THE COST OF THE MEDICAL LIABILITY SYSTEM PROPOSALS FOR REFORM, INCLUDING H.R. 5, THE HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2011

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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C O N T E N T S

WITNESSES

SUBMITTED MATERIAL

THE COST OF THE MEDICAL LIABILITY SYSTEM PROPOSALS FOR REFORM, INCLUDING H.R. 5, THE HELP EFFICIENT, ACCESSIBLE, LOW–COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2011

WEDNESDAY, APRIL 6, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:32 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Whitfield, Shimkus, Myrick, Murphy, Blackburn, Gingrey, Latta, Lance, Cassidy, Guthrie, Barton, Pallone, Dingell, Capps, Schakowsky, Gonzalez, Weiner, and Waxman (ex officio).

Staff Present: Clay Alspach, Counsel, Health; Debbee Keller, Press Secretary; Katie Novaria, Legislative Clerk; John O'Shea, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Heidi Stirrup, Health Policy Coordinator; Phil Barnett, Democratic Staff Director; Stephen Cha, Democratic Senior Professional Staff Member; Alli Corr, Democratic Policy Analyst; Ruth Katz, Democratic Chief Public Health Counsel; Karen Lightfoot, Democratic Communications Director, and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director for Heath; and Rachel Sher, Democratic Senior Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. Subcommittee will come to order. Chair recognizes himself for 5 minutes for an opening statement. An article in Health Affairs in September 2010 titled "National Costs of the Medical Liabilities System" estimated that the medical liability cost including defensive medicine were $55.6 billion in 2008 dollars, or 2.4 percent of total health care spending. According to the Kaiser Family Foundation, total payments on medical malpractice claims in 2009 totaled $3,471,631,100. The average claims payment for 2009 was $323,273.

Let me share with you what this means to my home State of Pennsylvania. According to Kaiser again, Pennsylvania ranks second behind New York in the total dollars paid out in malpractice

claims at $295,459,500 and the average claims payment in Pennsylvania was higher than the national average. Pennsylvania also paid more malpractice claims than any State except New York, California, and Florida with 767 paid claims in 2009. According to the Pennsylvania Department of Health, nearly 20 percent of the physicians who practice primary care say they will leave Pennsylvania in 5 years or less, and only one in three physicians who complete their medical degree in Pennsylvania plan to remain in the State to practice. Over the years, numerous physicians have called my office to tell me how the medical liability climate in Pennsylvania has affected their practices. Usually these are OB–GYNs, but sometimes doctors from other specialties call. Up until a few years ago they would tell me and my staff that while they had planned to practice for 5, 6, or even more years they were retiring early because they just couldn't afford their malpractice insurance premiums. Or, they would say they were forced to move their practices to nearby Delaware State to remain financially viable. Recently doctors have begun to tell me they are moving to North Carolina to set up practice.

Apparently other States have a much less onerous medical malpractice climate and Pennsylvania's loss is their gain. My home State consistently ranks as having one of the worst medical liability climates in the Nation. The high legal costs paid by Pennsylvania healthcare providers increase overall healthcare costs, limit access to medical care, and inhibit job growth. We all agree that patients who are injured by medical mistakes should be promptly and fairly compensated. However, capping non-economic medical malpractice awards does not deny patients their day in court or fair compensation. It merely reigns in over the top verdicts and allows conscientious doctors to afford insurance coverage and serve their patients.

The current medical liability system does not work for anyone especially patients who need access to quality healthcare. Like it or not, patients are inescapably intertwined in this malpractice mess where some receive unlimited court awards and the rest of us are left with limited healthcare and higher cost. We need to find a balance where conscientious doctors can afford insurance coverage and patients can get quality care when and where they need it.

I now yield the rest of my time to Dr. Gingrey.

[The prepared statement of Mr. Pitts follows:]

Rep. Joseph R. Pitts
Opening Statement
Energy and Commerce Subcommittee on Health
Hearing on "The Cost of the Medical Liability System Proposals for Reform, including H.R. 5, the Help Efficient, Accessibly, Low-cost, Timely Healthcare (HEALTH) Act of 2011"
April 6, 2011

The Subcommittee will come to order.

The Chair will recognize himself for an opening statement.

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According to the Kaiser Family Foundation, total payments on medical malpractice claims in 2009 totaled $3,471,631,100. The average claims payment for 2009 was $323,273.

Let me share with you what this means to my home state of Pennsylvania.

Again, according to Kaiser, Pennsylvania ranked second, behind New York, in the total dollars paid out in malpractice claims at $295,459,500, and the average claims payment in Pennsylvania was higher than the national average.

Pennsylvania also paid more malpractice claims than any state except New York, California, and Florida, with 767 paid claims in 2009.

According to the Pennsylvania Department of Health, nearly 20 percent of the physicians who practice primary care say they will leave Pennsylvania in five years or less; and only one in three physicians who complete their medical degree in Pennsylvania plan to remain in the state to practice.

Over the years, numerous physicians have called my office to tell me how the medical liability climate in Pennsylvania has affected their practices. Usually, these are OBGYNs, but sometimes doctors from other specialties call.

Up until a few years ago, they would tell me and my staff that while they had planned to practice for five, six, or even more years, they were retiring early because they just couldn't afford their malpractice insurance premiums.

Or they would say they were forced to move their practices to nearby Delaware to remain financially viable. Recently, doctors have begun to tell me they are moving to North Carolina to set up practice.

Apparently, other states have a much less onerous medical malpractice climate, and Pennsylvania's loss is their gain.

My home state consistently ranks as having one of the worst medical liability climates in the nation. The high legal costs paid by Pennsylvania health care providers increase overall health care costs, limit access to medical care, and inhibit job growth.

We all agree that patients who are injured by medical mistakes should be promptly and fairly compensated.

However, capping non-economic medical malpractice awards does not deny patients their day in court or fair compensation. It merely reins in over-the-top verdicts and allows conscientious doctors to afford insurance coverage and serve their patients.

The current medical liability system does not work for anyone, especially patients who need access to quality health care.

Like it or not, patients are inescapably intertwined in this malpractice mess, where some receive unlimited court awards and the rest of us are left with limited healthcare and higher costs.

We need to find a balance where conscientious doctors can afford insurance coverage and patients can get quality care when and where they need it.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Mr. Chairman, thank you so much for yielding to me on such an important issue. And as we know this country is on the verge of a medical liability crisis.

Focusing on just my specialty, Obstetrics and Gynecology, each OB–GYN will be sued three times in their careers. Think about 25 to 30 years of practice. Even though 50 percent of these cases are eventually dropped, dismissed, or settled without a payment for the plaintiff, 30 percent of OB–GYN fellows report increasing cesarean deliveries over traditional birth, but the rate in this country is probably now 29 percent. Twenty-six percent have stopped performing or offering traditional births altogether over this fear of being sued and ending their career. But why is this significant?

As I say, the cesarean sections can cost our health system twice as much if not three times as much as routine vaginal birth and that is just one example of what is referred to as defensive medicine. It is a glaring example, however. The order of tests or procedures simply to protect a medical provider from a lawsuit is really mounting. You can't get—go to emergency room with a headache without coming out with a bill for a CT scan or an MRI.

Studies, most notably one that was done by Pricewaterhouse Coopers, show that this defensive practice that doctors are engaging in across all specialties quite frankly resulted in about $210 billion in additional healthcare costs in 2008 and today these costs are certainly much higher because of the Patient Protection and Affordable Care Act. I have realized my time is running pretty short here and I know I am going to have to yield back, but I want to thank the chairman for yielding time. Maybe I can get someone else to yield me a little bit more time so I can finish my full statement, but it will go in the record and this is hugely important. I am so grateful for the witnesses and I look forward to your testimony. And I yield back, Mr. Chair. Thank you for the time.

Mr. PITTS. The Chair thanks the gentleman. The Chair recognizes the ranking member of the subcommittee, Mrs. Capps, for 5 minutes.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. CAPPS. Thank you, Mr. Chairman. Before we begin this hearing I would like to say that this is a bill we have heard before; a bill on which we have disagreed before. While the goal is clear, meaningful tort reforms that protect patients and medical professional and reduce healthcare costs it is also clear that differences in our approach remain. We certainly should be looking at ways to bring down the cost of medical malpractice insurance, but the bill before us today only limits the amount of money that patients who have been wrongfully harmed can collect to compensate them for their injuries. It does nothing to solve the root of that problem, reducing the incidents of malpractice.

I believe we should be focused on improving patient care and reducing the astounding number of costly, preventable, medical errors that claim 98,000 lives every year. Reducing medical errors would not only save lives, it would save a lot of money. And as the

number of studies have shown, focusing on improving patient care and reducing error has led to dramatic drops in medical malpractice payment. These medical—these studies are instructive on how to reduce the actual not-hypothetical cost of malpractice.

Another area where I think we should set the record straight is the notion that excessive or frivolous lawsuits are because of rising premiums. The problem is that the lawsuits affected by the bill are by definition not frivolous. Where large damages are awarded the jury has found that the patient has been severely harmed. And in fact, over the last 5 years malpractice insurance payments to patients have actually gone down all while premiums have continued to go up which raises the question of what is the real driving force for these expenses. There is also no evidence that capping the damages an injured person receives because of malpractice is the most effective way to solve this problem. It will not lower premiums. It will not even stabilize them. Instead, this proposal will penalize innocent victims of medical neglect—negligence.

Furthermore, H.R. 5 goes far beyond protections between patients and doctors. In fact, what is concerning is the extent to which this bill would protect drug companies and HMOs from lawsuits in cases where they have clearly hurt people. This expands the issue far beyond what many feel is the proper scope of this type of policy.

Lastly, we disagree about the extent of what the Federal Government's role in tort reform should be. At our Governors' hearing a few weeks ago, we repeatedly heard these Governors stress that the needs of their States were different from one another and that to meet the needs of their states they needed flexibility. I find it ironic that this majority who for so long has been champions of State government, State and local control are supporting a bill that would impose a Federal one-size-fits-all solution with no flexibility in an area that has been traditionally a matter of State law. I believe there can be State solutions to this problem and I am interested in seeing how the provisions of the Affordable Care Act can help solve them. The healthcare law authorizes $50 million over 5 years in grants to States to explore new approaches to settling losses including health court and disclose and offer models. This commitment to State solutions is also echoed in the President's budget which this year proposes $250 million in grants for States to rewrite their own malpractice laws in ways that seek to balance the interest of both doctors and patients. I look forward to seeing the innovative State solutions that these grants will spur. Despite the good intentions for this bill, H.R. 5 does not help patients. It does not help the medical profession move toward lowering healthcare costs in a really meaningful way. Instead, it just shifts the costs of malpractice from the party at fault to injured individuals, their families, and taxpayers through publicly funded programs such as Medicare, Medicaid, and disability benefits. And I yield back the balance of my time.

Mr. PITTS. Chair thanks the gentlelady and now recognizes the chairman emeritus of the full committee, Mr. Barton, for 5 minutes.

Mr. BARTON. Thank you, Mr. Chairman, and I am going to yield some of that time to Dr. Burgess and also to Dr. Gingrey.

Thank you for holding this hearing. As we have seen in my home State of Texas, medical malpractice reform can work. In Texas they have had cost savings of over $879 million. They have also added 21,640 positions since they did reform back in 2003. Of those 21,640 new doctors, over 1,200 have come from the great State of New York. In 2003, New York and Texas had basically the same medical malpractice premiums. Since Texas implemented its reform package, Texas's premiums have decreased by 28 percent while New York State's—excuse me, have increased by over 60 percent. The result is obvious. Doctors are coming to Texas. They are leaving New York. This is going to be a good hearing, and we look forward to our testimony from our witnesses. And at this point in time I would like to yield 3 minutes to Dr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. And I thank the gentleman for yielding. Mr. Chairman, this is an important hearing. First want to welcome Dr. Lisa Hollier who is an OB–GYN like me from Texas, that is—and she is going to share with us some of the good news that has come from on the ground, in the State of Texas since 2003 when Texas enacted its own liability reform—truly a 21st century solution to a problem that has been with us for a long time.

Now, the President in his State of the Union Address said that medical malpractice reform is needed to reign in frivolous lawsuits. Mr. President, I could not agree more. In fact, the very next morning I penned a letter in my own hand as you can see to the President saying "I want to work with you on this." He asked for ideas from on both sides of the aisle. I sent the letter down to the White House. I will ask unanimous consent to insert this as part of the record and Mr. President, I am still waiting on a response and I was serious about this offer. As you can see from this hearing, many of us are serious about this today.

I am so painfully aware that many doctors are forced to practice defensive medicine, or retire, or run for Congress in the face of constant threat of non-meritorious lawsuits and unsustainable medical liability insurance. I do not believe we need to study this anymore. In Texas, we know what works. Liability reform served as a catalyst to bring doctors to underserved regions of the State including those that had no access to a physician in the past.

Texas is one of the largest States in the Union, has a diverse population, diverse economy and geography, yet our reforms have proven successfully tailored to adapt and produce across-the-State results. Eighty-two Texas counties have seen a net gain in emergency room doctors including 26 counties who had none. The Texas State Board of Medical Examiners in 2001 licensed 2,088 new doctors, the fewest in a decade. Today, they are challenged to keep up with the physicians who now want to practice in our State. In 2008, over 3,600 new doctors—the highest number ever recorded. In my field of obstetrics, Texas saw a net loss of 14 obstetricians in the 2 years prior to reform. Since then the State has experience a net gain of 192 obstetricians and over 25 rural counties that never had one now do.

Texas has enjoyed a 62 percent greater growth in newly licensed physicians in the past 3 years compared to the 3 years preceding liability reform Texas has benefitted. I am happy to share this success that we are experiencing so that all States can reap the benefit. I have introduced H.R. 896 based on Texas reforms but there are other ideas from small to bold and we should be considering them. At this point I will yield the balance of the time to Dr. Gingrey.

[The information follows:]

MICHAEL C. BURGESS, M.D.
26TH DISTRICT, TEXAS

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January 26, 2011

President Barack Obama
The White House
1600 Pennsylvania Ave, NW
Washington, DC 20500

Dear Mr. President,

I listened intently last night as you delivered your third State of the Union address. While there were many topics included that hold a deep personal interest for me, I write to you today regarding the commitment you made to work with Republicans on tackling, "medical malpractice reform to rein in frivolous lawsuits" which are causing seasoned medical professional to leave their practice. I know this is an issue you have broached before, and I once again ask to join you in efforts to actively produce results that will have an impact.

As a physician, I am painfully aware that many doctors are forced to practice defensive medicine and face the constant threat of non meritorious lawsuits and unsustainable medical liability insurance rates. This results in unnecessary tests and procedures, and is a growing crisis which is pushing affordable health care but more importantly, access to physicians, beyond the grasp of many Americans. Also, rising insurance costs force doctors to make difficult decisions. Many doctors are also small business owners who are forced to trim their budget just to cover their insurance costs. In many cases this results in laying off staff, limiting access to certain aspects of their practice or closing their practice all together.

The States rightfully have, are, and will continue to be our laboratories of success. Let me be clear: I do not believe we need to study what *may* work; the states have done that work for us. However, in our pursuit of national medical malpractice reforms, it is vital we look to the states for proven methods and results.

As we make such an examination it is essential we look to those states that have *recently* enacted reform and produced just such results. Just as doctors, first we must do no harm. We do not want to interfere with progress made. However, as we look for commonsense policies that could be applied nationally or throughout the federal government, those successes which have been adopted in recent years and yielded proven success seem to not only be the logical, but the necessary places to explore.

In my home state of Texas, the 2003 liability reforms we adopted have served as a catalyst to bring doctors to underserved regions including those that did not have access to any physicians. Texas is one of the largest states in our Union, has a diverse population & economy and geography stretching from rural to urban. Yet, our reforms have proven successfully tailored to adapt and produce across the board results. For example, 82 Texas counties have seen a net gain in emergency room doctors including 26 counties which previously had none. After years in decline, the ranks of medical specialties, as well as primary care, are growing and charity care rendered by Texas hospitals has increased by 24 percent. The Texas State Medical Board in 2001 licensed only 2,088 new doctors the fewest in a decade. Today they are challenged to keep up with the physicians that now want to practice in our state. In 2008 Texas licensed 3,621 new doctors, the highest number ever recorded. Overall, Texas has enjoyed a 62% greater growth rate in newly licensed physicians in the past three years compared to three years preceding reform. While I am thrilled that Texas has so benefited, I am also happy to share the success we are experiencing to all states so that they too can reap the benefit of adopting such reforms.

But our conversation should not end there and states should be permitted to continue to act as laboratories in exploring and implementing new policies for pursuing medical liability reform. We can always do better and we are an ever changing nation. What we know we can do today, should not be the limit of our imagination of what we may be able to deliver tomorrow to ensure access to needed healthcare providers to our citizens; just as what may have worked decades ago, may not be a panacea for today's challenges. I am committed to finding areas of collaboration between the political parties to enact meaning reform which is beneficial to all Americans.

I agree that the urgency of this issue is one that cannot wait any longer for us to fully partner with our states to aid patients. I would greatly appreciate opportunity to review this issue and work together to achieve this goal that we both share. I would be honored if your staff would contact my Washington, D.C. office at 202-225-7772 to schedule a meeting.

Sincerely,

Michael C. Burgess, M.D.
Member of Congress

Mr. GINGREY. Yes, Mr. Chairman, I appreciated the vice chairman for yielding to me. I was beginning to like the sound of my voice when I got cut off a few minutes ago.

I was talking about the Provider Shield Act. I want to get to the more important act, H.R.5, but as Mr. Waxman, the Committee Ranking Member knows himself there is a growing concern among the provider and business community that Obamacare will increase the threat of liability tremendously and drive many providers out of practice if they follow their own medical subspecialty guidelines over the treatment edicts of Secretary Sebelius. And that bill, then H.R. 816 the Provider Shield Act would protect medical providers from these edicts and it has gained some bipartisan support.

But even if H.R. 816 becomes law, the crises that $200 billion in costs will inflict on our healthcare system remains and therefore I have introduces and we will talk about a bi-partisan bill legislation H.R. 5 the Health Act, along with Congressman David Scott and Chairman Lamar Smith of the Judiciary Committee to help bring meaningful medical liability reform to this country once and for all. If healthcare costs are truly a national concern then solutions to bring down these costs are desperately needed. And with that Mr. Chairman, I will yield back the expired time.

Mr. PITTS. Chair thanks the gentleman. If there is no one else from the minority wishing to make an opening statement I will now welcome and introduce our distinguished panel of witnesses. I would like to thank you for appearing before the committee this morning. Your willingness to take time out of your busy schedules underscores just how important this issue is to all of you as it is to all of us.

Your written testimony will be made a part of the record. We ask that you take 5 minutes each to summarize your testimony and at this point I will introduce the witnesses in which order I ask them to testify.

The first witness is Dr. Lisa Hollier. Dr. Hollier practices obstetrics and gynecology in Houston, Texas and is a Professor of OB–GYN and Director of the Lyndon B. Johnson Residency Program at the University of Texas Medical School at Houston. She is also a fellow of the American College of Obstetricians and Gynecologists.

The next witness is Ms. Joanne Doroshow. Ms. Doroshow is President and Executive Director, Center for Justice and Democracy, a public Interest organization in New York City that is involved in educating the public about issues relating to civil justice system.

The next witness is Dr. Allen Kachalia. Dr. Kachalia is a practicing physician at Brigham and Women's Hospital Harvard Medical School. He is the Medical Director for Quality and Safety at Brigham and Women's Hospital. He also has a law degree and conducts research and teaches about legal matters in medicine including the Medical Professional Liability System.

The next witness is Mr. Brian Wolfman. Mr. Wolfman has been a practicing lawyer for more than 25 years. He is a Visiting Professor of Law and Congress-Director, Institute for Public Representation at Georgetown Law School. He also spent almost 20 years with the Litigation Group of Public Citizen in Washington, DC.

And the final witness is Dr. Troy Tippett. Dr. Tippett is a practicing neurosurgeon with more than 35 years of experience. He is also past President of both the American Association of Neurological Surgeons and the Florida Medical Associations. Thank you for coming this morning. Dr. Hollier, you are recognized for 5 minutes.

STATEMENTS OF LISA M. HOLLIER, MD, MPH, FELLOW, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PROFESSOR AND DIRECTOR, LYNDON B. JOHNSON RESIDENCY PROGRAM, UNIVERSITY OF TEXAS MEDICAL SCHOOL AT HOUSTON; JOANNE DOROSHOW, EXECUTIVE DIRECTOR THE CENTER FOR JUSTICE AND DEMOCRACY; ALLEN B. KACHALIA, MD, JD, MEDICAL DIRECTOR OF QUALITY AND SAFETY, BRIGHAM AND WOMEN'S HOSPITAL, HARVARD MEDICAL SCHOOL; BRIAN WOLFMAN, VISITING PROFESSOR, GEORGETOWN UNIVERSITY LAW CENTER, CO–DIRECTOR, INSTITUTE FOR PUBLIC REPRESENTATION; AND TROY M. TIPPETT, MD, PAST PRESIDENT, AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS, PAST PRESIDENT, FLORIDA MEDICAL ASSOCIATION

STATEMENT OF LISA M. HOLLIER

Ms. HOLLIER. Thank you, Chairman Pitts. We applaud you and the subcommittee for holding this hearing. My name is Dr. Lisa Hollier and I am an obstetrician/gynecologist from Houston, Texas speaking on behalf of the American Congress of Obstetricians and Gynecologists (ACOG), an organization representing more than 54,000 physicians and partners in women's health dedicated to improving the healthcare of women. ACOG ultimately could not support passage of the Health Reform Bill in large part because it didn't include meaningful liability reform, an issue we see as critical to reforming our healthcare system.

We simply cannot build a reformed healthcare system on top of the broken medical liability system. Without meaningful reform, the doctors will continue to be driven out of their home States or out of their practices. When OB–GYNs discontinue the practice of obstetrics, curtail their surgical services or close their doors, women's healthcare suffers. For these reasons, ACOG strongly supports H.R. 5, the Health Efficient Accessible Low-Cost Timely Healthcare Act introduced by ACOG fellow representative, Phil Gingrey.

Additionally, we appreciate the support from the 17 Members of the committee who have cosponsored H.R. 5 including seven on the health subcommittee. Thank you Representatives John Shimkus, Mike Rogers, Sue Myrick, Marsha Blackburn, Bob Latta, Cathy McMorris Rodgers, and Brett Guthrie.

Every day OB–GYNs are faced with exposure to law suits. In fact, 90 percent of ACOG fellows report that they have been sued at least once and OB–GYNs are sued an average of 2.7 times during their careers. Nearly two-thirds of OB–GYNs have changed their practice during the last 3 years because of the high risk of liability claims. These changes include increasing the number of cesarean deliveries, reducing or not offering trial of labor after cesarean, decreasing the number of high-risk patients they accept, and

even stopping the practice of obstetrics altogether due to professional liability concerns. The average age at which physicians cease practicing obstetrics is now 48, an age once considered the midpoint of an OB–GYN's career.

Our current tort system fails providers and fails patients. It is costly, time consuming, inefficient, and unjust with widely variable and unpredictable monetary judgment. The system is wholly incompatible with the Institute of Medicine's vision for the future healthcare system as safe, effective, patient centered, timely, efficient, and equitable. This is a national problem which demands a national solution.

That national solution including caps on noneconomic damages and other reforms like those found in Texas and California would stabilize the medical liability insurance market, reduce healthcare cost, eliminate physician flight from high risk States and protect a patient's access to the healthcare they need. This is why we fully support H.R. 5, the Health Act.

H.R. 5 promotes speedy resolution of claims, fairly allocates responsibility, compensates patient injury, maximizes patient recovery, puts reasonable limits on the awarded punitive damages, ensures payment of medical expenses, allows State flexibility, and saves the Federal Government money. We know these reforms work. The landscape in my home State of Texas changed dramatically after implementing medical liability reform in 2003.

Statewide, 21,640 doctors have been newly licensed in Texas since its passage. Texas physicians have also seen their liability insurance premiums cut on average 28.3 percent and claims and lawsuits in most Texas counties have been cut in half. Additionally the State has gained 269 obstetricians after a net loss of 14 obstetricians from 2001 to 2003. Twenty-two rural counties added at least one obstetrician and 10 counties added their first obstetrician. Blanco County which had no obstetrician's pre-reform added eight. In all, 57 Texas counties have seen a net gain in obstetricians including 28 medically underserved counties and 20 counties designated as partially medically underserved.

These figures show that a primary result of these reforms is increased access to care for women across Texas. H.R. 5 holds the promise that increased access to care for even more women nationwide. We urge this subcommittee and the U.S. House to give H.R. 5 speedy approval so that we can better serve our patients. Thank you, Chairman Pitts for your commitment and your leadership on this issue.

[The prepared statement of Ms. Hollier follows:]

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Testimony of

Lisa M. Hollier, M.D., MPH

On Behalf of

The American Congress of Obstetricians and Gynecologists

to the

Energy and Commerce Committee

Subcommittee on Health

United States House of Representatives

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

April 6, 2011

Summary:

- ACOG ultimately could not support passage of the health reform bill, in large part because it didn't include meaningful medical liability reform, an issue we see as critical to reforming our health care system.

- Without meaningful reform, good doctors will continue to be driven out of practice or out of their home states. When ob-gyns discontinue the practice of obstetrics, curtail surgical services, or close their doors, women's health care suffers.

- Every day Ob-gyns are faced with exposure to lawsuits for adverse events over which they had no control – unfortunate outcomes, rather than malpractice -- with jury awards that exceed $100 million. For example, neurologically impaired infant cases account for 30% of obstetric claims, with average awards of nearly $1 million, despite well-regarded scientific studies showing that physician action has little to do with these outcomes.

- 90% of ACOG Fellows report they have been sued at least once and ob-gyns are sued an average of 2.7 times during their careers. Nearly two thirds have changed their practice during the last three years because of the high risk of liability claims. The average age at which physicians cease practicing obstetrics is now 48.

- Our current tort system fails patients and providers. It is costly, time-consuming, inefficient, and unjust, with widely variable and inconsistent monetary judgments awarded by lay juries to injured patients. It cannot accurately distinguish bad outcomes from genuine negligence.

- A national solution, including caps on non-economic damages, and other reforms like those found in Texas and California would stabilize the medical liability insurance market, reduce health costs, eliminate physician flight from high-risk states, and protect patients' access to needed care.

- The landscape in Texas changed dramatically after implementing medical liability reform in 2003. Statewide, 21,640 doctors have been newly-licensed in Texas since its passage. Texas physicians have also seen their liability insurance rates cut, on average, 28.3 percent and claims and lawsuits in most Texas counties have been cut in half.

- Texas has gained 269 obstetricians, after a net loss of 14 obstetricians from 2001 to 2003. Twenty-two rural counties added at least one obstetrician and ten counties added their first obstetrician. Blanco County, which had no obstetricians pre-reform, added eight. In all, 57 Texas counties have seen a net gain in obstetricians, including 28 medically underserved counties and 20 counties designated partially medically underserved.

Thank you, Chairman Pitts, for holding this important hearing, entitled "The Cost of the Medical Liability System Proposals for Reform, including H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011." I am Dr. Lisa Hollier, an ob-gyn from Houston Texas, representing the American Congress of Obstetricians and Gynecologists (ACOG), an organization representing more than 54,000 physicians dedicated to improving the health care of women. Thank you for the opportunity to present our views.

ACOG worked hard to win many of the provision in the Affordable Care Act that are important for women's health, including private insurance reforms. Ultimately, though, we could not support passage of the health reform bill, in large part because it didn't include meaningful medical liability reform, an issue we see as critical to reforming our health care system. We simply cannot build a reformed health system on top of a broken medical liability system.

Without meaningful reform, good doctors will continue to be driven out of practice or out of their home states. And when ob-gyns discontinue the practice of obstetrics, refuse high-risk patients, or reduce their ob surgical practice, women's health care suffers. For these reasons, ACOG strongly supports H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act, introduced by ACOG Fellow Representative Phil Gingrey, MD. Chairman Pitts, we applaud you and the Subcommittee for holding this hearing. Additionally, we appreciate the support from the seventeen members of the Committee who have co-sponsored H.R. 5, including seven members on the Health Subcommittee. Thank you, Representatives John Shimkus, Mike Rogers, Sue Myrick, Marsha Blackburn, Bob Latta, Cathy McMorris Rodgers, and Brett Guthrie.

In childbirth, there is never a guarantee of a perfect outcome, even for patients who receive perfect ob-gyn care. Obstetrician-gynecologists are faced daily with exposure to lawsuits for adverse events over which they had no control – unfortunate outcomes, rather than malpractice -- with jury awards that exceed $100 million. Neurologically impaired infant cases account for 30% of claims, with average awards of nearly $1 million. Highly respected scientific studies have shown, though, that few of these cases were caused by the physician. Clearly, a high number of claims does not mean medical negligence.

- Ob-gyns win 80% of claims filed against them.
- Over one-half of claims are dropped, dismissed, or settled without payment.
- Ob-gyns win 7 out of 10 cases by a jury or court verdict.

Our Nation provides exceptional medical education, training some of the world's finest obstetricians and gynecologists. Yet, 90% of ACOG Fellows report they have been sued at least once. On average, ob-gyns are sued 2.7 times during their careers, and nearly 63% have changed their practice during the last three years because of the high risk of liability claims. 35% have either decreased the number of high-risk obstetric patients treated or have ceased providing obstetric care altogether; 29.1% increased the number of cesarean deliveries; and 25.9% stopped performing or offering VBACs due to professional liability concerns. The average age at which physicians cease practicing OB is now 48, an age once considered the midpoint of an ob-gyn's career.

I. The Need For Reform

In 2002, the non-partisan Institute of Medicine reported that:

> *"The current liability system hampers efforts to identify and learn from errors, and likely encourages 'defensive medicine". Many instances of negligence do not give rise to lawsuits, and many legal claims do not relate to negligent care. ... Volatility in liability insurance markets has led to... closure of practices and shortages of certain types of specialists and services. The committee believes that changes in the liability system are a critical component of health care system redesign."*

Our current tort system is costly, time-consuming, inefficient, and unjust, with widely variable and inconsistent monetary judgments awarded by lay juries to injured patients. It cannot accurately distinguish bad outcomes from genuine negligence and it has the potential to devastate the practice of obstetrics. The system is wholly incompatible with the Institute of Medicine's vision of the future health care system as "safe, effective, patient-centered, timely, efficient, and equitable."

The Financial Burden on a Few "High-Risk" Specialties.

It takes years to settle and adjudicate cases, delays are onerous, and the costs of defending oneself are enormous. It has been estimated that patients who eventually receive compensation through the current system obtain less than 50% of the amount awarded. The remainder goes largely to the plaintiff's lawyer and court expenses.

The costs of the current tort system are borne by all obstetric caregivers -- nurses, residents, attending MDs, CNMs, and even medical students -- and the hospitals where they work, through the escalation of medical liability premiums. This contributes to a reduction in obstetric care by those currently practicing and in the number of American medical school graduates choosing to enter obstetric residency programs. As a consequence, the quality and availability of care for future generations of women in this country is threatened.

Defensive Medicine

Even though a very high percentage of liability claims are dropped, settled without payment or settled in favor of the defendant in court, the effect of fear of litigation is significant. Recent ACOG surveys show that obstetricians are performing more cesarean sections, discontinuing vaginal births after c-section (VBAC) attempts, decreasing the number of high-risk patients they are willing to care for, decreasing the total number of deliveries they do in a year, or discontinuing obstetrics entirely due to the current liability climate.

Patient Safety and Quality of Care

Meaningful reform of our broken liability system, in addition to reducing and stabilizing medical liability premiums, can make medical care safer and reduce medical errors. To further quality, comparative effectiveness medical research should take into account the role of medical liability laws in driving up health care costs and influencing practice patterns and behavior including defensive medicine. The liability climate should also be considered when assessing large variations across the country in prematurity rates and cesarean section rates.

Success in Texas

The medical liability landscape in Texas changed dramatically after implementing medical liability reform. Statewide, 21,640 doctors have been newly-licensed in Texas since passage of the 2003 reforms. The state has gained 269 obstetricians, after a net loss of 14 obstetricians from 2001 to 2003. Twenty-two rural counties added at least one obstetrician and ten counties added their first obstetrician. Blanco County, which had no obstetricians pre-reform, added eight. In all, 57 Texas counties have seen a net gain in obstetricians, including 28 medically underserved counties and 20 counties designated partially medically underserved.

Texas physicians have also seen their rates cut, on average, 28.3 percent and claims and lawsuits in most Texas counties have been cut in half. Ninety percent of Texas doctors have seen their rates slashed 30 percent or more.

A National Problem Demands a National Solution.

A majority of states continue to perpetuate a system that is needlessly expensive, inefficient, and often inequitable, while year after year rejecting significant efforts to rectify its flaws. The federal government can break the logjam. A national solution would stabilize the medical liability insurance market, reduce health costs, eliminate physician flight from high-risk states, and protect patients' access to needed health care. The federal government should provide adequate funding and other resources to states and health systems to test innovative solutions to a broken liability system as recommended by the Institute of Medicine.

II. A National Solution: H.R. 5 – The HEALTH Act

ACOG has for many years advocated reform of our broken medical liability system, including caps on non-economic damages, and other reforms like those found in Texas and California. We fully support H.R. 5, The HEALTH Act, introduced by ACOG-member Rep. Phil Gingrey, MD (R-GA), which would safeguard patients' access to health care and address the health care crisis.

Promotes Speedy Resolution of Claims

The Act balances the needs of all parties involved in litigation and promotes a fair result. Health care lawsuits can be filed no later than 3 years after the date of injury. Additionally, the bill aeknowledges that in some circumstances, it is important to guarantee patients additional time to file a claim. Aceordingly, the Act extends the statute of limitations for minors injured before age six.

Fairly Allocates Responsibility

Under the current system, defendants who are only 1% at fault may be held liable for 100% of the damages. This bill eliminates the incentive for plaintiffs' attorneys to search for "deep pockets" and pursue lawsuits against those minimally liable or not liable at all.

Compensates Patient Injury

H.R. 5 ensures injured patients are fairly and fully compensated. The Act does not limit the amount a patient can receive for physical injuries resulting from a provider's care, unless otherwise determined by state law. The Act only limits unquantifiable non-economic damages, such as pain and suffering, to no more than $250,000.

Maximizes Patient Recovery

Patients will receive the money needed for their health care. H.R. 5 discourages baseless lawsuits by limiting the incentive to pursue merit-less claims. Without this provision, attorneys could continue to routinely pocket large percentages of an injured patient's award.

Puts Reasonable Limits, Not Caps, on the Award of Punitive Damages

The Act provides for reasonable punishment without unnecessarily jeopardizing a defendant's fundamental constitutional rights or risking the defendant's bankruptcy. It does not cap punitive damages, rather, it delineates a guideline, allowing for punitive damages to be the greater of two times the amount of economic damages awarded or $250,000.

Ensures Payment of Medical Expenses

H.R. 5 ensures that injured patients will receive all of the damages to which they are entitled in a timely fashion without risking the bankruptcy of the defendant. Past and current expenses will continue to be paid at the time of judgment or settlement while future damages can be funded over time through the purchase of an annuity or other instrument of secured payment.

Allows State Flexibility

The HEALTH Act establishes a ceiling on non-economic damages, and guidelines for the award of punitive damages, only in those states where the state legislature has failed to act. A state legislature may also act at any time in the future to impose a cap the limits of which differ from those provided for in the HEALTH Act.

Saves Money

The Congressional Budget Office estimates that H.R. 5 would save the federal government $54 billion over ten years, incorporating savings from all provisions including the collateral source rule. Direct savings come from lowering premiums for medical liability insurance and indirect savings by reducing defensive medicine. These reductions in costs would lead to lower spending in federal health programs and lower private health insurance premiums.

III. Alternatives to Current Medical Tort Litigation

ACOG is fully committed to the enactment of a national law, patterned on H.R. 5 and the Texas and California medical liability reforms. Only these solutions will fully and meaningfully solve this problem.

While we work to attain that goal, we support interim measures that address the long delays, excessive costs, and unpredictability and inequality of compensation in our current system. Successful alternatives could help guarantee that injured patients are compensated fairly and quickly while promoting quality of care and patient safety.

Early Offer

Early offer programs would allow a physician or hospital to offer economic damages - past, present, and future - to an injured party without involving the courts. This offer would not constitute an admission of liability and would be inadmissible if a lawsuit was filed in the case. Physicians would have incentives to make good faith offers as early as possible after the injury is discovered and patients would have incentives to accept legitimate offers of compensation.

Early offer programs would require the injured party to meet a higher burden of proof and negligence standard if she chose to reject the offer and file a lawsuit.

Health Care Courts

Health care courts would allow for a bench or jury trial presided over by a specially trained judge to exclusively hear medical liability cases. A judge with specialized training would resolve disputes with greater reliability, consistency, and efficiency than untrained judges or juries, and could issue opinions that define standards of care or set legal precedent. De-identified claims information would enable patient safety authorities and providers to examine and correct patterns of errors.

Expert Witness Qualifications

This alternative would limit expert witness standing only to individuals who are licensed and trained in the same specialty as the defendant, have particular expertise in the disease process or procedure performed in the case, were in active medical practice in the same specialty as the defendant within 5 years of the claim, or taught at an accredited medical school on the medical care and type of treatment at issue.

I'm Sorry

These programs encourage physicians to directly discuss errors and injuries with a patient, apologize, and discuss corrective action. The apology is not permitted to be constructed as, or offered as evidence of, an admission against the physician's interest. Discussions are inadmissible if the patient brings a lawsuit.

Defined Catastrophic Injury Systems

These systems would establish a fund for individuals with bad outcomes regardless of fault. Birth injury funds are an example. Florida's program supports children born with substantial, non-progressive, neurologic motor deficits not caused by genetic or metabolic conditions.

Certificate of Merit

A certificate of merit program would require plaintiffs to file an affidavit with the court showing that the case has merit before the case can move forward. Certificates would require the written opinion of a qualified health care provider affirming that the defendant failed to meet the standard of care exercised by a reasonably prudent health care provider, which caused or directly contributed to the damages claimed.

IV. Conclusion

Thank you again for the opportunity to provide this statement to the House Energy and Commerce Subcommittee on Health on the issue of medical liability. We applaud your commitment and leadership on this issue, Chairman Pitts, and look forward to working closely with you and the Subcommittee to win passage in the House and consideration in the Senate.

Mr. PITTS. Chair thanks the gentlelady and recognizes Ms. Doroshow for 5 minutes.

STATEMENT OF JOANNE DOROSHOW

Ms. DOROSHOW. Thank you, Chairman Pitts and members of the committee. The Center for Justice and Democracy of which I am Executive Director is a national public interest organization dedicated to educating the public about the importance of the civil justice system. My testimony will focus primarily on medical malpractice issues since these issues clearly are the driver for H.R. 5.

I would like to first note that thanks to 30 years of insurance and medical industry lobbying the medical profession now has more legal protections for their negligence than any other profession in the country. As a result the number of injured patients bringing medical malpractice claims has reached historic lows. At the same time, premiums have been stable or dropping since 2006 and have further to drop until the soft market ends and this is no matter whether a State has passed tort reform or not.

Despite this, a myth exists of medical malpractice litigation is a huge driver of our healthcare costs. This is even though the Congressional Budget Office found that H.R. 5 would result in extremely small healthcare savings, about 0.4 percent. Of this, a trivial amount, 0.3 percent or less is due to slightly less utilization of healthcare services that is defensive medicine and 0.2 percent or less is due to reduced insurance premiums for doctors. As small as these figures are even they are inflated because CBO ignored factors that would likely increase the deficit.

In fact, when I met with CBO to discuss these admissions, they did not deny that liability restrictions lead to more injuries and deaths and could create new burdens on States and Federal deficits since the cost of injuries are not eliminated by enacting tort reform but merely shifted on to some—on someone else including the government. In fact, one of the three studies CBO does mention now that there would be a 0.2 percent increase in the Nation's overall death rate by enactment of H.R. 5. How could this possibly be an acceptable trade off?

And it is not like we don't have history as a guide here. In fact, history repeatedly shows for example that capping damages will not lower insurance rates because what drives these rate hikes has nothing to do with the State's tort law. It is driven by the insurance underwriting cycle and investment income and remedies that do not specifically address this cycle will fail to stop these wild price gyrations in the future. In fact, when I returned to New York we will be preparing a major new campaign to expose the insurance industry's major role in the pricing of medical malpractice insurance and to hold them accountable for creating cyclical insurance crises for doctors in this country. And we hope everyone on this panel joins us in this.

As for H.R. 5, this bill would establish a permanent across-the-board $250,000 cap on compensation for noneconomic damages in medical malpractice cases. Noneconomic damages compensate for injuries like permanent disability, disfigurement, blindness, loss of a limb, a damaged reproductive system, paralysis, or physical pain and suffering. Such caps are incredibly cruel and unfair.

H.R. 5 would also limit State statute limitations laws, an idea that lacks complete logic from a deficit reduction standpoint since its only impact would be to cut off meritorious claims. It would impose national wage controls on an injured patient's attorney preventing the patient from getting decent legal assistance. It would limit punitive damages even though only 1 percent of medical malpractice plaintiffs even receive punitive damages. Where is the crisis demanding that Congress interfere with State law in this area?

