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

BEFORE THE HOUSE COMMITTEE ON THE JUDICIARY

January 20, 2011

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OVERSIGHT HEARING ON "MEDICAL LIABILITY REFORM - CUTTING COSTS, SPURRING INVESTMENT, CREATING JOBS"

January 20, 2011

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

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

In addition, I served on the New York State Governor's Medical Malpractice Task Force in 2007 and 2008, which among other things, discussed ways to improve patient safety as the best way to reduce injuries, claims, lawsuits and costs to the system.

It should first be noted that, while we do not have specific legislation on which to comment yet, anything that Congress chooses to enact in this area would overturn traditional state common law and would be an unprecedented interference with the work of state court judges and juries in civil cases. Bills that Congress has considered in the past include across-the-board "caps" on compensation for "non-economic damages" - injuries like permanent disability, disfigurement, blindness, loss of a limb, paralysis, trauma, or pain and suffering.

These tort restrictions apply across the board to all cases, not just "frivolous" cases. Their provisions apply no matter how much merit a case has, or the extent of the misconduct of a hospital, doctor or HMO. They apply regardless of the severity of an injury. For many years, we have assisted families from around the nation who have traveled to Washington, D.C. to voice their strong opposition to bills like this. These families are the forgotten faces in the debate over

how to reduce health care and insurance costs, and I hope that at some point, this Committee decides to hear from them.

Bills that Congress has considered in the past would also undermine our constitutional right to trial by jury. They would limit the power and authority of jurors to decide cases based on the facts presented to them. Many states have found such tort restrictions unconstitutional in their state based on their own state law. They also raise significant federal constitutional problems, as well. As Justice Rehnquist has stated:

> The guarantees of the Seventh Amendment [right to civil jury trial] will prove burdensome in some instances; the civil jury surely was a burden to the English governors who, in its stead, substituted the vice-admiralty court. But, as with other provisions of the Bill of Rights, the onerous nature of the protection is no license for contracting the rights secured by the Amendment.[1]

They also would create new burdens on state and federal deficits. If someone is brain damaged, burned, or rendered paraplegic as a result of health care system negligence but cannot obtain adequate compensation through the tort system, he or she may be forced to turn to taxpayer-funded health and disability programs. In other words, the costs of injuries are not eliminated by enacting "tort reform," but merely shift onto someone else – including the government.

Finally, these bills always ignore the insurance industry's major role in the pricing of medical malpractice insurance premiums – an industry that is exempt from anti-trust laws under the McCarran-Ferguson Act. Repealing this act is critical to stabilizing the medical malpractice insurance market. There are also many other patient safety measures that Congress could be exploring. The best way to reduce death, injuries, claims, lawsuits is to reduce the amount of malpractice itself.

The Jobs Issue. The topic of this oversight hearing includes discussion of how limiting patients' legal rights will lead to job creation. As this Committee knows, medical malpractice litigation has been focus of attack by the insurance industry and medical lobbies for 36 years. Every state in the country has dealt with it. President George W. Bush made this a focus of his administration. This is the fourth time in eight and a half years that I have been asked to testify before a House committee on the issue, including by the Small Business Committee. Yet this is the first time I have ever heard an argument made that limiting patients' rights creates jobs. If it were true, surely we would have heard the argument made at some point in the prior 36 years. In fact, we should have heard it repeatedly. It would be the opinion of respected economists, not just lobbyists, or those who would benefit financially, or those whose work is paid for by "tort reform" groups.[2]

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

[2] For example, in 2008, Texans for Lawsuit Reform released a "study" that it paid for, supported by no documentation whatsoever, by Ray Perryman that "shows lawsuit reforms enacted in Texas beginning in 1995 have resulted in $112.5 billion in annual spending in Texas. 499,000 new, permanent jobs and a $2.6 billion increase in state tax revenue giving Texas a resounding competitive advantage in these challenging economic times." According to the *Wall Street Journal*, Mr. Perryman may be skilled at self-promotion, but little else. Here's what others said about him: "'He's the most bought economist in Texas,' says Austin City Council Member Brigid Shea, with whom he butted heads when he testified against proposed environmental regulations there. 'He will produce

"Tort reform" does not create jobs. In 2005, the Economic Policy Institute ("EPI") released a study debunking common myths about the costs of the legal system and its burden on consumers.[3] According to EPI, "There is no historical correlation between the inflated estimates of the costs of the tort system and corporate profits, product quality, productivity, or research and development (R&D) spending. Evidence suggests that the tort system, without the proposed restrictions, has actually been beneficial to the economy in all these areas." Moreover, says EPI, "significant tort law change would be more likely to slow employment growth than to promote it. Endlessly repeating that so-called 'tort reform' will create jobs does not make it true."

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

Since the first time I testified in 2002 before the Judiciary Committee's Subcommittee on Commercial and Administrative Law, much has happened in the area of medical malpractice.

THE MEDICAL MALPRACTICE EPIDEMIC

- **The amount of malpractice in U.S. hospitals has grown at alarming rates.**
    - It has been over a decade since the Institute of Medicine's seminal study "To Err is Human"[4] was published, and experts agree a meaningful reduction in medical errors has not occurred in the United States. According to a November 2010 study by the Office of Inspector General of the U.S. Department of Health and Human Services about 1 in 7 hospital patients experience a medical error, 44 percent of which are preventable. These errors cost Medicare $4.4 billion a year.[5] Moreover, "These Medicare cost estimates do not include additional costs required for follow-up care after the sample hospitalizations."[6] The study concludes, "Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events."[7]
    - Also in November 2010, a statewide study of 10 North Carolina hospitals, published in the New England Journal of Medicine, found that harm resulting from medical care

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any conclusion you want,' [and] 'He's got all these computer models he can never explain,' says Austin lawyer Bill Bunch, …. 'It's just this black box. Hocus-pocus,' [and] 'Go to an American Economics Association meeting and ask who Ray Perryman is. Nobody will have ever heard of him,' says Thomas Saving, chairman of the economics department at Texas A&M. The president of the AEA, the major trade group for academic economics, has never heard of Dr. Perryman, a spokeswoman says. Laura Johannes, Economist Ray Perryman Is Hailed As a Genius -- for Self Promotion, *Wall Street Journal*, May 10, 1995.

[3] http://www.epi.org/publications/entry/bp157/

[4] *To Err Is Human, Building a Safer Health System,* Institute of Medicine, 1999. This study found that between 44,000 and 98,000 patients are killed in hospitals each year due to medical errors.

[5] U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), pp. i-ii, found at http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.

[6] *Id* at ii-iii (emphasis in original).

[7] *Id* at iii.

was common, with little evidence that the rate of harm had decreased substantially over a 6-year period ending in December 2007. This is considered significant nationally because North Carolina is touted as a leader in efforts to improve safety. [8]

- The situation is probably even worse because 23 states have no medical-error detection program, and even those with mandatory programs miss a majority of the harm." [9] "Most medical centers continue to depend on voluntary reporting to track institutional safety, despite repeated studies showing the inadequacy of such reporting."[10]
- Texas is a good example. According to a 2009 investigative series by Hearst newspapers and the *Houston Chronicle* called "Dead By Mistake", [11] after Texas enacted its cap on non-economic damages, the number of complaints against Texas doctors to the Medical Board rose from 2,942 to 6,000 in one year. More than half of those complaints were about the quality of medical care." Yet, "Texas has fumbled attempts to establish a medical error reporting system, often leaving patients to discover errors the hard way — when a mistake costs them their livelihood or the life of a loved one. … In 2003, Texas hospitals were asked to report just nine broadly defined error categories. The Texas data kept from 2003 to 2007 kept hospital names secret. Only error totals were made available to the public." The data on the Texas Department of State Health Services' Web site is minimal and suspiciously low and "[f]amilies of patients found the general nature of the reporting infuriating." What's more, in 2003, "the Texas lawmakers established the fledgling Office of Patient Protection, designed to respond to complaints from the public not handled by the Medical Board." But, "it never got the chance to work. The Legislature eliminated the agency in 2005 and, without resistance from the hospital lobby, eliminated the error reporting system in 2007."

