repose
88: med mal structured settlements
92: med mal collateral source

Connecticut
85: med mal collateral source
86: joint and several (i.e. proportional) liability
86: contingency fees

Delaware
Pre-1985: collateral source; med mal contingency fees; med mal structured settlements

District of Columbia
Pre-1985: collateral source

Florida
86: joint and several liability
86: collateral source
86: med mal structured settlements
86: contingency fees
86 : punitive cap
88: cap noneconomic (but declared unconstitutional in 91)
88: med mal cap, noneconomic (depending on arbitration)

Georgia
87: punitive cap
87: joint and several liability

Hawaii
86: cap, noneconomic
86: joint and several liability (except medical products)
86: collateral source (liens)

Idaho
87: cap, noneconomic
87: joint and several liability
87: structured settlements
90: collateral source

Illinois
Pre-1985: med mal collateral source
85: medical malpractice structured settlements
85: med mal contingency fees
95: cap, noneconomic (but declared unconstitutional in 97)
95: joint and several liability (but declared unconstitutional in 97)
95: punitive cap (but declared unconstitutional in 97)

Indiana
Pre-1985: joint and several liability
86: collateral source
93: med mal cap, all damages
93: med mal contingency fee
95: punitive cap

Iowa
Pre-1985: joint and several liability; med mal collateral source
86: structured settlements
87: collateral source
87: prejudgment interest
87: structured settlements
97: joint and several liability
97: prejudgment interest

Kansas
85: med mal punitive cap (but expired in 88)
86: med mal cap (but declared unconstitutional in 88)
86: med mal structured settlements (but declared unconstitutional in 88)
87: cap, noneconomic
87: punitive cap
88: collateral source (but declared unconstitutional in 93)

Kentucky
88: joint and several liability (but codified common law rule)
88: collateral source (but declared unconstitutional in 95)

Louisiana
Pre-1985: med mal cap; med mal structured settlements (Patients Comp. fund); joint and several liability
87: joint and several liability
87: prejudgment interest
96: joint and several liability

Maine
85: med mal structured settlements
85: med mal contingency fees
88: prejudgment interest
89: med mal collateral source

Maryland
Pre-1985: collateral source
86: cap, noneconomic
86: structured settlements

Massachusetts
86: med mal cap, noneconomic
86: med mal collateral source
86: med mal contingency fees

Michigan
86: med mal cap, noneconomic
86: collateral source
86: structured settlements
86: prejudgment interest
87: joint and several liability
93: med mal cap, noneconomic
95: joint and several liability

Minnesota
86: cap, noneconomic (but repealed in 90)
86: collateral source
86: prejudgment interest
88: joint and several liability

Mississippi
89: joint and several liability

98: med mal statute of repose

Missouri
86: med mal cap, noneconomic
86: med mal structured settlements
87: joint and several liability
87: collateral source

Montana:
87: joint and several liability (but declared unconstitutional in 94)
87: collateral source
95: med mal cap, noneconomic
95: med mal structured settlements
97: joint and several liability

Nebraska
Pre-1985: collateral source; med mal cap (cap increased in 92)
86: prejudment interest (but improved prior standard)
92: joint and several liability (but improved prior standard)

Nevada
Pre-1985: med mal collateral source
87: joint and several liability
89: punitive cap

New Hampshire
86: cap, noneconomic (but declared unconstitutional in 91)
86: punitive abolished
89: joint and several liability
95: prejudgment interest

New Jersey
Pre-1985: contingency fees
87: joint and several liability
87: collateral source
95: punitive cap
95: joint and several liability

New Mexico
87: joint and several liability (but codified common law)
92: med mal structured settlement
92: med mal cap (except punitives)

New York
86: joint and several liability
86: collateral source
86: structured settlements
86: med mal contingency fees

North Carolina
95: punitive cap

North Dakota
87: joint and several liability
87: collateral source
87: structured settlements
93: punitive cap
95: med mal cap, noneconomic

Ohio
87: joint and several liability
87: structured settlements
96: cap, noneconomic
96: joint and several liability
96: punitive cap
96: collateral source
96: prejudgment interest

Oklahoma:
86: prejudgment interest
95: punitive cap

Oregon
87: cap, noneconomic
87: joint and several liability
87: med mal punitives abolished against doctors
87: collateral source
95: joint and several liability

Pennsylvania
Pre-1985: med mal collateral source
96: med mal punitive cap

Rhode Island
86: med mal collateral source
87: prejudgment interest

South Carolina
Pre-1985: med mal structured settlements (Patient Comp. Fund with annual cap)

South Dakota
Pre-1985: med mal collateral source; med mal cap; noneconomic
86: med mal cap, economic (but declared unconstitutional 96)
86: med mal structured settlements
87: joint and several liability

Tennessee
Pre-1985: med mal collateral source

Texas
87: med mal cap (but declared unconstitutional in 88, although allowed for wrongful death, 90)
87: joint and several liability (except environmental)

87: punitive cap
87: prejudgment interest
95: joint and several liability
95: punitive cap

Utah
85: med mal collateral source
86: med mal cap, noneconomic
86: joint and several liability
86: med mal structured settlements

Vermont:
Pre-85: joint and several liability

Virginia
Pre-1985: med mal cap (although cap raised in 83 and 99)
87: med mal (children injured at birth, no right to sue, no noneconomic or punitives)
87: punitive cap

Washington
Pre-1985: punitive cap; med mal collateral source
86: cap, all damages (but declared unconstitutional in 88)
86: joint and several liability
86: structured settlements

West Virginia
86: med mal cap, noneconomic
86: med mal joint and several liability

Wisconsin
Pre-1985: med mal (Patient Comp. Fund)
86: med mal cap, noneconomic (but expired 90)
86: med mal contingency fees
95: med mal cap
95: joint and several liability
95: med mal structured settlements
95: med mal collateral source

Wyoming
86: joint and several liability

NOTES

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[12] LeBoeuf, Lamb, Greene and MacCrae is the firm's current name.