It would eliminate joint several liabilities which CBO itself says could cause a deficit increase not decrease. Dr. Lora Ellenson, a pathologist at New York Presbyterian Hospital whose now 13-year-old son Thomas was brain damaged at birth due to negligence last month told the New York Daily News "My son cannot walk or talk. He is not able to carry out activities of daily living: eating, dressings, toileting, bathing without constant assistance from an adult. As a physician I have to come face to face with the knowledge that mistakes are made. Like most physicians I live with the reality that we might one day make an error and be sued. When that day comes I will be grief stricken. Not because of the process, although I am sure that won't be pleasant, but due the fact that I may have caused someone irreparable damage. My only hope is that the damaged person can get what they need to live in the best way they are able. As a physician I want to know that there will be compensation to rebuild a life that has been diminished, yet as a mother I also know that no typical physician nor the system within which they operate can possibly understand the true depths of these mistakes." I wish Dr. Ellenson's perspective were more represented by the physicians on this panel today. A study done in her hospital and other studies around the country have found that implementing comprehensive patient safety programs not only decreased severe adverse outcomes, but can also have an immediate impact on claims and compensation payments. That should be our focus, not stripping away the rights of children like Thomas Ellenson. Thank you.

[The prepared statement of Ms. Doroshow follows:]

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STATEMENT OF JOANNE DOROSHOW
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BEFORE THE HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

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

April 6, 2011

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April 6, 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 reform New York's insurance system and improve patient safety.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE MEDICAL MALPRACTICE EPIDEMIC

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

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

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

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

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

MEDICAL MALPRACTICE AND HEALTH CARE COSTS

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

- Of the 0.5% savings found in 2009, CBO found tiny health care savings – "0.3 % from slightly less utilization of health care services," or "defensive medicine."
    - Columbia University's Mailman School of Public Health Professor Fred Hyde, M.D. defined defensive medicine as follows: "The implicit hypothesis would appear to be the following: That, in contravention of good medical judgment, the basic rules of Medicare (payment only for services that are medically necessary), threats of the potential for False Claim Act (prescribing, referring, where medically unnecessary), physicians will, as a group, act in ways which are possibly contrary to the interests of their patients, certainly contrary to reimbursement and related rules, under a theory that excessive or unnecessary prescribing and referring will insulate them from medical liability."[20]
    - According to the CBO, if there is any problem at all in the area, it's with Medicare, specifically its emphasis on "fee-for-service" spending, whereas private managed care "limit[s] the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as 'defensive medicine')." In other words, CBO virtually admits that to the extent "defensive medicine" exists at all, it can be controlled through simply managing care correctly as

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

(See more discussion of defensive medicine, below)

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

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

CLAIMS AND LAWSUITS

For more than 30 years, the state medical and insurance lobbies have argued that establishing legal roadblocks in the way of injured patients was the only way to reduce periodically high malpractice insurance rates and keep doctors practicing. As a result of this lobbying, many state lawmakers succumbed to political pressure and enacted hundreds of state laws that weaken the rights of patients injured by medical negligence, make it more difficult for them to obtain fair compensation, or make it harder to hold accountable those responsible – so-called "tort reform." The medical profession now has more legal protection for their negligence than any other profession in the country. As a result, according to insurance industry analysts at A.M. Best, the number of injured patients bringing medical malpractice claims (i.e., claims frequency) has reached "historic lows."[22]

- **While the U.S. population and the number of doctors are steadily increasing[23], medical malpractice claims and lawsuits are dropping significantly.**
    - According to the National Center for State Courts, medical malpractice claims are in steep decline, down 15 percent from 1999 to 2008. The NCSC says rarely does a medical malpractice caseload exceed a few hundred cases in any one state in one year.
    - In 2009, our project, Americans for Insurance Reform, took a look at medical malpractice insurance claims, premiums and profits in the country at that time and for 30 years prior. In this report, called "*True Risk: Medical Liability, Malpractice Insurance and Health Care,*"[24] we found that according to the insurance industry's own data, medical malpractice claims, inflation-adjusted, are dropping like a rock, down 45 percent since 2000. Inflation-adjusted per doctor claims have dropped since 2002 from $8,676.21 that year to $5,217.49 in 2007 TO $4,896.05 in 2008. In fact, at no time during this decade did claims spike, or "explode." As A.M. Best put it, "Overall, the most significant trend in [medical professional liability insurance] results over the five years through 2008 is the ongoing downward slope in the frequency of claims...."[25]

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

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

(See more about defensive medicine, below).

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

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

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

MEDICAL MALPRACTICE INSURANCE

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

Despite the enormous hardships on innocent patients caused by "caps," or the fact that they shift compensation burdens onto others, insurers argue that caps are therefore worth enacting. However, this argument is based entirely upon a false predicate – that the U.S. civil justice system is to blame for insurance price-gouging. History repeatedly shows that capping damages will not lead to lower rates, because what drives rate hikes has nothing to do with a state's "tort" law. It is driven by the insurance underwriting cycle and remedies that do not specifically address this phenomenon will fail to stop these wild price gyrations in the future. Indeed, H.R. 5 entirely ignores the insurance industry's major role in the pricing of medical malpractice insurance premiums – an industry that is exempt from anti-trust laws under the McCarran-Ferguson Act. Repealing this act is critical to stabilizing the medical malpractice insurance market.

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

When interest rates drop or the economy turns causing investment decreases, or the cumulative price cuts during the soft market years make profits unbearably low, the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market. This usually degenerates into a "liability insurance crisis" often with sudden high rate hikes that may last for a few years. Hard markets are followed by soft markets, when rates stabilize once again.

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

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

Like all hard markets, it did not last. In fact, the entire country has been in a "soft" insurance market for several years now, stabilizing rates everywhere in the country – irrespective of whether a state enacted tort restrictions.[32]

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

    - According to A.M. Best, after reaching a high of 14.2% in 2003 during the last hard market, medical malpractice premium growth has been dropping, decreasing by 6.6% nationally in 2007, and an additional 5.3% in 2008.[33]
    - The insurance pure premium[34] or loss costs,[35] is particularly important to examine. This is the one component of an insurance rate that should be affected by verdicts, settlements, payouts, or so-called "tort reform." It is the largest part of the premium dollar for most lines of insurance. The Insurance Services Office (ISO)[36] shows the same cyclical pattern with the biggest increases during the hard market of 2002-2005, and dropping steadily since then with 2008 seeing an astonishing 11% decrease. This data confirms that we are experiencing a very soft market. Moreover, this decrease might have been even greater had 17 states not limited the decrease to 20%, likely because ISO wanted to control this drop. Most likely, this result was due to the recognition that, with profits as high as they were, medical malpractice insurance for doctors was greatly overpriced in prior years.[37]
    - Premiums have dropped irrespective of whether "tort reforms" were enacted in any particular state, such as Texas.[38] States with little or no restrictions on patients' legal rights have experienced the same level of liability insurance rate changes as those states that enacted severe restrictions on patients' rights.[39] Compare, for example, Missouri and Iowa, two neighboring Midwest states. Missouri has had a cap since the mid-1980s, as well as other "tort reform" in medical malpractice cases. Iowa has never had a cap. In the last five years, Missouri's pure premium increased 1%. Iowa's dropped 6%. Among states that had pure premium increases of more than 5% in the last five years were states with significant medical malpractice limits like FL, NV, and UT, and states with fewer restrictions like NH, VT and WY.
    - As mentioned above, rates are expected to drop even further! According to a December 2010 ISO publication, which examined reserves at year-end 2009, reserves are still redundant (i.e., excessive) for medical malpractice policies: 15% to 35% for occurrence policies and by 41% to 61% for claims made policies. *This means rates still have much further to fall.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

California

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

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

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

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

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

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

Illinois

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

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

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

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

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

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

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

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

HIGH INSURER PROFITS

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

"DEFENSIVE MEDICINE" AND HEALTH CARE COSTS

In over 30 years, premiums and claims have never been greater than 1% of our nation's health care costs.[76] Despite this, the claim is often made that these figures do not include the costs of so-called "defensive medicine," or the ordering of tests or procedures to avoid litigation and not because they are "medically indicated and necessary for the health of the patient," as required by Medicare.[77] However:

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

- In February, the Center for Justice & Democracy released excerpts from a working draft of a groundbreaking new article, "Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and 'Health Reform' in 'Tort Reform.'" The article was written by Fred Hyde, M.D., Clinical Professor in the Department of Health Policy and Management at Columbia University's Mailman School of Public Health. Dr. Hyde, who holds both medical and law degrees from Yale and an MBA from Columbia, consults for hospitals, physicians, medical schools and others "interested in the health of hospitals," has served twice as chief executive of a non-profit hospital and as vice president of a major university teaching hospital. The article was funded by a grant from CJ&D and has been submitted for publication. The following are excerpts from this article:
    - "'Defensive medicine' by all accounts has become such a myth, a combination of surveys of interested parties and the 'imagination' that those parties are avoiding--or believe they are avoiding—liability through alteration of their medical practices."
    - "The cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care."
    - Medical liability "acts as a guardian against under treatment, the primary concern which should now be facing policy-makers."
    - "If tort reform reduces or even eliminates sanctions associated with negligent care and activity, adverse events themselves may increase, and by a number far greater than .2, .3 or .7% of the American health care bill."
    - "The implicit hypothesis would appear to be the following: That, in contravention of good medical judgment, the basic rules of Medicare (payment only for services that are medically necessary), threats of the potential for False Claim Act (prescribing, referring, where medically unnecessary), physicians will, as a group, act in ways which are possibly contrary to the interests of their patients, certainly contrary to reimbursement and related rules, under a theory that excessive or unnecessary prescribing and referring will insulate them from medical liability. There are many more cases concerning incompetence in credentialing and privileging, negligent referral, unnecessary radiation, etc., to provide at least a counter hypothesis.
    - "[A]s reaffirmed in the CBO studies, and as reflected in the literature generally, all estimates of the 'indirect' costs of professional liability, including, for example, the cost, if any, of defensive medicine, are trivial, in comparison to the cost of health

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

- "The import of the phrase 'defensive medicine' is in its 'political' or strategic use: 'Defensive medicine has mainly been invoked as an argument for tort reform in the years between malpractice crises when other pressures for legal change have ebbed.' The methods used to study the existence, prevalence and impact of defensive medicine have been, primarily, survey of those (practicing physicians) who may be perceived as having a position or stance in the political discussion, in addition to having access to information necessary to answer the questions posed above.
- "Survey-type findings led to a conclusion that defensive medicine was significant among physicians in Pennsylvania who pay the most for liability insurance. In later studies (Mello [footnote omitted]), however, some of the same authors have cast doubt on the survey as an objectively verifiable means of establishing the presence, quantity or scope of defensive medicine.
- "The fee for service system both empowers and encourages physicians to practice very low risk medicine. Health care reform may change financial incentives toward doing fewer rather than more tests and procedures. If that happens, concerns about malpractice liability may act to check potential tendencies to provide too few services.
- "If most claims result from errors, and most errors result in injuries, and most injuries resulting from such errors result in compensation (73%), what is at stake in limiting access to the courts? If access is limited, it would be in recognition that the basic principle of civil justice, having a remedy available to enforce a right, is void."

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

procedure in which an examination and treatment of damage of the interior of a joint is performed using an arthroscope, an endoscope inserted into the joint through a small incision).

- The insurers require the imaging study in an attempt to protect against fraud. Orthopedic surgeons believe the MRI study prior to arthroscopy to be unnecessary; this was affirmed by a show of hands in the audience for the San Diego presentation.

- No mention was made of the potential for fraudulent billing if the MRI studies ordered were not for the benefit of the patient. If the box checked "defensive" were accompanied by a box that indicated "no bill to be rendered" or "bill referring physician" this would undoubtedly have been included in the report. It would be a reasonable assumption that, to the contrary, a bill was rendered to the patient or to the insurance company for the MRIs as ordered. Were the physicians really uninterested in the results of the MRI tests, and willing to risk sanction? Or did they "check the box" to "show support" without realizing that it might indicate a potentially fraudulent act?
- Finally, appearing in Pennsylvania especially,[79] this study should be regarded primarily as an advocacy position. This advocacy presentation has received disproportionate attention due to its timing in the context of current proposals before the Congress, not because of the credibility of the survey. The difficulty facing physicians especially in Pennsylvania concerning the cost and availability of malpractice insurance are well known, but are due to insurance issues, and not to causes directly related to tort law.

- **GAO.** As Professor Hyde notes, studies of defensive medicine frequently use anonymous physician "surveys" to establish its widespread existence. These are usually conceived by organized medicine, whose purpose it is to give the impression of a scientifically conducted poll, yet they are not. In fact, in 2003, the General Accountability Office condemned the use of "defensive medicine" physician surveys, noting everything from low response rates (10 and 15 percent) to the general failure of surveys to indicate whether physicians engaged in "defensive behaviors on a daily basis or only rarely, or whether they practice them with every patient or only with certain types of patients."[80] The GAO also noted that those who produced and cited such surveys "could not provide additional data demonstrating the extent and costs associated with defensive medicine." And, "some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can mitigate defensive practices." Moreover, "According to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit."

- **OTA.** In 1994, the congressional Office of Technology Assessment (OTA) found that less than 8 percent of all diagnostic procedures were likely to be caused primarily by liability concerns. OTA found that most physicians who "order aggressive diagnostic procedures . . . do so primarily because they believe such procedures are medically indicated, not primarily

because of concerns about liability." The effects of "tort reform" on defensive medicine "are likely to be small."[81]

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

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

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

    - The Medicare law states: "It shall be the obligation of any health care practitioner and any other person . . . who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act . . . will be provided economically and only when, and to the extent, medically necessary."[84] "[N]o payment may be made under part A or part B for any expenses incurred for items or services . . . which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[85]
    - Providers cannot be paid and/or participate in the Medicare program unless they comply with these provisions, and they impliedly certify compliance with these

provisions when they file claims. Thus, if they are not in compliance, the certifications and the claims are false. Providers who do not comply and/or file false claims can be excluded from the Medicare program.[86]

- Perhaps more importantly, the Medicare claim form (Form 1500) requires providers to expressly certify that "the services shown on the form were medically indicated and necessary for the health of the patient."[87] If the services are, to the doctor's knowledge, medically unnecessary, the claim is false.

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

- According to the consumer group Texas Watch, "Medicare spending has risen 16% faster than the national average since Texas restricted the legal rights of patients. Four of the nation's 15 most expensive health markets as measured by Medicare spending per enrollee are in Texas.[88]

- Texas Watch shows that growth in Medicare spending per enrollee in the three years before patients lost their rights was 3.80% in Texas compared to 3.36% for the national average. In the three years following so-called tort "reform," average Medicare spending increased 7.43% in Texas compared to 6.03% for the national average.

- According to Families USA and Texas Watch, family health insurance premiums for Texas families are up 92% - more than 4.5 times faster than income.[89] Texas has the nation's highest rate of uninsured with 24.5% of Texans without health insurance."[90]

- The Texas experience shows that removing litigation as a factor will not change the extent of tests and procedures that will be ordered. I noted earlier a June 1, 2009, *New Yorker* magazine article by Dr. Atul Gawande, called "The Cost Conundrum; What a Texas town can teach us about health care," which explored why the town of McAllen, Texas, "was the country's most expensive place for health care." It is worth repeating the following exchange took place with a group of doctors and Dr. Gawande:

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

ACCESS TO CARE

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

    - On August 29, 2003, the U.S. General Accountability Office released a study[91] ostensibly to find support for the AMA's assertions that a widespread health care access "crisis" existed in this country caused by doctors' medical malpractice insurance problems. The GAO found that the AMA and doctors groups had based their claims on information GAO determined to be "inaccurate" and "not substantiated," and that to the extent there are a few access problems, many other explanations can be established "unrelated to malpractice," that problems "did not widely affect access to health care," and/or "involved relatively few physicians." The health care access problems that GAO could confirm were isolated and the result of numerous factors having nothing at all to do with the legal system. Specifically, GAO found that these pockets of problems "were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services."
    - Other studies have also rejected the notion that there has been any legitimate access problem due to doctors' malpractice insurance problems. In August, 2004, the National Bureau of Economic Research researchers found: "The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt. The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings."[92]
    - Other state-specific studies draw the same conclusion. In April 2007, Michelle Mello of the Harvard School of Public Health published a study of physician supply in Pennsylvania in the peer-reviewed journal, *Health Affairs*. The authors "looked at the behavior of physicians in 'high-risk' specialties -- practice areas such as obstetrics/gynecology and cardiology for which malpractice premiums tend to be relatively high -- over the years from 1993 through 2002. They found that contrary to predictions based on the findings of earlier physician surveys, only a small percentage of these high-risk specialists reduced their scope of practice (for example, by eliminating high-risk procedures) in the crisis period, 1999-2002, when malpractice insurance premiums rose sharply.... What's more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion who did so during 1993-1998, before premiums spiked. 'It doesn't appear that the restrictions we did observe after 1999 were a reaction to the change in the malpractice environment,' said Mello, the C. Boyden Gray Professor of Health Policy and Law at the Harvard School of Public Health."[93]
    - Similarly, the *Cincinnati Enquirer* reviewed public records in Ohio in the midst of that state's medical malpractice insurance crisis. The investigation found "more doctors in the state today than there were three years ago ... '[T]he data just doesn't

translate into doctors leaving the state,' says Larry Savage, president and chief executive of Humana Health Plan of Ohio."[94]

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

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

- Injured Texans relinquished their legal rights because the insurance and medical lobbies told them this was the only way to prevent a doctor shortage in Texas. Yet doctors' shortages still loom in Texas today. This is apparently due to "[C]aps and cuts in Medicare and Medicaid funding, which help pay for residencies. Those have forced many healthcare agencies to freeze or scale back residency programs." Specifically, with a ratio of 158 doctors per 100,000 residents, Texas ranks 42nd among the 50 states and District of Columbia, according to the Texas Medical Association. "We are at a shortage of physicians of all types in Texas, both primary care and specialty care," said Dr. Gary Floyd, JPS Health Network chief medical officer said. "We would love to see this addressed in our new healthcare reform. How do we train more physicians?"[99]
- According to Texas Watch, nearly half of all Texas counties do not meet the national standard of having 114 doctors for every 3,500 people.[100]
- In December 2009, the *Ft. Worth Star-Telegram* reported,[101]

> The number of new doctors in family practice, the area most in demand, has increased by only about 200, about 16 percent, and more than 130 counties still did not have an obstetrician or gynecologist as of October, according to a *Star-Telegram* analysis of licensing data from the Texas Medical Board.
>
> At the same time, the number of specialists in Texas has increased sharply, with 425 psychiatrists, more than 900 anesthesiologists and five hair transplant physicians among the more than 13,000 new doctors in Texas in the five years after the Legislature's approval of the liability caps, the analysis found.
>
> More than half the new doctors settled in the state's largest urban areas, not in rural areas, where the shortage has been most apparent.
>
> Healthcare costs, meanwhile, have continued to rise in Texas. Proponents of malpractice caps predicted that costs would drop along with lawsuits and malpractice insurance rates.
>
> "Consumers are much worse off today," said Alex Winslow, executive director of Texas Watch, a consumer advocacy group in Austin. "Not only have they not seen the benefits they were promised in healthcare, but now they've lost the ability to hold someone accountable. I think that puts patients at greater risk."

- According to a Fall 2009 study by professors Charles Silver of the University of Texas School of Law, David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law and Bernard S. Black of the Northwestern University School of Law, when it comes to physicians engaged in patient care (in other words, considering physicians who retire, leave the state or step seeing patients), the data shows that the per capital number has not grown. In fact, the number grew steadily through 2003 and then leveled off. They write, "This is not the pattern you would expect a 2003 tort reform law was responsible."[102]

IMPACT OF RESTRICTIONS ON THE RIGHTS OF INJURED PATIENTS

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

DETERRENCE

- **Weakening the tort system will increase errors, injuries and deaths**
    - In its October 9, 2009 letter to Senator Orin Hatch on medical malpractice issues, the CBO noted, "The system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses ..." CBO wrote, "imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes," yet it brushed aside its significance, not because it is untrue, but because it says there are too few studies on the topic. However, of the three studies that address the issue of mortality, CBO notes that one study finds such tort restrictions would lead to a .2 percent increase in the nation's overall death rate.[103] If true, that would be an additional 4,853 Americans killed every year by medical malpractice, or 48,250 Americans over the 10-year period CBO examines.[104]
    - Based on these same numbers, another 400,000 or more patients could be injured during the 10 years that CBO examined (given that one in 10 injured patients die.[105]) The costs of errors, which the Institute of Medicine put between "$17 billion and $29 billion, of which health care costs represent over one-half," would clearly increase.[106] Consider, for example, that the average length of stay per hospitalization is around 4.4 days[107] and the average cost in the hospital is approximately $2,000 per day per injury.[108] Consider those costs in addition to physician utilization inherent in caring for these new patients.
    - David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law, and Charles Silver of the University of Texas at Austin School of Law, have researched and written extensively about medical malpractice.[109] They confirm, "The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. ... [T]wo major factors forced their hand: malpractice claims and negative publicity.... Anesthesiology [malpractice] premiums were ... among the very highest—in many areas, two to three times the average cost for all physicians. By the early 1980s, anesthesiologists recognized that something drastic had to be done if they were going to be able to continue to be insured.... Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it."[110] "As Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious. As the title of their most recent article says, 'it's the incentives, stupid': Providers are rational. When injuring patients becomes more expensive than not injuring them, providers

will stop injuring patients..... In short, the notion that errors would decline if tort liability diminished is ridiculous."[111]

- Numerous other medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. In addition to anesthesia procedures, these include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.[112] As a result of such lawsuits, the lives of countless other patients have been saved.
- "The authors of the Harvard [Medical Practice Study] study acknowledged, as well: '[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.'"[113]
- The *New England Journal of Medicine* published a 2006 article confirming this point: that litigation against hospitals improves the quality of care for patients, and that "more liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously."[114]
- No one said this better than Dr. Wayne Cohen, then-medical director of the Bronx Municipal Hospital, who said, "The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing."[115]

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

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

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

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

H.R. 5 SPECIFIC PROPOSALS

- **Preemption and Seventh Amendment issues.**

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

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

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

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

> The guarantees of the Seventh Amendment [right to civil jury trial] will prove burdensome in some instances; the civil jury surely was a burden to the English governors who, in its stead, substituted the vice-admiralty court. But, as with other provisions of the Bill of Rights, the onerous nature of the protection is no license for contracting the rights secured by the Amendment.[124]

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

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

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

University of Buffalo Law Professor Lucinda Finley noted in a recent study, "certain injuries that happen primarily to women are compensated predominantly or almost exclusively through noneconomic loss damages. These injuries include sexual or reproductive harm, pregnancy loss, and sexual assault injuries."[125] Also, "[J]uries consistently award women more in noneconomic loss damages than men ... [A]ny cap on noneconomic loss damages will deprive women of a much greater proportion and amount of a jury award than men. *Noneconomic loss damage caps therefore amount to a form of discrimination against women and contribute to unequal access to justice or fair compensation for women*."[126]

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

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

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

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

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

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

- **Contingency Fee Limits**

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

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

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

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

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

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

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

- **Limits on Punitive Damages.**

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

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

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

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

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

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

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

- **Structured Settlements.**

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

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

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

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

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

IMPROVING PATIENT SAFETY, INCLUDING FOR HIGH-COST OBSTETRICAL INJURIES

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

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

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

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

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

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

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

- **Rand Institute for Civil Justice**

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

CONCLUSION

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

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

NOTES

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

[20] Forthcoming article, Hyde, Fred. M.D., Clinical Professor, Department of Health Policy and Management, Columbia University's Mailman School of Public Health, "Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and 'Health Reform' in 'Tort Reform'" (2011)

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

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

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

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

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

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

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

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

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

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

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

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

[33] 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

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

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

the future since rates based on ISO loss costs are for a future period. Thus, loss costs include ISO's adjustments to make sure that everything is included in the price, even such factors as future inflation.
[36] The ISO has the largest database of audited, unit transaction insurance data of any entity in the United States.
[37] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. http://insurance-reform.org/pr/090722.html.
[38] *Ibid.*
[39] *Ibid.*
[40] AMA, *American's Medical Liability Crisis: A National View*, http://www.ama-assn.org/ama1/pub/upload/mm/450/med_liab_20stat.pdf (June 2004).
[41] Mary Ellen Schneider, *Maryland: A State in 'Crisis' for Ob.Gyns*, OB/GYN NEWS, Oct. 15, 2004.
[42] MD. CODE ANN., CTS. & JUD. PROC. §11.108.
[43] James Dao, "A Push in States to Curb Malpractice Costs," *New York Times*, Jan. 14, 2005.
[44] *Id.*
[45] AMA, *American's Medical Liability Crisis: A National View*, http://www.ama-assn.org/ama1/pub/upload/mm/450/med_liab_20stat.pdf (June 2004).
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[53] *E.g.* Joelle Babula, "Medical Liability Company Requests Premium Increase," *Las Vegas Review-Journal*, Feb. 11, 2003; Babula, "State Insurance Program Holds Off on Lowering Rates," *Las Vegas Review-Journal*, Aug. 14, 2002.
[54] *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; (Oct. 2003 rate filing from Texas Medical Liability Insurance Assoc. (JUA) to Texas Dep't of Insurance).
[55] "Insurer Switching to Unregulated Product to Raise Premiums," *Assoc. Press*, April 10, 2004.
[56] The GE Medical Protective filing can be found at: http://www.consumerwatchdog.org/insurance/rp/rp004689.pdf.
[57] See, http://www.multinationalmonitor.org/mm2003/032003/court.html
[58] See, Consumer Watchdog, "Insurance Rate Regulation, Not Medical Liability Limits, Lowered California Malpractice Insurance Premiums," http://www.consumerwatchdog.org/newsrelease/house-republicans-have-their-talking-points-california-backwards-insurance-rate-regulati,; *How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California and How Malpractice Caps Failed* 1 (March 7, 2003), http://www.consumerwatchdog.org/healthcare/rp/rp003103.pdf.
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[60] Foundation for Taxpayer and Consumer Rights, *Insurance Regulation, Not Malpractice Caps, Stabilize Doctors' Premiums*, http://www.ftcr.org/healthcare/fs/fs003013.php3 (last visited Feb. 16, 2005).
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Mr. PITTS. Chair thanks the gentlelady and recognizes Dr. Kachalia for 5 minutes for your opening statement.

STATEMENT OF ALLEN B. KACHALIA

Mr. KACHALIA. Mr. Chairman and members of the committee, I thank you for the opportunity to testify today. It is a privilege to be here. I am here today because I was asked to speak with regard to the evidence related to the need that we have for malpractice reform and the measures that are currently under consideration. It is exciting to see that Congress is considering malpractice reform especially given the need we have today to improve our healthcare system comprehensively.

I will quickly cover three main points: 1, what do we know about malpractice system performance; 2, what reform needs do we have; and 3, what does the evidence tell us with regard to the traditional tort reform measures that have been enacted in the States. I will base my testimony on both my clinical and research experience that you mentioned earlier.

So first I would like to start by discussing why we need malpractice reform. We have a malpractice system that theoretically exists to 1, duly compensate injured patients, and to 2, reduce substandard care. However, there is general agreement among many experts that the system is not serving these functions well. If we turned to frequently cited evidence with regard to performance of the malpractice system, we can learn that patients claim compensation in only about 2 percent of negligent injuries that occur. And even less frequently do they receive payment.

However, the problem is not just from the patient side. There is also a problem from the physician perspective. If we look at claims that have been filed there is concern that too low number of the claims that are filed actually contain negligence—approximately one in six. More recently generated evidence, however, indicates that about 60 percent of filed claims may actually have an error in them, but still the malpractice system does not seem to adjudicate these claims properly with about a quarter of them being improperly adjudicated. Now, this type of inaccuracy can actually undermine both patient and physician confidence in our system.

Compounding these problems in data that demonstrates that the majority of our premium dollars seem to go to fund overhead costs rather than compensating patients. All of this occurs in the context of which there are very high insurance premiums for many physicians and of course we cannot ignore the emotional costs that can be associated with a law suit whether or not the suit has merit. There are also unwanted, indirect offenses of the malpractice system. This includes of course defensive medicine and the fact of the possibility of litigation that is always present can undermine the trust that we need in the patient/physician relationship.

So what these findings show is what they show us what we need from reform. We need improvements that will actually fix the liability related shortcomings for both patients and physicians and a system that will perform these functions much more efficiently. But our reform targets should probably not stop there. Reform should also address how well the malpractice system improves the

quality of care that we provide. After all, this is one of the system's main goals.

So therefore, as Congress considers any reform it becomes important for Congress to determine what their primary goal is. Will legislation start in one area alone or will it try to tackle multiple problems at once and what is the interaction between making those choices? However, regardless of the approach that is taken, it remains important to contemplate any new reforms with the current evidence as to what we know in mind.

So if I can turn to the evidence here there is a number of States have enacted tort reform over the years there has been a growing base on the evidence that we have with regard to the effect of these reforms. Last year we completed a review of the evidence on the effect of many traditional tort reforms and briefly here is what we learned.

For caps on damages, the evidence seems to indicate that caps can lower the average size of claims payments which shouldn't be surprising because that is what they are designed to do and this actually appears to translate into lower premiums for physicians. There is good evidence to also suggest that caps made less in defensive practices, however, the effect of caps on the overall quality of care remains unknown.

For statute of limitations there is reasonable evidence to show that they may lower premiums but it is unclear what the statute of limitations do with regard to claims frequency and they also do not appear to change the average award size. The evidence on defensive practices and other care related metrics is limited in this regard.

For attorney fee limits, overall the evidence shows that fee limits do not seem to translate to lower claims frequency, cost, or insurance premiums and there is little evidence as to what happens with regard to care related metrics. So in summary as we continue to focus on how lower costs and improved quality in healthcare today, our medical malpractice system is a good target. Based on data on system performance as we consider how to reform the system it becomes important to evaluate reforms not just on liability consequences for patients and providers, but also to consider the effects on overall cost and quality of care.

As a practical matter, Congress may offer incremental reform, but it is important to keep in mind that the ultimate goal of reform should be reform that addresses all the ails of our system and that veil consideration of more comprehensive reforms has also been put out there by Members of Congress. I would like to emphasize that regardless of the type of reform that is passed, it is critical to measure its impact and to have plans that call for proper and timely adjustments based on what the data tells us. Just as we continue to seek better data and evidence in medical care, we should ask the same of our liability system. Thank you.

[The prepared statement of Mr. Kachalia follows:]

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

Subcommittee on Health
Energy & Commerce Committee

Wednesday, April 6, 2011

Allen Kachalia
Boston, Massachusetts

Introduction

Mr. Chairman and Members of the Committee, I thank you for the opportunity to testify today. It is a privilege to be here. I am here today because I was asked to testify with regard evidence concerning the need for malpractice reform and measures that are currently being considered in Congress.

I plan to cover three main points: what we know about the evidence on performance of our malpractice system, what reform needs we have, and what the evidence tell us about traditional tort reform measures that have been enacted.

I will base my testimony on both my clinical and research experience. I am a physician at Brigham & Women's Hospital and Harvard Medical School where I have clinical, administrative, research, and teaching responsibilities. I see patients as a general internist practicing hospital medicine. In my administrative role, I am the Medical Director for Quality and Safety for my hospital. I also have a law degree and conduct research and teach in legal matters in medicine, including our malpractice system.

System Performance and Problems

I'd again like to thank you for the opportunity to speak today. It is exciting to see that Congress is considering tort reform, especially given need we have today to improve our health care system in a comprehensive fashion.

First, I'd like to start by discussing why we need malpractice reform.

Health care today is not always delivered without error and can result in preventable injury. This creates the need for a well functioning system that will compensate eligible medical injuries and also help prevent errors from initially occurring or recurring (driving improvements in quality and safety).

We indeed have a malpractice system that theoretically exists to serve these two functions: to compensate patients and provide accountability for substandard care. However, the general perception and agreement among many experts is that the system is not serving these functions well and, in fact, may also be generating other unwanted secondary consequences such as defensive medicine.

If we turn to frequently cited evidence on the performance of the malpractice system, patients claim compensation in a very small number of negligent injuries (in some estimates, it is about 2% of all negligently injured patients) and an even lower number receive payment.[i] The problem is not just from the patient perspective though. If we look at the claims that are filed, there is concern that too low a number of claims (approximately 1 in 6) actual contain a negligent injury.

More recently generated evidence, however, shows that approximately 60% of filed claims likely have an error in them, but that the system may still not be properly adjudicating claims about a quarter of the time.[ii] This means that in about a quarter of the claims in which there is an error, patients may not be receive payment and in a quarter of the claims in which there is no error,

patients may still receive payment. This type of inaccuracy can undermine both patient and physician faith in the malpractice system.

Compounding this problem is data that show that the majority of premium dollars are paid to fund overhead costs of administering the system. In one estimate, about 54 cents on every dollar in premium is spent on attorney fees, other litigation related expenses such as expert witness fees, and running insurance companies.[2] Only about 46 cents is making it to injured patients.

All of this occurs in the context of very high insurance premiums for physicians, depending on the state and specialty of practice. Also, we cannot ignore the emotional cost that can be associated with a lawsuit—whether or not the suit has merit.

The problems with the malpractice system do not stop with its direct effects. There are also many indirect effects. The most notable is that of defensive medicine. While extremely difficult to quantify, the potential downstream consequences of defensive medicine may be considerable and include: limited access to care for patients and overutilization of resources. The latter has received tremendous attention with regard to the cost and quality implications. The threat of litigation and the perception that physicians are taking defensive measures can also undermine the quality of the patient-physician relationship.

Reform Needs

In light of these findings, I'd like to turn to what we need from reform:

We need improvements that will not only fix the liability-related shortcomings for both physicians and patients, but also perform these functions much more efficiently (including lower overhead costs). These needs are directly related to how well the system performs its compensation function.

However, reform improvements should not stop there. Reforms should also address how well the malpractice system improves the quality and safety of care. There is more than one way in which this can be accomplished and includes: leveraging the claims-related information that comes in to help prevent injuries from recurring, providing a better signal and deterrent effect, or reducing defensive practices. All of these methods also carry the potential to reduce costs by reducing unnecessary care.

Therefore, as Congress considers any reform, it first becomes important to determine what the primary goal of the legislation is--whether the legislation will tackle multiple issues (patient compensation, physician liability risks and costs, overhead costs, or efficiency and quality of care) at once or start in one domain. A limited approach may be easier to pass and implement and perhaps bring quicker change in a targeted area or areas. However, tackling only one problem area may come at the expense of the others. Comprehensive reform options (such as health courts, safe harbors, or encouraging disclosure-and-offer programs) may be more appealing in this regard, but it may be more difficult to design or to take too long to enact. Regardless of the approach, it is important to consider any new reforms based on what the current evidence on reforms tells us.

Evidence on Reforms

As a number of states have enacted tort reforms over the years, there has been a growing evidence base on their effects. The focus of the evaluations has often been on the liability-related effects (particularly that of claims, costs, and premiums) of these reforms. This has not been an unreasonable approach because the intent of many of these reforms was often to improve the liability insurance crisis for providers.

However, this has left a relative gap with regard to what we understand will happen to patient access to due compensation and the overall cost and quality of care when tort reforms are enacted.

Last year, we completed a review of the evidence with regard to the effect of many traditional tort reforms.[iii] Here is what we learned about measures that are contemplated in the current bill:

Caps on damages: Several states have passed caps, most of them being non-economic caps. It is also worth nothing that recently two states struck down caps as unconstitutional. However, evidence indicates that caps can lower the average size of claims payments (as would be theoretically expected) and this appears to translate into lower premiums for physicians. Interestingly, though, caps do not seem to lower the number of claims filed. There is good evidence to suggest that caps may lower the amount of defensive medicine that occurs, but their effect on the overall quality of care is unknown.

Statute of limitations: There is reasonable evidence that statutes of limitations may lower malpractice insurance premiums but it is unclear what they do with regard to claims frequency. They do not appear to change the average award size. The evidence on the effects of statutes of limitations on defensive medicine and other care related metrics is limited.

Attorney fee limits: This intervention may seem appealing for a couple reasons. Limiting contingency fees may reduce the overhead costs and place more compensation in the hands of patients and also decrease the number of non-meritorious suits. However, this has to be balanced against patient access to the number of attorneys that will take cases for a lower contingency fee. Overall, the evidence shows that fee limits do not seem to translate to lower claims frequency, costs, or premiums. There is little evidence on what happens with regard to defensive practice or overall quality of care.

Collateral source rule reform: This reform seeks to limit plaintiffs from "double recovery" (e.g., collecting subsequent care costs from both health insurance and the defendant). This reform's appeal is in the fairness of award amounts. The evidence indicates that there is no effect on claims frequency, claims costs, or premiums. There also appears to be no effect on defensive medicine or the overall quality of care.

Conclusion

In summary, as we continue to focus our attention on how to lower costs and improve quality in health care, our medical malpractice system is an area ready for reform. The system is currently falling short for both patients and providers at a high overhead price, and also causing unwanted indirect effects that raise cost and reduce quality, especially with regard to defensive medicine.

As we consider how to reform the system, it becomes important to evaluate reforms not just on the liability consequences for providers, but also to evaluate or consider the effects on patient access to compensation and the overall cost and quality of care.

As a practical matter, Congress may opt for incremental reform that addresses one area at a time, but it is also important to keep in mind that the ultimate goal should be reform that addresses all the ails of the malpractice system. In that vein, consideration of comprehensive reforms has also been recommended by members of Congress.[iv] I would like to emphasize that regardless of the types of reform passed, it will be critical to measure their impact and to have plans that call for proper and timely adjustments. Just as we continue to seek better data and evidence in the medical care we deliver, we should ask the same of our medical liability system.

Brief Summary

1. Research indicates that our medical malpractice system is not achieving its goals for both patients and providers. Very few negligently injured patients receive compensation and a substantial number of claims against physicians do not contain an error.

2. A significant number of meritorious claims do not receive compensation and significant number of non-meritorious claims receive compensation. This inaccuracy can undermine patient and provider faith in the malpractice system.

3. The malpractice system generates high overhead costs with the majority of every premium dollar being spent on litigation-related and insurance company expenses.

4. The malpractice system has also generated unwanted secondary effects that include defensive medicine, which can raise costs and reduce quality.

5. Reform needs include improvements in system performance for both patients and providers with lower overhead costs. Reforms should also be evaluated for their impact on care-related metrics such as defensive medicine, cost, and quality.

6. The current base of evidence on traditional tort reforms shows that, with the exception of damage caps, in general there is little to no effect on many liability system measures. The evidence on the effect of tort reforms on overall cost, access, and quality is limited. Damage caps, however, do appear to lower claims payments and liability premiums and reduce defensive practices.

7. As Congress debates incremental or comprehensive reform, it is important to plan to ultimately address all of significant shortcomings of our malpractice system. In addition, measurement and rigorous evaluation of all new reforms should be sought so that proper and timely modifications and adjustments can be made.

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Evaluation of Options for Medical Malpractice System Reform

A study conducted by staff from the Harvard School of Public Health and the Harvard Medical School for the Medicare Payment Advisory Commission

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EXECUTIVE SUMMARY

The report synthesizes the evidence and theoretical predictions regarding the potential of several leading medical malpractice reform ideas to positively affect the performance of the medical liability system and its impact on health care delivery. For most reforms, the report analyzes evidence from well-designed, controlled studies. Where such studies are unavailable, the analysis encompasses anecdotal reports, case studies, and descriptive findings regarding the operation of proposed systems or close analogues in the U.S. and foreign countries. For reforms that have not yet been tested, the report describes theoretical predictions about the likely effects of the reforms based on relevant scholarship in law and economics.

The analysis covers 8 reforms that have been widely implemented by states: caps on noneconomic damages, pretrial screening panels, certificate of merit requirements, attorney fee limits, joint-and-several liability rule reform, collateral source rule reform, periodic payment, and statutes of limitation/repose. It also examines 6 more innovative, less tested reforms: schedules of noneconomic damages, health courts, disclosure-and-offer programs, safe harbors for adherence to evidence-based clinical practice guidelines, subsidized reinsurance that is made conditional upon meeting particular patient safety goals, and enterprise medical liability.

The reforms are evaluated for their effects on the following outcome variables: malpractice claims frequency and costs, medical liability system overhead costs, health care providers' liability costs, defensive medicine (including health care utilization and spending), supply of health care services (including physician supply and patient health insurance coverage), and quality of care.

We find that although the evidence base for evaluating most traditional state tort reforms is substantial and mature, for most reforms, the evidence does not identify significant effects on the key outcome variables. The exception is caps on noneconomic damages, which have well-documented effects on several of the outcomes. The evidence base for evaluating the innovative tort reforms is extremely small, as most have not been tested in the U.S., analogous systems are not clearly predictive of how they would function, and much depends on the choices made about system design. However, based on theoretical predictions and the limited evidence available, most of these reforms are promising enough to merit controlled experimentation in the U.S., such as through demonstration projects.