CLAIMS AND LAWSUITS

- **While medical errors, the U.S. population and the number of doctors are steadily increasing[12], medical malpractice claims and lawsuits are dropping significantly.**

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[8] Christopher P. Landrigan et al., "Temporal Trends in Rates of Patient Harm Resulting from Medical Care," *N Engl J Med* 2010; 363:2124-2134, 2130 (November 2010)(citations omitted), found at http://www.nejm.org/doi/full/10.1056/NEJMsa1004404#t=articleTop.

[9] Cathleen F. Crowley and Eric Nalder, "Year after report, patients still face risks," *Times Union*, September 20, 2010, found at http://www.timesunion.com/local/article/Year-after-report-patients-still-face-risks-665059.php#page-1.

[10] Christopher P. Landrigan et al., "Temporal Trends in Rates of Patient Harm Resulting from Medical Care," *N Engl J Med* 2010; 363:2124-2134, 2130-2131(November 2010)(citations omitted), found at http://www.nejm.org/doi/full/10.1056/NEJMsa1004404#t=articleTop.

[11] See, http://www.chron.com/deadbymistake/; Terri Langford, "Texas laws are vague, abandoned or unfunded," *Houston Chronicle,* July 30, 2009.

[12] *Physician Characteristics and Distribution in the U.S.,* American Medical Association. It should be noted that there continues to be physician shortages, but medical malpractice cases have nothing to do with this. For example, according to a recent investigation by the *New York Times* less than one month ago, "More than 42,000 students apply to medical schools in the United States every year, and only about 18,600 matriculate, leaving some of those who are rejected to look to foreign schools. Graduates of foreign medical schools in the Caribbean and elsewhere constitute more than a quarter of the residents in United States hospitals. The New York medical school deans say that they want to expand their own enrollment to fill the looming shortage, but that their ability to do so is impeded

- According to the National Center for State Courts, medical malpractice claims are in steep decline, down 15 percent from 1999 to 2008. The NCSC says rarely does a medical malpractice caseload exceed a few hundred cases in any one state in one year.
- In 2009, our project, Americans for Insurance Reform, took a look at medical malpractice insurance claims, premiums and profits in the country at that time and for 30 years prior. In this report, called "*True Risk: Medical Liability, Malpractice Insurance and Health Care,*"[13] we found that according to the insurance industry's own data, medical malpractice claims, inflation-adjusted, are dropping like a rock, down 45 percent since 2000. As A.M. Best put it, "Overall, the most significant trend in [medical professional liability insurance] results over the five years through 2008 is the ongoing downward slope in the frequency of claims.…"[14]
- The data also show that the amount insurers are paying out in claims has been steadily dropping, as well. In *True Risk*, we found that according to the industry's own data, inflation-adjusted per doctor claims have been dropping since 2002 from $8,676.21 that year to $5,217.49 in 2007 and $4,896.05 in 2008. In fact, at no time during this decade did claims spike, or "explode." Rather, payouts in constant dollars have been stable or falling throughout this entire decade, down 45 percent since 2000. In sum, these data confirm that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs.
- In Texas, the non-economic damages cap has a disproportionate impact on the filing of legitimate cases involving children, the elderly and the poor.[15] In a Fall 2008 research paper published in the *Texas Advocate,* professors Charles Silver of the University of Texas School of Law, David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law and Bernard S. Black of the Northwestern University School of Law, estimated that "if the same cases were brought, the cap would result in an 18-25% drop in per-case payouts in settled cases, and a 27% drop in tried cases. We also find that a cap on non-economic damages will have different effects on different groups of plaintiffs, with larger effects on the unemployed and deceased, and likely on the elderly as well. … [O]ne would expect

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by competition with the Caribbean schools for clinical training slots in New York hospitals. The big Caribbean schools, which are profit-making institutions, are essentially bribing New York hospitals by paying them millions of dollars to take their students. "These are designed to be for-profit education mills to train students to pass the boards, which is all they need to get a license," said Dr. Michael J. Reichgott, a professor at the Albert Einstein College of Medicine in the Bronx. Anemona Hartocollis, Medical Schools in Region Fight Caribbean Flow, *New York Times*, December 22, 2010.

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

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

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

the cap to dissuade some plaintiffs from suing at all, especially those in the more severely affected groups.[16] Indeed, "We're taking one out of 300 cases," said one attorney.[17]

- Cases involving medical malpractice in emergency rooms have been knocked out almost completely, making Texas ER's some of the most dangerous in the country. "'What Texans don't know is that their Legislature has mandated a very low standard of care — almost no care,' says Brant Mittler, a Duke University-educated cardiologist in San Antonio who added malpractice law to his resume in 2001.'"[18]
- A June 1, 2009, *New Yorker* magazine article by Dr. Atul Gawande, called "The Cost Conundrum; What a Texas town can teach us about health care," explored why the town of McAllen, Texas, "was the country's most expensive place for health care." The following exchange took place with a group of doctors and Dr. Gawande:

> "It's malpractice," a family physician who had practiced here for thirty-three years said. "McAllen is legal hell," the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.
>
> That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. *Didn't lawsuits go down? "Practically to zero," the cardiologist admitted.*
>
> "Come on," the general surgeon finally said. "We all know these arguments are bullshit. There is overutilization here, pure and simple." Doctors, he said, were racking up charges with extra tests, services, and procedures.

- As this article seems to confirm, doctors' fear of lawsuits is "out of proportion to the actual risk of being sued" and enacting "tort reforms" have no impact on this phenomenon, according to an article in the September 2010 edition of *Health Affairs* by David Katz, M.D., associate professor of medicine with University of Iowa Health Care (and several other authors)."[19] Several explanations are suggested for this undue fear. One squarely blames the medical societies, which continuously hype the risk of lawsuits to generate a lobbying force to help them advocate for doctors' liability limits. A second possible explanation is that doctors will "exaggerate their concern about being sued, using it as a justification for high-spending behavior that is rewarded by fee-for-service payment systems." A third explanation relates to well-documented human tendencies to overestimate the risk of unfamiliar and uncommon events, such as a fear of plane crashes compared to much more common car crashes. They write, "Lawsuits are rare events in a physician's career, but physicians tend to

[16] "The Impact of the 2003 Texas Medical Malpractice Damages Cap on Physician Supply and Insurer Payouts: Separating Facts from Rhetoric," *Texas Advocate*, pp. 25-34, Fall 2008.
[17] Terri Langford, "Texas laws are vague, abandoned or unfunded," *Houston Chronicle,* July 30, 2009.
[18] "ER Patients Can't Find Attorneys, Blame Tort Reform," *Texas Tribune,* December 12-20, 2010
[19] "Physicians still fear malpractice lawsuits, despite tort reforms," *Health Affairs*, September 2010; Volume 29, Issue 9, http://content.healthaffairs.org/content/29/9.toc

overestimate the likelihood of experiencing them."