[13] *The Liability Insurance Crisis*, Hearings Before the Subcomm. On Economic Stabilization of the House Comm. On Banking, Finance and Urban Affairs, 99th Cong., 2nd Sess. 83 (1986)(Testimony of J. Robert Hunter)(Exh. I, sheet 3)(Excerpt from Report of Casualty Insurance Colloquium held for Alaska State Legislators by the Insurance Industry, September 17, 1985)(Statement by Jeff Johnson).

[14] Summary of Casualty Insurance Colloquium held for Alaska State Legislators by the Insurance Industry (September 17, 1985)(Statement from summary of presentation of John George, Director of Insurance, State of Alaska).

[15] *See, e.g.*, "Lloyd's Forecast is Bullish," *Journal of Commerce*, September 8, 1987.

[16] *See*, Joanne Doroshow and Adrian Wilkes, *Goliath: Lloyd's of London in the United States*, Center for Study of Responsive Law (1988), pp. 74-75.

[17] *The Liability Insurance Crisis*, Hearings Before the Subcomm. On Economic Stabilization of the House Comm. On Banking, Finance and Urban Affairs, 99th Cong., 2nd Sess. 83 (1986)(Testimony of J. Robert Hunter) (Exh. I, Sheet 1).

[18] Telephone Interview by Joanne Doroshow with Delegate Lawrence Wiser, October 13, 1987.

[19] Letter from Jim Roush, Staff Director, Fairness and Accountability in Insurance Reform to Joanne Doroshow, dated October 8, 1987.

[20] *Ibid*.

[21] "Study Finds No Link between Tort Reforms And Insurance Rates," *Liability Week*, July 19, 1999.

[22] Michael Prince, "Tort Reforms Don't Cut Liability Rates, Study Says," *Business Insurance*, July 19, 1999.

[23] Martha Leonard, "State has seen sharp increase in number of doctors," *Sunday Gazette Mail*, February 25, 2001.

[24] "Malpractice Association distorts facts," *Charleston Gazette*, March 1, 2001.

[25] Ann Wlazelek, "Doctors' ad campaign baseless; They're not fleeing Pa., but malpractice straits create 'hostile' climate," *Morning Call*, March 24, 2002; Josh Goldstein, "Recent census of doctors shows no flight from Pa," *Philadelphia Inquirer*, October 2, 2001.

[26] Josh Goldstein, "Recent census of doctors shows no flight from Pa," *Philadelphia Inquirer*, October 2, 2001.

[27] Ann Wlazelek, "Doctors' ad campaign baseless; They're not fleeing Pa., but malpractice straits create 'hostile' climate," *Morning Call*, March 24, 2002.

[28] Eleanor D. Kinney, "Malpractice Reform in the 1990s: Past Disappointment, Future Success?" 20 *J. Health Pol. Pol'y & L.* 99, 120 (1995), cited in Marc Galanter, "Real World Torts," 55 *Md. L. Rev.* 1093, 1152 (1996).

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[30] *See, e.g.*, Judy Aks, Anne Bloom, Michael McCann & William Haltom, "Hegemonic Tales and Subversive Statistics: A Twenty-Year Study of News Reporting about Civil Litigation," Paper presented at the annual Law and Society meetings in Miami, Florida, May 26-29, 2000, pp. 19-20; Marc Galanter, "An Oil Strike in Hell: Contemporary Legends About the Civil Justice System," 40 *Arizona L. Rev.* 717, 745 (Fall 1998), citing Oscar Chase's study, "Helping Jurors Determine Pain and Suffering Awards," 23 *Hofstra L. Rev.* 763, 771-73, 782 (Summer 1995); Daniel Bailis & Robert MacCoun, "Estimating Liability Risks with the Media as Your Guide: A Content Analysis of Media Coverage of Tort Litigation," 20 *Law and Human Behavior* 419 (1996).

[31] Marc Galanter, "An Oil Strike in Hell: Contemporary Legends About the Civil Justice System," 40 *Arizona L. Rev.* 717, 745 (Fall 1998), citing Oscar Chase's study, "Helping Jurors Determine Pain and Suffering Awards," 23 *Hofstra L. Rev.* 763, 771-73, 782 (Summer 1995).

[32] "Doctors trying to stay in business as price for malpractice insurance goes up," *ABC World News Tonight*, March 5, 2002.

[33] Joseph B. Treaster, "Doctors Face A Big Jump In Insurance," *New York Times*, March 22, 2002.

[34] Memo from Joanne Doroshow to Interested Persons with attached spreadsheet prepared by J. Robert Hunter, Director of Insurance, Consumer Federation of America, November 14, 2001.

[35] Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).

[36] Sidney Wolfe et al., *20,125 Questionable Doctors*, Public Citizen Health Research Group, Washington, DC (2000).

[37] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990).

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[39] Letter from Ralph Nader to Florida Speaker Mills and Senate President Vogt (1988).

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[41] "Tort Trials and Verdicts in Large Counties, 1996," U.S. Department of Justice, Bureau of Justice Statistics, NCJ 179769 (August 2000), p. 7.

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