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1. Objectives

The objective of this report is to evaluate the prospects for several leading medical malpractice reform proposals to positively affect the performance of the medical liability system and the system's impact on health care. During the 2009 federal health reform debate, and particularly since President Obama's September 2009 announcement that federal funds would be made available for pilot projects of medical liability reforms, discussion has centered on several reform possibilities, a number of which are considered innovative (Table 1). This report describes the essential features of each proposed reform and synthesizes the best available evidence about the likely effects of each of 6 outcome variables:

1. **Claims:** malpractice claim outcomes, including the number of claims filed, including the ease and equity with which patients receive compensation, and claims costs
2. **Overhead costs:** malpractice system administrative costs, including litigation costs and insurers' overhead expenses
3. **Liability costs:** malpractice liability costs for health care providers (i.e., malpractice insurance premiums)
4. **Defensive medicine:** defensive medical practices and overall health care spending and utilization
5. **Supply:** health care provider supply and patient access to care, including health insurance coverage and cost
6. **Quality of care:** potential to foster evidence-based care and improve patient safety

Table 1. Reform Options Evaluated

Reform	Basic Description
Traditianal State Reforms	*Reforms that have been widely implemented at the state level*
Caps on noneconomic damages	Limit the amount of money that a plaintiff can take as an award for noneconomic losses, or "pain and suffering", in a malpractice suit. The cap may apply to the plaintiff, limiting the amount she may receive, or to each defendant, limiting the total amount for which each may be liable.
Pretrial screening panels	Panel reviews a malpractice case at an early stage and provide an opinion about whether a claim has sufficient merit to proceed to trial. Typically, a negative opinion does not bar a case from going forward, but can be introduced by the defendant as evidence at the trial.
Certificate of merit	Requires a plaintiff to present, at the time of filing the claim or soon thereafter, an affidavit certifying that a qualified medical expert believes that there is a reasonable and meritorious cause for the suit.
Attorney fee limits	Limits the amount of a malpractice award that a plaintiff's attorney may take in a contingent-fee arrangement. The limitation is typically expressed as a percentage of the award; it may also incorporate a maximum dollar value.
Joint-and-several liability reform	In cases involving more than one defendant, such as a physician and a hospital, this reform limits the financial liability of each defendant

	to the percentage fault that the jury allocates to that defendant. Without this reform, the plaintiff may collect the entire amount of the judgment from one defendant if the other(s) default on their obligation to pay, even if the paying defendant bore only a small share of the responsibility for what happened to the plaintiff.
Collateral-source rule reform	Eliminates a traditional rule that if an injured plaintiff receives compensation for her injury from other sources, such as health insurance, that payment should not be deducted from the amount that a defendant who is found liable for that injury must pay.
Periodic payment	Allows or requires insurers to pay out malpractice awards over a long period of time, rather than in a lump sum. This enables insurers to purchase annuities (sometimes called "structured settlements") from other insurance companies which cost less than paying the whole award up front. Insurers are also able to retain any amounts that the plaintiff does not actually collect during her lifespan.
Statutes of limitations/repose	Limits the amount of time a patient has to file a malpractice claim. Statutes of limitations bar suits unless they are filed within a specified time after the injury occurs or is discovered. Statutes of repose bar suits unless they are filed within a specified time after the medical encounter occurred, regardless of whether an injury has yet been discovered.
Innovative Reforms	*Reforms that have had limited or no implementation in the U.S.*
Schedule of noneconomic damages	A hierarchy or tiering system is created for purposes of categorizing medical injuries and creating a relative ranking of severity. A dollar value range for noneconomic damages is then assigned to each severity tier. The schedule is used by juries and judges either as an advisory document or as a binding guideline.[1]
Administrative compensation systems or "health courts"	Routes medical injury claims into an alternative adjudication process involving specialized judges, decision and damages guidelines, neutral experts, and (under most proposals) a compensation standard that is broader than the negligence standard.
Disclosure-and-offer programs	Institutional programs that support clinicians in disclosing unanticipated care outcomes to patients and that make rapid offers of modest compensation in appropriate cases.
Safe harbors for adherence to evidence-based practice guidelines	Provides a legal defense to medical malpractice claims if a defendant health care provider can show that an applicable, credible clinical practice guideline was followed in caring for the plaintiff.
Subsidized, conditional reinsurance	State or federal government provides reinsurance to health care providers at discounted or no cost if they achieve patient safety goals.
Enterprise medical liability	Broadens the prospects for holding health care organizations, such as hospitals and managed care organizations, directly liable for medical injuries, in addition to or instead of holding individual clinicians liable.

Our evaluation is based on existing empirical studies of state tort reforms, including a comprehensive synthesis published in 2006[2]; case studies and anecdotal reports of particular federal,

state and institutional programs; legal scholarship on the structure and theoretical basis of reforms; and, where no evidence is available, our own judgments. In synthesizing extant empirical research, we do not include the large "grey literature" of reports issued by advocacy organizations, relying instead on academic, government, and foundation reports that meet accepted standards of scientific rigor. For studies evaluating the effects of tort reforms implemented in the states, this meant exclusion of study findings based solely on univariate or bivariate analysis, rather than a well-controlled multivariate regression analysis. A summary of data sources consulted is presented in Table 2.

Table 2. Scope of Literature Search

Source	Sources and Scope of Search
Legal literature	Westlaw's "Journals & Law Reviews" combined library, 1990-2009; Social Science Research Network (unrestricted date search); older articles cited in more recent works
Health and medical literature	PubMed, 1990-2009
Economics literature	EconLit, 1990-2009; Social Science Research Network (unrestricted date search); older articles cited in more recent works
Government reports	Reports collected on websites of the Congressional Budget Office, General Accountability Office, Office of the Assistant Secretary for Planning and Evaluation, Office of Technology Assessment (archive), and Agency for Healthcare Research and Quality, 1990-2009; website of the Washington State Task Force on Noneconomic Damages
Foundation reports	Reports collected on websites of the Institute of Medicine, Robert Wood Johnson Foundation, Kaiser Family Foundation, Commonwealth Fund, and Pew Charitable Trusts (unrestricted date search)
Other	RAND Compare Dashboard[3]; 2006 literature synthesis by Mello[2]

2. Traditional State Reforms

2.1. Caps on Noneconomic Damages

Caps on noneconomic damages limit the amount of money that a plaintiff can take as an award for noneconomic losses, or "pain and suffering", in a malpractice suit. The rationale for this reform is to reduce the number of multi-million dollar awards, which are difficult for liability insurers to plan for and pay and which may pose special difficulties for health care facilities that are self-insured. It is also motivated by a desire to reduce the high degree of variation[4] and perceived arbitrariness in jury awards for "pain and suffering". Twenty-six states currently impose a cap on noneconomic damages and 6 cap total damages. Medical professional societies strongly desire to see noneconomic damages caps adopted in the remaining states, through state legislation or imposition of a federal cap.

2.1.1. Key Design Features and Decisions

Key design choices for noneconomic damages caps include the following:

- Amount: Although the oldest and most widely publicized example of a noneconomic damages cap, California's, is $250,000, most states have found it politically difficult to implement such a stringent cap in more recent rounds of reform. It is more common for states to set the cap at $500,000 or more, and to opt for a tiered cap in which different amounts apply to different kinds of injuries. The appeal of a flat cap is its simplicity and, when set at a low amount, greater potential for cost control. The appeal of a tiered cap is its greater vertical equity—that is, more severe injuries are eligible for a higher award.

- Indexing: Some states adjust their caps for inflation, while others do not. If California's cap had been adjusted for inflation, it would be over $1 million today. Indexing maintains the intent of the legislature adopting the cap as to the appropriate valuation of noneconomic damages in real dollars, while declining to index provides greater long-term ability to constrain costs.

- Applicability to claims: Most states apply their cap to all medical malpractice injuries, but some limit it to particular kinds of claims—for example, wrongful death claims or claims relating to emergency department care. A decision to carve out particular types of claims may reflect legislative concern about liability stress within a certain clinical specialty or the potential for unpredictable, large damages awards for certain kinds of injuries.

- Applicability to litigants: A cap may be applied to the plaintiff, limiting the amount he may receive, or to each defendant, limiting the total amount for which each may be liable. The latter choice reflects a particular notion of equity, though it may result in inequitable awards in cases where multiple defendants have different shares of fault for causing the plaintiff's injury.

- Judicial waiver: Caps rules may allow a judge the discretion to waive the damages cap in cases where its application would seem especially unjust. The price of avoiding injustice in this fashion is lesser predictability around damages awards.

2.1.2. Effects on Key Outcome Variables

The evidence base concerning the effects of noneconomic damages caps is now quite mature. Although some studies have had conflicting findings, a fairly robust set of conclusions can be drawn based on the strongest studies.

- Claims Frequency and Costs.

The evidence concerning the effects of damages caps on claim frequency is mixed. Two recent studies found that caps were associated with lower claim frequency,[5-6] while two have found no association.[7-8] The theoretical link is that caps discourage plaintiff's attorneys from filing claims by lowering the expected value of the case, which in a contingent-fee system affects the attorney's expected return on investment. Overall, the evidence is too equivocal at this time to support a conclusion about the effect of caps on claim frequency.

Most studies of the effects of caps on claims payouts have found a significant effect, typically on the order of a 20 to 30 percent reduction in average award size.[5-6, 9-14] One recent simulation analysis of the $250,000 cap adopted by Texas in 2003 differentiated its effects on payouts from jury verdicts and

settlements, finding that the proportional reduction was larger for the former (27 percent average reduction) than the latter (18 percent average reduction).[14] One study found that caps significantly reduced total insurer losses in some, but not all, econometric models.[15] Finally, 3 studies did not find an effect of caps on payouts,[6, 8, 16] and one found an effect on claims payments in a regression model that used individual claims as the unit of analysis, but not in a model using states as the observational units.[16]

A null finding is difficult to explain, since the literal effect of caps is to reduce awards. It is typically explained by theorizing that caps change the mix of cases that are brought, such that the reduction in average awards due to the cap is offset by an increase in the average award due to an increase in the average severity of the injuries represented. Overall, the weight of evidence favors the conclusion that caps affect payouts.

Caps also have implications for the vertical and horizontal equity of payouts. Vertical equity refers to the extent to which awards increase with the severity of injury, while horizontal equity concerns the degree of homogeneity in awards for injuries of similar severity. Depending on the level at which they are set, and how this level compares to public judgments about appropriate compensation for very severe injuries, caps may undermine vertical equity. They may make awards for the highest-severity injuries the same as awards for less severe injuries. With respect to horizontal equity, caps are likely to make awards for the highest-severity injuries more uniform—they should fall at or near the cap.

- Overhead Costs.

One study has examined the effects of caps on defense costs in malpractice litigation, finding that caps were associated with a significant cost increase.[17] This is counterintuitive to the dominant theory about the effect of caps, which is that they encourage more rapid settlement by increasing certainty about the value of the case. However, the authors offered an alternative explanation: their result could reflect a greater propensity among insurers to allow cases to go all the way to trial, since the downside risk of trial is lower in jurisdictions that cap awards.

- Liability Costs.

The effect of damages caps on malpractice insurance premiums has been the subject of intense controversy. The issue has been exhaustively studied, with mixed findings among well-designed studies. Four studies have identified significant effects of caps,[13, 18-20] while four older studies found no effect.[8, 12, 16, 21] A reasonable conclusion based on strong, recent studies is that caps moderately constrain the growth of premiums over time, with an effect on the order of 6 to 13 percent.[2] One recent study[20] found larger effects—17 to 25 percent, depending on the specialty—but did not make an important market-share adjustment to its premium data.

The Congressional Budget Office (CBO) recently estimated the cost of a package of 5 reforms implemented together in all states: a $250,000 noneconomic damages cap, a punitive damages cap of $500,000 or twice the economic damages award, collateral-source offsets, a 1-year statute of limitations for adults and 3-year limit for children, and joint-and-several liability reform. Recognizing that many states already have some or all of these reforms in place, CBO estimated the marginal impact of the package as a 10 percent reduction in total national premiums for malpractice insurance.[22]

- Defensive Medicine.

There is good, but not uniform, evidence that damages caps are associated with lower rates of utilization of services that are considered to be indicators of defensive medicine. The best-known study of defensive medicine, by Daniel Kessler and Mark McClellan, found that states with one or more "direct reforms" (including damages caps, abolition of punitive damages, no mandatory prejudgment interests, and collateral-source rule reform) had significantly lower Medicare hospital payments for ischemic heart disease and myocardial infarction.[23] A more recent analysis of overall Medicare expenditures, however, found that these reforms had no significant effect on spending on patients with myocardial infarction, breast cancer, diabetes, or stroke.[24] Study findings regarding cesarean section are mixed,[2] but two strong, recent studies find caps to be predictive of lower rates of cesarean section.[25-26]

CBO's current judgment about the association between tort reforms (including but not limited to damages caps) and the use of health care services is that "the weight of the empirical evidence now demonstrates a link."[22] This finding supersedes its earlier conclusion that the evidence of a link between tort reforms and health care spending was quite limited and was confined largely to spending in the Medicare program.[27] Its current cost model estimates that nationwide implementation of the package of 5 reforms listed above would result in a 0.5 percent decrease in total national health care expenditures.[22] Another recent analysis (albeit one with methodological weaknesses) also found a significant relationship between caps and health care expenditures per capita, estimating that caps resulted in a 3 to 4 percent savings.[28]

- Supply.

There is moderate evidence that damages caps modestly increase the supply of physicians in a state, although studies have returned mixed findings.[2] One study with a very strong methodology found that states with caps and other "direct reforms" experienced 3 percent higher growth than states without caps.[29] Other studies, some of which are unpublished, have found effect sizes in the 2 to 12 percent range.[30-32] A recent study differentiated the effect on physicians in urban and rural areas, finding it to be significant only for rural physicians, with an effect size of approximately 5 percent.[30] Another examined only obstetrician-gynecologists and found no effect.[31] Finally, one unpublished analysis examined the number of hours physicians worked per year and concluded that damages caps had a significant, positive effect.[32]

It is difficult to draw conclusions about the effects of damages caps on health insurance coverage.[3] The theory underlying a relationship between caps (and all other liability-limiting tort reforms) and health insurance coverage is that the reforms will decrease defensive medicine, thereby lowering health care costs, thereby lowering health insurance premiums, thereby increasing the number of people who can afford insurance. This connection is quite remote.

Two studies have examined the relationship between damages caps and employer-sponsored health insurance premiums. One found no significant association,[33] while the other found that caps were associated with significantly (1.3 percent) lower premiums for self-insured plans, but no significant differences for fully insured plans, most of which were HMOs.[34] One unpublished study found a significant, negative association between the presence of a cap and the percentage of state residents under the age of 65 without health insurance, but the study did not control for the presence of other tort reforms.[35] Overall, the evidence concerning the effects of damages caps on physician supply suggests a modest, positive effect, while the evidence concerning health insurance coverage and cost is too limited and equivocal to draw a conclusion.

- Quality of Care.

The effect of damages caps and other tort reforms on quality of care has not been directly studied. As a proxy, several groups of researchers have examined the relationship between tort reforms and patient outcomes, but this is unsatisfactory for a number of reasons. Mortality, the outcome variable of choice in most studies, is a crude indicator of patient outcomes. More importantly, outcomes may bear only a weak relationship to quality of care.

One study of birth outcomes has found that noneconomic damages caps are associated with a statistically significant reduction in preventable complications of labor, but not in infants' Apgar scores.[26] Others have found no association between damages caps and patients' health or mortality.[23, 2436-37] Overall, the evidence base is not sufficient to draw inferences about the relationship between caps and quality of care.

2.1.3. Summary

There is a good evidence base regarding the effects of damages caps, though studies have returned mixed findings. The weight of the evidence suggests that caps achieve substantial savings in average claims payments, modestly constrain the growth of malpractice insurance premiums, modestly improve physician supply, and reduce at least some defensive medical practices. They may increase litigation expenses. Evidence concerning their effects on claim frequency, health insurance, and quality of care is too limited or equivocal to support firm conclusions.

2.2 Pretrial Screening Panels

The function of pretrial screening panels is to review a malpractice case at an early stage and provide an opinion about whether or not the claim has sufficient merit to proceed to trial. Typically, a negative opinion does not bar a case from going forward, but can be introduced by the defendant as evidence at the trial. The rationale for this reform is to reduce the number of nonmeritorious malpractice claims, and the litigation expenses incurred in defending them, by bringing expert judgment to bear before a large amount of legal expenses are incurred. Additionally, panel decisions can provide juries with a neutral source of expertise in cases that go to trial.[4] About 20 states currently have pretrial screening panels of some kind. Screening panels have been repealed in at least 7 states and overturned by courts on constitutional grounds in at least another 5.[4]

2.2.1. Key Design Features and Decisions

Key design choices for pretrial screening panels include the following:

- Timing of review: There is some variation across states in the length of time between the filing of a claim and review by the panel. Longer time periods permit the plaintiff a longer period in which to obtain information in support of the claim, but result in higher litigation expenses as the discovery period progresses.

- Composition of the panel: All states have included physician representation on the screening panel, but states vary as to whether nonphysicians (for example, judges, lawyers, and laypersons) are represented.

- Matters evaluated: Most screening panels evaluate only the merit of the case, but a handful of states have panels that also suggest a recommended amount of damages for meritorious cases.

- Effect of the decision: Among the alternative consequences of the panel's decision that a claim is nonmeritorious are (1) the claim is precluded from advancing; (2) the claim can proceed, but evidence of the panel's decision may be introduced by the defendant at trial; and (3) the claim can proceed, but the plaintiff must post a bond or in some other way provide an up-front payment that is forfeited to the defendant if the plaintiff does not prevail in the litigation.

- Mandatory vs. voluntary: Some states have opted for voluntary rather than mandatory pretrial screening. The rationale for voluntary screening is to create a venue for the parties to get an early, expert opinion about the case, which may encourage settlement or abandonment of the claim.

- Financing: The costs of running the screening panel could be borne by the state or federal government, or could be borne by the parties to litigation through user fees. Some states have adopted a "loser pays" system.

- Discovery powers: In order to ensure that plaintiffs have access to sufficient information to present their case before the panel, some states allow the plaintiff to conduct discovery prior to the panel hearing; some also require that the defendant(s) comply in a timely fashion with discovery requests.

2.2.2. Effects on Key Outcome Variables

- Claims Frequency and Costs.

Theoretically, screening panels should decrease the number of claims that progress to a mature stage and the number and cost of payouts in nonmeritorious cases. However, there is no evidence that they accomplish these objectives. No controlled studies have identified statistically significant effects on claim frequency or payouts, while 7 have found no association.[6, 8-1138-39] Some single-state, descriptive studies have actually identified a higher rate of claiming in the years following implementation of screening panels than in the years prior.[4] The reasons that claiming is not reduced are unclear. It may be that screening panels simply do not issue an adverse decision in many cases, or it is possible that plaintiff's attorneys pursue claims notwithstanding adverse panel decisions because they view panels as biased and unreliable.

- Overhead Costs.

Screening panels involve costs. Even if panel members serve on a volunteer basis, there are overhead expenses for convening panel meetings. In states where full hearings are held, both the panels and the litigants incur additional expenses for preparation, which may include substantial discovery activities. It is unknown whether these extra costs are offset by cost savings associated with (1) the termination of

some cases following the panel's decision, or (2) earlier settlements reached after a panel decision indicating the claim likely has merit.

Most expert commentary expresses the view that panels likely increase litigation costs overall.[4] Single-state, descriptive studies of screening panels have also reached this conclusion. They have found that although panels decrease the number of claims that go to trial, they cause significant increases in average time to claim resolution.[40] Two multivariate studies of the issue have been conducted. One found that mandatory pretrial screening was associated with a significant reduction in defense costs.[17] The other, which had methodological limitations, found that defense costs and the time from incident to resolution of a malpractice claim did not differ in states that had no screening panels, optional panels, or mandatory panels.[38] Overall, the evidence concerning insurers' defense costs is inconclusive, though it is fairly clear that screening panels involve administrative costs to run.

- Liability Costs.

Three studies have examined the relationship between screening panels and malpractice insurance premiums. One study found a significant effect,[21] while the others (one of which was methodologically stronger[8] and one of which was weaker[38]) did not. Overall, there is not a strong basis for concluding that premiums are affected. Theoretically, one would not expect a strong effect, since the effects on claiming and litigation expenses appear to be weak or adverse.

- Defensive Medicine.

The effect of screening panels on defensive medicine or health care spending has not been extensively investigated. Theoretically, the relationship would seem to be very remote. Only if physicians believed screening panels were an effective bulwark against nonmeritorious claims would an effect on defensive medicine be plausible. One study found that states with pretrial screening panels had significantly lower rates of cesarean section and higher rates of vaginal birth after cesarean section, suggesting that physicians may indeed perceive the panels as protective.[25]

- Supply.

No information is available regarding the effect of screening panels on physician supply. The relationship would seem to be very remote. An effect would only be seen if physicians believed strongly enough in screening panels to migrate to states that had them, which seems implausible in light of the prevalence of screening panels and continued high levels of malpractice fear among physicians in most states.

- Quality of Care.

No information is available regarding the effect of screening panels on quality of care, although one unpublished study found no effect on any of six birth outcomes.[37] There is no theoretical reason to believe a relationship exists.

2.2.3. Summary

A handful of well-designed studies have examined the effects of pretrial screening panels, and the weight of the evidence suggests that they are not effective in reducing claims costs, claim frequency, or malpractice insurance premiums. They may help reduce defensive medicine. The evidence concerning their effects on defense costs, physician supply, health insurance premiums, and quality of care is too limited or equivocal to support conclusions about those relationships. Panels involve their own administrative costs.

2.3. Certificate of Merit

Certificate of merit (COM) reforms require the plaintiff in a malpractice suit to present, at the time of filing the claim or soon thereafter, an affidavit certifying that a qualified medical expert believes that there is a reasonable and meritorious cause for the suit. Like pretrial screening panels, the rationale for COM requirements is to reduce the number of nonmeritorious malpractice claims and associated expenses by bringing expert judgment to bear early in the litigation.[4] At least 11 states have adopted COM requirements, but Washington State's COM law was recently struck down on constitutional grounds.[41]

2.3.1. Key Design Features and Decisions

Key design decisions for COM reforms include the following:

- Time to filing of certificate: State laws vary in the time allowed to file the COM, with some requiring simultaneous filing with the initial complaint and others allowing a few weeks or months.
- Definition of qualified expert: Some state statutes specify requirements concerning who may serve as an expert witness for purposes of a COM—for example, a requirement that the individual must spend most of his or her professional time practicing or teaching medicine, a maximum amount of time that may be spent on expert witness work, a requirement that the expert be certified in the same specialty as the defendant, or a requirement that the expert be licensed in the state in which the claim is filed.
- Nature of the affidavit: An affidavit sworn by the expert could be required, or it could be acceptable for the plaintiff's attorney to sign an affidavit attesting that he or she has obtained an expert's opinion that there is reasonable cause for filing the complaint. For expert affidavits, varying levels of substantive detail could be required, from a simple statement that the expert has reviewed the medical record and found there to be evidence of substandard care to a detailed opinion concerning the deviation from the standard of care and how it led to the plaintiff's injury.
- Nature of the attestation: At the outset of litigation, many facts concerning the plaintiff's care may be unclear. For this reason, some states have required experts to attest only that the plaintiff has a reasonable cause to file the claim, or that a reasonable investigation gave the plaintiff a good faith belief that grounds exist to file the claim. Others, however, require the expert to state that after conducting a review, they conclude that the standard of care was not met.[42] This may be difficult to do early in the litigation when discovery has not yet been completed and some facts are unclear.[4]

- Exceptions: Statutes may be drafted to carve out an exception for *res ipsa loquitur* claims—claims relating to injuries that ordinarily would not have occurred in the absence of a deviation from the standard of care (for example, wrong-site surgery). Arguably, an expert witness affidavit is not necessary to establish that such claims have sufficient merit to proceed. However, whether a particular injury constitutes a *res ipsa* claim may be unclear. Another issue is whether to create an exception or extension for plaintiffs in cases where the defendant has failed to produce the relevant medical records in a timely fashion, since this would hinder the plaintiff from obtaining expert review of the case.[42] An alternative mechanism for addressing this problem is to include in the statute a requirement that defendants promptly comply with plaintiff's requests for document production during the period between the filing of the complaint and the filing of the affidavit. This approach may help address conflicts between COM requirements and state constitutional provisions guaranteeing access to courts.[41]

- Consequences of failure to comply: In some states, where a plaintiff has not met all of the requirements of the COM statute, the case is dismissed with prejudice (meaning that the plaintiff cannot re-file the complaint). Other states allow a plaintiff to correct technical deficiencies in the affidavit of merit as long as the plaintiff is substantially in compliance with the COM requirement. Still others impose sanctions on the plaintiff's attorney for noncompliance.

2.3.2. Effects on Key Outcome Variables

Somewhat curiously, studies of state tort reforms have generally omitted COM statutes from their analyses.[4] Evidence concerning the effects of COM is extremely limited.

- Claims Frequency and Costs.

No information is available regarding the effect of COM requirements on claim frequency or payouts. Because COM requirements are often implemented as part of a package of several tort reforms, single-state studies that have found large reductions in the number of claims filed after implementation of reforms[43-44] do not permit inference about the specific effect of the COM law. Anecdotally, plaintiff's attorneys complain that COM statutes with heavy sanctions for noncompliance are used to defeat meritorious complaints: defendants allege some technical noncompliance with the requirement that results in the plaintiff's claim being dismissed.[45] Some experts have made the observation that experienced plaintiff's attorneys routinely obtain an expert opinion before agreeing to invest in bringing a case, calling into question the marginal value of a COM requirement.[4] If this is true, as seems likely, there is no strong reason to suspect that COM requirements will significantly reduce claims volume or costs.

- Overhead Costs.

COM requirements increase litigation costs for plaintiffs. Obtaining the affidavits entails direct costs for plaintiff's attorneys that are estimated at $1,000-$5,000.[46] In some states, COM requirements have led to additional legal expenses when the defendant has challenged whether the plaintiff's expert meets the statutory requirements.[46] Such wrangling is more likely to occur when the statutory language concerning expert witness qualifications is vague or subject to interpretation.

- Liability Costs.

No information is available regarding the effect of COM requirements on malpractice insurance premiums. The effect would be determined by the effect on claims frequency and cost. The theoretical prospects for reductions in premiums are not strong.

- Defensive Medicine.

No information is available regarding the effect of COM requirements on defensive medicine or health care spending. There is no theoretical reason to believe there would be a significant effect, since COM requirements do not appear to impose a substantial barrier to bringing malpractice claims. Reforms can affect defensive medicine if physicians perceive them as protective, even if they are in fact ineffective. However, there is no literature to suggest that physicians believe COM requirements provide strong protection. Physicians tend to believe that expert witnesses are widely available to provide whatever testimony plaintiff's attorneys seek.

- Supply.

No information is available regarding the effect of COM requirements on physician supply. The connection would seem to be quite remote.

- Quality of Care.

No information is available regarding the effect of COM requirements on quality of care. There is no theoretical reason to believe there would be a significant effect. One study of birth outcomes found no significant association between COM requirements and infant mortality.[36]

2.3.3. Summary

No methodologically strong studies have examined the effects of COM requirements. On their face, COM requirements add a modest amount to the cost of litigation. Theoretically, the prospects for affecting the key outcome variables appear quite weak.

2.4. Attorney Fee Limits

Attorney fee limits cap the amount of a malpractice award that a plaintiff's attorney may take as a contingency fee. Nearly all medical malpractice cases are handled by plaintiff's attorneys on a contingent-fee basis, meaning that the attorney takes a percentage of any award the plaintiff receives (legal expenses may be rolled into this percentage, or taken in addition to it), but the attorney receives nothing if no award is recovered. The rationale for attorney fee limits is to discourage plaintiff's attorneys from accepting cases of marginal or no merit by altering the attorney's expected return on investment in the case. Sixteen states currently have limits on attorney fees in medical malpractice cases.

2.4.1. Key Design Features and Decisions

Key design choices for attorney fee limits include the following:

- Nature of the limitation: Fee limits are typically expressed as a percentage of the award, but may also incorporate a maximum dollar value.

- Flat or sliding structure: A single limit may be applied, or some states have opted for a sliding structure that permits attorneys to take a larger share of smaller awards and a smaller share of bigger awards.

- Treatment of legal expenses: The fee limit may be specified to include all fees and expenses that a lawyer would charge, or may apply only to the attorney's fees. In the latter case, expenses such as expert witness payments, deposition expenses, and document filing fees could still be charged against a client's award.

2.4.2. Effects on Key Outcome Variables

- Claims Frequency and Costs.

Theoretically, attorney fee limits should reduce the number of malpractice claims by dissuading plaintiff attorneys from accepting cases that have a low expected return on investment. This effect is not targeted to nonmeritorious cases, as the expected value of a case to an attorney is a function of not only the probability of prevailing, but also the expected damages and the attorney's share of the damages. Contrary to theory, there is strong evidence that attorney fee limits do not affect claiming. Several multivariate studies have shown that attorney fee limits are not associated with either lower frequency of claims[6, 8] or lower average payouts.[6, 8-12] No studies have found a significant association with either of these outcome variables.

- Overhead Costs.

Theoretically, one may expect plaintiff attorneys to invest less time and resources in cases if their share of the proceeds is reduced. However, since lower investment also increases the risk of losing the case and recovering nothing, the theoretical relationship is unclear. Only one study has investigated this issue; it found that attorney fee limits were associated with a significant increase in average defense costs, possibly because attorneys were less inclined to bring small cases.[17]

- Liability Costs.

There is strong evidence that attorney fee limits do not affect malpractice insurance premiums. Two well-designed studies[8, 19] and two methodologically weaker studies[12, 21] have reached this conclusion, while no studies have found a significant association. The theoretical relationship to malpractice premiums is quite remote, and is mediated by the effect on claim frequency and payouts.

- Defensive Medicine.

The theoretical relationship between fee limits and defensive medicine or health care spending is tenuous at best, but has not been extensively investigated. CBO's 2006 model found no significant effect on either general or Medicare health care spending.[27] One recent study found no relationship

with rates of cesarean section or vaginal birth after cesarean section.[25] On the other hand, one study found limited evidence that implementation of one or more "indirect" reforms (attorney fee limits, periodic payment, joint-and-several liability reform, or patient compensation fund) reduced Medicare payments for patients hospitalized for myocardial infarction, breast cancer, diabetes, or stroke. However, the study's authors expressed concern that the result might be spurious.[24] Overall, the existing evidence does not support a relationship between fee limits and defensive medicine or health care spending.

- Supply.

Three multivariate studies directly examined the relationship between attorney fee limits and physician supply and found no relationship.[31, 36, 47] Another examined whether states that adopted one or more of 5 "indirect" reforms (attorney fee limits, periodic payment, joint-and-several liability reform, statute of limitations reform, or patient compensation funds) experienced different levels of growth in physician supply over time and found that they did not.[29] There is no strong theoretical relationship between the two.

- Quality of Care.

No studies have directly examined the effects of attorney fee limits on quality of care. There is no strong theoretical relationship between the two. One study found no relationship between "indirect" reforms, including fee limits, and 1-year mortality among Medicare patients,[24] and two others found no association between attorney fee limits and birth outcomes.[36-37] Overall, the limited evidence available does not support an inference that attorney fee limits affect quality of care or patient outcomes.

2.4.3. Summary

Several well-designed studies have evaluated the effects of attorney fee limits and have uniformly found no effect on claim frequency, claims payouts, malpractice insurance premiums, or physician supply. The limited available evidence concerning defensive medicine and quality of care suggest that fee limits have no effect on these variables.

2.5. Joint-and-Several Liability Reform

At common law, when an award was made against more than one defendant, each defendant would individually be fully liable ("jointly and severally liable") for paying the amount of the award in the event that the others did not pay, even if he bore only a small share of the causal responsibility for the plaintiff's injury. For example, if two physicians were both found liable for malpractice in the amount of $5 million, but one was insured for only $1 million and had no personal assets that could be used to satisfy the judgment against him, the other physician would be liable for the remaining $4 million. Thirty-nine states have adopted statutes modifying this common law rule to limit the financial liability of each defendant to the percentage fault that the jury allocates to that defendant. The rationale for this reform is to eliminate the unfairness involved in joint-and-several liability for "deep pockets" defendants.

2.5.1. Key Design Features and Decisions

The key design decisions for joint-and-several liability reform include the following:

- Applicability to types of damages: Joint-and-several liability can be abolished for all components of a plaintiff's award, or only for the noneconomic damages portion of the award.

- Relationship to comparative negligence: Joint-and-several liability can be abolished in all instances, or it can be maintained when a defendant's percentage share of the responsibility for an injury exceeds a certain threshold (typically 50 percent).[48]

- Relationship to private contractual arrangements: Two or more parties who reasonably anticipate that they may be named as joint defendants in malpractice litigation—for example, a hospital and a physician who has staff privileges at the hospital—may choose to specify in a contract how liability will be allocated between or among them. Joint-and-several liability reforms can be designed to respect these contracts or to supersede them.

2.5.2. Effects on Key Outcome Variables

- Claims Frequency and Costs.

The theoretical link between joint-and-several liability reform and claim frequency is highly tenuous. If many defendants were expected to default on their judgments, then the expected value of malpractice claims would be lower and plaintiff's attorneys would be discouraged from bringing them.[27] There would need to be a widespread belief that defendants commonly had insufficient resources to cover judgments in order for this to occur, however. Two studies have examined whether joint-and-several liability reform results in fewer claims. One found a significant reduction in per-capita claims frequency,[5] while the other found no significant association.[6] Overall, the evidence on this point is limited and inconclusive.

Four multivariate studies have examined the association between joint-and-several liability reform and claims payouts; none found an association.[5-6, 12, 16] However, one study found the presence of joint-and-several liability reforms to be associated with lower long-run medical malpractice losses for some, but not all, liability insurers.[15] (Insurer losses reflect both the number of paid claims and the average payment, and the study could not determine which component drove the lower losses.) Joint-and-several liability reform theoretically should result in lower claims payments for some defendants and higher payments for others, in cases in which one of the defendants could not pay his entire share. Overall, the evidence is weighted towards the conclusion that joint-and-several liability reform does not significantly affect claims costs in the aggregate.

- Overhead Costs.

There is no clear theoretical link between joint-and-several liability reform and litigation expenses. One study has examined this relationship and found no significant association between the reform and defense costs.[17]

- Liability Costs.

The effect of joint-and-several liability reform on malpractice insurance premiums has been studied by several research teams, with mixed results. Two strong studies[15, 19] and one weaker study[20] found no relationship to insurance premiums, while 3 studies with somewhat weaker methodologies found a

significant association with lower premiums.[12, 16, 18] Theoretically, the link between the reform and premiums is largely mediated by the reform's effect on claims costs, so the positive findings regarding premiums are difficult to explain. It has also been postulated that the reform could cause some physicians' insurance premiums to increase, if the effect of the reform was to decrease hospitals' share of liability in multi-defendant cases. However, there is no evidence to support or refute this thesis.[27] Overall, the weight of the evidence (particularly the evidence from more recent studies) slightly favors the conclusion that joint-and-several liability reform does not significantly affect insurance premiums.

- Defensive Medicine.

The effects of joint-and-several liability reform on defensive medicine have been extensively investigated in a handful of studies. The strongest theoretical possibility is that elimination of joint-and-several liability would increase defensive practices by physicians, because the effect of the reform is to increase physicians' liability relative to that of hospitals. Hospitals typically serve as the "deep pockets" defendants in cases involving both physician and hospital defendants, and eliminating joint-and-several liability removes the possibility that physicians' share of the award could be picked up by hospitals.[26] A recent CBO analysis lends support to this thesis, finding that joint-and-several liability reform was associated with an increase in general and Medicare health care spending per capita, as well as hospital spending per capita.[27] Another study of obstetrical practice found that joint-and-several liability reform led to decreased use of cesarean section and induction or stimulation of labor.[26] The authors interpreted this finding as suggesting that the reform leads to *more* defensive medicine because these obstetrical procedures are currently overused and carry a risk of injury to the patient, but others would interpret lower use of these procedures as representing *less* defensive medicine.

Other study findings muddy the waters further. One study (with somewhat weaker methods than CBO's) found no relationship to health care expenditures per capita;[28] another found the reform to be associated with lower spending for 4 diagnoses in Medicare patients,[24] and still another found no relationship.[25] In summary, the evidence on the relationship to health care spending and defensive medicine is equivocal.

- Supply.

Four multivariate studies have examined the effects of joint-and-several liability reform on physician supply. One found that states that adopted one or more of 5 "indirect" reforms, including joint-and-several liability reform, experienced levels of growth in physician supply over time no different from states that did not.[29] Two more recent studies that modeled joint-and-several liability separately from other reforms (one of which was limited to obstetrician-gynecologists) found no significant effect on physician supply.[33, 36] A third found the reform not to be significant in some models, and to have the effect of *reducing* physician supply in others.[47] Theoretically, there is no clear link between joint-and-several liability reform and physician supply. Overall, the evidence weighs in favor of a conclusion that there is no empirical relationship.

One unpublished study with strong methods examined the relationship between joint-and-several liability reform and employer-sponsored health insurance premiums and found that the reform was associated with significantly (1.4 percent) lower premiums for self-insured plans, but no significant differences for fully insured plans.[34]

- Quality of Care.

No studies have directly examined the effects of joint-and-several liability reform on quality of care, but 4 have examined patient outcomes. One study investigated the relationship between "indirect" reforms such as joint-and-several liability and 1-year mortality among hospitalized Medicare patients; in nearly all models, the association was not significant.[24] The other 3 examined birth outcomes, one finding evidence of a lower rate of preventable complications of labor, but none finding an effect on infants' Apgar score, likelihood of low birthweight, likelihood of preterm birth, likelihood of birth injury, or mortality or on maternal mortality.[26, 36-37] There is no plausible theoretical link between joint-and-several liability reform and quality of care, and the weight of the evidence finds no association.

2.5.3. Summary

There is a good evidence base regarding the effects of joint-and several liability reform. Although research findings are somewhat mixed, on balance, the evidence suggests that it has no significant effect on claims payouts, defense costs, liability insurance premiums, physician supply, or quality of care. It may be associated with lower health insurance premiums. The evidence concerning the effect on claim frequency and defensive medicine is equivocal.

2.6. Collateral-Source Rule Reform

At common law, a jury is not permitted to consider evidence that a plaintiff received compensation for his injury from other sources, such as health or disability insurance, when making a decision about how much to award in damages. Thirty-four states have modified this "collateral-source rule" so that any amounts received from other sources are deducted from the amount that a defendant who is found liable for that injury must pay. The rationale for this reform is to eliminate the unfairness and expense of this perceived double recovery to the plaintiff.

Collateral-source rule reforms interact with provisions in insurance contracts (and rules of the Medicare program), known as subrogration clauses, that permit insurers to recoup money they pay in connection with an injury to an insured person if the insured collects damages from a liable third party.[49] In effect, such provisions already prevent double recoveries. However, subrogation rights are not always exercised (indeed, they may rarely be exercised) because of the associated administrative costs.

2.6.1. Key Design Features and Decisions

The key design decisions for collateral-source rule reforms include the following:

- Types of collateral sources covered: Modifications to collateral-source rules could apply to all collateral sources, or only to a specified set of sources. For example, the reform could apply offsets to health insurance but not life insurance.

- Relationship to subrogation rights: Some states have made their collateral-source rule reforms inapplicable to sources that are entitled to a subrogation right. Some courts have interpreted

the subrogation rights in the federal statutes governing Medicare and Medicaid to override conflicting state law.[48]

- Mandatory or discretionary: The reform can be implemented by automatically reducing a plaintiff's award or by allowing defendants to introduce evidence of collateral sources at trial, allowing the trier of fact discretion to decide whether and how to adjust the award.[48]

2.6.2. Effects on Key Outcome Variables

- Claims Frequency and Costs.

Four multivariate studies have modeled the relationship between collateral-source offset rule reform and claim frequency. The oldest study found a significant, negative association;[10] the other studies did not find a significant association.[5-6, 8] There is no plausible theoretical link between the reform and claim frequency.

Seven multivariate studies have examined the association between collateral-source offset rule reform and claims payments or insurer losses. Two studies found a significant, negative effect,[9-10] while the other 5 found no association.[5-6, 11, 15] Theoretically, collateral-source offsets should substantially reduce average award size because the literal effect is to deduct money from the plaintiff's damages. However, somewhat curiously, most studies do not support this notion.

- Overhead Costs.

One study has examined the effects of collateral-source rule reform on defense costs and concluded that there is no significant association between the two.[17] The only theoretical link is that defendants may incur extra expenses investigating collateral sources.

- Liability Costs.

Seven multivariate studies have examined the association between collateral-source rule reform and malpractice insurance premiums. Five did not identify a statistical association on average.[8, 12, 18-19, 21] One more recent study found a significant effect on premiums for insurance companies but not others.[15] Another recent study with a notable methodological limitation found a significant effect for mandatory collateral-source offsets but not for laws that merely allow the jury to consider evidence of collateral sources.[20] Theoretically, to the extent that collateral-source offsets decrease claims payments, insurers should pass along their savings to their insureds in the form of lower premiums. Overall, the evidence suggests that this effect is weak or nonexistent.

- Defensive Medicine.