- **According to the Harvard School of Public Health, "portraits of a malpractice system that is stricken with frivolous litigation are overblown."**

    - In May, 2006, the Harvard School of Public Health published a study in the *New England Journal of Medicine* about the medical malpractice system. Lead author, David Studdert, associate professor of law and public health at HSPH, said, "Some critics have suggested that the malpractice system is inundated with groundless lawsuits, and that whether a plaintiff recovers money is like a random 'lottery,' virtually unrelated to whether the claim has merit. These findings cast doubt on that view by showing that most malpractice claims involve medical error and serious injury, and that claims with merit are far more likely to be paid than claims without merit."[20] The authors found:
        - Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.
        - Eighty percent of claims involved injuries that caused significant or major disability or death.
        - "The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers."
        - "Disputing and paying for errors account for the lion's share of malpractice costs."
        - "Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. … [F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims."

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

    - Fear of litigation is not the reason hospitals and doctors do not report errors or communicate with their patients. David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law and Charles Silver of the University of Texas School of Law, who have studied this problem, write, "[e]xhaustive chronicles

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

of malpractice litigation's impact on physicians never once assert that physicians freely and candidly disclosed errors to patients once upon a time, but stopped doing so when fear of malpractice liability increased. Instead, the historical evidence indicates that there was never much *ex post* communication with patients, even when liability risk was low."[21]

- In his book on medical malpractice, Tom Baker, then Connecticut Mutual Professor of Law and Director of the Insurance Law Center at the University of Connecticut School of Law, confirmed, "to prove that lawsuits drive medical mistakes underground, you first have to prove that mistakes would be out in the open if there were no medical malpractice lawsuits. That is clearly not the case."[22]
- A May 11, 2006 article in the *New England Journal of Medicine* noted that only one quarter of doctors disclosed errors to their patients, but "the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance" [i.e., no litigation against doctors] for decades. In other words, "There are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges."[23]
- According to a recent study by Dr. Thomas Gallagher, a University of Washington internal-medicine physician and co-author of two studies published in the *Archives of Internal Medicine*, "Comparisons of how Canadian and U.S. doctors disclose mistakes point to a 'culture of medicine,' not lawyers, for their behavior."[24] In Canada, there are no juries, non-economic awards are severely capped and "if patients lose their lawsuits, they have to pay the doctors' legal bills… yet "doctors are just as reluctant to fess up to mistakes." Moreover, "doctors' thoughts on how likely they were to be sued didn't affect their decisions to disclose errors." The authors believe "the main culprit is a 'culture of medicine,' which starts in medical school and instills a 'culture of perfectionism' that doesn't train doctors to talk about mistakes."[25]
- Another example is in Massachusetts, where nearly all hospitals fall under the state's charitable immunity laws that cap their liability at $20,000. Yet hospitals are still "vastly underreporting their mistakes to regulators and the public." According to *Boston Magazine,* "The biggest challenge is finding a way to break the culture of silence in hospital corridors that has long crippled efforts to cut medical errors, just as the blue wall of silence has stifled police investigations.[26]
- Hyman and Silver offer a number of explanations for physicians failure to report errors: a culture of perfectionism within the medical profession that shames, blames, and even humiliates doctors and nurses who make mistakes; fragmented delivery systems requiring the coordination of multiple independent providers; the prevalence of third-party payment systems and administered prices; overwork, stress, and

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[21] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," 90 Cornell L. Rev. 914 (2005).
[22] Tom Baker, *The Medical Malpractice Myth* (2005) at 97.
[23] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.
[24] Carol M. Ostrom, "Lawsuit fears aren't reason for docs' silence, studies say," *Seattle Times*, August 17, 2006 , citing from Thomas Gallagher, M.D., et al, "Choosing your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients," *Archives of Internal Medicine,* Aug. 14, 2006.
[25] *Ibid*.
[26] Doug Most, "The Silent Treatment," *Boston Magazine*, Feb. 2003.

burnout; information overload; doctors' status as independent contractors and their desire for professional independence; the Health Insurance Portability and Accountability Act (HIPAA); a shortage of nurses; and underinvestment in technology that can reduce errors.[27] They write, "It is naive to think that error reporting and health care quality would improve automatically by removing the threat of liability."[28]

INSURER PROFITS

- **Medical malpractice insurers have been incredibly profitable in recent years.**

  - In the 2009 report *True Risk*, Americans for Insurance Reform found that no matter how profits were measured, medical malpractice insurers were doing incredibly well, especially when compared to every other sector in the economy.[29] Medical malpractice insurers admitted that they had "a very good" 2008.[30] This came "after posting record profits in 2007."[31] A.M. Best predicted that their "operating profits will continue through 2009."[32] And a quick look at the most recent data shows this to be true.
  - We reported in *True Risk* that in 2007 – the last year data was available - the medical malpractice insurance industry had an overall return on net worth of 15.6%, *well over* the 12.5% overall profit for the entire property/casualty industry.[33] *According to the National Association of Insurance Commissioners most recent data, overall return on net worth for the medical malpractice insurers for 2009 remains high at 15.3 %.*
  - Profitability can also be measured by the loss ratio, which compares the premiums that insurers take in and the money expected to be paid in claims. The lower the loss ratio, the less the insurer expects to pay for claims and the more profitable the insurer likely is (assuming all other things are equal.) According to A.M. Best, the loss ratio for medical malpractice insurers has been declining for at least five years.[34] In 2008, it was remarkably low, at 61.1%. Put another way, medical malpractice insurers believe they will pay out in claims only 61.1 cents for each premium dollar they take in. The rest goes towards overhead and profit, in addition to the profit the insurer makes by investing premiums.
  - Another way to illustrate how well insurers have been doing in recent years is by examining "reserves" – the money set aside for future claims. Reserves are often

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[27] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," 90 Cornell L. Rev. 897-99 (2005); Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007).
[28] *Ibid*.
[29] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html.
[30] "Solid Underwriting Undercut by MPLI's Investment Losses," *Best's Special Report*, A.M. Best, April 27, 2009.
[31] *Ibid*.
[32] *Ibid*.
[33] *Ibid.; Report on Profitability by Line by State in 2007*, National Association of Insurance Commissioners, 2008, p. 38.
[34] "Solid Underwriting Undercut by MPLI's Investment Losses," *Best's Special Report*, A.M. Best, April 27, 2009.

manipulated by insurers for reasons having little to do with actual claims. Indeed, according to A.M. Best, reserves were "redundant" (i.e. excessive) during the last hard market - 2002 to 2004.[35] In those years, insurers told lawmakers that they needed dramatically to raise rates for doctors in order to pay future claims. It wasn't true. As reserves went up, so did rates.[36]

- Reserves are now dropping at a substantial rate, with a whopping 13.6% drop in the last two years examined by AIR.[37] Yet they have even further to go! According to a December 2010 ISO publication, which examined reserves at year-end 2009, reserves are still redundant (i.e., excessive) for medical malpractice policies: 15% to 35% for occurrence policies and by 41% to 61% for claims made policies. *This means rates still have much further to fall (see next bullet point)!*
- In Texas, an Austin-based medical malpractice insurer– American Physicians Service Group Inc. - agreed in September to be acquired by Alabama's ProAssurance Corp. for about $250 million in cash. The company earned $6.2 million on $20.7 million in revenue in the second quarter that ended June 30. … ProAssurance CEO W. Stancil Starnes said APS' strength in Texas made it an attractive acquisition candidate. ProAssurance currently writes about $10 million in premiums in Texas."[38]

MEDICAL MALPRACTICE PREMIUMS

- **Medical malpractice premiums, inflation-adjusted, are nearly the lowest they have been in over 30 years and they may go even lower.**

  - From the late 1980s through about 2001, doctors and hospitals nationwide experienced a relatively stable medical malpractice insurance market. Insurance was available and affordable. Rate increases were modest, often far below medical inflation. Meanwhile, profits for medical malpractice insurers soared, generated by high investment income. During this period, doctors benefited from an extended "soft market" period. That changed after 2001. After dropping interest rates and an economic downturn, compounded by years of cumulative price cuts during the prolonged soft market, insurers suddenly began raising premiums and canceling some coverage for doctors, or at least threatening to do so, in virtually every state in the country. This was an industry-wide insurance phenomenon, not just a medical malpractice phenomenon. It was not a state-specific phenomenon either. It was not even a country-specific phenomenon. It was even happening in countries like Australia and Canada that do not have jury trials in civil cases. This was a classic "hard market."

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[35] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html.
[36] Americans for Insurance Reform, Stable Losses/Unstable Rates 2007, http://www.insurance-reform.org/StableLosses2007.pdf.
[37] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html.
[38] Lori Hawkins, "Alabama health care policy writer says American Physicians Service Group will be a good fit for both companies," *Austin American-Statesman*, September 1, 2010.

- Texas' cap on non-economic damages was passed at the end of the last "hard market," when rate hikes were still skyrocketing around the country. Not surprising, after Prop. 12 passed, major insurers requested rate hikes as high as 35 percent for doctors and 65 percent for hospitals.[39] The insurance commissioner disallowed these. In April 2004, after one insurer's rate hike request was denied, it announced it was using a legal loophole to avoid state regulation and increase premiums 10 percent without approval.[40]
- Like all hard markets, it did not last. In fact, the entire country has been in a "soft" insurance market for several years now, stabilizing rates everywhere in the country – not just Texas![41] According to A.M. Best, after reaching a high of 14.2% in 2003 during the last hard market, medical malpractice premium growth has been dropping, decreasing by 6.6% nationally in 2007, and an additional 5.3% in 2008.
- The insurance pure premium[42] or loss costs,[43] is particularly important to examine. This is the one component of an insurance rate that should be affected by verdicts, settlements, payouts, or so-called "tort reform." It is the largest part of the premium dollar for most lines of insurance. The Insurance Services Office (ISO)[44] shows the same cyclical pattern with the biggest increases during the hard market of 2002-2005, and dropping steadily since then with 2008 seeing an astonishing 11% decrease. This data confirms that we are experiencing a very soft market. Moreover, this decrease might have been even greater had 17 states not limited the decrease to 20%, likely because ISO wanted to control this drop. Most likely, this result was due to the recognition that, with profits as high as they were, medical malpractice insurance for doctors was greatly overpriced in prior years.[45]
- Premiums have dropped irrespective of whether "tort reforms" were enacted in any particular state, such as Texas.[46] States with little or no restrictions on patients' legal rights have experienced the same level of liability insurance rate changes as those states that enacted severe restrictions on patients' rights.[47] Compare, for example,

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[39] *E.g.* Darrin Schlegel, "Some Malpractice Rates to Rise Despite Prop. 12," *Houston Chronicle*, Nov. 19, 2003; Darrin Schlegel, "Malpractice Insurer Fails in Bid for Rate Hike," *Houston Chronicle*, Nov. 21, 2003; (October 2003 rate filing from Texas Medical Liability Insurance Association (JUA) to Texas Department of Insurance).

[40] "Insurer Switching to Unregulated Product to Raise Premiums," *Assoc. Press*, April 10, 2004.

[41] See data from the Council of Insurance Agents & Brokers cited in Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html. See also, Joanne Doroshow, "Here's Really Why Your Insurance Rates Go Up - and Then Don't," http://www.huffingtonpost.com/joanne-doroshow/heres-really-why-your-ins_b_775077.html

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

[43] "Loss cost" is the term for the portion of each premium dollar taken in, that insurance companies use to pay for claims and for the adjustment of claims. Insurers use other parts of the premium dollar to pay for: their profit, commissions, other acquisition expenses, general expenses and taxes. Loss costs include both paid and outstanding claims (reserves are included through an actuarial process known as "loss development") but also include trends into the future since rates based on ISO loss costs are for a future period. Thus, loss costs include ISO's adjustments to make sure that everything is included in the price, even such factors as future inflation.

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

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

[46] *Ibid.*

[47] *Ibid.*

Missouri and Iowa, two neighboring Midwest states. Missouri has had a cap since the mid-1980s, as well as other "tort reform" in medical malpractice cases. Iowa has never had a cap. In the last five years, Missouri's pure premium increased 1%. Iowa's dropped 6%. Among states that had pure premium increases of more than 5% in the last five years were states with significant medical malpractice limits like FL, NV, and UT, and states with fewer restrictions like NH, VT and WY.

- As mentioned above, rates are expected to drop even further! According to a December 2010 ISO publication, which examined reserves at year-end 2009, reserves are still redundant (i.e., excessive) for medical malpractice policies: 15% to 35% for occurrence policies and by 41% to 61% for claims made policies. *This means rates still have much further to fall.*

ACCESS TO CARE

- **There is no correlation between where physicians decide to practice, their choice of specialty, and liability laws.**

  - On August 29, 2003, the U.S. General Accountability Office released a study[48] ostensibly to find support for the AMA's assertions that a widespread health care access "crisis" existed in this country caused by doctors' medical malpractice insurance problems. The GAO found that the AMA and doctors groups had based their claims on information GAO determined to be "inaccurate" and "not substantiated," and that to the extent there are a few access problems, many other explanations can be established "unrelated to malpractice," that problems "did not widely affect access to health care," and/or "involved relatively few physicians." The health care access problems that GAO could confirm were isolated and the result of numerous factors having nothing at all to do with the legal system. Specifically, GAO found that these pockets of problems "were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services."
  - Other studies have also rejected the notion that there has been any legitimate access problem due to doctors' malpractice insurance problems. In August, 2004, the National Bureau of Economic Research researchers found: "The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt. The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings."[49]
  - Other state-specific studies draw the same conclusion. In April 2007, Michelle Mello of the Harvard School of Public Health published a study of physician supply in Pennsylvania in the peer-reviewed journal, *Health Affairs*. The authors "looked at the behavior of physicians in 'high-risk' specialties -- practice areas such as obstetrics/gynecology and cardiology for which malpractice premiums tend to be

[48] *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* General Accounting Office, GAO-03-836, Released August 29, 2003, http://www.gao.gov/new.items/d03836.pdf
[49] http://www.dartmouth.edu/~kbaicker/BaickerChandraMedMal.pdf

relatively high -- over the years from 1993 through 2002. They found that contrary to predictions based on the findings of earlier physician surveys, only a small percentage of these high-risk specialists reduced their scope of practice (for example, by eliminating high-risk procedures) in the crisis period, 1999-2002, when malpractice insurance premiums rose sharply.… What's more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion who did so during 1993-1998, before premiums spiked. 'It doesn't appear that the restrictions we did observe after 1999 were a reaction to the change in the malpractice environment,' said Mello, the C. Boyden Gray Professor of Health Policy and Law at the Harvard School of Public Health."[50]