There is no plausible theoretical link between collateral-source offsets and defensive medicine or health care spending. Three studies found no significant effect on health care spending,[24, 2728] and other work found no relationship to rates of cesarean section, induction or stimulation of labor, or vaginal birth after cesarean section.[25, 26]

- Supply.

Three studies have directly measured whether collateral-source rule reform is associated with higher physician supply, and each found no association.[31, 33, 34] Another study found that states that had adopted collateral-source offsets and/or 3 other "direct" reforms had 3 percent higher growth in physician supply over time,[29] but the individual effects of the various reforms cannot be ascertained on the basis of this analysis. The theoretical association is tenuous, as physicians are unlikely to perceive the protection of the offsets as substantial enough to justify a decision to practice in a particular state. Overall, the evidence suggests there is no relationship between collateral-source rule reform and physician supply.

One unpublished study with important methodological limitations examined the relationship between collateral-source rule reforms and the prevalence of health insurance coverage among under-65-year-olds and found no significant association.[35] Another unpublished study with stronger methods found that collateral-source rule reforms were significantly associated with lower health insurance premiums for self-insured plans, but not for fully insured plans.[34] The theoretical relationship between these variables is tenuous. Subrogation rights allow health insurers to recoup from health care providers the amounts they paid in medical expenses for patients injured by malpractice, which could result in lower premiums. However, these rights may be exercisable whether or not the plaintiff's award was offset for the collateral source, and the rights may not be exercised much in practice.

- Quality of Care.

No studies have directly examined the effects of collateral-source rule reform on quality of care, but 4 have examined patient outcomes. One study found no association between adoption of one or more "direct" reforms, including collateral-source offsets, and 1-year outcomes for Medicare patients hospitalized for myocardial infarction, breast cancer, diabetes, or stroke.[24] Of the 3 studies that examined birth outcomes, 2 found no relationship to rates of preventable complications of labor or infant health or mortality[26, 37] and the third found a reduction in infant mortality.[36] There is no plausible theoretical link between collateral-source rule reform and quality of care. Overall, the evidence weighs against the conclusion that patient outcomes are affected.

2.6.3. Summary

The evidence base concerning collateral-source rule reform is fairly strong. On balance, the evidence suggests that the reform does not significantly affect claim frequency, claims payouts, overhead costs, liability insurance premiums, defensive medicine, physician supply, or patient outcomes. It may reduce health insurance premiums.

2.7. Periodic Payment

Periodic payment allows or requires insurers to pay out malpractice awards over an extended period of time, rather than in a lump sum. This enables insurers to purchase annuities (sometimes called "structured settlements") from other insurance companies which cost less than paying the entire award up front. Insurers are also able to retain any amounts that the plaintiff does not actually collect during

his or her lifespan. The rationale for this reform is to smooth out an insurer's expenses over time and to permit the purchase of annuities. Thirty states currently permit or require periodic payment.

2.7.1. Key Design Features and Decisions

The key design decision for periodic payment is whether to make it mandatory in all cases, mandatory in cases involving damages over a certain amount, or simply available at the request of either of the parties.

2.7.2. Effects on Key Outcome Variables

- Claims Frequency and Costs.

There is no theoretical reason to believe that periodic payment would affect either the number of claims filed or the average amounts awarded. They do not affect the valuation of a case, only the means through which the award is paid out. Three studies have examined the effect on claim frequency; one found a significant reduction,[6] while the others found no effect.[5, 9] Five studies have examined the effects of periodic payment on claims payments; 4 found no significant effect.[6, 9, 11, 12] while one found a significant reduction).[5] Overall, the evidence concerning claim frequency is too limited and equivocal to support a firm conclusion, while the evidence concerning claims payouts suggests that periodic payment does not result in a significant reduction.

- Overhead Costs.

No information is available regarding the effects of periodic payment on overhead costs. In theory, periodic payment could increase insurers' administrative expenses (e.g., search and transaction costs for annuities; tracking periodic payments over time) or decrease these expenses (e.g., by smoothing out shocks due to large awards that may make reinsurance more expensive or difficult to find).

- Liability Costs.

Theoretically, periodic payment should result in modest savings to insurers due to the availability of annuities. Whether they pass along these savings in the form of lower liability insurance premiums is, however, another matter. Only 2 studies have examined this issue; one found no significant association between periodic payment and premiums[12] and in the other, the results varied across medical specialties.[20] Overall, the evidence concerning this effect is limited and equivocal.

- Defensive Medicine.

Very limited information is available regarding the effects of periodic payment on defensive medicine. There is no plausible theoretical nexus between the two. One recent study found no significant relationship between periodic payment and rates of cesarean section or vaginal birth after cesarean section.[25] Another found that implementation of one or more "indirect" reforms, including periodic payment, was associated with lower spending for 4 diagnoses for Medicare patients, but the authors were skeptical of the finding.[24] Overall, the evidence is too limited and equivocal to support a firm conclusion about the effect on defensive medicine.

- Supply.

The theoretical relationship between periodic payment and physician supply is tenuous at best. There is no reason to think physician location decisions would be influenced by a reform that affects only insurers directly and has no demonstrated effects on physician insurance premiums. Three studies have examined periodic payment in isolation from other reforms, and all found no significant association with physician supply.[31, 36, 47] Another study that lumped 5 indirect reforms, including periodic payment, together also found no significant effect on physician supply.[29]

- Quality of Care.

No studies have directly measured the effects of periodic payment on quality of care. There is no plausible theoretical nexus between the two. One study examined the relationship to 1-year mortality among Medicare patients; in most models, the association was not significant.[24] The only other pertinent study, an unpublished work, examined 6 birth outcomes and found no significant relationship to periodic payment reforms.[37]

2.7.3. Summary

The effects of periodic payment have not been extensively studied. The limited evidence available suggests that it has no beneficial effects on claims payments or physician supply. The evidence is too limited to draw conclusions about the effect on overhead costs, defensive medicine, or quality of care. The evidence concerning claim frequency and liability insurance costs is equivocal.

2.8. Statutes of Limitations/Repose

This reform aims to restrict the amount of time a patient has to file a malpractice claim. Statutes of limitations bar suits unless they are filed within a specified time after the injury occurs or is discovered. Statutes of repose are more stringent, specifying that the time limit runs from the date of injury regardless of when the injury is discovered. All states have adopted statutes of limitation or repose for medical malpractice claims, though they vary in length and triggering event. Statutes of limitations typically are set at 2 or 3 years, and statutes of repose at 3 to 4 years.

The primary rationale for this reform in the context of malpractice claims is to shorten the long "tail" associated with such claims—that is, the long time between the incident date and the date the insurer learns what its liability for the incident will be. The tail problem is believed to be one of the factors driving insurer mistakes in pricing malpractice insurance. Many insurers are thought to have underestimated their liability in the 1990s, not realizing what lay in their tail, which led to price shocks in the early 2000s. A second rationale for statutes of limitation and repose is to avoid the difficulties of litigating claims when the evidence has grown stale (for example, when people's recollections of an event have faded over time).

2.8.1. Key Design Features and Decisions

Key design decisions for this type of reform include the following:

- Discovery rule: Statutes of repose are quite stringent because the time period for filing the claim begins to run from the date of injury, regardless of when the patient discovered the injury. Some types of malpractice injuries, such as missed diagnoses of cancer, may not become known for several years. An alternative is to set the statute of limitations to run from the date of discovery (or the date that a reasonable person would have recognized the injury).

- Length of period: In setting the length of time to file, the competing considerations are, on the one hand, allowing a reasonable period of time for an injured plaintiff or grieving family to obtain legal representation and assemble the information needed to support a claim, and on the other, providing reasonable protection for health care providers against claims relating to incidents that have faded from the recollection of the involved parties.

- Applicability to minors: States typically apply a special rule to minors, allowing the statute to run only after they have reached the age of majority, but the alternative is to put the onus on the minor's parents to file within a specified period of time from the date of injury or discovery of the injury.

2.8.2. Effects on Key Outcome Variables

- Claims Frequency and Costs.

In theory, shorter statutes of limitation/repose should reduce the number of malpractice claims by barring suit by plaintiffs who wait too long to file. Multivariate studies that have examined the association between statutes of limitation/repose and claim frequency have returned mixed findings. Two well-designed studies found a significant effect,[8, 10] while two strong studies did not.[6, 9] Overall, the evidence concerning claim frequency is too equivocal to ground firm conclusions.

Statutes of limitation/repose should not affect average claim payments, and all studies of this issue but one[9] confirm this theoretical prediction.[6, 8, 11, 12]

- Overhead Costs.

Theoretically, shorter statutes of limitation/repose could decrease liability insurers' operating expenses by improving their ability to predict their long-term losses, thereby facilitating accurate decisions about reserving, investment, and reinsurance practices. However, the one study to examine this issue found no significant relationship between the reform and defense costs.[17]

- Liability Costs.

Four studies have looked at the relationship between statutes of limitation/repose and malpractice insurance premiums. In theory, shorter statutes should decreases insurers' losses and the degree of unpredictability around their long-term liability, both of which could translate into lower premiums for physicians and hospitals. The study with the strongest methodology found a significant effect on premiums,[8] but 2 others studies did not.[12, 21] The remaining study found a significant association for some clinical specialties but not others.[20] Overall, study findings are mixed, but the evidence weighs slightly in favor of a conclusion that premiums are reduced.

- Defensive Medicine.

Very limited information is available regarding the effects of shorter statutes of limitations/repose on defensive medicine or health care spending. The theoretical connection between the two is tenuous at best. One recent study found no effect on rates of cesarean section or vaginal birth after cesarean section.[25]

- Supply.

Only one study has examined the effect of statutes of shorter statutes of limitations/repose on physician supply, though it did not isolate that effect from the effects of other reforms. It found that the change in physician supply in a state over time was not significantly affected by the state having adopted one or more of the 5 "indirect" reforms.[29] There is no plausible theoretical nexus between statutes of limitations and physician supply.

- Quality of Care.

No information is available regarding the effects of shorter statutes of limitations/repose on quality of care. There is no plausible theoretical nexus between the two. The only relevant study is an unpublished study finding no relationship between this reform and any of 6 birth outcomes.[37]

2.8.3. Summary

The evidence base concerning statutes of limitation/repose is of fair size and strength. The weight of the evidence suggests that this reform does not significantly affect claims payouts, defensive medicine, or physician supply. A limited amount of evidence suggests a beneficial effect on liability insurance premiums. The evidence concerning the reform's effect on claim frequency is equivocal. The evidence concerning overhead costs and quality of care is too limited to ground firm conclusions.

3. Innovative Reforms

3.1. Schedule of Noneconomic Damages

A schedule of noneconomic damages is an alternative to a flat cap that adjusts the amount of damages awarded for pain and suffering according to the severity or the injury. A more sophisticated version of a tiered cap, a schedule involves (1) creation of a multi-tier hierarchy categorizing medical injuries, (2) assignments of relative value weights to each tier reflecting variations in severity across tiers; and (3) assignment of dollar values for noneconomic damages awards for each tier. The schedule is used by juries and judges either as an advisory document or as a binding guideline.

The rationale for this reform is to achieve the goals of a flat cap on noneconomic damages while avoiding the inequities that occur in applying a single, relatively low dollar amount to all injuries regardless of severity level. Schedules promote both horizontal equity (similar injuries receive similar compensation) and vertical equity (more severe injuries receive higher compensation).[50-51] Schedules also serve the goal of absolute fairness in compensation—that is, setting damages to match (and not exceed) societal expectations about what constitutes appropriate compensation for particular injuries.[51]

Finally, they avoid the negative ramifications of unpredictability in damages awards, including instability in the cost of liability insurance, weakened deterrence of medical error, and loss of public faith in the legitimacy of the compensation system.[50, 52]

No states have adopted a noneconomic damages schedule, but some have considered it.[53] Many public compensation programs for other kinds of injuries award compensation on the basis of schedules, including the Social Security Disability Insurance program and workers' compensation programs.[54] Schedules are also used for determination of damages in many foreign compensation systems, including administrative compensation schemes for medical injuries in Denmark and Sweden, workers compensation schemes in Australia, the civil justice systems in Belgium, France, Italy, Netherlands, United Kingdom, and Hong Kong, and the traffic accident compensation system in Finland.[52, 55-57]

3.1.1. Key Design Features and Decisions

Key design decisions for a noneconomic damages schedule include the following:[52]

- Creation of severity tiers: What source of information should be used to create the injury severity tiers for the schedule and group injuries within tiers? Several options are available, none of which perfectly capture the construct of hedonic (quality-of-life) loss:[50, 52]
    - *Standardized valuation scenarios*:[50, 58] Standardized injury descriptions and tier assignments for each could be developed and provided to juries and judges, which could then choose the tier/description that most closely resembled the case at bar. This approach is used in the United Kingdom. An advantage of this option is that it provides very concrete injury description. A disadvantage is that it requires considerable judgment to place injuries that do not closely resemble the examples into a tier.
    - *National Association of Insurance Commissioners' (NAIC) Severity of Injury Scale*:[59] The 9-point NAIC scale is widely in use among malpractice insurers and other insurers in valuing claims. It is based on the concept of injury-associated disability, dividing disability into 9 levels from "emotional disability only" to "permanent grave" and "death". For each level, the Scale describes a representative group of injuries (e.g., "permanent grave" injuries include "quadriplegia, severe brain damage, lifelong care, and fatal prognosis"). An advantage of this option is that it may be easier for juries to classify injuries if they are given broad category descriptions. The scale has also been shown to have high interrater reliability for injury classification.[52] A drawback is that it may lump together injuries of quite different severity—for example, both mild fright and severe emotional trauma would be classified in the lowest tier. Additionally, the focus on degree of disability obscures other important aspects of hedonic loss, such as disfigurement or pain that does not affect physical functioning.
    - *Group consensus*: A less quantitative approach to tiering would involve convening a group of experts and asking them to make ex ante judgments about how to classify a wide range of injuries. Examples of such an approach include the American Medical Association's *Guides to the Evaluation of Permanent Impairment*,[60] which is widely used by state workers compensation programs, and the panels appointed in Sweden and Denmark to scale noneconomic damages awards for their civil justice and no-fault compensation systems.[52] An advantage—or, from another perspective, a disadvantage—of this approach is that it is anchored in expert judgments about loss. Medical experts are very familiar with the effects of injuries and illnesses, but may value

quality-of-life impacts differently from the lay public or those afflicted with injuries or disease.

- *Health utilities indexes*: Decision science researchers have developed a variety of schemes for valuing states of ill health and disability based on what members of the public would be willing to trade off in order to avoid the state. The most widely used metric is quality-adjusted life years (QALYs), but there are others. Other research has described in detail how these metrics could be used to devise a scale for a noneconomic damages schedule.[52, 61] An advantage of this approach is that it is grounded in public judgments about hedonic loss and incorporates a broad array of information about hedonic loss (as opposed to just information about disability). Criticisms include the complexity of the method and the documented errors that healthy individuals make in predicting the disutilities associated with health states they have not experienced.[62]

- Consideration of plaintiff characteristics in tiering: Although the basic tiering scheme in a schedule of noneconomic damages is based on the severity of the injury, additional cells could be added reflecting the plaintiff's age, at least for permanent injuries.[57] The rationale would be that younger plaintiffs will endure the quality-of-life decrements associated with permanent injuries for a longer period of time than older plaintiffs. A more complicated tiering structure could also incorporate other plaintiff characteristics, such as whether the plaintiff's pre-injury occupation or personal interests made the injury particularly devastating, but care would need to be taken to avoid highly subjective determinations.

- Determination of weights and dollar values: Relative weights must be assigned to each tier in a damages schedule. Assigning numerical weights or "relative values" permits comparison of injuries in different tiers—indicating, for example, that an injuries in Tier 9 is considered three times as severe, in terms of pain and suffering, as an injury in Tier 5.[50, 52] These weights are then used to assign dollar values to each tier (i.e., some baseline value is determined for Tier 1, and the weights are used as a multiplier to derive values for other tiers).

  How should weights and the initial dollar values be assigned? The principle of absolute fairness in compensation suggests that assignment should be accomplished through a deliberative, representative, public process.[52] One option is to base values on jury awards or settlements in previous, similar cases.[51, 58, 6163-64] This approach reflects extant public decisions about fairness in compensation (at least to the extent that it reflects jury awards), but results in a schedule that is grounded in the judgments of juries who received no guidance.[61] A second option is to assign the task to a committee with representation from all major stakeholder groups and access to information about existing awards and how injuries are valued in other kinds of compensation systems. Such a process would have to be very carefully designed in order to have public legitimacy. A third option is to appoint a group of experts in medicine, decision science, and law to evaluate research about the quality-of-life impacts of various states of ill health and disability and arrive at values based on the findings. This approach would be quite evidence based, but might be perceived as excluding lay opinion. A fourth option is to simply apply a multiplier of the economic damages award or medical expenses award.[62] However, because lost income and medical expenses may not be highly correlated with pain and suffering (particularly for injuries that cause suffering but not extensive functional impairment and that have no effective treatments), this option strays quite far from the purpose of noneconomic damages. It could also induce strategic behavior by plaintiffs to try to inflate their medical expenses and income loss.[65]

- Expression of dollar values for each tier: Damages for each severity tier can be expressed with a single dollar figure (adjustable for inflation) or as a dollar value range.

- Updating: A process should be identified for periodically considering whether advances in medical care or other factors suggest a need to reevaluate the classification of particular injuries into particular severity tiers. Dollar values should also be adjusted for inflation and other relevant factors on a regular basis.

- Effect on jury and judicial decisions: A schedule could be made binding on juries and judges, merely advisory, or presumptive.[52] Binding schedules maximize predictability and equity in compensation, but may pose constitutional difficulties in states whose constitutions have been interpreted to preserve the right of juries to determine damages.[50] They also may result in seemingly unjust awards if juries have no discretion for departures in exceptional cases. Advisory schedules avoid constitutional difficulties, but clearly have less potential for standardizing awards and preventing very large awards. Presumptive schedules fall in the middle, requiring the jury to find a strong reason justifying an upward or downward departure from the schedule. In the context of binding schedules, an alternative way to permit some measure of discretion for the trier of fact would be to permit "special damages" to be awarded in certain narrowly defined types of cases.[54]

- Inclusion of wrongful death cases: Fatal injuries could be classified into one of the severity tiers, but do not create the same kind of hedonic losses as non-fatal injuries. It may be desirable to treat wrongful death cases specially, either through creation of a special injury tier or by exclusion from the schedule.

3.1.2. Effects on Key Outcome Variables

Although many foreign civil justice systems and some U.S. systems of administrative compensation use damages schedules, none of these settings is sufficiently analogous to the American medical malpractice system to permit strong, evidence-based inferences to be drawn about the likely effect noneconomic damages schedules would have on the key outcomes evaluated in this report. However, it is possible to make some theoretical predictions based on these analogues and on evidence concerning how caps on noneconomic damages have worked in the U.S.

- Claims Frequency and Costs.

Although there is some evidence that noneconomic damages caps affect claims frequency, there is no strong reason to believe that a noneconomic damages schedule would necessarily do so. The extent to which plaintiff and attorney incentives to bring claims are dampened by a schedule would depend on how the dollar values chosen for the schedule compare to what is available in the status quo. Most advocates of schedules envision that awards for the high-severity tiers would be higher than those permitted by the damages caps laws that operate in many states. Overall, no conclusions can be drawn about the likely effect on claim frequency without making assumptions about the level of damages available under a schedule.

Similarly, whether scheduling would increase or reduce claims costs depends on the generosity of the damages available in each tier. Clearly, many possibilities can be envisioned, and foreign countries that

utilize schedules vary tremendously in the amounts awarded for noneconomic damages for similar injuries.[55]

These outcome variables might also be affected by whether the schedule is binding on juries, presumptive, or merely advisory. Interestingly, however, experimental research suggests that even purely advisory guidance to juries on noneconomic damages substantially reduces award variability.[66] Survey research indicates that jurors tend to express frustration at the lack of guidance they receive about noneconomic damages valuation in current jury instructions,[67] further suggesting that juries would be receptive to even advisory schedules. Behavioral economics research documenting the effects of "anchoring" on people's valuation decisions[68] lends further credence to the likely efficacy of advisory or presumptive damages schedules in influencing award decisions. Thus, regardless of whether or not the schedule is mandatory, it is likely to reduce the variance in awards. It remains an open question, however, whether this convergence will be to a mean that is higher or lower than average awards in the current system.

- Overhead Costs.

The process of creating and updating damages schedules would involve administrative costs, which may be quite significant for some of the more complex methodologies.[62] On the other hand, improved predictability of the value of a case at trial should promote settlement, reducing litigation costs.[50, 58] Litigation expenses may also be reduced because litigants would not have to offer expert opinion as to the extent of hedonic loss in a case. Overall, it is not clear how these countervailing cost considerations would net out, but it seems likely that schedules could reduce total system overhead costs.

- Liability Costs.

Schedules would improve the predictability of damages awards, enabling insurers to perform more accurate actuarial assessments and make appropriate reserving decisions.[58] Arguably, they would improve predictability to an even greater extent than flat caps, since they would provide more granular information about the expected noneconomic damages awards for different types of injuries. Hopefully, insurers' savings would be passed on in the form of lower premiums.[52] To the extent that schedules lowered claims costs, this could also redound to the benefit of providers through lower prices.

- Defensive Medicine.

Theoretically, defensive medicine might be reduced if schedules enabled physicians to better predict the consequences of malpractice. Law-and-economics theory posits that one of the important reasons for defensive medicine, or "overdeterrence" of medical error, is that physicians tend to overvalue their potential liability and therefore make non-cost-justified precautions.[50] Evidence concerning noneconomic damages caps suggests that such an effect occurs. However, if what providers fear is the psychological and reputational costs of being sued, rather than the economic sanction of the ultimate payout on the claim, then the effect of schedules on defensive medicine may be rather slight. Overall, there is a reasonable basis for predicting a modest improvement in defensive medicine.

- Supply.

There is evidence that damages caps are associated with small increases in physician supply. However, whether the same would be true for schedules may depend on the levels at which damages are fixed. If schedules do not (or are not perceived as) significantly limiting physicians' liability, merely making it more predictable, there may not be a supply response. Overall, there is no strong theoretical prediction that emerges on this point.

- Quality of Care.

Some commentators have argued that schedules may undermine optimal deterrence, giving health care providers less incentive to practice safely. The decisions made about valuation of noneconomic loss in a scheduling system may not accord with the valuations necessary to induce socially optimal levels of precaution taking by health care providers.[62] This disjunct may, however, be equally or more true of the current system of awarding noneconomic damages. Moreover, scholars have argued, deterrence should be reinforced by improving the predictability of the sanction that would result from a breach of the standard of care.[50] That is, health care providers would be more likely to take optimal precautions if they had a better sense of the likely damages awards that would result from malpractice suits. Overall, no clear prediction about the effect of schedules on quality of care emerges from these considerations.

3.1.3. Summary

Very little evidence is available to support conclusions about the likely effects of damages schedules on the key outcome variables. However, analogous systems and law-and-economics theory suggest that schedules could have beneficial impacts on overhead costs, malpractice insurance premiums, and defensive medicine. It is not possible to draw conclusions about the effects on claims frequency and costs, physician supply, or quality of care without making assumptions about how the amount of money available for an injury of a given severity level under a damages schedule would compare to the amount available under the current system.

3.2. Administrative Compensation Systems or "Health Courts"

The use of administrative compensation systems or "health courts" for medical injury has frequently been proposed over the last 40 years.[69-85] Proposals for administrative systems or health courts can contain several differing features, but most fit into one of two general models. In one model, often described as a *medical court*, a jury is replaced with a specially (in most proposals, medically) trained judge to adjudicate the negligence determination. Most of the other features of the present tort process are kept without much change. In the second model, an administrative agency investigates and adjudicates claims for medical injury. In this *administrative model*, claims would first be filed with an administrative body (as opposed to a court) that would process the claim, just as an insurance agency would process a claim. Both models are similar in that they attempt to replace the current jury model with a more efficient process, but variations in their approaches can translate to different effects.

The medical court model is a smaller departure from the present tort system than an administrative model. In the former, the primary departure is the replacement of the lay judge and fact-finder (either a judge or jury) with a judge and fact-finder with both medical and legal training. In some medical court models, the court could seek opinions from its own specialized neutral experts on a case-by-case basis.

Other variations are possible, such as changing the compensation standard, but most medical court proposals keep the remainder of the tort process intact. This model is rooted in the notion that better equipped judges and fact-finders would make quicker and more accurate decisions. The objective is not necessarily to improve patient access to compensation, but rather to handle the claims filed more accurately and efficiently.

In the administrative model, compensation decisions are no longer made in court, but rather by an administrative agency. This agency would act as a neutral fact-finder and adjudicator so that the process would not be slowed down by an adversarial fact-finding process. Decisions could theoretically be rendered more cost-effectively because neither attorneys nor experts to represent each point of view would be required. Because filing a claim should be easier, administrative models can have the additional benefit of increasing the number of patients with access to the compensation system. To further boost access to compensation, most administrative models call for the use of a compensation standard broader than negligence, such as "avoidability".

Because no comprehensive administrative systems for medical injury have been launched in the United States, little direct evidence exists regarding the effects of administrative compensation system models on the key outcome variables evaluated in this report. However, some analysis regarding key design features and outcomes is possible based on the limited administrative systems operating in the U.S., foreign experience with administrative models, and research on the effects of other tort reforms.[72-73, 85-89] Administrative systems in the United States include Florida's Birth-Related Neurological Injury Compensation Plan and Virginia's Birth-Related Neurological Injury Compensation Program, both of which aim to provide compensation for birth-related injuries.[86, 88-89] In addition, the U.S. National Vaccine Injury Compensation Program has been operating since 1998 to compensate for vaccine-related injuries.[72, 87] Scandinavian nations (notably Denmark and Sweden) and New Zealand have also operated administrative compensation models since the 1970s when their nations began to abandon their negligence-based system for medical injury.[73, 85]

3.2.1. Key Design Features and Decisions

The key design decisions for health courts include the following:

- Exclusivity of remedy: In the design of any administrative compensation system, one of the first questions that must be answered is whether the system will be patients' only legal remedy for malpractice, or whether claimants can opt to pursue their claims in the administrative system or in the courts. Although the administrative system should be attractive to claimants due to the ease with which a claim can be filed, some claimants may prefer the tort system—for example, because it is more likely to lead to a larger award or because juries are perceived as fairer or more sympathetic than judges.[76, 78]

  Any exclusive system must be designed to pass constitutional muster. The United States Constitution and state constitutions guarantee several rights that bear on the constitutionality of health courts, including due process, the right of access to courts, and the right to a jury trial.[72, 77, 90-91] A detailed constitutional analysis is beyond the scope of this report, but has been conducted elsewhere.[77, 90-91] Other exclusive administrative systems, such as workers' compensation systems, have been successfully designed and implemented while withstanding constitutional challenges.[77, 92]

A voluntary design avoids these constitutional difficulties for the most part, but has other disadvantages. Due-process rights would still require that a mechanism for informing patients about their choice and eliciting informed consent to participation be developed. Laws in some states may prohibit such pre-injury agreements.[80, 91] A significant loss of cost-control potential arises from possible selection effects if claimants are permitted to choose the system (administrative vs. tort) that best serves their needs. Such an approach perpetuates the current inefficiencies of the tort system and essentially creates two tracks for compensation, leading to greater complexity.[76, 78, 84] Claimants with higher-value claims may disproportionately select into the tort system, resulting in lost opportunities to curb very high-cost awards through an administrative process.

- Appeals rights: Whether or not use of the administrative system is mandatory, the administrative system will need to address parties' rights to appeal unfavorable decisions.[77, 91] Claimants may wish to appeal findings that no compensation is warranted or findings as to the appropriate amount of compensation. Providers may also wish to appeal the adjudicator's findings, particularly if an adverse decision results in an unwelcome consequence for the provider, such as a report to the National Practitioner Data Bank. Appeal rights may be structured to provide direct appeal to judicial courts or judicial appeal only after an intermediate, administrative appeal. The standard of appellate review can be specified at various levels ranging from *de novo* review (a fresh look at the evidence, with no deference given to the initial tribunal's decision) to an "arbitrary and capricious" standard (the initial adjudicator's decision will only be overturned if it appears to be totally arbitrary).

- Types of claims: An administrative system will also need to specify what types of claims it will handle. A system may opt to process all claims for medical injury. It may also just hear a subset of them, for example: injuries representing certain types of harm (e.g., neurological injuries to newborns); injuries resulting from specific causes (e.g. medication-related injuries); or injuries of a certain severity level (e.g., only injuries that have resulted in 5 days or more of lost work time). Examples of medical injury schemes that cover specific injuries include Florida's Birth Related Neurological Injury Compensation Plan and Virginia's Birth-Related Neurological Injury Compensation Program.[76, 88-89] A scheme that covers harm based on the cause of injury is the National Vaccine Injury Compensation Program.[87] The Swedish and Danish administrative systems provide an example of schemes that apply severity thresholds; in Sweden, claims must be valued above approximately USD$275 to be eligible for compensation, and in Denmark, approximately USD$1700.[73]

  One potential benefit of defining a subset of claims for administrative system jurisdiction is the creation of a more predictable set of claims to adjudicate. However, the potential impact on system-wide costs, access to compensation, and other variables is obviously smaller the narrower the set of included claims is. Additionally, legal wrangling may arise over whether a particular claim meets the defined categories for jurisdiction.

- Filing method: In the current tort system, plaintiffs may file without an attorney, but navigating the process is daunting enough that most claimants need an attorney. Administrative systems can be designed to be navigable without an attorney.[73-74] The complexity of the model—whether administrative or medical court model—and the particular claim will determine the likelihood that an attorney will be needed.

The removal of the need for an attorney carries the potential to make filing easier, particularly for claimants whose claims are too small to interest attorneys working on a contingent-fee basis. On the other hand, it would be expected to result in the filing of more claims, possibly including a greater number of nonmeritorious claims.

- Compensation standard: Administrative models generally propose to replace the negligence standard with broader alternative standards that do not require proof of provider negligence or fault. Among the options are an *avoidability* standard (compensating all injuries that ordinarily should not occur in the hands of the best specialist or an optimal system of care) or a *no-fault* or strict liability standard (compensating all injuries attributable to medical management, except for some known, frequent complications). A *no-fault* standard is broader than an *avoidability* standard because it can provide compensation in cases of unexpected or rare complications that may not meet an *avoidability* standard. For example, a *no-fault* standard would compensate a patient who suffers a severe and unexpected adverse reaction to a properly prescribed and administered medication; under an *avoidability* standard, this injury would not be compensable because it could have happened in the hands of the best specialist.

  Relevant considerations in selecting a standard include patient access to compensation, operational feasibility, alignment with principles and practices in patient safety, and administrative and liability costs. A broader standard may not only bring compensation to a greater number of patients, but also improve system efficiency because it is more easily adjudicated than negligence.[73, 75, 93] In addition, an avoidability standard may also better match the concept of preventable harm that dominates the patient safety movement (i.e., provide compensation for injuries which, although not the result of unreasonable actions, are still avoidable or preventable).[73, 75, 93] An even broader standard, such as no-fault, would be even easier to administer.[73] A no-fault standard would not compensate all injuries caused my medical care, but just those that are not "necessary and ordinary to" medical care (e.g., the loss of hair due to chemotherapy would not be compensable but a post-surgical infection would be).[73] A no-fault standard would, however, be more expensive because a greater proportion of claims would be paid. It also would not align as well with patient safety principles that focus on preventability of harm.

  To bring further efficiency, accuracy, and consistency around application of a compensation standard, some commentators have recommended that consideration be given to creating "accelerated-compensation events" (ACEs) which are automatically or presumptively eligible for compensation on a "fast track" because a group of experts has judged them to be almost always negligent or avoidable (e.g., retained foreign bodies).[94-96]

- Adjudicators: For the medical court model, the adjudicator will likely be a physician-judge. In the administrative model, the options include a judge who specializes in malpractice cases, a physician-judge, and (at lower levels of decision making) an administrative claims manager (with or without a background in law or health care) with expert physician support. Administrative models, such as those in New Zealand and Scandinavia, tend to rely heavily on administrative claims managers with only limited review by other adjudicators.[73] The design of both models will need to include how adjudicators will be assisted in (1) using the best available evidence to yield accurate decisions and (2) how precedent will be created and followed for consistency of decision-making. Some proposals suggest that adjudicators be assisted by both neutral experts

and decision guidelines developed in advance by a group of experts covering considerations relevant to commonly seen injuries.[74]

- Award types and amounts: Except in states that have adopted statutory limits, the tort system does not set limits on the damages (economic, noneconomic, and punitive) that juries and judges may award. The design of an administrative compensation system will need to include whether or not limits on damages (economic, noneconomic, or punitive) will be applied. One option is to adhere to any existing damages caps legislation but impose no other restrictions. Another is to strike the existing caps and allow the adjudicator full discretion, but this may pose cost-control problems. A third option is to create a schedule of noneconomic damages and award full or close to full economic damages.

- Financing: If a new paradigm for compensation will be used, financing options will need to be considered. Maintaining the status quo (liability or self insurance model) is an option, but may encounter some resistance from the insurance community if a broader compensation standard is used or filing made easier (due to uncertainty of total compensation payouts). Other financing options include a tax on medical care, a tax on providers, or a general financing mechanism. A combination is also possible. Private insurers could continue to provide primary-layer insurance but the government could step in to provide reinsurance or other stop-loss protection.

- Potential links to quality and patient safety improvement: The current tort system is not designed to systematically capture and catalog the adverse events represented in claims.[74, 93, 97] If such data were collected, a database to promote patient safety could be developed. An administrative compensation system could be designed to do so.[74, 93, 97-98] The more claims that flow through the system, the more useful the database would become. In this sense, a more liberal compensation process and simple filing procedure would, by encouraging claims filings, provide for greater learning about medical errors and how to prevent them. A linkage to patient safety would directly foster achievement of one of the laudable goals of our current tort system: to help reduce future injury.

- Relationships to provider reporting and discipline: Currently, if a plaintiff files a claim against a physician, the physician must report these claims on state licensing applications and renewals and to credentialing committees and insurance companies. In addition, if a claim is paid on behalf of a physician, the payment must be reported to the National Practitioner Data Bank. Separate Board of Medicine disciplinary investigations may be requested or launched on a claim-by-claim basis. A new administrative system would need to determine how to handle reporting within the current regulatory environment or whether current reporting obligations need to be modified. This can be of particular importance if a compensation standard broader than negligence is selected because many reporting mechanisms are built based on the level of fault required for a negligence determination.

- Level of jurisdiction: The current tort system operates primarily at the state level. Whether or not the administrative system will operate at the state or federal level will need determination. A federal system would likely create greater uniformity and a greater potential pool of claims for patient safety analysis, but may be more challenging to implement.

3.2.2. Effects on Key Outcome Variables

- Claims Frequency and Costs.

Theoretically, total liability costs (compensation paid to claimants) in an administrative system will be a function of the number of claims generated, the claims success rate, and the amount of the average award (economic plus non-economic costs). We consider each of these components in turn for each model.

Medical court model: Based on current evidence, it is difficult to determine what effect a medical court model would have on claims frequency. If the medical court model gives the impression that claims with less merit are less likely be successful, there may be a reduction in the number of claims seen. However, if it appears that more accurate adjudication of claims will lead to greater claims success rates, more claims may result. As discussed above, screening panels and certificates of merit, which also strive to improve the accuracy of adjudication through application of expertise, have not been demonstrated to significantly affect claim frequency. On balance, though, a medical court model that retains a negligence standard and requires an attorney for filing is unlikely to affect claim frequency.

Based on one recent study of malpractice claims, the claims success rate may not change much, either. This study found that approximately 60 percent of all claims contain medical error. Approximately equal proportions (about 25 percent) of claims containing medical error and claims not containing medical error are resolved discordantly with their merit (i.e., errors are unpaid and non-errors are paid).[99] A more accurate system of adjudication would theoretically reduce the number of claims incorrectly paid, but this may be more than offset by greater number of claims that would now receive payment.

It is unclear what would happen to the average award in a medical court model, as it would depend on what type of guidance judges or juries were given on damages and the extent to which damages were limited by design. Overall, a medical court model's costs are hard to predict without making assumptions about its rules around damages.

Administrative model: One of the main goals of an administrative model is to make the claim filing and adjudication process easier. It rationally follows that more claims will result from the decreased transaction costs. Altering the compensation standard to be more favorable to claimants should also increase the number of claims filed by affecting the expected value of the claim. International systems that have adopted administrative models (with broader standards than negligence) see higher claiming rates per population.[73] Estimates of claims per million persons per year are 200 in the U.S.; 1000 in Sweden and Denmark; and 750 in New Zealand.[73]

The claims success rate is likely not to change much if the standard is maintained at negligence (similar to medical courts), but will increase if a broader standard (such as avoidability or no-fault) is used.

The average award will depend on the whether and how compensation award limits are set. However, because of the lack of a need for an attorney, many smaller claims can be anticipated. Thus, it is very likely that claim frequency will rise and the average award will shrink. One study utilized malpractice claims in Utah and Colorado (for the year 1992) to model costs based on an avoidability standard (and also applied some disability thresholds, caps to pain and suffering, and some reasonable limits on allowable benefits, as the administrative compensation systems in Sweden and Denmark do).[75,84] The authors found that the number of compensated events would rise, but that total costs would remain

approximately the same in Utah (approximately $55 million) and drop in Colorado (from $100 million to $82). The savings was due to lower awards and overhead costs. Overall, weighing the changes in all three factors—a larger number of claims, a likely greater number of successful claims, and on average smaller awards—the total liability costs are somewhat uncertain, but could be neutral if design choices similar to those made in the Nordic countries were made.

In summary, total claims are likely to remain the same in a medical court model and to rise in the administrative model. In both models, the claims success rate may climb a small amount if negligence is the standard or a larger amount if an easier standard is chosen. The average award will depend upon what damage limits, if any, are set, but is likely to remain the same (in a medical court model) or decline (in an administrative model).

- Overhead Costs.

Medical court model: Medical court models are also designed to streamline the adjudication process through the use of neutral fact finders with medical expertise. This change can reduce the overhead costs currently used to educate juries and hire experts. However, no firm conclusions can be drawn from available evidence.

Administrative model: Administrative models are designed to help lower overhead costs by reducing the adversarial nature of the adjudication, making use of neutral experts and decision guidelines, and reducing the need for attorney involvement. These alterations result in streamlined compensation determinations. Data from the Florida, Virginia, and foreign systems have shown a lower administrative cost structure than compared to tort.[73, 76, 78, 85-86, 99-102] Current overhead cost estimates are as follows: U.S. tort system, 40 percent; Florida and Virginia's birth-related injury systems, about 8-10 percent; Sweden and Denmark, 15-20 percent, New Zealand, 10 percent.[85, 99, 101-102]

For both models though, the overall effect on overhead costs can depend on how often the courts are utilized for appeal.[103] With proper system design, it would be anticipated that the contribution of appeals to overhead costs would be minimal. Appeals rates in the foreign administrative systems (Sweden, Denmark, and New Zealand) have been about 18-20 percent.[73]

- Liability Costs.

The liability costs that a provider will experience will depend on the choice of system financing. If the present financing system is retained (liability insurance), provider insurance costs will be a function of claims costs, but as noted above, these are unclear under both models. However, if a different method of financing, such as a general tax on medical care or on providers or a general public levy, the liability costs providers experience could drop substantially.

- Defensive Medicine.

To the extent that either model creates a perception that claims will be adjudicated correctly and assuages fears that "non-defensive" medicine is legally risky, defensive medicine may decline.[23-24, 104] Many other model features such as financing of the system and provider reporting requirement can also be adjusted to reduce defensive behavior.

Medical court model: It is unclear how a medical court model (using a negligence standard and not changing the current provider reporting requirements) would change perception unless it was able to disseminate information on the accuracy of its judgments. Physicians may, however, be reassured by the knowledge that claims will be evaluated by a fellow physician.

Administrative model: The greater number of claims and claims success rate (if using a broader standard) could lead to increased defensive medicine. However, the use of an alternative compensation standard that does not carry the stigma of negligence could reduce the reputational and psychological costs of being sued, potentially enervating the propensity to practice defensively. Additionally, the use of decision guidelines could reduce defensive medicine by sending a clearer signal to providers about the legal standard of care.

- Supply.

Medical court model: A medical court model, if it can help reduce liability insurance costs and non-meritorious claims, may decrease physicians' likelihood of leaving practice or restricting their scope of practice. As discussed above, some evidence concerning traditional tort reforms supports a link between reduced liability pressure and increased physician supply. However, with respect to medical courts, it is unclear what will happen to liability costs and how financing of the model would be undertaken. To the extent that a medical court model could be designed to reduce overhead and liability costs, a small increase in physician supply may occur.

Administrative model: As with the medical court model, to the extent that an administrative compensation model decreases physicians' liability insurance premiums or liability risk, it could decrease their propensity to leave practice or restrict their scope of practice. However, if financing of liability costs is kept as is, and liability costs increase, physician supply could be adversely affected. Overall, changes in supply with an administrative model are not possible to predict.

- Quality of Care.