- Similarly, the *Cincinnati Enquirer* reviewed public records in Ohio in the midst of that state's medical malpractice insurance crisis. The investigation found "more doctors in the state today than there were three years ago … '[T]he data just doesn't translate into doctors leaving the state,' says Larry Savage, president and chief executive of Humana Health Plan of Ohio."[51]
- Past studies have also shown there to be no correlation between where physicians decide to practice and state liability laws. One study found that, "despite anecdotal reports that favorable state tort environments with strict … tort and insurance reforms attract and retain physicians, no evidence suggests that states with strong … reforms have done so."[52] 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."[53]
- It is well-documented that lifestyle considerations are the most important factor for determining not only a doctor's choice of location, but also his or her choice of specialty - far more important than income and expenses. As reported in the *New York Times*, "Today's medical residents, half of them women, are choosing specialties with what experts call a 'controllable lifestyle.'… What young doctors say they want is that 'when they finish their shift, they don't carry a beeper; they're done,' said Dr. Gregory W. Rutecki, chairman of medical education at Evanston Northwestern Healthcare, a community hospital affiliated with the Feinberg School of Medicine at Northwestern University.… Lifestyle considerations accounted for 55 percent of a doctor's choice of specialty in 2002, according to a paper in the Journal of the American Medical Association in September by Dr. [Gregory W.] Rutecki and two co-authors. That factor far outweighs income, which accounted for only 9 percent of the weight prospective residents gave in selecting a specialty."[54] For example, compared to dermatology, which is becoming a more competitive specialty, "'The

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[50] "Malpractice Premium Spike In Pennsylvania Did Not Decrease Physician Supply; Contrary To Survey Responses, The Number Of Physicians In "High-Risk" Specialties In Pennsylvania Who Restricted Or Left Their Practices Did Not Increase During Malpractice "Crisis", *Health Affairs,* April 24, 2007; http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.3.w425.

[51] Tim Bonfield, "Region Gains Doctors Despite Malpractice Bills," *Cincinnati Enquirer*, October 11, 2004.

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

[53] Kinney & Gronfein, "Indiana's Malpractice System: No-Fault by Accident," 54 *Law & Contemp. Probs.* 169, 188 (1991), *cited in* Marc Galanter, "Real World Torts," 55 *Maryland L. Rev.* 1093, 1152-1153 (1996).

[54] Matt Richtel, "Young Doctors and Wish Lists: No Weekend Calls, No Beepers, *New York Times,* January 7, 2004.

surgery lifestyle is so much worse,'' said Dr. [Jennifer C.] Boldrick, who rejected a career in plastic surgery. 'I want to have a family. And when you work 80 or 90 hours a week, you can't even take care of yourself.'"

- Another key factor is age. University of California-San Francisco study of New York doctors found that the main reason doctors cease providing obstetrics care is advancing age. The UCSF study, of New York State physicians during the mid-1980s insurance crisis, found no association between malpractice premiums and doctors' decisions to quit. The study did find that the decrease in doctors practicing obstetrics was associated with the *length of time* since receiving a medical license in New York. This relationship "very likely represents the phenomenon of physician retiring from practice or curtailing obstetrics as they age."[55]
- Finally, we asked David Goodman, M.D., M.S., Professor of Pediatrics and Health Policy at Dartmouth Medical School, about his views on the subject. Goodman is co-investigator of the highly respected Dartmouth Atlas, which analyzes and ranks health care spending and has been the basis of a lot of discussion about why certain areas of the country are so costly. His email to us said: "We haven't explicitly analyzed this, but I agree with the impression that physician supply in general bears no relationship to state tort reform, or lack thereof."

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

  - Injured Texans relinquished their legal rights because the insurance and medical lobbies told them this was the only way to prevent a doctor shortage in Texas. Yet doctors' shortages still loom in Texas today. This is apparently due to "[C]aps and cuts in Medicare and Medicaid funding, which help pay for residencies. Those have forced many healthcare agencies to freeze or scale back residency programs." Specifically, with a ratio of 158 doctors per 100,000 residents, Texas ranks 42nd among the 50 states and District of Columbia, according to the Texas Medical Association. "We are at a shortage of physicians of all types in Texas, both primary care and specialty care," said Dr. Gary Floyd, JPS Health Network chief medical officer said. "We would love to see this addressed in our new healthcare reform. How do we train more physicians?"[56]
  - According to Texas Watch, nearly half of all Texas counties do not meet the national standard of having 114 doctors for every 3,500 people.[57]
  - In December 2009, the *Ft. Worth Star-Telegram* reported,[58]

    > The number of new doctors in family practice, the area most in demand, has increased by only about 200, about 16 percent, and more than 130 counties still did not have an obstetrician or gynecologist as of October, according to a *Star-*

[55] NYPIRG, Center for Medical Consumers and Public Citizen, *The Doctor* Is *In: New York's Increasing Number of Doctors*, October 2004 at 20, citing Grumbach, et al. Charges for Obstetric Liability Insurance and Discontinuation of Obstetric Practice in New York, *The Journal of Family Practice,* Vol. 44, No. 1 (Jan. 1997) at 61.
[56] "JPS official warns Texas legislators of doctor shortage," *Star-Telegram*, October 19, 2010.
[57] http://www.tafp.org/news/stories/attachments/090601releaseHB2154.pdf
[58] Diana Hunter, "Tort law brought more doctors, but its effect on patients is unclear," *Fort Worth Star-Telegram*, December 20, 2009.

Telegram analysis of licensing data from the Texas Medical Board.

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

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

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

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

"DEFENSIVE MEDICINE" AND HEALTH CARE COSTS

- In over 30 years, premiums and claims have never been greater than 1% of our nation's health care costs.[59] Despite this, the claim is often made that these figures do not included the costs of so-called "defensive medicine," or the ordering of tests or procedures to avoid litigation and not because they are "medically indicated and necessary for the health of the patient," as required by Medicare.[60]

- In October 2009, the Congressional Budget Office has presented a new analysis (in the form of a 7-page letter to Senator Hatch) on "the effects of proposals to limit costs related to medical malpractice ('tort reform')" finding that "tort reform could affect costs for health care." It based its new analysis on a small handful of studies, several of which are noted to contradict each other. One of them suggests that 50,000 more people could die in the next ten years (beyond the 98,000 that already die annually from medical errors[61]) should Congress further limit legal rights of patients.

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

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

[61] *To Err Is Human, Building a Safer Health System,* Institute of Medicine, 1999.

- CBO finds that even if the country enacted the entire menu of extreme tort restrictions listed,[62] it can go no farther than to find an extremely small percentage of health care savings, "about 0.5% or $11 billion a year at the current level -- far lower than advocates have estimated"[63]
- CBO found no evidence of pervasive "defensive medicine."[64] It found tiny health care savings – "0.3 percent from slightly less utilization of health care services" -- if severe tort reform were passed nationally. According to the CBO, if there is any problem at all, it's with Medicare, specifically its emphasis on "fee-for-service" spending, whereas private managed care "limit[s] the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as 'defensive medicine')." In other words, CBO virtually admits that to the extent "defensive medicine" exists at all, it can be controlled through simply managing care correctly as opposed to taking away patients' rights and possibly killing and injuring more people.
- CBO says federal government spending will decrease by $41 billion while revenue will increase $13 billion,[65] yet direct financial burdens on the government should these laws pass are not recognized by CBO.
    - If someone is brain damaged, mutilated or rendered paraplegic as a result of the medical negligence, but cannot obtain compensation from the culpable party through the tort system, he or she may be forced to turn elsewhere for compensation, particularly Medicaid. None of these increased Medicaid costs are considered.
    - Whenever there is a successful medical malpractice lawsuit, Medicare and Medicaid can both claim either liens or subrogation interests in whatever the patient recovers, reimbursing the government for some of the patients' health care expenditures. Without the lawsuit, Medicare and Medicaid will lose funds that the government would otherwise be able to recoup. Again, none of these lost funds are factored in by the CBO.

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[62] A $250,000 cap on non-economic damages, $500 cap or two times the amount of economic damages, repeal of the collateral source rule, one-year date of discovery statute of limitations (3 years for children), and repeal of joint and several liability.

[63] 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

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

[65] This number seems somewhat farfetched. It is based on the theory that savings, which are assumed, will find their way into the pockets of wage earners and, as such, become taxable. Moreover, it assumes these "savings" rise steadily each year, suggesting that the practice of medicine will so change based upon these tort restrictions that there will be a never ending increase in the savings, or that the cost to the government for health care will increase each year and, as such, the dollar figure of the "savings" will proportionately increase. In any event, if there is raw data to support this number, it is certainly not provided here.

        - Any legitimate analysis of tort system costs must consider the countervailing cost benefits of the legal system due to its deterrence function - future injuries and deaths prevented, health care costs not expended, wages not lost. Even Tillinghast Watson, which annually issues bloated "tort cost" (based on insurance cost) figures each year, qualifies its numbers by noting it fails to factor in the benefits or cost-savings from the tort system.
    - Studies of defensive medicine frequently use anonymous physician "surveys" to establish its widespread existence. These are usually conceived by organized medicine, whose purpose it is to give the impression of a scientifically conducted poll, yet they are not. In fact, in 2003, the General Accountability Office condemned the use of "defensive medicine" physician surveys, noting everything from low response rates (10 and 15 percent) to the general failure of surveys to indicate whether physicians engaged in "defensive behaviors on a daily basis or only rarely, or whether they practice them with every patient or only with certain types of patients."[66] The GAO also noted that those who produced and cited such surveys "could not provide additional data demonstrating the extent and costs associated with defensive medicine." And, "some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can mitigate defensive practices." Moreover, "According to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit."
    - In 1994, the congressional Office of Technology Assessment (OTA) found that less than 8 percent of all diagnostic procedures were likely to be caused primarily by liability concerns. OTA found that most physicians who "order aggressive diagnostic procedures . . . do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability." The effects of "tort reform" on defensive medicine "are likely to be small."[67]
    - Much has been written about how the problem of "self-referral" contributes to overutilization. Not too long ago, the *Washington Post* obtained some Wellmark Blue Cross and Blue Shield documents, which showed that in 2005, doctors at a medical clinic on the Iowa-Illinois border were ordering eight or nine CT scans a month in August and September of 2005. But after those doctors bought their own CT scanner, within seven months, those numbers ballooned by 700 percent. The *Post* did a similar analysis of the Wellmark data for doctors in the region and found that after CT scanners were purchased, the number of scans they ordered was triple that of other area doctors who hadn't purchased such equipment. The *Post* also cited consistent data from the GAO and MedPac. Jean M. Mitchell, a professor for public

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[66] *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* General Accounting Office, GAO-03-836, Released August 29, 2003, http://www.gao.gov/new.items/d03836.pdf

[67] Office of Technology Assessment (OTA) U.S. Congress, Office of Technology Assessment, Defensive Medicine and Medical Malpractice, OTA-H--6O2 (1994).

policy and a health economist at Georgetown University suggested, getting rid of profit-driven medicine like this "could reduce the nation's health care bill by as much as a quarter."[68]

- Many other factors contribute to overutilization. For example, an investigative team recently took a look at C-Section rates in California, which has had a $250,000 cap since 1975. It found, "[W]omen were at least 17 percent more likely to have a cesarean section at a for-profit hospital than at a nonprofit or public hospital from 2005 to 2007. A surgical birth can bring in twice the revenue of a vaginal delivery.… In addition, some hospitals appear to be performing more C-sections for nonmedical reasons -- including an individual doctor's level of patience and the staffing schedules in maternity wards, according to interviews with health professionals. ... In California, hospitals can increase their revenues by 82 percent on average by performing a C-section instead of a vaginal birth."[69]

- **The impact of Texas "tort reform" on health care costs.**

  - According to the consumer group Texas Watch, "Medicare spending has risen 16% faster than the national average since Texas restricted the legal rights of patients. Four of the nation's 15 most expensive health markets as measured by Medicare spending per enrollee are in Texas.[70]
  - According to Families USA and Texas Watch, family health insurance premiums for Texas families are up 92% - more than 4.5 times faster than income.[71] Texas has the nation's highest rate of uninsured with 24.5% of Texans without health insurance."[72]

IMPACT OF RESTRICTIONS ON THE RIGHTS OF INJURED PATIENTS AND TAXPAYERS

We are somewhat hampered in our presentation today because we are unclear about what specific limits on patients' legal rights are being contemplated. However we can say without hesitation that limiting the rights of injured patients would have terrible consequences for both patients and taxpayers. "Tort reform" is a cost-shifting device. "Tort reform" laws take money from the hands of injured patients and their families and put it into the pockets of insurance companies. Those left to pick up the tab may be taxpayers, who may have the responsibility to pay for the care of the most seriously hurt. In other words, these measure would most likely increase the deficit, while unfairly increasing the obstacles that sick and injured patients face in the already difficult process of seeking compensation and prevailing in court. They will also reduce the financial incentive of institutions, such as hospitals and HMOs, to operate safely, which will lead to more costly errors.

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[68] Shankar Vedantam, "Doctors Reap Benefits By Doing Own Tests," *Washington Post*, July 31, 2009 http://www.washingtonpost.com/wp-dyn/content/article/2009/07/30/AR2009073004285.html

[69] See, e.g., http://www.dailybreeze.com/news/ci_16105879?source=rss

[70] See analysis by Texas Watch, http://www.texaswatch.org/wordpress/wp-content/uploads/2010/10/MedicareSpeding-HealthCosts.pdf 3

[71] Texas-Style "Reform" Fails Patients; Costs Up, Access Down, Texas Watch.