To the extent that either model would decrease defensive medicine or improve access to treatment (physician supply), quality of care may be improved. However, as noted above, the likely effects of administrative systems on defensive medicine and physician supply are opaque. Nevertheless, administrative compensation models hold promise for improving quality of care by providing the infrastructure for patient safety improvement (e.g., a database of medical injuries and their contributing factors). Precedent for the systematic use of claims to improve safety exists, as seen in the Anesthesia Closed Claims Project in the United States and the foreign administrative compensation systems.[73, 98, 105] For example, the foreign systems have started cataloging claims into electronic databases so that they can analyze them for patient safety related issues. They have also created feedback mechanisms to health care institutions.

3.2.3. Summary

Proposals for administrative compensations systems or "health courts" come in two general models: a medical court model in which the specially trained judges adjudicate claims or an administrative model that replaces the courts with an administrative agency to adjudicate claims. Both seek to reduce the high overhead costs associated with the tort system as well as create more accurate and consistent

decisions. Both can be designed to capture and catalog events to drive patient safety improvements. Both can also be designed to improve access to compensation by using a broader compensation standard, but most recent proposals for broader standards relate to the administrative model. An administrative model also offers the added advantage of easing the claiming process for patients, and the resultant disadvantage (from a cost-control perspective) of increasing claim frequency.

Very little actual experience on administrative systems for medical injury in the United States exists, but it possible to learn from narrowly crafted administrative compensation systems for vaccine injuries, birth injuries, and workplace injuries, as well as from other nations that have switched from negligence-based tort to administrative systems. Collectively, these systems demonstrate that an administrative model can reduce overhead cost and boost quality and safety improvement efforts. The number of new claims remains unknown, but is likely to remain fairly static under a medical court negligence model and grow substantially under an administrative model. Some modeling has predicted that total costs in an administrative compensation system may remain unchanged or slightly decline as compared to the negligence based tort system. Total costs, nevertheless, will vary based on the compensation standard and award limits (if any). Effects on defensive medicine and quality of care are likely to be positive, while effects on insurance premiums and physician supply are difficult to predict.

3.3. Disclosure-and-Offer Programs

Disclosure and offer (D&O) programs support clinicians in disclosing unanticipated care outcomes to patients and make rapid offers of compensation in appropriate cases. Presently, they are operated by a handful of hospitals and liability insurers (predominantly self-insured hospital systems). The goals of D&O programs are to encourage honest and transparency around unanticipated care outcomes, expedite compensation to injured patients, reduce malpractice claims and average payouts, and reduce overhead costs for claims processing.

D&O programs vary in their structures and processes, but contain some common elements:

1. When an unanticipated outcome occurs, clinicians are asked to promptly report it to institutional risk management. Disclosures of the outcome are made whether or not it is believed that the outcome is due to a medical error.
2. With the institution's support, clinicians disclose the unanticipated outcome to patients and/or their families. A disclosure occurs when a provider reveals and explains an adverse event and apologizes. Depending on the results of the institution's investigation into the cause of the injury, the apology may be a statement of sympathy ("I'm sorry this happened to you") or a statement of responsibility ("I'm sorry that I injured you during the operation").
3. A rapid investigation into the cause of the error is conducted, and further disclosures are made regarding the findings of the investigation. Disclosure is viewed as an ongoing process that unfolds along with the investigation.
4. The institution makes an expedited decision about whether compensation in some form is appropriate, based on the compensation standard it has adopted. If the standard is met, an offer is made to the patient.
5. Incidents not resolved through settlement after this process can go on to become malpractice claims in the tort system.

D&O programs as we define them are different from programs or policies of full disclosure that many health care institutions have adopted. They are both broader and potentially more narrow than full-disclosure policies: broader in that they include both a disclosure process and a compensation

determination, but potentially narrower in that D&O programs may exclude particular kinds of incidents from eligibility for the program. Depending on their design, D&O programs could coexist with extant full-disclosure policies, routing some or all of the disclosed incidents into the expedited compensation process.

D&O programs (and full disclosure policies more generally) appeal to many clinicians because they are consonant with principles of medical ethics (fiduciary duty, patient autonomy, and justice).[106-107] Leading organizations such as The Joint Commission and the National Quality Forum have also called for disclosure as part of greater patient safety agendas.[108-110] In additional, several states require that disclosure alone be made to patients and families in certain circumstances in which a harmful error occurs and protect information conveyed in apologies.[111-112]

On the other hand, there are significant barriers to greater transparency around medical errors. Liability risk is widely regarded to among the chief barriers, and the number of institutions with formal D&O programs remains limited.[113-115] Other barriers to disclosure include the emotional difficulty of the conversation, shame and guilt, the stress of a possible lawsuit, potential consequences in credentialing processes, and reputational harm.[113, 116-117]

D&O programs differ from the varying types of statutory "Early Offer" programs that have been proposed.[118-127] In these proposed programs (including one proposed in a federal bill in 1984), providers are given a defined period of time (e.g., 120 or 180 days) to make an offer of compensation for claims asserted against them.[121-123, 125, 127] The offer need only include a promise to make periodic payments for economic damages. With the offer, the provider would ideally also disclose any error in care. In many Early Offer proposals, claimants do not receive noneconomic damages, but do receive reasonable attorney fees. The patient may refuse the offer and sue for all damages, including noneconomic damages. However, the claimant either must prove a more culpable breach than negligence (e.g., gross misconduct) or face a higher burden of proof (e.g., clear and convincing evidence). Statutory amendments may also allow for modified National Practitioner Data Bank reporting requirements to mitigate reporting effects.

Early Offer programs seek to improve upon the tort system by creating administrative efficiencies (less litigation), quicker compensation for patients (less litigation with an offer deadline for providers), awards that better reflect the "real" losses patients suffer (by eliminating or limiting "pain and suffering" payments), and improved quality of care (by sending clinicians clearer signals). However, there are no real-world examples of Early Offer programs to test the extent to which they achieve their aims. In 2003, the Institute of Medicine called for system demonstrations of Early Offer programs with limits on noneconomic damages coupled with government-provided reinsurance.[125]

Early Offer programs are different than disclosure programs in the sense that their primary driver is remedying the ails of the tort system (it is a means to manage asserted claims and not necessarily cases of harm that are not known to the patient) whereas disclosure programs are primarily driven by ethical and patient safety principles (whether or not a claim is filed). For the remainder of this section, we discuss design features, decision, and outcomes related to D&O programs.

3.3.1. Key Design Features and Decisions

- Eligibility: D&O programs could be available for all injuries, or only a subset. Some extant programs exclude very severe injuries, deaths, or cases that already involve an attorney or a

written demand for payment. Although on principled grounds, all harmful events merit disclosure, some institutions have opted for restricted eligibility for early compensation. For example, the Colorado Physician Insurance Company's (COPIC's) 3Rs program is not available to patients who make a written demand for compensation or have obtained an attorney or in cases of death.[111, 128-129] The COPIC program simply seeks to assist patients who have experienced an unanticipated medical outcome by facilitating candid, early communication between a physician and a patient, thereby preserving the relationship. The program assists a physician in: (1) responding in a timely fashion to an unanticipated medical outcome; (2) communicating with the patient in an empathetic manner; and (3) arranging for additional care or services the patient might need as a result of the outcome

- Compensation standard: D&O programs could award compensation only in cases in which the legal standard of care appears not to have been met, in all cases in which the institution "could have done things better," or in all cases involving an injury due to medical management, regardless of its avoidability. The more stringent the compensation standard, the more extensive the required investigation, but the lower the program's total compensation costs.

- Types of damages: A determination of what types of damages will be provided with offers should be made. Most programs make some offers that include only a waiver of medical charges and courtesy items such as complimentary hotel stays for family members during the patient's hospitalization. The next step up is to provide only reimbursement for out-of-pocket expenses. Alternatively, some or all of the patient's economic losses (including lost income) could be compensated. Finally, programs could also offer some amount representing noneconomic loss, whether characterized as "pain and suffering" or "loss of time." The more generous the offer, the less likely a patient or family may be to file a lawsuit. On the other hand, program costs will obviously be higher with more generous settlements. There are existing models of each of these types of compensation.

- Timing of compensation assessment: Some programs specify target timelines for investigation and compensation decisions, while others do not. Timelines could vary from a few days to a few months. Programs also must determine how they will make offers to patients with injuries that are permanent, uncertain in duration, or uncertain in extent. This issue is most acute for severe neurological injuries to newborns, as the developmental implications for the child may not become apparent until testing can be conducted at 2 years of age. Programs could opt for periodic payments based on regular assessments of the severity of injury or for a lump sum payment. The former improves accuracy in compensation, while the latter achieves a rapid disposition of the case and enables the insurer to better understand its extent of liability.

- Amount of damages: Programs will also need to decide if there is a maximum amount that will be offered for economic and noneconomic damages. Setting maximums may help speed negotiations, but may also result in more patients rejecting the offer. A further issue, particularly for programs with no preset maximums, is the basis for valuation of the case. Offers could be determined based on what the insurer believes the case would be worth if it went to trial, or based on its own assessment of what is required to make the patient whole.

- Assignment of responsibility: For D&O programs that are based at an institution, it will be important to determine on whose behalf the offer and settlement will be made. For self-insured institutions or insurers that are covering all involved parties, the financial consequences of who

accepts responsibility can be minimal for the insurer. However, there can be reporting ramifications for the involved physicians. If the error is a system-level error, a health care institution (such as a hospital) may opt accept responsibility and have individual clinicians dropped from the financial settlement. This may obviate the need for provider reporting to the National Practitioner Data Bank, but may also run afoul of the intent of the Data Bank statute.

- Attorney involvement: Once a disclosure is made to an injured patient or family, some D&O programs may suggest that the patient or family get attorney representation. This may occur only in certain cases—for example, high-severity cases or cases in which the institution feels that the patient or family has inflated expectations of the value of the case. Attorney representation can affect not only the equity of patient compensation, but also the perception of how fairly patients are treated. In some cases, it may result in lower, more rapid settlements, as families' expectations are adjusted by their attorney.

- Waiver of rights: Programs must decide whether acceptance of an early compensation offer will constitute a waiver of further liability claims for the event or whether patients will not be asked to waive their right to sue. The advantages of waiver are clarity and finality for the involved providers and insurer. The advantage of not requesting a waiver is that it may increase the patient's or family's belief in the good faith of the institution at low risk, since few families reportedly go on to sue even in the absence of a waiver.

- Non-institution based/Non-self insured program: Providers or institutions that are not self-insured will need to ensure that the disclosure and offer program is compatible with duty-to-cooperate clauses so that their insurers will not attempt to deny coverage.[130] These clauses are frequently found in malpractice insurance policies and require insured providers to cooperate with the insurance company in its defense of the claim. Cooperation clauses commonly forbid insureds from admitting liability without the consent of the insurance company.

- Enrollment of physicians: A D&O program could be designed to automatically include all physicians insured by the sponsoring insurer or could require physicians to formally enroll in the program (at or before the time of an incident). The advantage of a universal program is its comprehensiveness and uniformity of approach, while an opt-in program preserves autonomy for clinicians who do not want to participate in disclosures while creating a mechanism for targeting disclosure training and outreach to willing providers and comparing outcomes for participating and nonparticipating physicians.

3.3.2. Effects on Key Outcome Variables

Though the concept of disclosure with offer continues to capture interest, there is little evidence in the public domain concerning its effect on key outcome variables.[111, 115] To date, only one health system has published the effect of its D&O program on malpractice-related compensation costs.[131] In addition, COPIC has published some information on its 3Rs program.[129]

- Claims Frequency and Costs.

There remains a fair amount of uncertainty about the effects of the D&O approach on claims volume and costs. Several commentators and a simulation analysis of injury and claims data have suggested

that full disclosure policies may increase health care providers' liability by alerting patients to the fact and cause of a medical error.[111, 113-115, 132] Although survey research suggests that disclosure improves trust in providers, that patients often sue out of a sense of "cover up", [133-136] and that patients are more likely to sue if they learn of an error on their own as opposed to having a provider disclose it,[137-138] At least one survey study has found that disclosure is unlikely to dissuade patients from seeking legal advice.[139] Rather, a substantial number of patients will expect compensation if informed of a harmful error in their care.[137-138]

However, D&O programs go beyond full disclosure to provide a remedy—early settlement offers—that may avoid the consequences that may otherwise flow from disclosure. This result seems particularly likely if patients perceive the disclosures in these programs to be carried out well and the compensation offers to be part and parcel of the provider's acceptance of responsibility for the error that has been disclosed. There is some anecdotal evidence that D&O programs are successful in reducing the number and cost of claims.

The University of Michigan, which has operated a formal D&O program since 2001, has seen the number of claims drop almost 50 percent in the first five years of the programs operation.[140] The COPIC 3Rs program has been in operation since 2000 and they have reported a decline the number of legal claims closed from 643 in 2003 to 584 in 2005.[129] During that same time COPIC reported a drop in the average claim payout and number of paid claims from $303,326 (138 cases) in 2003 to $258,799 (99 cases) in 2005.

A Veterans Affairs Medical Center (VAMC) in Lexington, Kentucky, after adopting a policy of full disclosure with offer, saw its total liability compensation costs drop from the top to the bottom quartile compared to its peers.[131] Generalizability of the VAMC experience is open to question, as liability in that system is limited by the Federal Tort Claims Act. The other anecdotal reports arise from self-insured academic medical centers and may not be generalizable to other kinds of organizations.

Nonetheless, there are strong theoretical reasons for optimism in the ability of D&O programs to constrain claims costs. Logically, average payouts should be lower in a D&O program because (1) many patients would willingly trade off the possibility of a larger award for a quick resolution; (2) the reduced involvement of attorneys should alter the existing incentives in the contingent-fee system to seek a large award (although attorney involvement could also help manage the expectations of some patients who seek large awards); and (3) a greater number of low-severity incidents should receive a payment under D&O programs than in the tort system. The last effect arises from the fact that disclosures and offers are carried out even for low-severity injuries, whereas in the tort system, claims with low expected value may not be brought due to lack of interest on the part of plaintiff's attorneys. This raises the countervailing possibility that the lower average payouts could be offset by a large increase in the number of low-severity incident compensate, but there is no indication that this has occurred in any of the existing programs. In summary, the evidence concerning the effects of D&O programs on claims volume and costs derives from unverified, anecdotal reports by a small number of institutions. However, the reported results are remarkable, making these programs attractive candidates for further experimentation and study.

- Overhead Costs.

D&O programs may require additional administrative FTEs to run—for example, to administer disclosure training and support services and to enable risk management to more quickly investigate incidents.

However, it is very likely that the D&O approach reduces insurers' overhead costs substantially overall. Early settlement of incidents, in most cases without recourse to litigation, avoids costs relating to protracted investigation and discovery, consultation with external expert witnesses, involvement of outside counsel, and preparation for trial.[119] Although no controlled studies are available, anecdotal reports from the University of Michigan indicate a significant decline in legal overhead costs.[97]

- Liability Costs.

Whether providers will see lower liability costs will depend upon what happens to sum of the claims costs and compensation costs. Overhead costs are likely to decline and it is also possible, but not proven, that total compensation costs will also decline. With the adoption of its D&O program, the University of Michigan has seen its reserves (the amount of money set aside in anticipation of having to pay claims) drop by more than two-thirds.[140] If insurers pass along any savings, it is possible providers may see lower premiums.

- Defensive Medicine.

It remains unclear what effect a properly run D&O system will have on defensive medicine. If a climate of disclosure creates greater trust between patients and providers or lessens the liability threat (litigation and costs), it is conceivable that this could diminish defensive medicine, but no evidence exists with which to evaluate this empirically.

- Supply.

It is unclear whether and to what extent widespread use of the D&O approach would affect physician supply. At least two key factors could be affected by a D&O model: liability costs and the quality of physician-patient relationships. Of these, liability costs will likely have the largest influence on supply. Based on available data that indicate that liability-reducing tort reforms can improve physician supply, it seems likely that a jurisdiction where successful D&O programs were widespread might be more attractive as a practice location for physicians than higher-risk jurisdictions. There is no evidence available to indicate whether individual institutions that have implemented D&O programs have seen an effect on physician recruitment or retention.

- Quality of Care.

Efforts to improve the prevalence of disclosure are on the agendas of several organizations that seek to improve quality and safety.[108-109, 111, 140-141] Greater disclosure itself is a measure of higher quality care because of the (1) greater transparency and honesty delivered to patients, (2) trust that can be built as a result of it, and (3) better informed decision-making that can result. In addition, disclosure may also have a secondary, downstream benefit on quality improvement efforts. If providers disclose their errors to patients, many subsequent and critical steps to improve patient safety will be made easier: promotion of a culture of transparency and safety, facilitation of reporting of errors (because the error is now known to the patient), and the open discussion of errors so that efforts to improve can be initiated. While disclosure's direct and immediate effect on greater quality is fairly clear, the subsequent downstream quality and safety benefits have not yet been proven.

3.3.3. Summary

D&O programs have only been implemented by a handful of institutions, and only 2 have made public any information about the performance of the programs. Consequently, the evidence base for evaluating the effects of such programs on the key outcome variables is extremely small. However, the anecdotal reports from extant programs are highly impressive in terms of reductions in claim frequency, payouts, and overhead costs. Program administrators also report positive effects on the culture of safety and quality of care within institutions, but these are subjective reports with no accompanying empirical measurements.

On theoretical grounds, widespread implementation of D&O programs appears to hold considerable promise for effecting improvements in all of the key outcome measures. However, there is some risk associated with experimentation with this approach. Most extant programs are in self-insured hospital systems with relatively good ability to influence physician practice, and the potential to achieve high rates of reporting, disclosure, and physician behavior change may be lower for other types of insurers. There is also a risk that poorly executed disclosures or inadequate offers of compensation may inflame patients and families, prompting additional claims. Not all states provide legal protection for statements of apology, so disclosures may result in admissible evidence in malpractice litigation. Finally, there is no information available to shed light on which particular design choices for D&O programs produce the greatest gains.

3.4. Safe Harbors for Adherence to Evidence-Based Practice Guidelines

"Safe harbors" proposals would strengthen health care providers' ability to use evidence that they adhered to an accepted, applicable clinical practice guideline to defend a malpractice claim. There are two primary rationales for this reform. First, it is intended to help prevent or quickly dismiss claims that lack merit. A reasonable plaintiff's attorney arguably would investigate whether practice guidelines were applicable to the incident and complied with during the incident before agreeing to pursue a malpractice claim. Nonmeritorious claims would be more easily defended because defendants could offer evidence of the applicable guideline to obtain a rapid judgment on the claim and/or to avoid the "battle of the experts" that typically dominates malpractice trials. Second, safe harbors are intended to reduce the prevalence of defensive medicine. If health care providers know that they will not be held liable for failing to provide tests and services that are not indicated according to the accepted medical standard of care, they will have less incentive to provide such services.

Several states experimented with safe harbors in the early 1990s under limited-time demonstration projects:

- **Maine:** In 1990 and 1991, the Maine legislature passed legislation creating a five-year demonstration project known as the Maine Medical Liability Demonstration Project (MLDP).[142] The MDLP created an affirmative defense for physicians in four selected specialties (obstetrics and gynecology, anesthesiology, radiology, and emergency medicine) who adhered to designated clinical practice guidelines.[143] In total, about 100 physicians practiced in the state of Maine in these specialties. Physicians were permitted to opt in to the system, and rates of participation varied from 58 percent (in anesthesiology) to 90 percent (in obstetrics and gynecology).[144] The applicable guidelines were selected by a committee composed mostly of physicians, and the committee chose guidelines issued by the national medical associations for the relevant specialties, with some modifications to reflect local practice in Maine.[145] The affirmative defense was (through legislation introduced in 1991) permitted to be raised before

Maine's pretrial screening panel. The MLDP authorizing legislation did not include funds for an evaluation, but did require insurers to report data on malpractice claims in the 5 years prior to the project and during the project period. In addition to an interim evaluation by the Maine Bureau of Insurance,[146] the project attracted external evaluators, including the General Accounting Office[145] and the Agency for Health Care Policy and Research.[147]

- **Florida:** For a 4-year period beginning in 1994, Florida operated the Cesarean Demonstration Project (CDP), which allowed physicians to introduce evidence of compliance with practice guidelines for cesarean section as a defense to a malpractice claim.[148] A limited evaluation of the CDP's effect on cesarean section rates was conducted.[149] Based on the findings, the project was not renewed in 1998, although the evaluator's report recommended further experimentation with practice guideline safe harbors.[149-150]
- **Minnesota:** In 1992, Minnesota passed legislation allowing the state's Health Care Commissioner to approve practice guidelines for use as an absolute defense to malpractice claims.[145] No information is available concerning any formal program evaluation. The program was not renewed and Minnesota law now expressly forbids the admission of guidelines issued by a "review organization" into evidence in malpractice litigation.[151]
- **Vermont:** Vermont passed legislation very similar to Minnesota's in 1992,[145] but no information on the program is available.

In addition to these demonstration projects, current Kentucky law states that health care providers who adhere to practice guidelines approved by the executive director of the state worker's compensation program will be presumed to have met the standard of care in malpractice litigation.[152] The safe harbor is, however, limited to providers who are rendering services in connection with injuries eligible for worker's compensation. The executive director is given latitude to develop the guidelines or to adopt any guidelines issued by "qualified bodies, as determined by the executive director."

Safe harbor proposals were considered in the Clinton health reform initiative, by Medicare's Physician Payment Review Commission in 1990, and during the current round of health reform.[153-154] Aside from Kentucky's limited program, no state currently has a formal safe harbor. However, courts in all states allow experts testifying in malpractice cases to discuss clinical practice guidelines and their relevance to the standard of care and allow litigants to introduce documents containing the guidelines into evidence.[155] Thus, the primary effects of safe harbors reforms are to increase the weight given to clinical practice guidelines, give litigants the ability to introduce them into evidence without the accompanying testimony of a medical expert, and permit their introduction at an early stage in the litigation in support of a motion to dismiss or motion for summary judgment.

3.4.1. Key Design Features and Decisions

Key design decisions for safe harbors reforms include the following:

- Nature of the safe harbor: Although safe harbors for practice guideline compliance are sometimes described as creating "immunity" from suit, applying blanket immunity is not feasible because it will often be unclear whether a covered guideline applies to the particular clinical situation before the court.[156] Instead, safe harbors need to be designed to allow consideration by some qualified decision maker of whether the guideline is relevant to the physician, patient, and clinical situation in the case. Thus, a judge could consider whether to dismiss or enter summary judgment in the case on the basis of the defendant's proffer of the guidelines. The weight given to the guidelines can vary: the strongest protection would come

from establishing an *irrebuttable presumption* that a health care provider's compliance with a specified guideline in an applicable situation constitutes adherence to the legal standard of care. The plaintiff could dispute the applicability of the guideline, but if it was clearly relevant to the plaintiff's clinical situation, the defendant would have a very strong defense. A lesser form of protection would be to create a *rebuttable presumption*; this would open the door for the plaintiff to contest that the guideline, indeed, reflects reasonable and customary medical practice.[63, 66]

- Mechanism of invoking the defense: Safe harbors are typically described in terms of an *affirmative defense* that a defendant can assert in pleadings at an early stage of the litigation (indeed, state law often requires affirmative defenses to be plead in the defendant's initial answer to the complaint). In states with pretrial screening panels, the defendant can present the guidelines as evidence for consideration by the panel. An alternative would be to require defendants to wait until trial to introduce the guidelines into evidence, but this approach has less potential to reduce litigation costs.[143] The timing issue is critical not merely because it affects litigation expenses, but also because it determines who will decide whether the proffered guidelines are applicable to the plaintiff's situation. Vesting judges of general jurisdiction with the authority to make this decision on the basis of motions and briefs alone, without benefit of input by medical experts, carries some risk of error in decision making. Judges who believe that important factual issues are contested at this stage will be bound to deny a defendant's motion for dismissal or summary judgment and allow the case to proceed. Pretrial screening panels, in contrast, generally are staffed by physicians, though perhaps not in relevant specialties.

- Selection of covered guidelines: The selection of which practice guidelines, among the thousands in existence, will constitute the basis for a safe harbor is likely to be contentious.[155] The decision probably should be reposed with an expert committee, but the composition of the committee itself, particularly the balance between medical experts and other stakeholders, is likely to be controversial.[157] Although Maine relied heavily on physicians to select the guidelines, such an approach carries the risk that the public will perceive the process as biased. An alternative would be to allow trial judges the discretion to determine whether a guideline offered by the defendant is authoritative and applicable,[156] although this removes the decision from individuals with relevant medical expertise.

- Continuing review process: A process must also be established for continuing review of selected guidelines to ensure that they remain current and appropriate, and for considering how local variations in medical practice can or should be accommodated in a safe harbors system. The obsolescence of the covered guidelines in the Maine demonstration project has been cited as one reason the project was not more successful.[150]

- Universal vs. opt-in program: A safe harbor could be made available to any health care provider or only to those who choose to enroll in a safe harbor demonstration project. A universal program has greater potential to impact practice patterns and cost, while an opt-in program may facilitate better tracking of program outcomes and may allow the program administrator to condition the safe harbor on the physician's commitment to perform certain actions or meet certain goals.

- Covered providers: The safe harbor program should specify which types of medical providers are eligible to invoke the safe harbor. Options include: all institutional and individual health care providers; all individual providers; physicians only; and physicians or providers in particular specialties only. The inclusion of providers in a particular specialty only makes sense if the safe harbor includes guidelines that are relevant to that specialty.

- Inculpatory use of guidelines: Some states that have experimented with safe harbors have allowed plaintiffs to use the defendant's noncompliance with the specified guidelines for inculpatory purposes—that is, to show that the defendant was negligent. Others have only permitted the use of guidelines by defendants, to show that they were in compliance with the standard of care. The appeal of the first approach is its evenhandedness and the possibility of reinforcing legal incentives for guideline adherence,[158] while the latter is more narrowly tailored to the goal of reducing nonmeritorious litigation.

3.4.2. Effects on Key Outcome Variables

The evidence base for safe harbors is very small, consisting almost solely of the limited evaluations of the Maine and Florida demonstration projects.

- Claims Frequency and Costs.

In theory, safe harbors should discourage plaintiff's attorneys from bringing claims that clearly lack merit because the facts suggest that a practice guideline was followed. A small empirical literature shows that adherence to practice guidelines in obstetrical practice is associated with reduced medicolegal risk.[159-160] However, there is no evidence from the state demonstration projects to support or rebut the notion that safe harbors decrease the frequency or cost of claims.

It was difficult to evaluate the effect of Maine's demonstration project on claims because the project was so limited in scope. The 22 guidelines selected in Maine covered only select areas of practice within 4 specialties, estimated to constitute 3-4 percent of all medical practice in the state. Moreover, because claims are a rare event for any given physician, an experiment involving such a small number of physicians could not support quantitative evaluation of changes in claiming and claim disposition over time.[144, 161] Five years into the demonstration, only one claim in which a participating physician invoked a covered guideline as a defense had been reported.[145]

Florida's project was even more limited in clinical scope than Maine's. Moreover, the CDP evaluators were unable to obtain data on the frequency of malpractice claims.[150] At the time of evaluation (January 1998), there was no known case of a participating physician invoking a CDP-covered guideline as a defense in a malpractice claim.[150]

- Overhead Costs.

No information is available regarding the effect of safe harbors on overhead costs. Theoretically, litigation costs should decrease substantially in cases in which guidelines are applicable and were complied with. However, such cases could represent a small proportion of all claims.

- Liability Costs.

No information is available regarding the effect of safe harbors on liability insurance premiums. The Maine superintendent of insurance estimated that the MLDP would result in a 0.5 percent savings in medical malpractice premiums, but the Bureau of Insurance subsequently reported that it was unable to determine the effects of the MLDP on premiums.[146, 157] The Florida evaluators also were unable to obtain data to permit an evaluation of the CDP's effect on malpractice premiums.[150] The theoretical connection between safe harbors and insurance premiums is remote; it is mediated by the extent to which quality of care improves as a result of better guidelines adherence and the extent to which attorneys are discouraged from bringing claims.

- Defensive Medicine.

Even if safe harbors have no effect on claims frequency and cost, they may nonetheless have a reassuring effect on physicians that leads to reductions in defensive medical practice. The reassurance may spring from a perception that frivolous claims will be less likely to be brought or easier to defend, or simply from greater clarity about what standard of care the law requires. The appeal of safe harbors is that they target defensive medical practices for which there is little or no evidence of a salutary effect on patient care.[40] Theoretically, the effect of safe harbors on defensive medicine should vary according to the strength of the safe harbor, the clarity and comprehensiveness of the selected guidelines, the level of physician awareness of the safe harbor, and the extent to which physicians are already practicing in compliance with the guidelines.[40]

The most relevant available evidence concerning these effects is the AHCPR evaluation of the Maine demonstration project.[147] Using medical record reviews and physician and hospital surveys, the evaluation compared obstetrical practice in Maine in the four years following implementation of the project to (1) practice in Maine in the five years prior and (2) practice in Vermont and New Hampshire during the project period. Among the key findings of the evaluation were the following:

- The MLDP did not affect rates of diagnosis of failure to progress and prolonged pregnancy (which are associated with cesarean section) or rates of cesarean section. All of these rates declined among MLDP-participating physicians during the intervention, but similar or greater decreases were seen in the comparison groups.
- The MLDP did improve adherence to guidelines for management of fetal distress. Adherence increased among all groups, but the increase was significantly larger among MLDP-participating physicians. The effects of guideline adherence on birth outcomes were not evaluated.
- Documentation of adherence to the guidelines was higher among MLDP-participating physicians than among others.
- Low proportions of Maine physicians perceived the MLDP to have reduced malpractice risk (38 percent), defensive medicine (25 percent), or cesarean section (10 percent). Only 1 in 5 physicians reported that the MLDP had led them to make changes to their practice; many reported in this and an earlier survey[145] that they were already in compliance with the guidelines.

An earlier evaluation of the Maine project by the General Accounting Office was unable to draw conclusions about the effect of the MLDP on defensive medicine because of the unavailability of baseline data on utilization of sentinel procedures and inability to control for confounding effects of regulatory changes, changes in insurance coverage, and changes in insurance reimbursement in Maine during the study period.[162]

The results of the Florida evaluation are not publicly available at this time. However, the Florida CDP had very limited uptake among eligible physicians: only 20 percent of obstetricians chose to participate. This limits the prospects for affecting any of the key outcome variables.

- Supply.

No information is available regarding the effect of safe harbors on physician supply. Theoretically, a safe harbor program with demonstrated success in reducing malpractice risk could serve as a magnet for physicians who experience liability pressure in other states.

- Quality of Care.

Safe harbors programs have considerable theoretical promise for improving the quality of care by providing incentives for adherence to evidence-based practice guidelines (assuming that the guidelines selected for coverage by the safe harbor reflect high-quality, evidence-based care). However, little is known about how this plays out in practice. The effects of the MLDP on outcomes of care were not evaluated, nor were its effects on adherence to practice guidelines in specialties other than obstetrics. The MLDP resulted in higher adherence to guidelines for management of fetal distress among participating physicians than among comparators, but was not associated with higher rates of adherence to other practice guidelines. Survey evidence suggests that obstetrical practice may have been relatively static under the MLDP because most physicians believed they were already following the selected guidelines at the time of project implementation.[147]

3.4.3. Summary

Safe harbors have considerable appeal as a mechanism for discouraging frivolous malpractice claims, reducing defensive medicine, and providing incentives to move toward evidence-based care. However, existing experimentation with safe harbors is too limited and too poorly evaluated to provide reliable evidence for or against the concept.

3.5. Subsidized, Conditional Reinsurance

Reinsurance is defined as insurance purchased by primary insurers to limit their loss exposure for very high-severity claims. More broadly, the concept of secondary-layer insurance is that some third party offers insurance coverage that kicks in when a claim exceeds a particular dollar threshold. In this discussion, we use the term "reinsurance" in this broad sense and discuss proposals to offer such reinsurance to health care providers on a subsidized basis if they achieve particular patient safety goals or satisfy other conditions.

A precedent for government-subsidized medical liability reinsurance exists in state-run patient compensation funds (PCFs). At least thirteen states have enacted legislation authorizing PCFs.[163-164] The funds are currently operated in 10 of these states (IN, KS, LA, NE, NM, NY, PA, SC, WI, WV).[163-164] Of the remaining 3, PCFs were never implemented in 2 states (OR, WY), and in 1 state (FL) the PCF has been

closed.[163-164] The goals of PCFs are to make affordable insurance coverage available and affordable to providers and to ensure that patients will have access to larger awards.[164-165] In general, these funds operate by providing liability coverage for judgments or settlements in excess of the primary insurance coverage. Nearly all states have minimum levels of primary coverage that providers must carry, but the amounts vary from state to sate. PCFs may assume liability above a specified threshold or between two specified thresholds.

PCFs are typically financed by a surcharge levied on individual and institutional health care providers, and may be partially subsidized by the state government. Physician participation in PCFs can be voluntary or mandatory. PCFs can be subject to issues of adverse selection if voluntary and issues of equity if mandatory (providers in low-cost areas will subsidize those in high-risk areas). Despite their long existence, PCFs have received very little attention in the academic literature.[164]

There is no precedent for conditioning subsidized reinsurance on patient safety improvements or other requirements. Participation in PCFs has traditionally been open to all providers on the basis of licensure status and payment of the surcharge. However, a related proposal is found in the Institute of Medicine's 2003 report, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations.*[125] The report recommended experimentation with state-based demonstration projects of Early Offer or administrative compensation in which participants would be given government reinsurance or other umbrella coverage. The purpose of the reinsurance was to provide incentives for participation by minimizing the downside risk.

In considering the potential for conditional, subsidized reinsurance to impact the key outcome variables discussed in this report, it is useful to consider not only the experience of PCFs, but also that of "pay-for-performance" programs implemented by health insurers. The rationale for conditioning part of a provider's reimbursement on the achievement of certain goals or standards is to provide a financial incentive for quality and outcomes improvement. The past decade has seen considerable growth of pay-for-performance schemes,[166-171] with Medicare, Medicaid, and several private payers now offering payment for a broad range of measures.[166-169, 171-172] The evidence base concerning the effectiveness of pay-for-performance, too, is growing. Some studies show modest improvements in health outcomes and process measures of quality of care, but others do not demonstrate any improvement).[166, 173-179]

3.5.1. Key Design Features and Decisions

Innovative programs that conditioned reinsurance for providers on the achievement of patient safety or risk management goals would confront several key design choices.

- Value of subsidy: The program will need to determine how much of a subsidy will be offered for the reinsurance and how extensive the reinsurance coverage will be (i.e., what the triggering threshold is). The greater the subsidy and coverage, the larger the incentive to the provider to achieve the specified conditions. If the financial benefits of the subsidy are minimal (or eclipsed by the cost of meeting the performance goal), the incentive to motivate the selected patient safety benefits may be trivial.[173, 177, 180] One recent analysis of the Bridges to Excellence pay-for-performance program found that with larger physician incentives, there was greater physician participation.[181] Of note, subsidized reinsurance will have less value in states with lower liability costs.

Subsidy financing: The program will also need to decide how the subsidy will be financed. PCFs have almost universally been funded by assessments on providers, with one state providing public funding.[164] Subsidized reinsurance could be financed through mandatory provider surcharges that are later refunded to providers who meet the specified conditions; through surcharges levied only on non-performing providers; or through general state revenue that is used to purchase policies for performing providers. Analogously, pay for performance can either be arranged as a withhold on physician reimbursement or as an additional bonus pool. Logically, if payment rates are identical in the two choices, physicians would prefer the bonus model. However, behavioral economics research suggests that people are more risk averse in the domain of losses, so withholds and surcharges may induce stronger compliance.

- Mandatory primary coverage and minimums: If reinsurance will be offered at a subsidized rate, providers should carry primary coverage to prevent all risk from being shifted to the reinsurance pool. All PCFs have set minimum primary coverage limits.[164-165]

- Mandatory vs. voluntary reinsurance purchase: If reinsurance purchase is mandatory, this will help more evenly spread the reinsurance pool risk. It will also help strengthen the incentive because all providers will have an additional expense that can be reduced through the achievement of patient safety goals. If the reinsurance if voluntary, not only does the risk of adverse selection rise, but the incentive is lost for those not purchasing.

- Selection of patient safety goals: The selection of appropriate patient safety goals can be a broad and daunting task. However, if the goal is that the government to bear some liability risk, it would make sense to select goals in areas of patient harm that are known to increase liability exposure. This strategy would best synchronize patient safety improvement with liability reduction. Targets of opportunity could be centered in the areas that comprise the bulk of malpractice claims costs: medication-related injury, missed and delayed diagnoses, surgery-related injuries, and obstetrical injuries.[99] By contrast, many current pay-for-performance metrics are focused on quality of care initiatives that do not necessarily impact high-liability-risk areas.[172] There do, however, exist many areas of overlap between the current quality-focused environment and high-liability areas. For example, The Joint Commission maintains accreditation standards on reducing the risks associated with anticoagulants (medication-related); wrong-site surgeries and surgical infections (surgery-related), and critical test results (missed and delayed diagnoses).[182] Care must be taken to select measures that will not lead to unintended consequences.[175, 177]

- Selection of target level performance: Once the goals or measures are determined, setting the target performance becomes important.[168] Targets can be set for a provider to score relatively high compared to predetermined peers, meet an absolute target, meet an absolute target and improve from the previous year, or improve from the previous year.

- All or nothing vs. incremental returns for performance: Some providers may make progress toward, but not entirely achieve target performance levels on selected patient safety goals. For these providers, a decision will have to be made on whether or not they will be eligible to receive a portion of the subsidy or none of it. The benefit to creating the possibility of a partial return is that it gives a continuing incentive to improve performance even if the ultimate target will not be reached. Research on pay-for-performance also suggests that all-or-nothing,

threshold-based systems tend to reward already high-performing providers, enervating incentives for low baseline performers to improve.[179]

3.5.2. Effects on Key Outcome Variables

In the absence of direct evidence pertaining to subsidized reinsurance conditioned on the achievement of patient safety goals, conclusions concerning the likely effects of this reform can only be hazarded based on the findings from the two related initiatives we have identified, PCFs and pay-for-performance schemes, as well as theoretical predictions.

- Claims Frequency and Costs.

Whether or not subsidized, conditional reinsurance will affect claims will depend upon three major factors: (1) the effect of higher coverage limits on claims; (2) how often providers will achieve the selected safety goals; and (3) how effective the goals are at reducing claims.

There is no theoretical reason to believe that reinsurance would alter the number of claims brought. States with PCFs have not been found to experience higher frequency of paid claims.[164] Theoretically, ensuring that providers have access to affordable reinsurance could increase claims payouts by expanding the pool of resources available to claimants. One concern frequently voiced about PCFs is that primary insurers have less incentive to settle high-value cases because they do not bear the risk associated with a large trial verdict.[17] Moreover, to the extent that subsidized reinsurance makes more compensation available for patients (via greater availability of higher coverage limits), total liability payouts may rise. These theoretical predictions have not been tested. No studies have examined whether average claim payouts or insurers' total losses vary systematically across states that do and do not have PCFs.

For a discussion of the prospects for reducing injuries that lead to claims, please see the Quality of Care section below. Overall, there is no basis for concluding that subsidized, conditional reinsurance would lower claim frequency or total claims costs significantly.

- Overhead Costs.

To the extent PCFs may act as passive financial intermediaries, claims may be settled more quickly (because primary insurers will have a reduced incentive to litigate large claims down to upper coverage limits) and lead to a reduction in overhead costs. Limited experience from PCFs has demonstrated that this may indeed be the case.[17, 164]

The incentive portion of the subsidy for safety goals program need not necessarily affect overhead costs per claim, but the administration of the incentive program (i.e., selecting patient safety goals and target levels and measuring performance) will involve its own overhead costs. These costs will not be allocated to malpractice claims handling, but would be new expenses nevertheless.

If the patient safety goal that providers must achieve is implementation of an Early Offer or D&O program, as opposed to instituting particular clinical process improvements to reduce medical errors, additional savings in overhead costs may result from the accompanying improvements in time to incident resolution.[119, 123, 126]

- Liability Costs.

Although subsidized, conditional reinsurance may not decrease total claims costs, it would shift the burden of these costs away from physicians' primary insurers. Primary carriers should pass along this benefit to their insured physicians in the form of lower premiums..[17, 164] Whether physicians' *total* liability insurance costs decrease, however, depends on whether a surcharge is levied on physicians to fund the reinsurance and the amount of the surcharge. Of course, reinsurance that was entirely paid for by the government, with no surcharge levied on providers, would result in lower premium costs for providers relative to what they now pay for full coverage.

Researchers have not been able to conclusively show that PCFs affect the availability or affordability of malpractice insurance.[164] Although it would seem certain that the availability of PCFs would reduce primary insurance premiums, the combined cost of primary- and secondary-layer coverage will not necessarily be lower. It does seem plausible that the widespread availability of reinsurance in a state would make the state attractive to primary insurers, thereby helping to ensure availability of primary-layer coverage. This has been reported anecdotally concerning PCFs.[164] Greater competition among carriers in a market may help constrain the growth of premiums as well. In addition, to the extent that the "carrot" of subsidized reinsurance is effective in stimulating providers to make patient safety improvements, long-term savings in liability costs could be realized through reduction of medical errors, although this is quite speculative.

- Defensive Medicine.