[72] See http://pubdb3.census.gov/macro/032007/health/h06_000.htm

DETERRENCE

- **Weakening The Tort System Will Increase Errors, Injuries and Deaths**

    - In its October 9, 2009 letter to Senator Orin Hatch on medical malpractice issues, the CBO noted, "The system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses …" CBO wrote, "imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes," yet it brushed aside its significance, not because it is untrue, but because it says there are too few studies on the topic. However, of the three studies that address the issue of mortality, CBO notes that one study finds such tort restrictions would lead to a .2 percent increase in the nation's overall death rate.[73] If true, that would be an additional 4,853 Americans killed every year by medical malpractice, or 48,250 Americans over the 10-year period CBO examines.[74]
    - Based on these same numbers, another 400,000 or more patients could be injured during the 10 years that CBO examined (given that one in 10 injured patients die.[75]) The costs of errors, which the Institute of Medicine put between "$17 billion and $29 billion, of which health care costs represent over one-half," would clearly increase.[76] Consider, for example, that the average length of stay per hospitalization is around 4.4 days[77] and the average cost in the hospital is approximately $2,000 per day per injury.[78] Consider those costs in addition to physician utilization inherent in caring for these new patients.
    - David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law, and Charles Silver of the University of Texas at Austin School of Law, have researched and written extensively about medical malpractice.[79] They confirm, "The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. … [T]wo major factors forced their hand: malpractice claims and negative publicity.… Anesthesiology [malpractice] premiums were ... among the very highest—in many areas, two to three times the average cost for all physicians. By the early 1980s, anesthesiologists recognized that something drastic had to be done if they were going to be able to continue to be insured.… Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it."[80] "As Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious. As the title of

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[73] CBO says, "[t]here is less evidence about the effects of tort reform on people's health, however, than about the effects on health care spending – because many studies of malpractice costs do not examine health outcomes."
[74] Based on 2,426,264 deaths according to the Center for Disease Control and Prevention. http://www.cdc.gov/nchs/FASTATS/deaths.htm
[75] Study of California hospitals cited in Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press, 2005.
[76] *To Err Is Human, Building a Safer Health System,* Institute of Medicine, 1999.
[77] http://www.cdc.gov/nchs/data/injury/InjuryChartbook79-01_UtilPayment.pdf
[78] http://www.rtihs.org
[79] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," 90 Cornell L. Rev. 893, 917 (2005).
[80] *Ibid* at 920, 921.

their most recent article says, 'it's the incentives, stupid': Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients..... In short, the notion that errors would decline if tort liability diminished is ridiculous."[81]

- Numerous other medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. In addition to anesthesia procedures, these include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.[82] As a result of such lawsuits, the lives of countless other patients have been saved.
- "The authors of the Harvard [Medical Practice Study] study acknowledged, as well: '[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.'"[83]
- The *New England Journal of Medicine* published a 2006 article confirming this point: that litigation against hospitals improves the quality of care for patients, and that "more liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously."[84]
- No one said this better than Dr. Wayne Cohen, then-medical director of the Bronx Municipal Hospital, who said, "The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing."[85]

SPECIFIC PROPOSALS

- **Caps on Non-Economic Damages**

Non-economic damages are sometimes dismissed as unimportant or frivolous injuries. It is first important to understand what they are.

The joy of life - what makes it really worth living - is not the earning of money to pay to others for life's necessities. When a person is seriously injured, the greatest loss is the loss of the enjoyment of life, the pleasure, the satisfaction or the utility that human beings derive from life, separate and apart from earnings. These are non-economic injuries.

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

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

[83] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing Paul C. Weiler, Joseph P. Newhouse, & Howard H. Hiatt, A Measure Of Malpractice: Medical Injury, Malpractice Litigation, And Patient Compensation 133 (1993).

[84] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

[85] Dean Baquet and Jane Fritsch, "New York's Public Hospitals Fail, and Babies Are the Victims," *New York Times,* March 5, 1995.

What is truly valuable to us as human beings is our ability to live life on a daily basis free of any debilitating physical or emotional problems that diminish our capacity to enjoy life and compromise our sense of self-worth, dignity, and integrity. The pleasure of living lies in our ability to participate fully in the give and take of marriage, family and career. It lies in our experience of the ordinary day: waking up without pain; drinking a cup of coffee without someone's help; dressing a child in mismatched clothes that she insists on wearing, rather than have that child dress you; walking to the bus stop or subway in the brisk air, rather than being wheeled to a lift van; accomplishing a job well done at work, rather than being limited to a make-work project for the disabled; deciding what to make for dinner and preparing it; these and thousands of everyday things are what we live for.

In addition to physical pain and suffering, the seriously injured victim suffers great mental anguish, anxiety and often shame at being transposed from an able-bodied working person respected for his or her accomplishments and contributions to others to an individual who is dependent on others. A seriously injured person is compromised in his or her ability to make decisions and realize them, to take independent action, and to reciprocate when someone helps them. A seriously injured person is also deprived of the pleasure of engaging as equals with other people, including family members, or participating in athletic activities, social and civic events, hobbies, volunteer activities and other interpersonal interactions.

These are sufferings which seriously injured people encounter each time they attempt to perform any of the myriad tasks of daily life the rest of us take for granted. This is the loss that the law describes as "non-economic," and which goes to the very essence of our quality of life.

Caps on non-economic damages do nothing but stop the most severely injured patients from getting adequate compensation.[86] They apply to all patients no matter how egregious the misconduct or devastating the injury. Clearly, juries are better able to determine compensation in individual cases than politicians in Washington, D.C.

They also have a devastating impact on Medicare patients and will add to the deficit, not decrease it. Noneconomic damages caps disproportionately hurt senior citizens, forcing Medicare to pay for their care instead of the culpable hospital's insurance company. That is because caps on non-economic damages make their cases economically impossible for attorneys to bring. The same goes for any injured person with low wages, such as women who work inside the home, children and the poor, who are more likely to receive a greater percentage of their compensation in the form of non-economic damages. In fact, this has already happened in states with non-economic damages caps, like California. Insurance defence attorney Robert Baker, who defended malpractice suits for more than 20 years, told Congress several years ago, "As a result of the caps on damages, most of the exceedingly competent plaintiff's lawyers in

[86] A survey by the RAND Corporation found that the "most significant impact" of California's three decades-old $250,000 cap "falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes." Source: "RAND Study: California Patients Killed or Maimed by Malpractice Lose Most Under Damage Caps," Consumer Watchdog, July 13, 2004.

California simply will not handle a malpractice case … There are entire categories of cases that have been eliminated since malpractice reform was implemented in California."[87]

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

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

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

> [C]ollateral source reform leads to a statistically significant increase in infant mortality.... For whites, the increase is estimated to be between 10.3 and 14.6 additional deaths per 100,000 births. This represents an increase of about 3 percent. For blacks, the collateral source reversal leads to between 47.6 and 72.6 additional deaths per 100,000 births, a percentage increase between 5 and 8 percent. These results suggest that the level of care provided decreases with the passage of collateral source reform.…The relationships we estimate between reform measures and infant mortality rates appear to be causal.... In summary, these results show that collateral source reform leads to increased infant mortality."[88]

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

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

- **Modifying joint-and-several liability.**

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[87] See, http://www.multinationalmonitor.org/mm2003/032003/court.html

[88] Jonathan Klick & 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?," Sept. 24, 2003, available at http://www.aei.org/events/eventID.614/event_detail.asp.

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

We also note that this proposal is unfair to injured patients. The doctrine of joint and several liability has been a part of the common law for centuries. It is a rule that applies to allocating damages when more than one defendant is found *fully responsible* for causing an entire injury. If one of them is insolvent or cannot pay compensation, the other defendants must pick up the tab so the innocent victim is fully compensated. Courts have *always* held that it applies only to injuries for which the defendant is fully responsible. That means that their negligent or reckless behavior must be an "actual and proximate" cause of the entire injury, a high standard.[89] Having said that, joint and several liability limits have already been enacted in over 40 states, so the proposal is also superfluous.[90]

- **"Health courts" for medical malpractice lawsuits.**

No one believes health courts would save money, especially if health court proponents are taken at their word. In fact, they would significantly increase costs. For example, in their book *Medical Injustice: The Case Against Health Courts* (2007), Case Western Reserve professors Maxwell J. Mehlman and Dale A. Nance, noted, "The Republican Policy Committee states, for example: 'The health court proposal is not about reducing costs overall (since many more people may be compensated at smaller amounts).'"[91] These authors made the following additional observations:

> 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."[92]
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> "[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, the system costs should increase by a factor of at least 28, all other things (like system efficiency) being equal."[93]
>
> "[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

[89] *See, e.g.*, Richard Wright, "The Logic and Fairness of Joint and Several Liability," 23 *Memphis State Law Review* 45 (1992).
[90] See, e.g., Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, Appendix C, July 2009. http://insurance-reform.org/pr/090722.html.
[91] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 74.
[92] *Id*. at 72.
[93] *Ibid*.

total direct system costs multiplied by a factor of about 8.5, again as a low end estimate."[94]

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."[95]

In addition to the significant cost issues, there are many other problems with health courts. Health courts force patients into an alternative system without juries, without any accountability mechanisms, without procedural safeguards, and without any meaningful appeals process. These hardships, coupled with the burden of having to prove fault or "causation," render the injured patient virtually powerless and at the mercy of the insurance and medical industries. Even patients with catastrophic injuries, including the families of brain-damaged babies, would have to fight a "causation" battle to obtain compensation for a potential lifetime of care. Decision-makers would be heavily weighted toward health industry or business representatives, who even might have conflicting financial interests in rejecting or reducing compensation. Some proposals suggests that compensation for injuries would be determined by a benefits "schedule" (so much for a lost leg, so much for an eye) developed by the medical establishment or political appointees instead of decided on a case-by-case basis by a jury.[96]

There are substantial constitutional problems with state and/or federal health court proposals, as well.[97]

- **Allowing "safe haven" rules 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, providing immunity for those who follow practice guidelines raises serious fairness and patient safety concerns. Moreover, the medical communities in states that have tried it have rejected this idea. In other words, the medical profession itself has not accepted clinical practice guidelines as appropriate legal standards, even for exculpatory purposes. And the few states that have tried – and subsequently rejected – this proposal saw no impact on claims costs or premiums.

First, we note that clinical practice guidelines should never be the legal basis for determining whether or not patient harm was the result of negligence. There is already a general recognition that conflict of interest and specialty bias are ongoing problems in the development of clinical

[94] *Ibid*.
[95] *Id*. at 73.
[96] See, Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006.
[97] See, Amy Widman and Francine A. Hochberg, "Federal Administrative Health Courts Are Unconstitutional: A Reply to Elliott, Narayan, and Nasmith," 33(4) Journal of Health Politics, Policy and Law 799 (2008); Amy Widman, "Why Health Courts are Unconstitutional," 27 Pace L. Rev. 55 (Fall 2006).

practice guidelines. If medical and specialty societies are allowed to participate in writing guidelines they know will be exculpatory for their members, conflicts of interest and bias will escalate. For example, specialty societies, like the American College of Obstetricians and Gynecologists (ACOG), have been aggressive leaders in the medical lobbies' push for liability limits in the last few years and remain committed to that goal. It would be fundamentally unjust for patients to have their cases judged by liability standards chosen by ACOG for the purpose of exculpating fellow obstetricians.

But the reality is that no matter who writes them, it is impossible to develop single authoritative guidelines for every medical condition, let alone to trust any entity to suddenly become the sole arbiter of acceptable medical practice.[98] It is estimated that more than 1,400 sets of clinical practice guidelines exist today. While some standards, such as those in anesthesia, are clear and easily complied with, others, such as in obstetrical cases, are complicated and can be contradictory. Moreover, as they are written for "average patients" and cannot encompass the huge variation in how patients present, there may be good reason to vary from a guideline's recommendation for a patient.

That is why to date, only a few states have attempted to develop and use certain guidelines as legal standards. These limited state experiments, which began and ended in the 1990s, provide no support for adoption of guidelines as national policy.

For example, in the 1990s, Maine established a program that allowed doctors in four specialties--anesthesiology, emergency medicine, obstetrics and gynecology, and radiology--to participate in a program allowing use of guidelines as exculpatory evidence in lawsuits.[99] Other specialties were encouraged to take advantage of this program but did not. The program expired, and the Maine Bureau of Insurance concluded, "The medical demonstration project had no measurable effect on medical professional liability claims, claims settlement costs, or malpractice premiums."

In 1996, Florida also began a demonstration project for cesarean deliveries, but reportedly "garnered relatively little support among physicians--only 20% of physicians eligible to participate chose to do so and 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)."

Finally, allowing use of guidelines only by a physician or facility to defend itself against a medical malpractice claim and not by an injured patient to show negligence lacks any purpose except to exempt medical providers at injured patients' expense.

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

For medical malpractice insurers, high-pressure tactics have paid off and will pay off again unless Congress takes responsible, remedial steps to reign in the power and control the abuses of

[98] See, http://www.ahrq.gov/clinic/jhppl/rosoff1.htm
[99] See, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2793844/.

insurance companies. Otherwise, we will never be able to deal systematically with the tactics of this industry, which consistently looks for scapegoats to cover up its own instability and mismanagement.

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

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

PATIENT SAFETY IS THE ANSWER, INCLUDING FOR HIGH-COST OBSTETRICAL INJURIES

I served on a New York State medical malpractice task force in 2007 and 2008, which among other things, discussed ways to improve patient safety as the best way to reduce injuries, claims, lawsuits and costs to the system. The presentation by Dr. Ronald Marcus Director of Clinical Operations, Department of Ob/Gyn at Beth Israel Deaconess Medical Center and Assistant Professor of the Harvard Medical School, was instructive. His presentation not only acknowledged the extent of birth injuries caused by OB error, but discussed the reasons for this and proven methods to correct the situation.

Dr. Marcus specifically discussed the concept of team training or crew resource management that was developed by NASA to deal with pilot error. Dr. Marcus found that with crisis management training in OB emergencies, patient outcomes dramatically improved, with a 50 percent decrease in low Apgars, neonatal encephalopathy. With crew resource management in place, he has seen a 23 percent decrease in frequency and 13 percent decrease in severity of adverse events, and a 50 percent decrease in OB malpractice cases. It should be noted that if medical errors were not the cause of a certain birth-related injuries, as some doctors insist, clearly these kinds of statistics would not exist.[100]

[100] See also, Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 (An earlier study by Rosenblatt and Hurst examined 54 obstetric malpractice claims for negligence. For cases in which settlement payments were made there was general consensus among insurance company staff, medical experts and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the cases in which these various reviewers decided there was no lapse in the standard of care.").

CONCLUSION

History is clear on this matter: taking away the rights of the most seriously injured in our society has been and continues to be a failed public policy. Laws and proposals that increase the obstacles sick and injured patients face in the already difficult process of prevailing in court are certainly the wrong way to respond to the important economic problems that face this country. Tort restrictions will add to the deficit and will reduce the financial incentive of institutions like hospitals and HMOs to operate safely, when our objectives should be deterring unsafe and substandard medical practices while safeguarding patients' rights. Indeed, our goal must be to reduce medical negligence. Moreover, effective insurance reforms, like repealing the McCarran-Ferguson Act, are the only way to stop the insurance industry from abusing its enormous economic influence, which it uses to promote a legislative agenda that bilks taxpayers and severely hurts the American public.