To the extent that PCFs can protect providers from larger awards, they may reduce incentives to practice defensive medicine. However, a larger driver for defensive medicine is likely the psychological stress of a suit (e.g., the fear of reputational harm, the discovery and trial process, and reporting requirements), rather than the amount of the award. Although reinsurance theoretically reduces the risk that a physician will incur a judgment in excess of his policy limits, threatening his personal assets, research suggests that in practice, malpractice cases rarely settle above the defendant's policy limits.[183] Overall, the impact on defensive medicine is likely to be minimal, but no data exist to inform conclusions.

- Supply.

To the extent that patient compensation funds would make liability coverage more available and affordable, physician supply may increase. However, studies evaluating the effects of PCFs on physician supply have not found any improvement.[24, 29] If the creation of unconditional insurance subsidies does not improve physician supply, it follows that insurance subsidies that are harder to obtain because they are conditioned on performance goals are even less likely to benefit physician supply.

- Quality of Care.

The linkage between PCFs and quality of care has not been studied, presumably because that is not PCFs' purpose. PCFs are created to address providers' concerns about insurance availability and affordability and patients' access to sufficient resources to pay large damage awards. Theoretically, the presence of PCFs or other forms of reinsurance may dampen incentives for safety improvement by reducing the economic consequences of harmful errors.[164]

Pay for performance, in contrast to PCFs, is designed to improve the quality of care. However, as discussed above, it is too early to draw conclusions about whether pay for performance can induce significant improvements in quality.[166-167, 175] There have been some success stories which suggest it has promise—for example, a recent evaluation of the impact of the Centers for Medicare and Medicaid Services' pay-for-performance demonstration project for hospital care found an improvement of 2.6 to 4.1 percent in performance measures over a 2-year period. Overall, though, substantial returns to quality or patient safety are not in evidence.[174, 178]

A key question is whether provision of subsidized reinsurance will be enough of an incentive to motivate safety-enhancing change on the part of physicians and health care organizations. Rational actors will weigh the relative costs of investment in safety improvements against the savings associated with the reinsurance subsidy. They may find that the cost-benefit balance disfavors attempts to meet the conditions established for obtaining the subsidy. On balance, there is a very thin basis for predicting effects of subsidized, conditional reinsurance on quality of care, but the pay-for-performance literature is mildly suggestive of modest benefits.

3.5.3. Summary

Government provision of subsidized reinsurance for providers who achieve patient safety goals can be viewed as a pay-for-performance initiative aimed at easing providers' liability cost concerns and improving patient safety. The evidence base for evaluating this proposal is very limited, requiring reasoning by analogy from the experience of PCFs and pay-for-performance reimbursement programs. Overall, the evidence does not suggest that subsidized, conditional reinsurance would substantially affect claim frequency or total claims cost, although it would shift the cost burden away from physicians and primary insurance carriers unless a surcharge was levied on them to pay for the scheme. To the extent that subsidized reinsurance can lower or stabilize the premiums that physicians pay, an increase in physician supply is possible, but the available data do not support such an effect. Perhaps the most alluring aspect of subsidized, conditional reinsurance is the direct incentive to improve quality and safety in high-risk clinical areas. Effective incentives will depend on the relative costs of the subsidy compared to the clinical interventions needed to improve safety.

3.6. Enterprise Medical Liability

Enterprise medical liability is a legal doctrine assigning liability to a health care organization for tortious injuries that occur within its facilities or are caused by its clinical staff affiliates, including but not limited to its employees. Under this system, the liability of individual physicians and other clinicians is reduced or eliminated.

Courts historically have been reluctant to impose liability for medical malpractice on hospitals, and state statutes prohibiting the "corporate practice of medicine" have made it difficult for litigants to argue that hospitals should be held liable for malpractice. Although some judicial loosening in this area has been visible over time, it remains difficult to hold health care facilities directly liable for medical malpractice outside of a few narrow circumstances. These circumstances include negligence in the administrative functions that hospitals perform, such as credentialing decisions and general quality oversight; vicarious liability for the acts of hospital employees; and negligent acts by anesthesiologists, radiologists, pathologists, and others who perform services for which patients look to a hospital (as opposed to a

particular physician).[184-186] In other situations, it is individual, non-employee physicians who are held liable.

The two most important rationales for imposing enterprise medical liability are economic efficiency and fairness. In the malpractice context, enterprise medical liability addresses the perceived unfairness of holding individual health care providers liable for "systems failures" within an organization that lead to preventable injuries and that the individuals have little or no ability to control. The efficiency rationale is that placing liability on the organization provides economic incentives for the organization—which *does* have control over the "systems failures" and is in a position to prevent injuries at a lower cost than the clinician —to invest in cost-justified changes to improve patient safety.[187] Future injuries will therefore be prevented at a socially efficient level. Without enterprise medical liability, the tort system sends an economic signal to actors who arguably are not in a good position to effect the kind of changes that are needed to prevent injuries.

A third rationale for enterprise medical liability is to ensure that injured plaintiffs receive the compensation to which they are entitled. Holding health care organizations liable introduces "deep pockets" defendants that can pay judgments that individual physicians may not be well enough insured to pay in full.

A fourth rationale is that enterprise medical liability permits more effective use of experience rating in insurance.[188] Experience rating is the practice of pricing insurance premiums to reflect the insured's past claims experience. This is actuarially difficult to do for individual physicians because they are sued so infrequently, but it is considerably easier at the level of the health care organization. The advantages of experience rating are that it more fairly apportions insurance costs to those who create losses and that it more accurately targets the "deterrent signal" of the tort system to those who most need to modify their behavior in order to prevent injuries.

Although there is variation across states in the circumstances under which a health care organization can be held liable for malpractice, enterprise medical liability is not currently available in any state. A proposal for demonstration projects of health-plan-based enterprise medical liability was part of the Clinton health reform package. However, the proposal did not advance due to adverse reactions, ranging from disinterest to strong opposition, on the part of key stakeholder groups, including physician organizations, liability insurers, plaintiff's attorneys, and managed care organizations.[185, 189]

3.6.1. Key Design Features and Decisions

Key design decisions for enterprise medical liability reform include the following:

- Liable enterprise: Some proposals for enterprise medical liability have focused on health plans as the locus of liability,[73, 7473, 75, 76190] while others have suggested that hospitals and other health care provider organizations serve as the responsible enterprise.[48, 185, 188, 191-192] Today, the latter formulation receives more attention in policy debates, largely due to the ascendency of network-model managed care organizations in the market, which have less control over their affiliated physicians than closed-panel HMOs.[189] The "accountable care organization" (ACO) is another, more modern concept with potential applicability for this reform.[193] Economic theory suggests that liability should be placed on an organization that can realistically be expected to have the power to institute systemic patient safety improvements within health care systems and influence individual physician behavior. ACOs may be more likely than health insurers and

some hospitals to have this characteristic.[191] Health insurers' leverage may vary considerably depending on their market share and the nature of their affiliation with physicians, and many community hospitals (as opposed to academic medical centers) may not have close relationships with the physicians they credential. On the other hand, placing liability on health plans is argued to serve as a counterweight to health plans' extant incentives to provide less care than might be medically optimal.[189]

- Role of individual liability: Most proposals for enterprise medical liability specify that there would no longer be any liability for individual clinicians.[48] An alternative would be to greatly expand the potential for holding health care organizations liable while retaining the possibility of holding individuals liable as well. Different rules could be imposed depending on whether the care was rendered within the walls of a hospital or other health facility as opposed to a non-hospital-affiliated physician office. Individual liability might also remain available in the rare case of extreme negligence or deliberate conduct on the part of the physician. The strongest rationale for allowing individual liability is the fairness argument that health care facilities and payers cannot completely control the actions of individuals, particularly when the individuals are not employees of the organization. If the responsible enterprise is a health care facility or system rather than a health plan, one must also consider the need to make compensation available to patients who are injured in an unaffiliated physician office. The strongest argument against retaining individual liability is that pure enterprise medical liability maximizes the incentive for the organization to institute systems improvements to improve patient safety, including improvements designed to detect and mitigate the consequences of error on the part of individuals working within the organization. Pure enterprise medical liability is also a simpler regime that avoids fights among defendants in a malpractice case about who was responsible for the injury.

- Scope of liability: In the context of facility-based enterprise medical liability, the organization's liability could be limited to injuries that occur within its walls or could extend to all injuries caused by physicians whose primary affiliation is with the facility.[185] The former would more tightly tie liability to the hospital's ability to prevent injuries, but administrative costs would be higher because physicians would still need to purchase insurance to cover injuries that occur outside the hospital, and physicians and hospitals could expend resources disputing where the injury occurred. Where the locus of liability is a health plan, the plan's liability could be limited to injuries caused by physicians who receive the greatest share of their reimbursement from that payer, or could extend to any injury incurred by the plan's insured patients. The former would better peg liability to the plan's ability to influence the physician's practice, since the plan's threat not to contract with physicians in the future if they did not improve would have greater financial consequence for the physician. However, it could allow plans that did not have a large market share to evade liability altogether.

- Contributory or comparative negligence defense: Most states currently allow evidence of a plaintiff's own negligence to be introduced and allow juries and judges to reduce a plaintiff's award according to her own percentage fault. In some states, if a plaintiff is more than 50 percent contributorily negligent, she will recover no money at all, even if the defendant was also negligent. For example, a plaintiff who failed to disclose an important risk factor in his medical history before a surgical procedure might be held contributorily liable for an adverse surgical outcome relating to that risk factor. A decision should be made about whether these defenses will apply in cases involving enterprise medical liability. The strongest argument in favor of

eliminating them is to maximize the enterprise's economic incentive to improve safety. The strongest arguments against eliminating them are fairness to the defendant and the need to incentivize organizations to invest only in the socially optimal level of precaution-taking.

- Status of damages caps and charitable immunity laws: States with laws providing not-for-profit hospitals with total immunity from malpractice suits or limiting their liability would need to be reconsider them if enterprise medical liability were imposed. Charitable immunity laws would need to be struck. Damages caps could theoretically be retained, but would undermine the intent of enterprise medical liability. In a pure regime where no suit against individual physicians was possible, caps could also severely limit the available compensation for injured patients.

- Financial arrangements: The shift to enterprise medical liability would involve cost shifting from physicians to health care facilities or health plans, as physicians reduced or eliminated their separate malpractice insurance coverage and the liable enterprise increased its own coverage. Presumably, the liable enterprise would choose to transfer some of these costs back through their contractual arrangements with physicians—for example, by applying surcharges on hospital admitting privileges or adjustments to insurance reimbursement rates.[185] Since Medicare's fee schedule already includes a factor for malpractice insurance costs, Medicare reimbursements rates for both physician and hospitals certainly would be adjusted in a health-plan-based enterprise liability scheme.

- Voluntary or mandatory: Enterprise medical liability is generally discussed in the literature as a mandatory scheme imposed by statute. An alternative is that health plans or health care facilities could voluntarily elect to assume liability for some or all of their affiliated physicians, with the physicians agreeing by contract to the necessary financial adjustments to finance the new arrangement. (Patients would also need to given notice of the arrangement and an opportunity to consent to being subject to it.) An advantage to this approach would be that it permits experimentation with different approaches. One drawback would be that hospitals or health plans who opted in to higher liability costs and failed to fully pass them back to physicians could find themselves at a competitive disadvantage in the marketplace.[189] A second disadvantage would be the fragmentation of incentives that would occur if not all physicians affiliated with the sponsoring hospital or health plan agreed to participate in the new arrangement. Similarly, incentives for safety improvement within hospitals would be fragmented if some, but not all, important payers assumed liability for malpractice.

3.6.2. Effects on Key Outcome Variables

There is a very limited evidence base upon which to base conclusions about the likely effects of enterprise medical liability. Although there are several institutions in the U.S. that reflect principles of enterprise liability, no studies are available comparing their experience and performance on key outcome variables to other types of institutions in a manner that enables isolation of the effect of the enterprise liability. The relevant institutional examples include:

- **Veterans Health Administration (VA) hospitals.** Individual VA physicians cannot be sued; under the Federal Tort Claims Act, the U.S. government consents to be sued for malpractice relating to care in VA hospitals, but a range of special conditions apply. The government also makes available an administrative process for obtaining service-connected disability compensation for

injuries incurred in VA hospitals. The range of special circumstances surrounding the VA system makes it an inapt analogy for how enterprise medical liability would work in non-federal hospitals.

- **Hospitals owned and operated by the University of California.** State law makes the Regents of the University of California liable for the actions of physicians practicing within them.[40]
- **Academic medical centers** that are self-insured and directly employ physicians, along with other clinical staff, providing them with malpractice insurance through the hospital as part of their employment arrangement. Physicians in these centers can, of course, be sued. However, the "channeling" of insurance into a single policy makes the medical center financially responsible, and as a practical matter, many such hospitals encourage malpractice plaintiffs to drop individual clinicians from their claim and proceed only against the medical center.
- **Integrated delivery systems** such as Kaiser Permanente, which serve as both insurer and health care provider, directly employing their clinical staff and furnishing liability insurance as part of the employment contract. Although physicians can be sued in such systems, the institution foots the bill for the liability.

- Claims Frequency and Costs.

No conclusions about the effect of enterprise medical liability on the frequency of malpractice claims can be drawn on the basis of the available evidence. There is no theoretical reason that claims should become more or less frequent in the absence of individual physician liability.

No conclusions about the effect of enterprise medical liability on the cost of malpractice claims can be drawn on the basis of the available evidence. The fact that liability is borne by one entity rather than another does not affect the valuation of any particular plaintiff's damages, and should not affect indemnity payments in that respect. It is possible that plaintiffs could have an easier time proving a case against a hospital than against individual clinicians, but this is not clear. It is possible, but not proven, that enterprise liability could spur health plans or hospitals to invest in safety improvements that result in lower malpractice costs. However, because most instances of medical error and negligence never result in malpractice claims, but there are many claims that do not actually involve negligence, even significant improvements in patient safety may not translate into a large reduction in malpractice claims.[194]

- Overhead costs.

No conclusions about the effect of enterprise medical liability on the frequency of malpractice claims can be drawn on the basis of the available evidence. Theoretically, defense costs should be lower in a system of pure enterprise liability for claims involving injuries in which more than one health care provider is implicated. In such cases, there is no need for individual clinicians to be represented by separate counsel and no battling among litigants as to who is responsible for the plaintiff's injury. Overhead costs for liability insurance should also be lower in a pure enterprise liability system because individual clinicians should not need to take out separate insurance policies (except to cover claims arising from conduct that is carved out of enterprise liability, such as intentional acts).

- Liability costs.

Under enterprise medical liability, physicians would certainly pay less (perhaps nothing) for malpractice insurance. However, the responsible enterprise likely would find mechanisms for transferring some or all liability costs back to physicians through other means.

- Defensive medicine.

No conclusions about the effect of enterprise medical liability on defensive medicine can be drawn on the basis of the available evidence. In theory, enterprise medical liability should provide considerable relief to physicians who currently feel pressured by liability concerns to practice defensively. However, this relief would be undercut if the responsible enterprise transferred liability costs back to individual clinicians by adjusting their salary or reimbursement or levying a surcharge.

- Supply.

No conclusions about the effect of enterprise medical liability on defensive medicine can be drawn on the basis of the available evidence. To the extent that physicians felt more comfortable practicing in settings in which they did not have individual liability, institutions with enterprise medical liability theoretically should attract physicians. There is some evidence that during the recent malpractice insurance crisis, physicians in one hard-hit state, Pennsylvania, sought closer ties to hospitals that could offer them more affordable insurance coverage.[195] However, there has not been a general influx of physicians into institutions such as the VA or academic medical centers that offer channeled insurance.

- Quality of care.

No conclusions about the effect of enterprise medical liability on the quality of care can be drawn on the basis of the available evidence. There are strong theoretical reasons to believe that hospital- or ACO-based enterprise medical liability would spur greater efforts to improve the safety of medical care. Recent research indicates that medical error causation tends to reflect a complicated web of individual and system factors.[187, 196] Academic medical centers and other hospitals that have some means of exerting influence over the physicians that practice within them are well placed to implement systemic improvements and communicate necessary improvements in individual physician practice to physicians. Additional tort liability could create the necessary economic incentives to spur hospitals to invest in safety-enhancing practices, although as long as malpractice claiming rates are low relative to the actual incidence of medical error, the incentive will remain enervated.[197]

No systematic studies are available to examine the safety-enhancing effects of enterprise medical liability, but anecdotal evidence of initiatives launched by academic medical centers are often cited as "proof of concept." There is no evidence that care is safer overall in such hospitals than in hospitals that do not bear as large a share of tort liability, but anecdotes abound of proactive hospitals and captive insurers who recognize areas of significant loss among their malpractice claims and institute programs to reduce risk in those areas. The best known example is the Harvard hospitals' successful anesthesia safety initiative,[198] but there are many others.[188]

The prospects for health-plan-based enterprise liability to produce changes in quality of care seem more limited. Most health insurers have a fairly low degree of control over the practices of their affiliated physicians and hospitals, although this varies across health plans. Direct controls such as utilization review have given way to "pay for performance" (P4P) programs that seek to incentivize changes in

practice pattern rather than directly alter them. These programs have met with limited success.[179] It seems likely that P4P programs would be the main mechanism through which health plans would seek to influence physicians and hospitals to adhere to safe practices and avoid malpractice claims, but it is not clear that enterprise liability would produce significant marginal gains relative to what has been achieved through existing P4P programs.

An argument that is sometimes raised against enterprise medical liability is that removing individual liability would dampen physicians' incentives to practice safely. There is no evidence to support or refute the notion that greater insulation from tort liability results in less safe care by physicians, and many theoretical reasons to question the value of tort liability in spurring safer practices among physicians.[191] Because hospitals experience malpractice claims more frequently than individual physicians, arguably, the incentive to institute improvements and to monitor and encourage improvement among "problem" physicians is stronger at the hospital level.

3.6.3. Summary

Enterprise medical liability is promising on theoretical grounds, but existing examples of this arrangement in the U.S. are limited and have not been evaluated in a way that supports inferences about its effect on any of the key outcome variables.

4. Conclusions

The findings of this analysis concerning the effects of traditional and innovative tort reforms are summarized in Tables 3 and 4, respectively. Table 3 describes the level of empirical *evidence* underlying the reforms' effect on each of the outcomes variables. In contrast, because the base of evidence for the innovative reforms is so limited, Table 4 describes the certainty with which the effects can be *predicted* based on theory, anecdotal reports, and related programs, rather than the strength of the direct evidence.

We find that the evidence base for evaluating most traditional state tort reforms is large and mature. However, studies have generated limited or no evidence that most reforms have significant effects on the key outcome variables examined in this report. The exception is caps on noneconomic damages, which have well-documented effects on several of the outcomes.

The evidence base for evaluating the innovative tort reforms is extremely small. Most have not been tested in the U.S., and where experimentation has taken place, the programs have not been systematically evaluated, at least in materials released to the public. Analogous systems in the U.S. and abroad are not clearly predictive of how these innovative systems would function in the American medical liability setting, and much depends on the choices made about various aspects of system design. However, based on theoretical predictions and the limited evidence available, most of these reforms show sufficient promise for impacting some of the key outcome variables to merit controlled experimentation, such as through demonstration projects.

Two important limits on the scope of our analysis should be noted. First, constitutional and other legal barriers to implementing these reforms have been noted only selectively and in passing. They merit much more serious consideration in any process of further experimentation, particularly with the more innovative reforms and particularly where patient participation in an alternative system is made

mandatory. Second, this report has not considered how the various reforms could be implemented through the Medicare program. However, other scholarship provides some insights.[81, 199-201]

In closing, tort reform in the states to date has been characterized by a pattern of imitation of reforms implemented in other jurisdictions—even in the absence of evidence that they are effective in achieving their goals. Reform initiatives have often been driven by health care providers' and insurers' urgent demands that policy makers do something to ameliorate the effects of highly volatile liability environments. Today, most states are experiencing at least a moderate easing of the "crisis" conditions of the last decade. This environment presents more favorable conditions for experimentation with more novel reforms.

Table 3. Summary of Evidence Concerning the Effects of Traditional Tort Reforms

	Claims frequency and costs	Overhead costs	Liability costs	Defensive medicine	Supply	Quality of care
Caps on noneconomic damages	0 for frequency (M) ↓↓ for costs (M)	↑ (L)	↓ for premiums (M)	↓ (H)	↑ (M) for physician supply 0 (L) for health insurance premiums	0 (L)
Pretrial screening panels	0 (H) for frequency and costs	↑ (L)	0 (M)	↓ (L)	0 (L)	0 (L)
Certificate of merit	0 (L) for frequency and costs	↑ (L)	0 (L)	0 (L)	0 (L)	0 (L)
Attorney fee limits	0 (H) for frequency and costs	↑ (L)	0 (H)	0 (L)	0 (M)	0 (L)
Joint-and-several liability reform	0 (L) for frequency, 0 (H) for costs	0 (L)	0 (M)	0 (M)	0 (M) for physician supply ↓ (L) for health insurance premiums	0 (L)
Collateral-source rule reform	0 (M) for frequency, 0 (H) for costs	0 (L)	0 (M)	0 (H)	0 (M) for physician supply ↓ (L) for health insurance premiums	0 (M)
Periodic payment	0 (L) for frequency, 0 (M) for costs	0 (L)	0 (L)	0 (L)	0 (M)	0 (L)
Shorter statute of limitations/repose	0 (M) for frequency, 0 (M) for costs	0 (L)	↓ (M)	0 (L)	0 (L)	0 (L)

Notes:
Effects are classified as large increase (↑↑), modest increase (↑), no change (0), modest decrease (↓), or large decrease (↓↓).
Evidence or certainty levels for these effects are classified as low or theoretical only (L), moderate (M), or high (H).

Table 4. Summary of Probable Effects of Innovative Tort Reforms

	Claims frequency and costs	Overhead costs	Liability costs	Defensive medicine	Supply	Quality of care
Schedule of noneconomic damages	0 (L) for frequency 0 (L) for costs (highly dependent on award levels)	↓ (L)	↓ (L)	↓ (L)	0 (L)	0 (L)
Administrative compensation systems or "health courts"	Medical court model: 0 (L) for frequency 0 (L) for costs Administrative model: ↑↑ (M) for frequency, 0 (L) for costs	Medical court model: ↓ (L) Administrative model: ↓↓ (H)	Medical court model: 0 (L) Administrative model: 0 (L)	Medical court model: 0 (L) Administrative model: ↓ (L)	Medical court model: 0 (L) Administrative model: 0 (L)	Medical court model: 0 (L) Administrative model: ↑ (M)
Disclosure-and-offer programs	↓ (L) for frequency, ↓ (L) for costs	↓↓ (M)	↓ (L)	0 (L)	0 (L)	↑ (M)
Safe harbors for adherence to evidence-based practice guidelines	0 (L) for frequency, 0 (L) for costs	↓ (L)	0 (L)	↓↓ (L)	↑ (L)	↑↑ (L)
Subsidized, conditional reinsurance	0 (M) for frequency, 0 (M) for costs	↓ (L) (possibly greater savings with early offer or disclosure programs)	0 (M) (possibly ↓ with early offer or disclosure programs)	0 (L)	0 (M)	↑ (L)
Enterprise liability	0 (L) for frequency, 0 (L) for costs	↓ (L)	↓ (L)	↓ (L)	0 (L)	↑ (L)

Notes:
Effects are classified as large increase (↑↑), modest increase (↑), no change (0), modest decrease (↓), or large decrease (↓↓).
Certainty levels for these predicted effects are classified as low (L), moderate (M), or high (H).

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Mr. PITTS. Chair thanks the gentleman and recognizes Mr. Wolfman for 5 minutes.

STATEMENT OF BRIAN WOLFMAN

Mr. WOLFMAN. Chairman Pitts and members of the committee, thank you for the opportunity to appear today in opposition to H.R. 5. I want to focus on what H.R. 5 calls medical product claims: suits brought by patients claiming that their injuries were caused by a defective or mislabeled drug or medical device. I will address three particularly harmful attributes of H.R. 5: its limits on noneconomic damages, attorney fees, and punitive damages.

The act would limit noneconomic damages to $250,000. What does that mean in human terms? My written testimony answers this question in detail, but today I will focus on one example. In Wyeth v. Levine, Diana Levine, a musician lost an arm because of the negligence of a huge drug company Wyeth. She was awarded $5 million in noneconomic damages. Ms. Levine experiences phantom pain in her missing arm every day, sometimes excruciating. She had been a well-known Vermont musician who loved to play and create music, but her life was fundamentally altered forever. She is beset by depression, the mental anguish that frays relationships, and undermines desire from living a life that will never be fully restored. The idea that $250,000 can fully compensate for these life altering injuries is, to be blunt, absurd, and that H.R. 5 fixes noneconomic damages at $250,000 forever regardless of the impact of inflation underscores the conclusion that the cap is not a genuine attempt at gauging the impact on real people's lives of noneconomic injuries.

Wyeth defended this case with great tenacity. Ms. Levine's lawyers were required to hire four experts, take wide ranging discovery, conduct a trial, defend pre and post trial motions, and defend lengthy multi-year appeals. The financial impact of Ms. Levine's injuries became so severe that she went into massive debt during the case and had to take out a large loan against her judgment. In preparing for this testimony, I asked Ms. Levine's small-town Vermont lawyer if he would have taken on Ms. Levine's case had the law limited economic damages to $250,000. His answer: one word, no.

Studies show that a $250,000 cap on noneconomic damages disproportionally harms women, members of minority groups, and older people all of whom rely heavily on noneconomic damages to be made whole. Society should compensate harm and discourage negligent conduct just as much when it is visited upon a relatively poor person as when it is visited upon someone who is economically advantaged.

The act would also limit contingent attorney fees to just 15 percent on recoveries over $600,000. Those figures appear to be plucked out of the air with no explanation of how they would correct a supposed distortion in the market for contingent fee legal services. For someone who does not understand the economic reality of risk taking in a free enterprise economy, this provision may appear pro-consumer. After all, limiting the lawyer's recovery helps the client, right? Wrong.

The free market does not cap contingent fees at 15 percent because lawyers are not willing to offer that term in a free market to their clients. The risk and expense of complex medical products litigation is too great. Ms. Levine audibly obtained a significant verdict but her lawyer did not know that result going in. He knew that Wyeth was likely to put on a formidable defense and take the case all the way to the Supreme Court. Viewed in hindsight, of course, Ms. Levine would have done better if a large chunk of her lawyer's fee had been paid to her. But if the Congress of the United States had demanded that a small town Vermont lawyer limit his fees to 15 percent, Ms. Levine never would have been able to find a competent lawyer to take her case in the first place.

H.R.5 also bars punitive damages in cases where the product was approved by the FDA. Given the reality of FDA regulation, that makes no sense. Prescription drugs are FDA approved after relatively small clinical trials that do not always unearth all of the product's hazards and side effects. After approval the product is used by the public at large, a sort of mammoth clinical experiment and the manufacturer learns more about the product. In fact, fully half of all drug labeling updates to warn of serious adverse drug reactions occurs seven or more years after the drug is approved. Many drug liability suits concern information that not before the FDA at the time of the drug's approval. And so it is irrational to immunize the manufacturer based on that approval particularly where the manufacturer was grossly negligent in assuring that its product label remained up to date. But H.R. 5 would do just that.

For this reason as well, H.R. 5 would undermine consumer health and safety and the committee should reject it. Thank you.

[The prepared statement of Mr. Wolfman follows:]

TESTIMONY OF BRIAN WOLFMAN*

Testimony in Opposition to H.R. 5, the HEALTH Act of 2011
Before the Subcommittee on Health of the Committee on
Energy and Commerce of the U.S. House of Representatives

April 6, 2011

Introduction

Chairman Pitts and members of the subcommittee: Thank you for the opportunity to appear today in opposition to H.R. 5, the HEALTH Act of 2011. I have practiced law for more than 25 years. I am not a member of the private plaintiff's bar and never have been. I do not represent defendants in product liability or medical malpractice suits and never have. I have worked exclusively for non-profit organizations. I worked for nearly five years as a staff lawyer in a rural civil legal services program in Arkansas and, then, for nearly 20 years, at Public Citizen Litigation Group, the last five as its Director. Now, I'm the co-director of a non-profit student-centered legal clinic at Georgetown Law School. I'm no partisan when it comes to the civil justice system. Indeed, for years, my colleagues and I have challenged unfair class action settlements proposed by plaintiffs and defendants, because we believe that the civil justice system must serve the litigants and American consumers more generally.

But I believe that I know a bad deal for consumers when I see one, and H.R. 5 is a

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*Visiting Professor of Law and Co-Director of the Institute for Public Representation, Georgetown University Law Center. My affiliation is provided for identification purposes only. This testimony is provided in my individual capacity.

very bad deal. The free market works reasonably well in individual law suits, where the client's interest in maximizing recovery and the lawyer's interest in a fair fee are well aligned and do not require the kind of micro management and anti-free market regulation that H.R. 5 would impose. As I explain below, H.R. 5's draconian limits on recoveries and on attorney fees will harm consumers and undermine their health and safety. For those reasons, I urge the committee to reject H.R. 5.

H.R. 5's Treatment of Medical Product Claims Would Undermine The Interests of American Consumers.

H.R. 5 mainly concerns medical malpractice claims, but it also applies to claims involving injuries from what the Act terms a "medical product," which in turn is defined as a prescription drug, medical device, or biological product, as those terms are defined in the Federal Food, Drug, and Cosmetic Act.[1] My testimony focuses on these medical product claims — specifically, claims by injured patients against drug and device manufacturers alleging that their products were defectively designed or manufactured and/or were not accompanied by adequate warnings.

Although I believe that nearly all of H.R. 5 would, if enacted, harm the American public, my testimony will focus on three of its most troubling provisions: its limits on non-economic damages, attorney's fees, and punitive damages. Before discussing those provisions in more detail, I want to take a moment to explain why state-law suits against

[1]H.R. 5, § 9(14) (2011).

drug and device manufacturers benefit the public, which depends on safe and effective drugs and medical devices.

First, state "common-law claims," such as those involving medical devices and drugs, "necessarily perform an important remedial role in compensating accident victims."[2] Thus, if H.R. 5 undercuts a patient's ability to be fully redressed for her injuries or to attract competent counsel to challenge the massive resources of drug and device companies — and, as explained below, H.R. 5 would do both — people harmed by defective or mislabeled drugs and devices will go without needed compensation.

Second, the civil justice system deters the sale of unsafe and ineffective products and encourages the sale of products that are, in fact, safe and effective. This role is particularly important with respect to products regulated by the Food and Drug Administration (FDA), which, with limited funding, must oversee thousands of products and review tens of thousands of reports of product failures and other adverse events. As the Supreme Court put it just two years ago:

> The FDA has limited resources to monitor the 11,000 drugs on the market, and manufacturers have superior access to information about their drugs, especially in the postmarketing phase as new risks emerge. State tort suits uncover unknown drug hazards and provide incentives for drug manufacturers to disclose safety risks promptly.[3]

The Supreme Court understands that these two roles — compensation and safety

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[2] *Sprietsma v. Mercury Marine*, 537 U.S. 51, 64 (2002).

[3] *Wyeth v. Levine*, 129 S. Ct. 1187 (2009) (footnote omitted).

— are interrelated. The state-law tort system "serve[s] a distinct compensatory function that may motivate injured persons to come forward with information," which, in turn, informs the FDA and the public about unsafe products.[4] Thus, "the FDA [has] long maintained that state law offers an additional, and important, layer of consumer protection that complements FDA regulation."[5]

As I now explain, H.R. 5 threatens to undermine these positive attributes of the civil justice system.

H.R. 5, § 4(b) — The $250,000 Limit on Non-Economic Damages

H.R. 5, § 4(b) limits to $250,000 non-economic damages in cases, among others, involving injuries from FDA-approved products. The most common forms of economic damages are lost income and the costs of medical care. But a person grievously injured by a drug or medical device is harmed in many ways that are non-economic and not fully captured by the non-descriptive term "pain and suffering." A person who has gone blind or contracted cancer or lost a limb or developed a severe neurological disease from a defective or mislabeled device or drug may have lost the ability to work. But the damages go much farther. The victims of these kinds of injuries may never get to see or hold their grandchildren; they may never again have sex with their husband or wife; they not only may never draw another paycheck, but they may never experience the joy of hard work or

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[4] *Id.* at 1202.

[5] *Id.* (footnote omitted).

professional challenge or satisfaction; they may experience excruciating phantom pain for the rest of their lives; they may live in constant fear of forgetting to take their anti-cancer or heart disease medication necessitated by their injuries; they may worry constantly about their inability to provide for their children; and they may fear abandonment by their friends and loved ones as their injuries become more debilitating. The idea that $250,000 can fully compensate for these types of injuries — injuries that may last a lifetime — is, to be blunt, absurd. And the fact that H.R. 5 fixes non-economic damages at $250,000 *forever*, regardless of the impact of inflation, underscores the conclusion that the $250,000 cap is not a genuine attempt at gauging the impact on real people's lives of non-economic injuries.

Moreover, whether injured people are able to file meaningful suits against drug and device manufacturers depends entirely on their ability to attract competent counsel with the financial incentive to take on the litigation. Drug and device manufacturers almost always have large war chests for litigation. But ordinary people who are harmed by defective products do not. They cannot front the out-of-pocket expenses of product liability litigation, and they cannot pay their lawyers on an hourly basis. They depend on properly incentivized contingent-fee lawyers, who know that, if their clients succeed, the expenses of the litigation and their fees will come out of the clients' awards. (And, of course, those lawyers take the grave risk that if they are unsuccessful, they will be out all of the costs of litigation and receive no compensation for their time.)

Because of the disparity of power between the drug and device companies and the typical injured patient, the companies cannot be taken on without an investment *by the plaintiff's lawyer* of a large (sometimes massive) outlay of out-of-pocket expenses — for expert witnesses (and non-testifying experts), deposition transcripts, document search and reproduction, medical examinations, forensics, and the like — not to mention the huge expenditure of time and overhead for discovery, extensive motion practice, trial, and, not infrequently, one or more appeals (both before and after trial). Section 4(b)'s severe limit on non-economic damages will make it impossible for some injured patients to find lawyers, particularly in cases that are complex and difficult or involve the most deep-pocketed opponents — the very cases in which you want the most skilled, tenacious plaintiff's counsel. And even in cases where the $250,000 limit does not make it impossible to find a lawyer, the limit — just like any limit on the return on one's investment — will mean that the lawyer will not be able to invest the time and resources (for instance, for hiring qualified experts or appellate counsel) needed to counter the defendant's effort. Put another way, even for cases that are filed, the $250,000 limit will make it more likely that the plaintiff will lose, and that will become more and more likely as the limit loses value to the ever-present effect of inflation.

Moreover, the $250,000 limit on non-economic damages would have a disproportionate impact on the victims of unsafe drugs and medical devices who are women, elderly, and/or members of economically disadvantaged minority groups.

Because these individuals are less likely than others to have significant (or any) wage income, their economic damages may be non-existent, small, or difficult to measure (as in the case of individuals who do not work outside the home). Put another way, legislation that limits the amount of non-economic damages an injured person may recover, disadvantages lower income people, who tend not to have significant wage income (the loss of which is a component of economic damages in many tort suits) and must rely more heavily on non-economic damages to be made whole. Thus, under H.R. 5, an older person who is retired and has been permanently and gravely injured by a mislabeled prescription drug could be limited to $250,000 in damages, which would be grossly insufficient to compensate that person for her losses and, in any event, would likely make it impossible for that person to attract competent counsel.[6] That makes no sense because society should want to compensate harm and discourage negligent conduct or intentional misbehavior just as much when it is visited upon a relatively poor person, as when it is visited upon someone who is economically advantaged.

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So far, I've described what I will call the logic of the problem: Tort cases against large drug and device companies are expensive, both in terms of out-of-pocket costs and

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[6]The disproportionate impact of limits on non-economic tort compensation on women, older people, and members of minority groups has been demonstrated empirically in studies of similar limits imposed by state legislatures. *See, e.g.*, "The Hidden Victims of Tort Reform: Women, Children, and the Elderly," 53 Emory L.J. 1263 (2004); *see also* Finley, "Female Trouble: the Implications of Tort Reform for Women," 64 Tenn. L. Rev. 847 (1997).

time, and they will not be brought if the amounts recoverable are so low that they render the investment risks too great.

But it is also useful to review real cases. In each of the examples that follow, the costs of litigation were high, the defense of the litigation was tenacious, and the plaintiff claimed severe non-economic losses. In some cases, the plaintiff won; in others, the defendant won. But one should not measure whether the tort system properly incentivized the plaintiff (and his and her lawyer) to come forward to sue based on the results of the litigation. The question is whether before suit was filed a plaintiff, armed with a competent, risk-taking contingent-fee lawyer, would have been willing to take on a well-heeled drug or device company, with its team of well-paid lawyers. In each case, I believe that, if non-economic damages had been limited to $250,000, it is quite unlikely that such a plaintiff would have come forward.

Wyeth v. Levine[7]

In this well-known case, the Supreme Court held that the FDA's approval of prescription drug labeling does not preempt a state-law tort suit premised on the drug manufacturer's failure to warn of the hazards associated with the drug. The plaintiff, Diana Levine, a professional musician, went to the hospital for treatment of a headache. After being injected with a drug manufactured by the drug company Wyeth, Ms. Levine suffered injuries that led quickly and irreversibly to the loss of her right arm. More

[7]129 S. Ct. 1187 (2009), *aff'g*, 944 A.2d 179 (Vt. 2006).

specifically, Ms. Levine's arm had to be amputated because Wyeth's drug Phenergan, prescribed to alleviate nausea associated with a migraine headache, reached Ms. Levine's arteries. Here's a short recap of the facts:

> On April 7, 2000, Diana Levine received injections of Wyeth's prescription drug Phenergan to treat nausea associated with a migraine headache. The drug was first administered by intramuscular injection. Later that day, the drug was administered intravenously through a technique known as direct IV, or "IV push." In this method, a syringe pushes medication directly into the patient's vein. The method is called "direct" to distinguish it from a more common means of intravenous administration in which the medication is placed into a stream of saline flowing from a hanging IV bag. Wyeth has known for decades that when Phenergan is administered by the IV push method, even by experienced clinicians, inadvertent arterial contact can result. In fact, there were at least 20 reported cases where Phenergan has caused an amputation, all resulting from IV push. Based on undisputed expert testimony, the trial court found as fact that [o]ne way to reduce the risk of inadvertent intra-arterial injection is to set up a free-flowing IV bag and introduce the drug into the IV solution. This is an alternative to injection through the [IV push] infusion set into a patient's vein. Administration through a free flowing IV bag reduces the risk of inadvertent arterial injection because the nurse or physician can be more certain that the needle has been placed in a vein. A solution dripping from an IV bag will not flow freely into an artery due to back pressure from the patient. An expert testified that using a hanging IV bag involves virtually no risk of arterial exposure and is "far safer" than IV push.
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> The testimony indicated that Wyeth knew that when Phenergan comes in contact with an artery, the artery dies, and necrosis, gangrene, and amputation result. Four experts testified that if Phenergan is used intravenously, it should be done only through a hanging IV bag and that the label should have precluded use of IV push, but it did not do so. Indeed, even one of Wyeth's experts acknowledged that he would hesitate to use direct IV injection for use in non-life-threatening situations and stated that he would have written the label to instruct that Phenergan be administered into a running, established IV. Another Wyeth expert agreed with Ms. Levine's expert that it was safer to administer Phenergan through a free-flowing IV than through the direct method.

> Because the IV push method was used to administer Phenergan to Ms. Levine, the drug penetrated her artery. For seven weeks after the injection, Ms. Levine suffered unimaginable physical and emotional pain as she watched her right hand turn black and die. As one witness put it: "Pain scales usually are run from one to ten. This is a ten. ... there's not much worse than this type of scenario." Ms. Levine herself testified about her excruciating pain, terror, and fear of dying and losing her arm. In short, as a result of being subjected to an unsafe and unnecessary method of administration of a drug to curb nausea, Ms. Levine endured two amputations. She first lost her right hand and then her right arm up to the elbow, which forever destroyed her ability to play music — her profession and lifelong passion.[8]

Ms. Levine was represented by a very skillful, small-town Vermont lawyer. He was up against one of the largest drug companies in the world. Wyeth had as many lawyers as it needed, including, when the case was on appeal, teams of lawyers from two of the largest Washington, D.C. law firms; they filed multiple pre-trial motions and fought the case at every turn (as they had every right to do). To do a competent job, Ms. Levine's lawyer had to hire four experts, pay for reams of depositions, and endure the rigors of a contested trial. Out-of-pocket expenses ran into the tens of thousands of dollars, all spent years before either he or Ms. Levine knew whether they would ever see a dime. The jury returned an award of $7.4 million, $5 million of which was for non-economic damages, but that was five years before the appellate process would run its course. During that process, the financial impact of Ms. Levine's injuries became so severe that Ms. Levine accumulated massive debt and had to take out a large loan against

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[8]The facts are taken from the record in the *Levine* case. I read the trial transcript when I was representing Ms. Levine in the Supreme Court.

the judgment.

I want to be clear about what Ms. Levine's $5 million in non-economic damages entailed. It's not what you might think, and it's not what the Chamber of Commerce wants you to think. The sterile terms "non-economic damages" or even "pain and suffering" do not adequately describe those injuries. Ms. Levine experiences phantom pain in her missing arm every day. Sometimes it is excruciating. And she has pain and tendinitis in her other arm because, having lost one arm, the other arm has to do a disproportionate amount of the physical work that most people accomplish with two arms. Ms. Levine had been a well-known Vermont musician who loved to play and create music. You can hear that clearly if you listen to one of her CDs, as I have. All that has been fundamentally altered — forever. Imagine the difficulty of completing ordinary tasks — driving, cooking, dressing, fixing one's hair, to name a few — that able-bodied people do easily every day. There's the disfigurement that will always be with her. And then there's the depression, the mental anguish that frays relationships, undermines desire, and just plain hurts — all stemming from the experience of losing one's arm, the constant physical pain, and the realization that she is living a life that will never be fully restored.

Someone might think the potential award of $2.4 million in economic damages ought to have been sufficient to have induced a competent lawyer to have taken on Ms. Levine's case. But, again, that's not how a system of economic incentives works. No one

knows the result of the case before it is litigated. In preparing for this testimony, I called Ms. Levine's lawyer and asked him whether, given the possibility of an award of economic damages, he would have taken the case if there had been a $250,000 limit on non-economic damages. There was a long pause, and I think I know why. Not because $250,000 in non-economic damages is an adequate incentive to take on a case like Ms. Levine's. It isn't. Her lawyer paused, I believe, because knowing what Ms. Levine had gone through and how much she had needed him, he didn't want to say "no." But, in fact, after that long pause, he did, quietly, say "no."

Boles v. Merck[9]

Plaintiff Shirley Boles, a woman in her 50s, was suffering from osteopenia — a weakened condition of the bones. The condition often precedes osteoporosis. She was prescribed Fosamax, which is supposed to inhibit bone resorption. Several years later, Ms. Boles had a tooth extracted and developed complications that suggested the presence of an infection. She underwent curettage and debridement of the affected area, but they were not effective. Her condition worsened. In 2005, her jaw began to exhibit areas of exposed necrosis — that is, the death of a bone. The damage extended to her inferior alveolar nerve, which innervates the cheek, gums, and lower lip. The first trial against Merck ended in a mistrial. During a second trial in which Ms. Boles argued that Fosamax led to the death of her jaw, she put on six expert witnesses (some or all for a second time)

[9]2010 WL 5086699 (S.D.N.Y. June 25, 2010).

in clinical trials, oral surgery, gynecology, infectious diseases, oral surgery, and new drug review/approval procedures. She was eventually awarded $8 million for "past and future pain and suffering." A case requiring six experts would not have been brought if non-economic damages had been capped at $250,000.

Eichmiller v. Wyeth[10]

Linda Eichmiller, a 54-year-old nurse, took the diet drug Pondimin, manufactured by Wyeth. In 1997, the drug was pulled from the market because studies showed it increased the risk of heart disease. Ms. Eichmiller contracted valvular heart disease and claimed, consistent with the drug's removal from the market, that Pondimin was responsible. Ms. Eichmiller employed five experts, one each in cardiology, medical care, general medicine, epidemiology, and pharmacology. The jury came back with a verdict for Wyeth, and Ms. Eichmiller received nothing. Given that risk, why would someone take on the pharmaceutical giant Wyeth, and hire six experts, if she were limited to $250,000 in non-economic damages?

Bartlett v. Mutual Pharm. Co.[11]

Karen Bartlett was prescribed a non-steroidal anti-inflammatory drug (NSAID) called Clinoril for pain in her right shoulder. Within weeks, Ms. Bartlett went to the emergency room complaining of skin blisters, eye irritation, and other symptoms. She was

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[10]2008 WL 22998351 (Ga. Super. Nov. 26, 2003).

[11]2011 WL 32520 (D.N.H. Jan. 5, 2011).

soon diagnosed with Stevens-Johnson syndrome (SJS), which progressed to toxic epidermal necrolysis (TEN), a serious and potentially fatal condition characterized by necrosis of the skin and mucous membranes. Her doctors concluded that the SJS/TEN was caused by Clinoril. She spent about three months in the hospital recovering — two of them in a medically induced coma — and ended up with permanent injuries, including blindness. Ms. Bartlett litigated under three theories, two of which were rejected by the court, after a series of motions filed by the defendant. After several more rounds of briefing regarding the sufficiency of Ms. Bartlett's claim, almost 50 additional challenges to expert witnesses and testimony in advance of trial, and nearly 50 motions in limine, the court held a three-week trial in August 2010. The plaintiff used four expert witnesses — a pharmacologist, burn surgeon, an economist, and a life-care planner. The jury returned a verdict for about $21 million, $16.5 million of which was for pain, suffering, and loss of enjoyment of life. Ms. Bartlett's lawyers then successfully fought a series of post-trial motions challenging her expert witnesses among a slew of other legal challenges.

Even if we assume that Ms. Bartlett had determined before she filed suit that she had a 50-50 chance of obtaining *some* economic damages, the massive costs of the case — hiring four of her own experts, pre-trial motions that threw out two of her three claims, 50 motions challenging her experts, 50 motions in limine, presumably a large number of expert and other depositions, not to mention the post-trial motions — almost certainly would have dissuaded a rational lawyer from pursuing the case if it had been subject to a

$250,000 limit on non-economic damages.

Rush v. Wyeth[12]

At age 65, Helen Rush, a newsletter writer began to undergo hormone therapy as a result of a gynecological condition. The hormone was manufactured by Wyeth. She was diagnosed with breast cancer and sued Wyeth, alleging that the breast cancer warning on the drug was inadequate and that the risks, including breast cancer, of hormone therapy outweighed its benefits. The jury found for Wyeth. Ms. Rush's case involved six experts — in family medicine, epidemiology, cancer, new drug review and approval procedures, and breast surgery. The jury's verdict left Ms. Rush with nothing, which is the risk she and her lawyer took. But Ms. Rush almost surely would not have taken that risk had her non-economic damages been limited to $250,000, particularly because, at age 65, Ms. Rush's future earnings potential may not have been very great.

H.R. 5, § 5 – Restrictions on Contingent Fees

Section 5 of H.R. 5 imposes severe restrictions on contingent fees and is perhaps the Act's most anti-consumer provision, the one most likely to undermine the public's health and safety. Section 5 limits attorney fees to 40% of the plaintiff's recovery up to $50,000; to 33 1/3% of the next $50,000; to 25% of the next $500,000; and to 15% of the recovery in excess of $600,000. These numbers appear to have been plucked out of thin air, with no explanation of whether they somehow correct purported distortions in the

[12] 2007 WL 912211 (Feb. 15, 2007).

market for contingent-fee legal services. Moreover, in perhaps the Act's greatest affront to free-market contracting, § 5 gives a court the power in any case to "redirect" to the plaintiff a part of the previously agreed-on attorney fee whenever it wishes "based upon the interests of justice and the principles of equity."[13]

At first blush, for someone who does not understand the economic reality of contingent-fee legal practice, or, indeed, the economic reality of risk taking in a free-enterprise economy, § 5 may appear rational and pro-consumer. After all, once the plaintiff's recovery hits $600,000, why not limit the lawyer's recovery to 15% of the excess? To be sure, once a case has been won or a settlement finalized, § 5 "benefits" the client, who may receive a much larger portion of the pie than she would if she were required to live up to the 1/3 contingent fee to which she had earlier agreed. So, why should we care, if the client — whose interests we want to protect — takes home more money?

But that looks at the attorney-client transaction after-the-fact, which makes no sense. This may be easier to explain outside of the attorney-client context. Say, for instance, a person decides to open a coffee shop. She invests a quarter million dollars, her entire life savings (much like a contingent-fee lawyer might invest in expert witnesses, deposition costs, various office overhead, and the like). The prices she charges for coffee and other items are set by the market (just like the market sets lawyer's contingent fee

[13]H.R. 5, § 5(a).

rates).The coffee shop may fail entirely (like a contingent-fee lawyer may lose all or most of his cases); it may struggle, providing some jobs for its workers and just enough for the owner to scrape by (like a contingent-fee lawyer who wins a few cases here and there), or the coffee shop may hit it big, with lines out the door and large profits for the owner (akin to a multi-million dollar verdict for the contingent-fee lawyer). The latter situation is rare. Some businesses fail and others struggle. But when the business succeeds, in a free-enterprise system, we do not say that the coffee shop owner has achieved a windfall, and the law certainly does not require the successful owner to rebate some of the coffee shop profits to her customers on the ground that she has victimized them. Why not? Because we know that, if we treat *all* entrepreneurs as if they failed or have barely scraped by, we won't have any entrepreneurs; they will not be willing to take the risks that the market imposes if they cannot reap the rewards that the market promises to people who have worked hard, invested sensibly, and understood what it takes to win.

So, let's return to the market for contingent fee lawyers. A plaintiff harmed by a drug or medical device shops for a lawyer. Depending on the locality, the difficulty of recovery, the complexity of the case, and the expected tenacity of the defendant, the contingent fee may be 25%, 33%, or 40%, or even higher on occasion, if the case has to be tried or appealed. Sometimes the contingent fee contract itself builds in differing percentages based on the amount of recovery. Not all contingent fee contracts are alike, and the client is of course free to shop around for a lawyer based on the contract terms

(with the understanding, of course, that, as in most situations, you get what you pay for).

If the market does *not* cap contingent fees at 15% for recoveries above $600,000, it is presumably because lawyers are not willing to offer that term to their clients. And that is understandable. This risk of product liability litigation is too great. In the *Bartlett* case discussed above, though the client ultimately obtained a multi-million dollar verdict, the lawyer did not know that result going in. But the lawyer might well have known that the opposing side was likely to put on a formidable, scorched-earth defense, requiring the hiring of four experts, the defense of dozens upon dozens of pre-trial motions (which resulted in the loss of two of the plaintiff's three claims), depositions, and an appeal. Sure, viewed in hindsight, Ms. Bartlett would have done better if a larger chunk of the lawyer's fee had been paid to her, but given (1) that the market values generally lawyer's contingency services at well above 15%, (2) the high-risk nature of the case, and (3) the immense investment that were needed to prevail, it seems highly unlikely that a 15% fee would have attracted competent counsel to take the case. And, don't forget, buying the services of a lawyer is not like buying coffee. If the market for trendy coffee shops dries up because of overzealous regulation, you can still make a pretty good cup of coffee at home. You cannot take on Wyeth or Pfizer or Merck on your own. If the market dries up there, or if the market is comprised of only the least capable lawyers, the drug and device companies may rejoice, but patients will suffer.

Moreover, complex product liability cases, such as those involving drugs and

devices, are the last kinds of case that a legislature would want to subject to a cap on attorney fees. Those cases require lawyers with the most talent and drive, willing to take the most risk. They involve complex issues of medical causation, a wide array of very difficult legal doctrines, an understanding of the drug approval process, and, as has been noted, investment of lots of time and expense. If you want to drive good, non-risk-averse lawyers out of the business of representing people injured by defective and mislabeled drugs and devices, § 5 is the best way to do it. For these reasons, I urge you to reject § 5.

H.R. 5, § 7(c) — Restrictions on Punitive Damages

H.R. 5, § 7 contains limits on punitive damages, none of which is sensible and all of which would harm consumers. I want to focus on a special limit on the award of punitive damages that would apply to drug and device cases. Under § 7(c), no punitive damages may be awarded if the product was approved, cleared, or licensed by the FDA or if the product "is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations ...."

Rather than trust the state tort systems to determine whether and in what circumstances regulatory compliance should serve as a defense to punitive damages,[14] § 7(c) would establish a nearly categorical rule prohibiting an award of punitive damages if the product was approved by the FDA. Given the reality of FDA regulation, that makes

[14] *See* Restatement (Third) of Torts: Prods. Liab. § 4(b) & cmt. e (1988); 63B Am. Jur. 2d Prods. Liab. § 2022 (2007).

no sense. With respect to medical devices, products are frequently updated. The updated product may replace an earlier version of the product that had safety problems, although the old version may stay on the market. Even where the manufacturer continues to sell a defective or ineffective version solely to maximize its profits and clear its inventories,[15] under §7(c), no court would be able to impose an award of punitive damages.

Prescription drugs present a different problem. Drugs are approved by the FDA as safe and effective after relatively small clinical trials that necessarily do not always unearth all of the product's hazards, contraindications, and side effects. After approval, the product is used by the public at large — a sort of mammoth clinical experiment — and the manufacturer learns more about the product. Indeed, fully half of all drug labeling updates to warn of serious adverse drug reactions occur seven or more years after the drug is first approved.[16] As a result, many, perhaps most, product liability suits regarding drug safety concern information that was not before the FDA at the time of the drug's approval, and, thus, it is irrational to immunize the manufacturer based on that approval. Under § 7(c), however, the manufacturer would be insulated from an award of punitive damages by FDA approval, even in cases where the manufacturer was grossly negligent (or worse) in monitoring the product's safety record after approval and in assuring that its

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[15]*See Blunt v. Medtronic, Inc.*, 2007 WL 2176136, ¶¶ 2-3 (Wis. App. 2007); *id.* ¶ 22 (Fine, J., dissenting).

[16]*See* Lasser, et al., "Timing of New Black Box Warnings and Withdrawals for Prescription Medications," 287 JAMA 2215 (May 1, 2002).

product label remained up-to-date. For this reason as well, H.R. 5 would undermine consumer health and safety, and the committee should reject it.

Mr. PITTS. The Chair thanks the gentleman and recognizes Dr. Tippett for 5 minutes.

STATEMENT OF TROY M. TIPPETT

Mr. TIPPETT. Thank you, Chairman Pitts, and—thank you, Chairman Pitts and Ranking Member Pallone, for holding this important hearing to consider this essential business of fixing our country's broken medical liability system. I am grateful for the opportunity to appear before this distinguished committee on behalf of the Health Coalition on Liability and Access or HCLA to strongly endorse and support passage of H.R. 5, the Health Act of 2011 as it was originally introduced in January.

HCLA represents a broad, national coalition of physicians, hospitals, employers, healthcare liability insurers and those who have joined together to seek some common sense solutions that will help reduce healthcare costs for all Americans and insure patient access to quality medical care by enacting medical liability reform at the Federal level. We believe all Americans pay the price when the profits of personal injury lawyers take precedence over patient care.

Today our current medical liability system increases healthcare costs to unsustainably high medical insurance premiums and by encouraging the practice of defensive medicine. It reduces access to care as we see more and more physicians, particularly younger physicians avoid high risk specialties and procedures that are the frequent target of lawsuit abuse. Also, it has become a significant factor in the erosion of the all important doctor/patient relationship. HCLA believes H.R. 5 is the kind of comprehensive solution that would bring fairness and common sense back to our medical liability system. Any reform legislation should include the following points.

There should be no limit on awards for economic damages. It should have a reasonable statute of limitations on the medical malpractice claims. It should have a reasonable limit of $250,000 on awards for noneconomic damages, and it should have a replacement of joint and several liability with a fair share rule. And there should be limits on the contingency fees that lawyers can charge so that more that that money goes back to the patient, and it should have a collateral source rule reform.

Last month, the CBO published two reports that clearly show enactment of this legislation and similar legislation would help lower healthcare costs by lowering medical health insurance liability premiums by reducing the practice of defensive medicine and by lowering private health insurance premiums. The CBO estimated that passage of legislation would save the government $62 billion. Now, I don't know where you come from, but in my part of the woods that is a significant amount of money. $62 billion is worth saving. A number of States have made significant gains in reducing medical lawsuit in views, but as personal injury lawyers work State by State to overturn liability reforms and expand areas open to litigation it is clear that medical liability remains a national problem that requires a comprehensive Federal solution.

We look forward to working with the committee and others in Congress to develop the kind of Federal remedy that will bring con-

sistency and common sense back to the system. There can be no real healthcare reform without meaningful medical liability reform. We ask you to please pass H.R. 5.

[The prepared statement of Mr. Tippett follows:]

Statement of

Troy M. Tippett, M.D.

on the subject of

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

before the

Subcommittee on Health

Energy and Commerce Committee

U.S. House of Representatives

April 6, 2011

EXECUTIVE SUMMARY

The Health Coalition on Liability and Access (HCLA) supports H.R. 5, the HEALTH Act, to help reduce health care costs for all Americans and to ensure patient access to quality medical care by enacting medical liability reform at the federal level.

The medical liability system today is broken and all Americans pay the price when the profits of personal injury lawyers take precedence over patient care. The current system:

- Increases health care costs through unsustainably high medical liability insurance premiums and by encouraging the practice of defensive medicine
- Decreases access to care as physicians avoid high-risk specialties and procedures that are the frequent target of lawsuit abuse
- Erodes the doctor-patient relationship
- Hurts the economy and costs America jobs at a time when we can least afford it

Two CBO reports released last month show clearly that enactment of legislation, which reflects the key elements of H.R. 5, will lower health care costs by:

- Lowering medical health insurance liability premiums
- Reducing the practice of defensive medicine
- Lowering private health insurance premiums
- Increasing federal revenues ($13 billion 2012-2021)
- Reducing direct federal spending on health care ($50 billion 2012-2021)
- Reducing the federal deficit ($62 billion 2012-2021)

A number of states have made significant gains in reducing medical lawsuit abuse but as personal injury lawyers work state-by-state to overturn liability reforms and expand areas open to litigation, it is clear that medical liability is a national problem that requires a comprehensive federal solution.

HCLA believes there can be no real health care reform without meaningful medical liability reform. Congress must finish the job by passing H.R. 5.

INTRODUCTION

Thank you, Chairman Pitts and Ranking Member Pallone for holding this important hearing to consider the essential business of fixing our country's broken medical liability system. I am grateful for the opportunity to appear before this distinguished committee to enthusiastically support passage of H.R. 5, the HEALTH Act of 2011, as it was originally introduced on January 24th of this year.

If I could, I'd like to take just a moment to present my credentials. I am currently the Medical Director for the Neurosurgical Group located in Pensacola, Florida and have been a practicing neurosurgeon for more than thirty years. I am the Immediate Past President of the American Association of Neurological Surgeons and past president of the Neurosurgical Society of America. I am also past president of both the Florida Medical Association and the Florida Neurosurgical Society.

Thank you again for the opportunity to appear here today. As health care costs continue to rise, patient access to care continues to be at risk, and the nation's physicians continue to be the targets of lawsuit abuse, I am here to voice the support of the Health Coalition on Liability and Access (HCLA) for H.R. 5. We are a national advocacy coalition working to help reduce health care costs for all Americans and to ensure patient access to quality medical care by enacting medical liability reform at the federal level.

HCLA represents a broad national coalition from physicians to hospitals, employers to health care liability insurers. While our areas of expertise and responsibility differ, we share one basic belief: our medical liability system is broken and it is time to protect patients now by passing H.R. 5 and passing it quickly.

Twenty-five years ago, President Ronald Reagan created a task force to study the need for tort reform. Its final report concluded:

> "In sum, tort law appears to be a major cause of the insurance availability/affordability crisis which the federal government can and should address in a variety of ways."

The task force recommended among other things limiting non-economic damages to a fair and reasonable amount, eliminating joint and several liability, and limiting attorneys' contingency fees.[1]

Today, nearly three decades later, America's patients and health care providers are still waiting for reform. Medical lawsuit abuse is still negatively impacting not just physicians and health care providers, but patients too. In fact, all Americans pay the price when the profits of personal injury lawyers take precedence over patient care. The adverse effects of frivolous lawsuits against doctors and hospitals are felt every time a woman can't deliver her child in a health care facility close to home because her local hospital no longer supports obstetrics. The reason? The risk of lawsuits is too high and so are the liability insurance rates.

The impact is felt when states that have failed to enact medical liability reform, face doctor shortages in high-risk specialties. Young doctors, saddled with hundreds of thousands of dollars of debt, are choosing lower risk specialties or opting to practice in states that have enacted effective reforms. Adding to the problem, experienced doctors are limiting their practices to low risk patients and procedures or are retiring altogether.

The impact is felt when the fear of junk lawsuits erodes the doctor-patient relationship, which is crucial to delivering exceptional health care. Medical lawsuit abuse is also driving up health care costs at a time when the country continues to suffer from a weak economy and a lack of jobs. Higher health care costs aren't the right prescription for lower unemployment.

Defensive medicine has become common practice as physicians understandably attempt to protect themselves from abusive lawsuits. They have little choice; but as health care costs rise for workers and business, especially small business, America's competitiveness suffers. With medical liability reform and lower insurance rates, doctors would be able to direct resources toward better patient care through increased hiring and improved technology. Increased resources mean more money to invest in medical technology and equipment, which can also help spur economic growth in important industries, especially manufacturing.

The clock is ticking on our health care system. So, today, HCLA asks you to take action. We ask you to create a climate for patient centered care by reforming the medical liability system that continues to put everyone's health care at risk.

WHY A FEDERAL SOLUTION TO MEDICAL LAWSUIT ABUSE

We believe H.R. 5 is the solution that will help create the environment for patient centered care, and the HCLA supports the adoption of its key provisions:

- No limit on awards for economic damages.
- A three-year statute of limitations for medical malpractice claims, with certain exceptions, from the date of manifestation of an injury.
- A reasonable limit of $250,000 on awards for non-economic damages.
- A cap on awards for punitive damages that would be the larger of $250,000 or twice the economic damages, and restrictions on when punitive damages may be awarded.
- Replacement of joint and several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury.
- Sliding-scale limits on the contingency fees that personal injury lawyers can charge.
- Implementation of collateral source rule reform to "eliminate 'double recovery" by plaintiffs who have their medical expenses paid by health insurance or worker's compensation...and still obtain jury awards.

While opponents of medical liability reform, some of the most vocal generously funded by personal injury lawyers, continue to lobby for the status quo, the need for this kind of

federal liability reform is clear and its benefits are undeniable. Last month, the Congressional Budget Office (CBO) issued a cost estimate for H.R. 5 that definitively refutes arguments of critics who have stalled liability reform for decades. The case for passage of medical liability reform is now indisputable.

According to the report, H.R. 5 would, on balance, "lower costs for health care.... directly by lowering premiums for medical liability insurance and indirectly by reducing the use of health care services prescribed by providers when faced with less pressure from potential malpractice suits. Those reductions in costs would, in turn, lower spending in federal health programs and lower private health insurance premiums."[2]

A second CBO report, also issued in March 2011, looked at options to reduce the federal deficit, including the impact of medical liability reform on health care costs as well as federal spending and revenues. According to the report, reforms that limit medical liability (including reforms similar to those contained in H.R. 5) would:

- Increase federal revenues by $13 billion from 2012-2021 as employers, paying lower health care premiums, redirect compensation to taxable wages and other fringe benefits.
- Reduce federal direct spending for Medicare, Medicaid and the Federal Employees Health Benefits program saving $50 billion during the 2012-2021 period.
- Reduce federal deficits over the same period by $62 billion.[3]

Despite some successful state initiatives to rein in medical liability costs, medical lawsuit abuse remains a national problem that needs a comprehensive solution. Congressional leaders and the President acknowledged as much by placing demonstration projects in the Patient Protection and Affordable Care Act. While we welcome those projects as an acknowledgement that our medical liability system is broken, they are not sufficient to remedy the problems that patients and physicians are facing today.

A FEDERAL FRAMEWORK IS COMMON SENSE AND CONSTITUTIONAL

Because a number of states have made significant gains in reducing medical lawsuit abuse, some favor leaving it solely to the states to enact medical liability reform. We respectfully disagree. HCLA strongly believes that the comprehensive medical liability reforms embodied in H.R. 5 should be applied nationwide for several reasons.
While the state-by-state approach to reform has paid dividends to some patients, it is clear that state liability reforms, including reasonable limits on non-economic damages, are always under the threat of legal action by personal injury lawyers looking to maintain a system that only serves to enrich them.

In many of those states where reforms are bringing the practice of medicine back into balance, personal injury lawyers have used the courts to attempt to overturn not only legislative liability reform but also to subvert the will of the people who have voted for medical liability reform through ballot initiatives or through the passage of state

constitutional amendments. Texas is a good example of a jurisdiction in which such efforts, thankfully, have failed so far.

Illinois wasn't so lucky when its State Supreme Court struck down reforms passed in 2005. Despite clear progress in terms of lessening the medical liability crisis while the reforms were in place, today Illinois' doctors find themselves back in the quicksand of lawsuit abuse. The same can be said for Georgia's doctors who lost their liability protections when the Georgia Supreme Court overturned the state's liability limits last year. Further, in states like Pennsylvania, passing medical liability reform is proving to be particularly challenging – to say the least. Meanwhile, patient access to care in that state continues to be threatened.

Activist courts in Alabama, Illinois, Kansas, Louisiana, New Hampshire, North Dakota, Oklahoma, Oregon, South Dakota, Washington and Wisconsin have also intervened in the legislative process to strike down reasonable limits on non-economic damages. Often, these anti-reform judges employ state constitutional rationales to justify these rulings.

Enacting a federal statue, we believe, is the most effective avenue available to rein in judicial activism, address the medical liability crisis and ensure patient access to health care. H.R. 5 would level the playing field for doctors, hospitals, patients and attorneys, provide needed consistency to the system and eliminate the patchwork of protections in favor of a federal framework based on fairness and common sense.

There is plenty of legal justification for moving in this direction – some that goes as far back as James Madison and his persuasive arguments in support of the Commerce Clause. This important provision gives Congress the ability to regulate interstate commerce (a definition which the health care industry clearly meets) when done in the public interest. In a 2003 report, the Congressional Research Service (CRS) confirmed this view, concluding that Congress has the authority to enact tort reform legislation generally, under its power to regulate interstate commerce.[4] This legal logic has already been applied to an earlier medical dilemma when Congress passed the National Vaccine Injury Compensation Program, a federal program that preempts state court tort awards to protect vaccine manufacturers from bankruptcy in the face of extreme state tort jury awards. A precedent has been set, and we believe now is the time for Congress to act by passing federal medical liability legislation that protects doctors, patients and the states.

Some argue that a federal approach is an overreaction. But the attempt by personal injury lawyers to overturn democratically enacted medical liability reforms state-by-state is only the tip of the iceberg. One of the most disturbing new initiatives is their effort to dramatically expand the arena in which to sue doctors. The best example is a ruling by the Massachusetts State Supreme Court that reinstated a suit against a doctor for prescribing a blood pressure medicine to a 75-year-old cancer patient who later struck and killed a pedestrian with his car. The man had finished his course of chemotherapy and died later that same year. The pedestrian's family filed suit against the doctor. The

Worcester Massachusetts *Telegram* wrote of the ruling, "Indeed, making doctors legally liable not only for their treatment of their patients, but also for an extended chain of events over which they have no control, will certainly change the way physicians treat their patients, and certainly not for the better."

In fact, legitimate concerns have also been raised that the Patient Protection and Affordable Care Act (PPACA) may create new causes of action for medical liability lawsuits, thus potentially greatly increasing the number of liability claims that are filed. The potential harm done by a flood of new lawsuits arising under the Act only further demonstrates the need to fix our medical liability system through federal action – and to do it in a timely manner.

CONSENSUS ON MEDICAL LIABILITY REFORM IS GROWING

Whether it's health care policy experts, legislators, opinion leaders or just plain folks, there is a growing consensus that medical liability reform must be a priority for this Congress. President Obama's former Director of OMB acknowledged as much in a *New York Times* editorial (10/20/10) on the health care reform bill, "...it does almost nothing to reform medical malpractice laws. Lawmakers missed an opportunity to shield from malpractice liability any doctors who followed evidence-based guidelines in treating their patients."[5] Mr. Orzag is right.

He is not alone in the Administration. HHS Secretary Kathleen Sebelius admitted in a news conference in September 2009, "...we've got a situation where there are frivolous

lawsuits being filed against practicing physicians, discouraging some from practicing in certain areas."[6]

Both the Bipartisan Policy Center's Debt Reduction Task Force and the National Commission on Fiscal Responsibility and Reform also recognized the role medical liability reform could play in helping reduce our nation's growing deficit.

The President himself has indicated support for the idea of reform on multiple occasions, including in an article he wrote in the *New England Journal of Medicine* in Oct. of 2008, stating that he "would be open to additional measures to curb malpractice suits and reduce the cost of malpractice insurance. We must make the practice of medicine rewarding again."[7] Most recently, he reiterated the need to enact medical liability reforms in his January 2011 State of the Union address.

In HCLA's poll done in October 2009, we found that 69 percent of Americans favored including medical liability reform in any new health care reform legislation. An even higher 72 percent believed lawsuit abuse put their access to quality medical care at risk by pushing good doctors out of medicine. A Rasmussen poll done at the same time found that 57 percent of people favored limiting jury awards.[8]

In an AP poll, conducted by Stanford University in November 2009, 54 percent of people favored making it harder to sue doctors and hospitals for medical errors while only one-

third were opposed. This view crossed party lines with 58 percent of Independents, 61 percent of Republicans and 47 percent of Democrats in support.[9]

HCLA believes there can be no real health care reform without meaningful medical liability reform. Congress must finish the job.

We understand that enacting liability reform is a difficult task. HCLA isn't asking you to eliminate medical liability. Like you and most Americans, our coalition believes that patients who have suffered injury due to negligence should be compensated fairly. That must not change. But one could hardly describe the current state of medical liability in America as "fair."

MEDICAL LIABILITY IN AMERICA: NO DOCTOR IS IMMUNE

Once, the medical liability system was designed to protect patient rights and improve the quality of health care. Today, it has become something akin to a "courtroom ATM" that rewards personal injury lawyers with big payoffs usually self-characterized as consumer protection. In reality, medical lawsuit abuse is weakening our health care system, putting the doctor-patient relationship at risk.

Even a cursory review of the personal injury lawyers' win/loss record shows that the majority of the cases brought against health care providers have little legitimacy. According to the Physician Insurers' Association of America, which compiles statistics on

medical liability outcomes, in 2009, 64 percent of all medical liability cases were withdrawn, dropped or dismissed as being without merit. A mere 0.8 percent resulted in a plaintiff verdict, but a lack of merit seems to be no impediment to personal injury lawyers.[10]

Instead, their "litigate first – worry about the merits later" approach has taken an even more aggressive turn. In 2009, the Institute for Legal Reform released a report showing that television ads for medical liability lawsuits increased by 1,400 percent in four years as spending reached an all-time high of $62 million – up from just $3.8 million in 2004.[11]

Professor Richard A. Epstein, director of the law and economics program at the University of Chicago Law School made the case in an *American Medical News* story comparing U.S. litigation costs with those of other countries. He said, "Nobody is as hospitable to potential liability as we are in this country. The unmistakable drift is we do much more liability than anybody else, and the evidence on improved care is vanishingly thin."[12]

The U.S. is in a league of its own when it comes to medical liability costs. Not only are they at least twice those in other developed countries,[13] they make up 10 percent of all tort cases.

But the case against our current system becomes even stronger when we put the macro numbers into perspective. The National Association of Insurance Commissioners found

that total indemnity losses in 2009 reached a staggering $3.9 billion and the costs of defending these lawsuits was pegged at an additional $2.5 billion.[14] When physicians, hospitals or other health care providers find themselves on the receiving end of a frivolous lawsuit, they can expect to pay an average of $26,000 to defend a case that is dropped before trial and as much as $140,000 if the case actually goes to court, regardless of the merits.[15] It's a no win situation for most health care providers. Even when the case is without merit, they can count on lost time, lost money and a loss of their reputation as personal injury lawyers play roulette with providers and patients alike.

While no doctor is immune from lawsuit abuse, a doctor's choice of specialty or locale can make him particularly vulnerable to these abuses. The following list illustrates the frequency doctors can expect to be sued by specialty:

- Orthopedists, trauma surgeons, ER doctors and plastic surgeons: likely to be sued in any given year.[16]
- Neurosurgeons: sued every two years on average.[17]
- OB-GYNs: nearly three out of five sued at least twice in their careers. The American College of Obstetricians and Gynecologists (ACOG) 2009 Medical Liability Survey found nearly 91 percent of OB-GYNs surveyed had experienced at least one liability claim filed against them, most without merit.[18]

Indeed, according to a recent AMA study,[19] my own specialty holds the distinction of being sued the most. A whopping 79 percent of all neurosurgeons have been sued at least once in their career and 62 percent have been two or more times. Clearly the vast

majority of neurosurgeons in this country cannot all be bad doctors; rather, the medical liability system is broken.

But the cost of the lawsuits isn't the only burden doctors in high-risk specialties must shoulder. Over the last ten years, their insurance premiums have increased substantially. In my own state of Florida, OB-GYNs and surgeons in Miami Dade, for example, paid up to a whopping $202,000 a year for liability insurance in 2010.[20] That was more than the median price of a single family home in that portion of my state.[21] But similar stories can be found across the country in states where liability reforms have either not materialized or failed to alleviate the toxic litigation environment that drives high rates.

In Nassau and Suffolk Counties, New York, for example, OB-GYNs were hit with insurances premiums as high as $187,000 from one insurer in 2010, a 5 percent increase over the year before. New Jersey OB-GYNs' hit was slightly less – only $160,000 a year. But it's not just OB-GYNs who face these astronomical rates. In Cook County, Illinois, some general surgeons paid almost a $128,000 annually for their insurance in 2010.[22] Neurosurgeons fare even worse.

A new survey[23] on defensive medicine conducted recently by the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) found, for example, that neurosurgeons in Illinois now pay in excess of $300,000 a year in insurance premiums. Eighty percent in that state pay at least $200,000. Study data

from New Jersey showed every respondent paid more than $150,000 a year and in New York, 83 percent of respondents reported paying more than $200,000 a year. Just under half of those who answered our survey in Pennsylvania paid more than $200,000 and 71 percent, over $150,000. These rates are simply not sustainable.

It should be noted that these rates are not the result of insurers gouging their insureds. In each of these states, as in many states, the largest insurers are owned or operated by physicians themselves. In order to believe these companies are overcharging for medical liability coverage, one must then believe that the physicians who run these companies are making a conscious decision to overcharge themselves for the benefit of the insurer. The very concept is absurd on its face.

While we have seen some relief in the past two or three years as premiums have leveled off or decreased slightly in some areas, they still remain a significant problem for many doctors. Many of us fear that as the new health care plan is implemented, we may see a resumption of the rising liability insurance rates that drove doctors out of medicine earlier in the decade and put patient care in jeopardy.

While the excessive number of claims also has flattened out in the last couple of years, the cost and size of the claims have not. In 2009, our most recent data, the average jury award escalated to almost $600,000 from about $280,000 in 1996.[24]

Those kinds of payouts are even attracting the attention of investors, banks and hedge funds that are investing in medical liability lawsuits in hopes of a big payoff. Yes, medical lawsuit abuse has become one of the financial industry's latest hot tickets.[25] Today, companies are loaning plaintiffs $100 million a year to help fund personal injury lawsuits. They also charge borrowers exorbitant interest rates while lobbying for exemptions from consumer protection laws regulating lending. According to a *New York Times* story, "The loans are repaid from winnings, with costs that can exceed 100 percent a year."

Unless Congress acts, the system will continue to benefit lawyers at the expense of patients, doctors and the country's financial future. As Michelle Mello, a Harvard professor of law and public health, put it, "It would be hard to design a more inefficient compensation system or one which skewed incentives more away from candor and good practices."[26]

DEFENSIVE MEDICINE: A MATTER OF SELF-PRESERVATION

With doctors practicing under a constant threat of what amounts to legal harassment, it's not surprising that many have turned to defensive medicine as a matter of self-preservation which, in turn, leads to higher health care costs. Philip K. Howard, Chairman of Common Good, a legal reform coalition, wrote in an April 2009 *New York Times* opinion piece on defensive medicine:

> "The legal system terrorizes doctors. Fear of possible claims leads medical professionals to squander billions in unnecessary tests and procedures... Defensive medicine is so prevalent that it has become part of the standard protocol..."

Mr. Howard's words should serve as a red flag for those tasked with reducing health care costs, putting the nation's fiscal house in order and creating jobs. It's important to understand that defensive medicine is comprised of both assurance behavior and avoidance behavior, and each has implications for patient care and the long-term public good.

A*ssurance behavior* is best described as ordering additional tests, particularly imaging tests, diagnostic procedures or referrals to give the treating physician a stronger defense against an abusive lawsuit, and today it has become common practice. According to a study in the *Archives of Internal Medicine*, nine in ten physicians said doctors ordered more tests and procedures than patients need in order to protect themselves against lawsuits.[27] While there are varying estimates of the cost of lawsuit abuse, a 2006 PricewaterhouseCoopers study, put the numbers at upwards of $210 billion a year.[28] They reported, "While the bulk of the premium dollar pays for medical services, those medical services include the cost of medical liability and defensive medicine...Defensive tests and treatment can pose unnecessary medical risks and add unnecessary costs to healthcare."

Doctors agree. In a recent Gallup survey of American physicians, the research found the fear of lawsuits drove nearly 21 percent of all the tests and treatments ordered by physicians. That equates to 26 percent of all health care spending and comes to a astounding $650 billion.[29] According to a study of medical liability costs and the practice of medicine in *Health Affairs*, overuse of imaging services alone, driven by fear of lawsuits, costs as much as $170 billion a year nationally.[30]

State data shows similar results. A Massachusetts Medical Society study showed that 83 percent of the physicians surveyed admitted practicing defensive medicine and that an average of 18 to 28 percent of tests, procedures, referrals and consultations and 13 percent of hospitalizations were ordered for defensive reasons. Estimates are that assurance behavior costs Massachusetts a staggering $1.4 billion annually.[31] A Pennsylvania study found 93 percent of physicians acknowledged practicing defensive medicine as well.[32]

While the costs of defensive medicine are sobering in and of themselves, an equal concern is the very real possibility that if we don't act to rein in the medical liability system soon, defensive medicine will become the standard of care pushing health care costs still higher but without an equal increase in benefit to patients – the worst of both worlds. The second factor in defensive medicine is *avoidance behavior*, and access to care is its usual victim, as physicians, particularly those in specialties targeted by junk lawsuits, restrict their practices. They do so by limiting higher risk procedures like trauma surgery,

vaginal deliveries and brain surgery to cite some examples. Some doctors simply avoid patients with complicated health issues. All these responses diminish access to care.

Over the years, a range of studies has shown both the financial and human costs of avoidance behavior. The AANS/CNS survey[33], mentioned earlier, found that when asked how often they ordered tests for defensive purposes, 12 percent of responding neurosurgeons said "always," 38 percent said "very often" and 43 percent said "sometimes." That's a staggering 93 percent who find it necessary to practice defensive medicine at some point. We've also found that more than one third said they changed the types of cases they treated because of rising medical liability insurance premiums or increased risk of a lawsuit.

Roughly 73 percent now limit or don't take pediatric cases. Fifty-seven percent no longer treat intracranial aneurysms and 19 percent of these responding neurosurgeons told us they limit or don't treat brain tumors at all anymore. It's not surprising. Fifty-seven percent of the respondents told us they had been sued between one and three times. These results are similar to our findings in an earlier survey done in 2004, demonstrating that the current system is broken and fails patients and doctors alike.

Neurosurgery is certainly one of the more high-risk specialties but the defensive medicine behaviors we see reflected in the AANS/CNS research can be found in a number of specialties. Orthopedic surgeons, for example, are much the same with 55 percent admitting they avoid certain procedures for similar liability concerns. One in five has

stopped emergency room calls, six percent don't perform surgery at all and one in twenty has retired early.[34]

In the years ahead, we can expect this kind of avoidance behavior will inevitably lead to increasing shortages of doctors, particularly in high-risk specialties. It's understandable that young doctors will hesitate to choose crucial specialties that put them in the cross hairs of personal injury lawyers. The American Hospital Association has found that 55 percent of hospitals have difficulty recruiting doctors because of medical liability concerns.[35] Three out of four emergency rooms say they have had to divert ambulances because of a shortage of specialists and more than 25 percent lost specialist coverage due to medical liability issues.[36]

One emergency room physician was quoted as saying, "The lack of on-call specialists affects the numbers of patients referred to tertiary care facilities even for basic specialty related diseases (like orthopedics). This adds to emergency department crowding in some facilities, and it means that patients have to travel across town or greater distances for a relatively simple problem that could have been resolved if the specialist had been on call at the initial facility."[37] Just a few short months ago in Arizona, we all saw the value of a world-class trauma center and the availability of neurosurgical care. When dealing with traumatic injuries, minutes, even seconds, can be the difference between life and death.

One group deserves special mention when it comes to the impact of defensive medicine: women. Albert L. Strunk, M.D., deputy executive vice president of ACOG put it this way, "....the medical liability situation for ob-gyns remains a chronic crisis and continues to deprive women of all ages – especially pregnant women – of experienced ob-gyns,"[38]

A 2009 ACOG survey found that 63 percent of OB-GYNs had made changes to their practice because of the risk or fear of liability claims. Even more alarming, between seven and eight percent said they had stopped practicing obstetrics altogether. Before lawsuit abuse became a crisis, most obstetricians would have considered the age of 48 as mid-point in their career. Today, according to ACOG, that's the average retirement age.[39]

State by state studies paint an increasingly bleak picture for women and their babies. Take Hawaii. In 2007, 42 percent of the state's OB-GYNs had stopped providing prenatal care.[40] Dr. Francine Sinofsky, an OB-GYN in East Brunswick, N.J., pinned the blame for two of her practice's seven members giving up obstetrics squarely on the cost of medical liability. A $14,000 annual insurance premium for gynecologists; more than $100,000 for adding obstetrics to the practice. [41]

In 2008, 1500 counties in America, eight counties in New York alone, didn't have a single obstetrician as liability issues chased good doctors out of obstetrics.[42]

But the serious impact of lawsuit abuse on women's health isn't limited to obstetrics. Today, growing numbers of radiologists are declining to read mammograms and fewer and fewer medical residents are choosing radiology as a specialty. Why? Because a missed diagnosis is the most likely allegation in most liability lawsuits.[43] That makes radiologists the number one group of physicians affected.[44]

FEWER DOCTORS

We are already seeing the effects of lawsuit abuse on access to care as doctor shortages take an increasing toll and the situation is likely to get worse, perhaps much worse. The Patient Protection and Affordable Care Act (PPACA) may well add more than 30 million people to the health care rolls in the next few years. The Association of American Medical Colleges (AAMC) has predicted that once the new health care reform provisions take effect in 2015, "the shortage of physicians across all specialties will more than quadruple to almost 63,000."[45] Another group, the American Academy of Family Physicians, has projected the shortfall of family physicians will reach 149,000 by 2020.[46]

AAMC also found the country will need 46,000 more surgeons and other specialists to meet demand in the next decade and that those living in rural or inner city locations will suffer the most severe impact. "This will be the first time since the 1930s that the ratio of physicians to the population will start to decline," according to Dr. Atul Grover, of the AAMC.[47]

Pennsylvania is a perfect case study of this growing problem. A *Bucks County Courier Times* article in February 2009 indicated that 17 maternity wards had closed their doors since 1997 and the Philadelphia suburb of Chester County, home to half a million people, had no trauma center to treat them. Pennsylvania's problem wasn't producing outstanding doctors. The state has a world-class medical education system turning out exceptional young physicians. The problem was keeping them.

The state's medical graduates were opting to practice in states with friendlier liability environments. In 1992, 60 percent of its medical residents stayed in the state after medical training. By 2009, that number had dipped to only 20 percent as Pennsylvania failed to enact needed liability reforms.[48] An aging specialist population compounded the state's doctor shortage with more than 40 percent of its practicing physicians over 50.[49] Over the next decade, Pennsylvania's doctor shortage is expected to balloon to 20 percent, forcing patients to drive further and wait longer for health care services.[50]

There are many factors driving the nation's doctor shortages, but why continue a broken medical liability system that evidence shows is adding to the problem?

If action isn't taken to reduce medical liability insurance premiums and litigation rates, we simply won't have the doctors our growing health care system will need in the years ahead.

LEARNING FROM STATES' SUCCESS

The good news is we know what works because many states have led the way forward with a proven track record of success across the country. Comprehensive medical liability reform that includes full compensation for economic damages (lost wages, medical expenses) and reasonable limits on non-economic damages ("pain and suffering") are reducing health care costs, attracting doctors to their states, strengthening the doctor-patient relationship and most important – preserving access to quality care.

A brief state-by-state look at some of the most successful medical liability reform efforts proves the point.

California:

For more than 30 years, California's Medical Injury Compensation Reform Act (MICRA) has led medical liability reform efforts while holding down health care costs and improving access to care. And it has done this while protecting consumers' rights. HCLA believes MICRA can serve as a good model for federal reform efforts.

Missouri:

Doctors' insurance premiums are 17 percent below those states without limits on non-economic damages and as of 2009, new medical liability lawsuit filings reached a 10-year low.[51]

Alaska:

This state has the sixth lowest medical costs in the country along with strong expert witness laws that are keeping doctors in the exam room, not the courtroom.[52]

Mississippi:

This was once one of the country's hotbeds of lawsuit abuse. In 2004, Mississippi enacted a hard $500,000 limit on non-economic damages and put other reforms in place to bring equity back to the liability system.[53] The number of medical liability lawsuits fell by nearly 90 percent and liability insurance premiums decreased 30 to 45 percent.[54]

The Texas Miracle:

Once Texas had the dubious distinction of being named one of the country's "judicial hellholes" by the American Tort Reform Association. Doctors were fleeing the state in droves. Texas was 48th out of the 50 states in the number of physicians per capita with 152 MD's for every 100,000 people.[55] Over a four-year period, Texas physicians were hit with insurance premium rate hikes of between 22.5 and 128 percent; hospital rates more than doubled.[56] The litigation atmosphere had become so toxic that there were 300 lawsuits for every 100 doctors in some areas of the state.[57]

In 2003, the legislature put limits on non-economic damages and the people of Texas passed Proposition 12, a constitutional amendment, which blocked trial lawyers' effort to overturn reforms.

The charts in the appendices following this testimony illustrate the positives outcomes that medical liability reform has brought to Texas. The number of liability filings dropped significantly and specialists who had been leaving the state saw dramatic increases in the years following reform. After reform, Texas' problems centered on trying to deal with a big backlog in the state's licensing system as doctors streamed back into the state.

The state's largest insurers reduced rates as much as 31 percent and competition has grown as new insurance companies have entered the market.[58] Since reform in 2003, 82 counties have seen net gains in the number of emergency physicians. What has been especially encouraging has been the increases in 43 medically underserved counties.[59] It's not surprising that Congressman Burgess' "Medical Justice Act" reflects the successful Texas reforms, which have brought desperately needed litigation relief to this once battered state.

CONCLUSION

Unfortunately, the health care reform bill passed last year did not move comprehensive federal liability reform forward. Former Governor and Democratic National Committee Chairman Howard Dean told us why, "The reason that tort reform is not in the bill," he said, "is because the people who wrote it did not want to take on the trial lawyers...and that is the plain and simple truth."[60]

Now, this Congress has the opportunity to rectify this situation.

The time is right because the American people are on the side of reform. A poll done by the HCLA in October 2009 found a solid margin, 70 percent, of Americans support full payment for lost wages and medical expenses *and* reasonable limits on awards for non-economic "pain and suffering." Sixty-eight percent of those polled also favor a law to limit the fees personal injury attorneys can take from an award or settlement.

The time is right because state reform efforts, though plagued by the trial attorneys' relentless attempts to overturn the will of the people, have shown us that medical liability reform can work – for patients and providers. Who it doesn't work for are personal injury lawyers who cling to a status quo that serves only them.

The time is right because so many Members of the 112th Congress are committed to reforming the medical liability system. We look forward to working with this Committee and others in the Congress to develop the kind of federal remedy that will bring consistency and common sense back to the system.

It has been twenty-five years since the Reagan task force on tort reform recommended the reforms embodied in H.R. 5. The trial bar has successfully blocked those reforms for more than two decades.

I am here today on behalf of the thousands of health care providers who provide the best medical care in the world every day to 300 million Americans to ask you to finish the job.

Pass H.R. 5 and pass it soon. Reform the medical liability system before health care costs go higher and patient access to quality care worsens. Before defensive medicine and doctor shortages change the health care system that serves this country and its people so well. Before the doctor-patient relationship is irretrievably damaged. Before it's too late.

Thank you very much.

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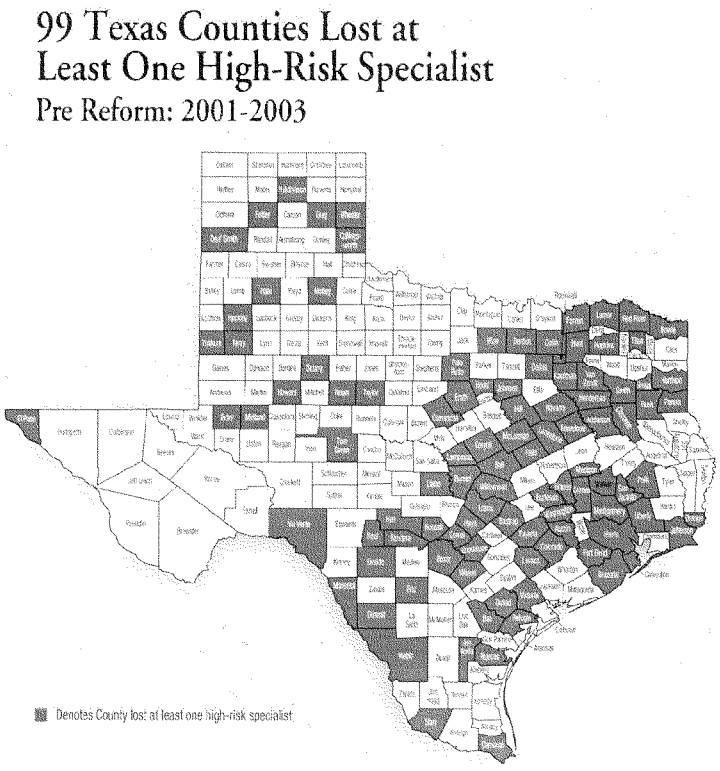
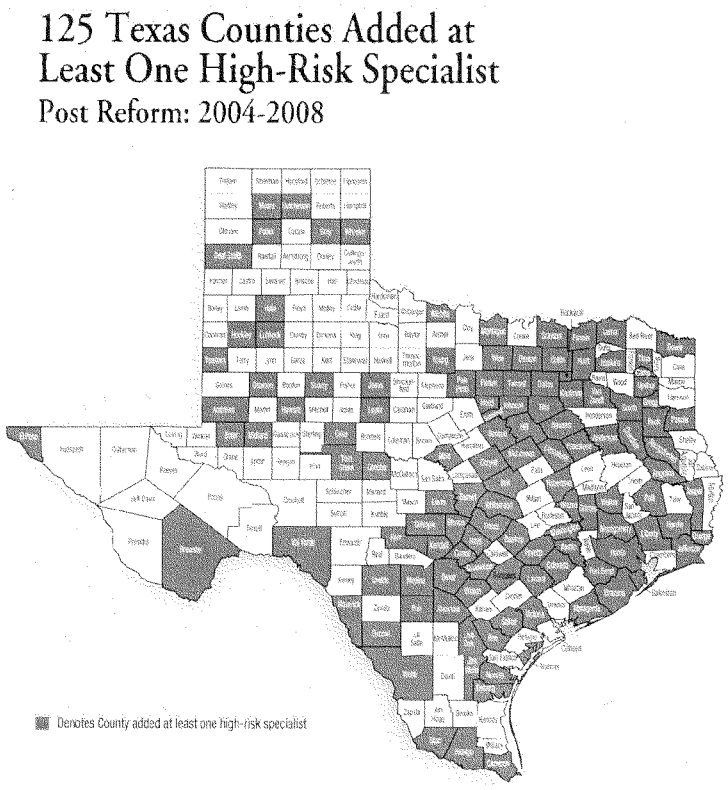
APPENDIX A:
99 TEXAS COUNTIES LOST AT LEAST ONE HIGH-RISK SPECIALIST
PRE REFORM: 2001-2003



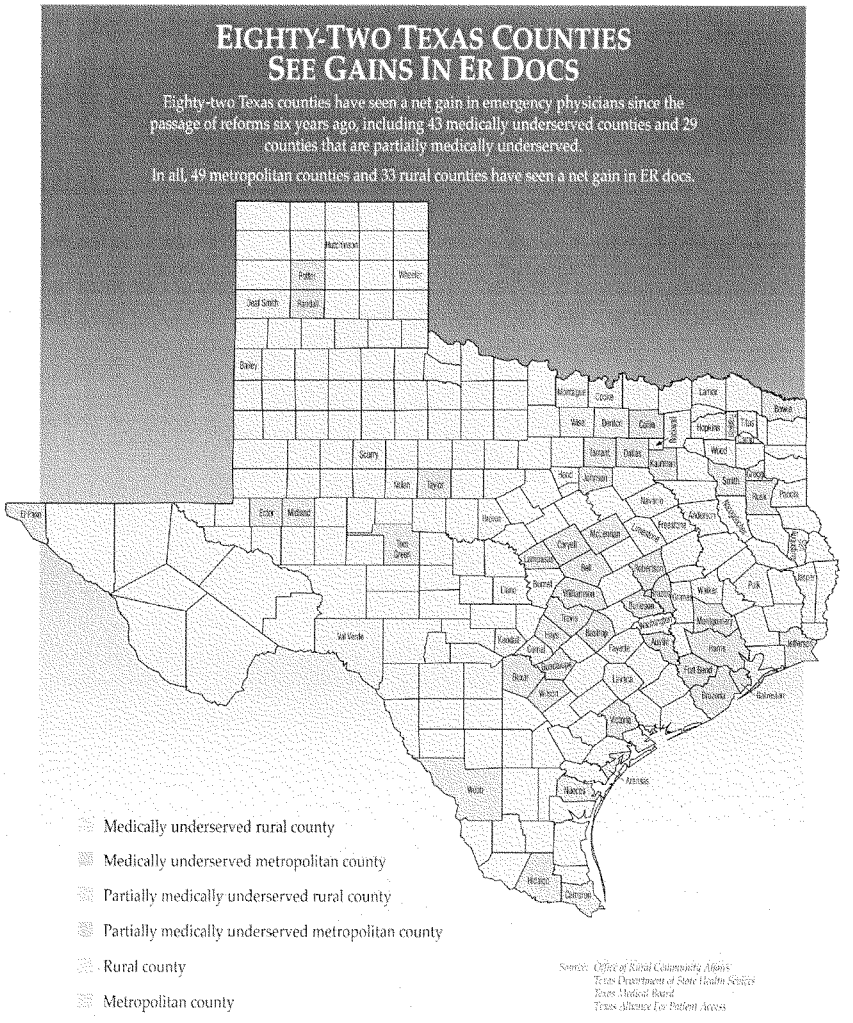
SOURCE: Texas Alliance for Patient Access

APPENDIX B:
125 TEXAS COUNTIES ADDED AT LEAST ONE HIGH-RISK SPECIALIST
PRE REFORM: 2001-2003



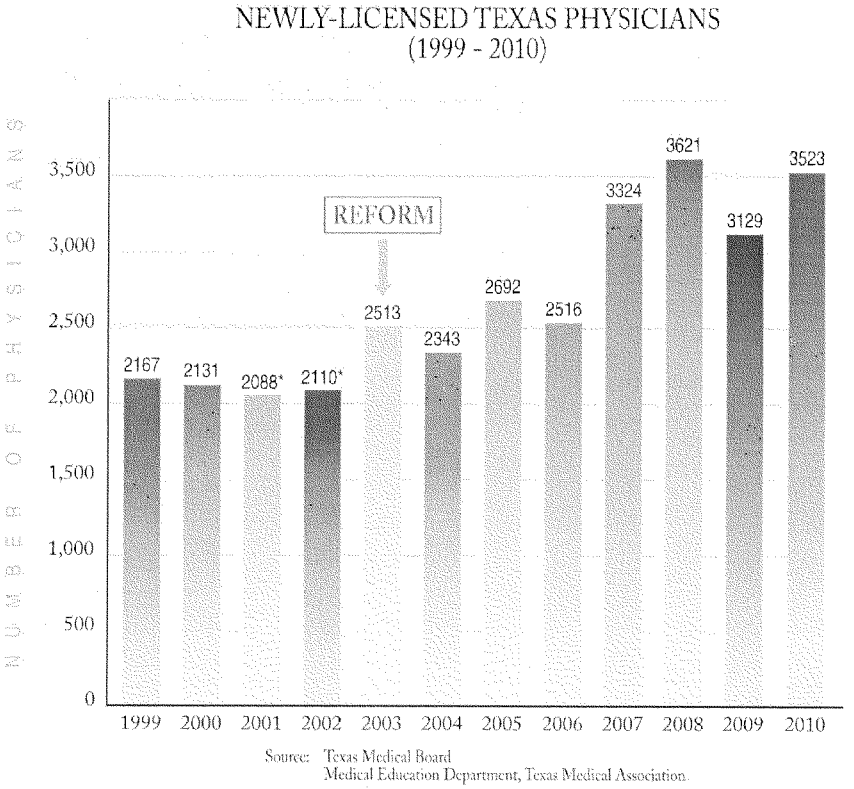
SOURCE: Texas Alliance for Patient Access

APPENDIX C:
EIGHTY-TWO TEXAS COUNTIES SEE GAINS IN ER DOCS



SOURCE: Texas Alliance for Patient Access

APPENDIX D:
NEWLY-LICENSED TEXAS PHYSICIANS (1999 – 2010)

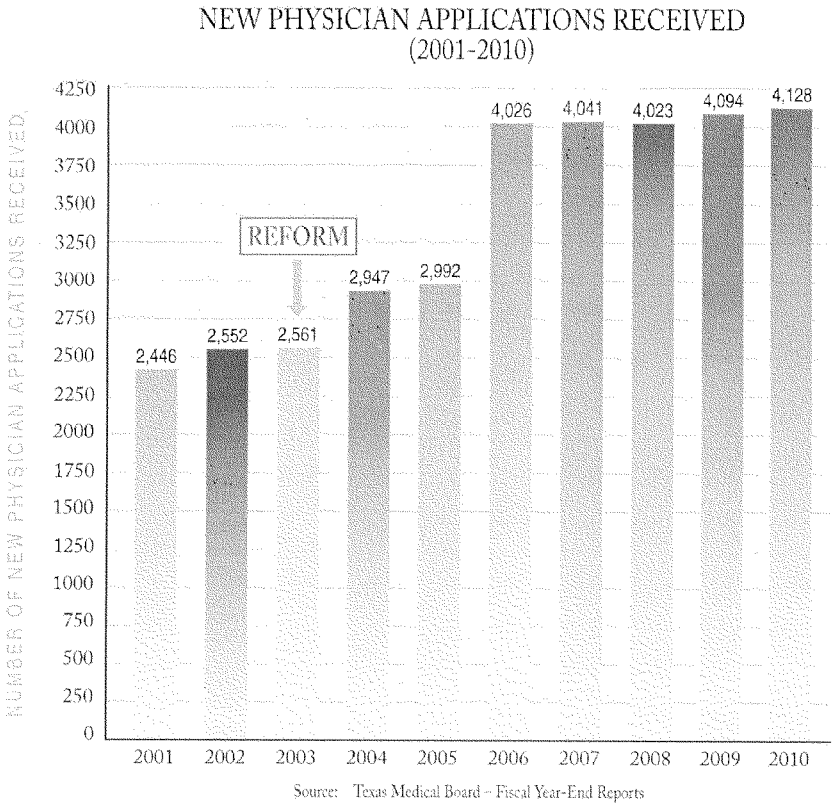


Source: Texas Medical Board
Medical Education Department, Texas Medical Association

* *In FY 2001, the Texas Medical Board meeting scheduled for late August was postponed until September 2, 2001, moving it to FY 2002. At that meeting, 701 initial licenses were issued and 15 licenses were reissued. The statistics have been adjusted based on the assumption that the group licensed in September (FY 02) would have been licensed in August (FY 01).*

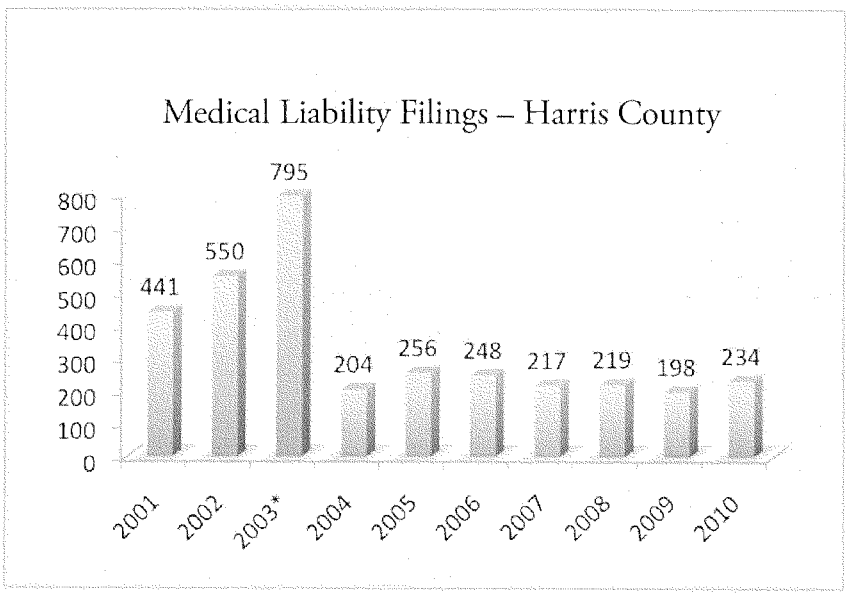
SOURCE: Texas Alliance for Patient Access

APPENDIX E:
NEW PHYSICIAN APPLICATIONS RECEIVED (2001 – 2010)



SOURCE: Texas Alliance for Patient Access

APPENDIX F:
MEDICAL LIABILITY FILINGS – HARRIS COUNTY



*Denotes rush to courthouse to beat effective date of new law

Mr. PITTS. Chair thanks the gentleman. I would like to thank the panel for their opening statements and I will now begin the questioning and recognize myself for 5 minutes for that purpose.

Dr. Hollier, you have been practicing in Texas for a number of years. Some of that time was before the State enacted medical liability reform. Can you tell us how things have changed for you since medical liability reform in terms of your ability to provide healthcare to your patients, please?

Ms. HOLLIER. Thank you, Mr. Chairman. The reforms in Texas have truly changed the climate in which we practice medicine. I work in a medical school and I counsel medical students on a routine basis. Before the passage of medical liability reforms, many of my students asked questions and were very concerned about entering a specialty such as obstetrics because of professional liability concerns. In the era after our reforms had passed, those medical students have regained their interest in our specialty and are excited about the practice of obstetrics.

We have seen literally hundreds of thousands of extra patient visits because we have increased access to doctors across the State of Texas because those doctors are more able to provide the care that our patients need.

Mr. PITTS. Thank you. Dr. Tippett, in order to help us understand why a doctor might practice defensive medicine, can you give us some sense of what it means professionally to be named a defendant in a malpractice suit? Even in the case doesn't result in a judgment against you, most neurosurgeons have been sued. Would you please elaborate?

Mr. TIPPETT. Yes, thank you very much. Well, in Florida you can count on the one out of one permanent resident year just about these days unfortunately, but just—my—when I first started practicing in Pensacola, Florida, in 1976 I will never forget it. Within a year of when I started practice, one day I opened the door and there is a Deputy Sheriff. He is handing me this subpoena and I am, you know, I am kind of naíve. I didn't know what—I said what in the world is this and I opened it up and it said you are being sued. And I—you would have thought I had stuck my hand in electrical current with a hot—with cold water on my face. I mean it is that shocking.

And the devastation doesn't stop for about 4 years after that, I can tell you. It doesn't go away. First of all I say, well, I don't even know who this patient is. Well, it turns out it was a patient that I had walked in the room that they were operating on when I was a resident in Memphis, Tennessee, several years before. I didn't have any idea who the patient was. Well, they tried to get him to drop me from the trial. Of course they didn't. I ended up—I had just started my practice in Pensacola. I had to take time out of my practice. I would go to Memphis, Tennessee, for the trial. I sat in the courtroom for a week not—my name is not mentioned one time. At the end of the presentation of the plaintiff's case the judge—the first time my attorney says anything is will you dismiss my client and the judge says yes. And so you know I am kind of stunned. I don't know what is going on. I am walking out of the room and the plaintiff's attorney stops me and says—shakes my hand and says, you know, no offense. And I am saying—here, you know I have just

been stabbed in the back and no big deal. And that is just one. I could go on with other.

Mr. PITTS. Thank you. Dr. Kachalia, you and your colleague Michelle Mello have done an exhaustive review of this issue, possibly the most exhaustive review to date. From what I can tell, part of your message is that the data regarding some aspects of medical liability reform are not robust at this time. However, there does seem to be mature data about caps on noneconomic damages. I found it interesting in your research that caps do not seem to reduce the number of claims, but study—studies of the effects on caps on claim payouts have found a significant effect—typically on the order of 20 to 30 percent reduction in the average award size. If the number of claims remains stable, it would seem that patients are still able to bring cases, but the number of unpredictably high awards is reduced. That seems like exactly what we would want medical liability reform to do. In your opinion is that a fair thing to say? Would you elaborate?

Mr. KACHALIA. So, I think you are right with regard to what we would want liability reform to do which is to bring—if awards are thought to be excessive to make them more reasonable. And with regard to caps they do seem to—as you pointed out, they do seem to lower the average payment and the premiums to go with it. And they—from what we can see from the evidence they don't seem to have an effect on the total number of claims that occur. So if caps were working without harming patient access to compensation, that is exactly how we would want them to work, but most of these studies weren't necessarily—they don't necessarily tell us as you pointed out—there is very little data with regard to what happens to patient access to compensation in overall quality of care. So those still remain unknown questions. But you are right, at the end of the day to some extent caps can help lower the premiums which is what they are meaning to do.

Mr. PITTS. My time is expired. Chair recognizes the ranking member for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I do appreciate your having this hearing today because I can't support and never have supported H.R. 5, but I do understand that medical malpractice and liability is a real problem for doctors in my home State in the country. But I also think we can't forget that medical malpractice reform also affects patients and any truer form has to take a balanced approach and include protections for the legal rights of patients, because many people are serious injured through medical malpractice.

Now I want to focus on three things which I have been articulating for years about H.R. 5. It has been around—I don't know how many times we have taken this up, you know, since—when the Republicans were in the majority. I have three problems with it. First of all it extends way beyond medical malpractice. You know it has new protection and nursing home, pharmaceuticals, device, insurance companies and others and I really feel very strongly that if we are really going to focus on this issue it just should be medical malpractice. It shouldn't be all these other types of tort reform.

The second thing is that the 250,000 cap is just unworkable and unrealistic. I mean it has been around for 10, 20 years and you

know, with inflation and everything you talk about $250,000 cap I just think is unrealistic. And the last thing is I don't believe that just having caps is going to truly control premiums. I think the only—I mean it may be a factor, but a more important factor is actually having some kind of controls on the premiums themselves. You know some kind of you know actual way of saying, you know, premiums can't go above a certain amount, whatever. So those are my questions. I want to ask questions and I am going to try to get all three in in the 3 minutes that I have left. Let me start with Ms. Doroshow.

First of all, this $250,000 cap, it seems to me it is very unrealistic and secondly the idea of just tort reform being an answer to reducing or controlling premiums for doctors—I mean isn't it true that in California example—I know Mr. Waxman has often used this as an example that you know when they just did the tort reform premiums kept going up. And it wasn't until they actually instituted something I guess with one of their propositions that actually said—that addressed prices. And so if you would ask me that a 250 cap and the need for price controls or however you want to call it and not just talking about the caps?

Ms. DOROSHOW. Well, look at California because that was the State that first enacted a $250,000 cap in 1975 without an inflation adjustment. And I think if you were to adjust to today this would be well over a million dollars in terms of a limit. It is incredibly low and cruel amount of money that as Brian mentioned has a disproportionate impact on seniors, children, low wage earners, women who don't work outside the home.

In terms of the insurance issue, after the cap passed rates went up about 450 percent until 1988 when Prop 103 passed. This is the strongest insurance regulatory law in the country and since then rates have stayed below what the national average is. And in the last hard market between 2001—2003 there were—or 2005 there were three attempts by insurers in California to raise rates. Because of Prop 103 there is a hearing requirement. The consumer groups came in, challenged the rate hikes and all three of them were reduced saving doctors about $66 million in California. Nothing will work unless you institute insurance reform.

Mr. PALLONE. All right, let me just—and I appreciate this answer to the questions, but Mr. Wolfman, to my third point which is this bill you know not just dealing with all these other tort reforms with farm devices, all that. I mean is that necessary? Isn't the problem primarily with doctors? Why are we throwing all the—the kitchen sink in here?

Mr. WOLFMAN. Representative Pallone, as I said the—this bill seems—I am not here to speak about malpractice, but this seems particularly ill fitted to claims against device and drug manufacturers that bring out enormous or war chests to litigate cases. And the notion that you in difficult cases where you need the best lawyers, the notion that you can go forward when there is extreme negligence with no opportunity for punitive damages. A $250,000 cap and these draconian nonmarket limitations on attorney's fees is just fantastic. It is not going to happen. And——

Mr. PALLONE. Well, let me say this, Mr. Chairman, you know I just want you to know that if you and the Republicans were willing

to work with us on these three issues, you know unrealistic cap, just narrowing this to doctors or medical malpractice, and third you know including actual going after the rates and actually controlling rates then I think we could come to a workable solution. But the way H.R. 5 is now, it is going to—same thing over and over again. It will never go anywhere and it is just a waste of time.

Mr. PITTS. Gentleman's time is expired. Chair recognizes the vice chairman of the committee, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. I thank the chairman. You know I am actually tempted to ask the gentleman from New Jersey if he would look at 896 since he just made that gracious offer. On the other hand, Texas receives so many of your recently educated physicians from New Jersey that I am worried about disrupting our physician workforce pipeline because, as you know, we did pass a year ago or sign into law a year ago a bill—you may have heard of it—called the Patient Protection and Affordable Care Act, which is going to ensure according to congressional an additional 32 million people. And although I have my doubts about that figure, they are all going to need doctors. In Texas we may be well on the way to satisfying that demand because we have done the right thing with liability reform on the ground in Texas.

I am so intrigued by the concept of what has been talked about on limiting attorney's fees. You know, maybe doctors have gone about it the wrong way. Maybe we should have gone to the billable hour several years ago and not let Medicare dictate our fees as has happened in this country for years. But we do live under a federally imposed fee schedule and maybe if we could apply that to our legal brethren maybe some of these problems would go away as well so I am going to be on the phone to Dr. Berwick shortly after this hearing ends and see if we cannot extend the benefits of the sustainable growth rate formula to the Nation's attorneys.

Well, we did pass medical liability reform in 2003. Dr. Hollier, do recall did anything similar to the proposition in California pass that limited—was a price control on medical liability, the cost of the insurance itself, or were simply the reforms that we built into the system? Of course the legislature passed the law in June of 2003. The State passed—the people of the State of Texas passed a constitutional amendment in September of 2003 that allowed the law to circumvent the court's process and become immediately implemented. That seemed to me to be the big break point, not putting a cap on what malpractice insurance can charge. Can you address that?

Ms. HOLLIER. Yes, sir, there were no additional measures such as those implemented in California. Liability premiums for physicians began to decrease relatively soon after the September passage of the amendment. And physicians had seen their liability premiums decrease by about 28 percent keeping many of these doctors in their practice keeping patients with the ability to access the specialty care that they need close to home.

Mr. BURGESS. Yes, of course you work in a medical school and it is not just a medical school. It is my medical school, so I am grateful for your service there. But give us an idea of what that

28 percent means to the practicing OB–GYN in the greater Houston metropolitan area.

Ms. HOLLIER. For many physicians prior to liability reform, obstetrician/gynecologists were paying premiums in excess of $100,000, some as high as $150,000. So 28 percent reductions are very important. And what it means for our doctors is that we can continue to stay in practice and provide care for our patients.

Mr. BURGESS. And the story about counties in Texas having ER doctors and OB–GYNs that had never had one before is that just some fantasy made up by doctors or is that an actual fact?

Ms. HOLLIER. That is an actual fact, Representative Burgess.

Mr. BURGESS. And you know we talk about Texas, but let me talk about New York for a moment because I happened to be in New York a couple of weeks ago and the New York Times had this wonderful ad. When these doctors say we need liability reform there are 350,000 reasons to trust them and there you see what I like to call mature physicians standing there holding infants in their arms. And I asked—this was given to me by the head of the Greater New York Hospital Association, and I asked him what the liability premium was in the city of New York for an OB–GYN and he said in excess of $200,000. And clearly that is a barrier for the young physician getting out of their medical school and their residency experience. And they probably owe—well, Dr. Hollier or Dr. Kachalia, tell us what is a young doctor likely to owe today getting out of a 4-year OB–GYN residency? $150,000 in student loans, $200,000?

Ms. HOLLIER. I think that is a reasonable estimate, sir.

Mr. BURGESS. And on top of that before they can deliver their first baby a $200,000 liability payment because no one can afford to practice—you couldn't dare run the risk of practicing without liability insurance. So how in the world are we asking our cadre of young doctors to begin practice in—with this environment in the city of New York? No wonder they look to the allegiant fields of Houston, Texas, and Fort Worth, Texas. They may not be green fields, because it is pretty hot in the summertime, but they are certainly greener fields than in New York. Thank you, Mr. Chairman. I will yield back the balance of my time.

Mr. PITTS. Chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Gonzalez for questions.

Mr. GONZALEZ. Thank you very much, Mr. Chairman. Dr. Hollier, do we have a medical malpractice—not an emergency, but let—not a crisis, but do we have medical malpractice problems in the State of Texas?

Ms. HOLLIER. Sorry, sir. I think the climate in Texas has changed dramatically post reform. And I think our patients have had significant benefits.

Mr. GONZALEZ. Well, let me ask you. I will put it this way. Do we have occurrences of medical malpractice in Texas?

Ms. HOLLIER. Yes, sir.

Mr. GONZALEZ. But those doctors make mistakes?

Ms. HOLLIER. Yes, sir.

Mr. GONZALEZ. And sometimes they are pretty serious mistakes?

Ms. HOLLIER. Yes, sir.

Mr. GONZALEZ. All right, you know a lot of doctors, don't you, I assume? And if I was a member of your family would there be certain doctors that you would not recommend that I go to, honestly?

Ms. HOLLIER. I don't have a list in my mind such as that.

Mr. GONZALEZ. OK. Dr. Tippett, in Florida are there occurrences of medical malpractice?

Mr. TIPPETT. Yes, sir, there are occurrences of malpractice, but what we are talking about here is to try to continue to provide access to medical care in the State of Florida. In South Florida, for example, most——

Mr. GONZALEZ. And Doctor, I only have 5 minutes and I understand where you are going, but since I only have the 5 minutes I would like to get where I would like to get but I end up in this discussion. You know a lot of doctors. If I was a member of your family, would there be certain doctors that you wouldn't recommend I see?

Mr. TIPPETT. Would not recommend you see?

Mr. GONZALEZ. Sure.

Mr. TIPPETT. I would put it in the other way. There are certain doctors that I would prefer over some other physicians. For example, I sent my daughter yesterday to my partner. I think that——

Mr. GONZALEZ. But why would I send them to the doctors at the bottom of the list?

Mr. TIPPETT. I am sorry?

Mr. GONZALEZ. Why wouldn't you send your daughter to those doctors at the bottom of this hierarchy of qualified doctors? You are sending them to the one that you respect the most. I understand that. But you must have questions about all those others that are practicing that you would not send your daughter to.

Mr. TIPPETT. Well, I wouldn't send my daughter to every doctor in town. I would only pick out as you would in your family the one you thought that was most appropriate.

Mr. GONZALEZ. Well, that is my point.

Mr. TIPPETT. It is not always based on quality of the care. It is based on whether all of those factors——

Mr. GONZALEZ. Qualifications, ability, and competency in every profession, including the legal. That is why we have malpractice suits, because I will tell you this: In my private conversations with my friends who are doctors they would definitely tell me who to stay away from. And I venture to guess anybody up here today that has a dear friend or a family member or even Dr. Burgess himself who is a physician before he came to Congress obviously—knows those members of the medical profession that pose a danger to their patients.

But like any profession we are going to have that. The problem is the profession doesn't really discipline and regulate itself. Most professions don't. So somehow we have to have a system that will protect the rights of those patients. I understand where we are all coming from: affordable healthcare, quality healthcare, defensive medicine and so on. So let us look at the Texas experiment. This is the goal standard, the goal standard.

Average liability premium for internal medicine—malpractice premiums for internal medicine are 27 percent higher in Texas than in States without caps because what we are trying to do is

take that basic cost out of the equation and provide quality healthcare for everyone. But if someone is injured as a result of negligence they may just be left out in the cold. But let us just leave that aside. What we are trying to accomplish is reducing malpractice insurance premiums. General surgeons, OB–GYN malpractice premiums for doctors averaged across specialties are 6 percent higher in Texas than in States without caps. Malpractice premiums for general surgery are 21 percent higher in Texas than in States without caps.

Those are the realities and we also know that the practice of defensive medicine may be an issue, but studies also show that that may be more attributable to overutilization because we know that is out there. It also may be due to unreasonable patients that is bigger—I have got an insurance company or the government's going to pay so run every test that you can run on me. There are other reasons for the increased testing other than what we have referred to as defensive medicine. I am just saying let us be fair to the physician, but let us be fair to the patient and make sure that they have an adequate remedy when they are injured, disfigured, and disabled. Thank you, I yield back.

Mr. PITTS. Chair thanks the gentleman. Yields 5 minutes to the gentleman from Georgia, Dr. Gingrey.

Mr. GINGREY. I thank the chairman for yielding. Let me first go to Ms. Doroshow. I see that you represent the Center for Justice and Democracy. Let me ask you a series of questions and these are just strictly yes or no. Do you believe that all Americans in this country deserve justice?

Ms. DOROSHOW. Yes.

Mr. GINGREY. That is easy. Do you believe that medical providers should be held financially responsible for their share of medical errors?

Ms. DOROSHOW. If they are fully responsible.

Mr. GINGREY. Yes or no? Their share of medical errors?

Ms. DOROSHOW. Well, are you talking about the——

Mr. GINGREY. If I say their share, obviously the question means they are not fully responsible. They have made some responsibility. I am asking you yes or no, should they be held financially responsible for their share of the medical error?

Ms. DOROSHOW. If the——

Mr. GINGREY. Yes or no?

Ms. DOROSHOW. Yes, but——

Mr. GINGREY. All right, your answer is yes. I have got another—a number of questions so we need to move on. Do you believe that medical providers should be sued and held financially responsible for medical errors that they did not cause? Surely you can answer that yes or no.

Ms. DOROSHOW. I think not. That is correct.

Mr. GINGREY. They should be?

Ms. DOROSHOW. No, they shouldn't.

Mr. GINGREY. Thank you. I expected that. Do you believe that off-duty medical providers who happen to witness a horrible car crash and step in because victim's life hangs in the balance should have liability protections, understanding that oftentimes they would be working without the benefit of any medical equipment or

a stable environment? They are on the street. They are trying to provide emergency care. Should they be held liability?

Ms. DOROSHOW. These are good Samaritan laws and they—most States have them. That is different from an emergency room law.

Mr. GINGREY. So most States have a law that would hold them not liable?

Ms. DOROSHOW. Right.

Mr. GINGREY. Your answer is yes.

Ms. DOROSHOW. They are not expected to encounter——

Mr. GINGREY. Thank you. So basically the reason I ask you these questions is justice is a subjective term for your organization. Is it not? Is justice a subjective term?

Mr. DOROSHOW. Exactly. I mean this is a determination by the jury if you are talking about a lawsuit, and that is what we believe in, the judge and jury.

Mr. GINGERY. Well, we don't have a jury here. We just simply have a panel of witnesses——

Ms. DOROSHOW. Well, we are talking about the civil justice system.

Mr. GINGREY. And I am asking you pretty straightforward yes or no question. OK. Well, let me move on. Thank you very much for your response. I am going to go to Dr. Tippett. Dr. Tippett, thank you for your testimony. I have heard from many medical providers that in the bill PPACA, Affordable Care Act we sometimes refer to it on this side as Obamacare, not pejoratively, of course. We—you know it has created some new liability concerns. How does Obamacare create new liability concerns, Dr. Tippett?

Mr. TIPPETT. Well, there are any number of ways and it is so we don't yet know about what many things that may come of this progress, but of this bill. But for example if some panel determines that you can't have this sort of treatment under Medicare and you have the treatment anyway, and things don't go well, you may be sued in that regard. We considered this bill when we looked at it overall as a growth industry for the plaintiffs bar in terms of things that they could find that doctors do wrong. When there—comparative effectiveness I think is probably the most fertile ground for the plaintiffs bar. Any time——

Mr. GINGREY. Well, let me—I want to interrupt you just for a second because I get your drift. Do you then think that medical providers need to be protected from these new liability causes of action that may be embedded in the new Obamacare law?

Mr. TIPPETT. Absolutely, yes, sir.

Mr. GINGREY. Well, I want to once again let the panel know that I have a bipartisan bill, bipartisan bill H.R. 816 and I hope Congress will move quickly because if Obamacare is going to deepen this liability crisis it must be stopped. And of course that is what the provider shield law will actually do, and I think it is very important that we get that passed. Let me in my remaining minute to go to Dr. Hollier. Dr. Hollier, it is great to have you as a witness because you are a fellow OB–GYN, an American College of OB–GYN. And I am a very, very proud member and I practiced in that specialty as you probably know for 26 years delivering over 5,000 babies, so it is near and dear to my heart and I appreciate you being with us. According to studies almost 30 percent of OB–GYNs

have increased the number of cesarean deliveries and 26 percent have stopped performing or offering traditional deliveries because of liability concerns and defensive medicine. Is that correct?

Ms. HOLLIER. Yes, sir. According to our recent surveys by the American Congress of Obstetricians and Gynecologist our physicians are increasing those.

Mr. GINGREY. All right, very quickly are cesarean deliveries more expensive than traditional—let us say a VBAC vaginal birth after a cesarean delivery?

Ms. HOLLIER. Yes, sir.

Mr. GINGREY. You state in your testimony that patients who eventually receive compensation through our current liability system obtain less than 50 percent of the amount awarded. What happens to the remaining 50 percent of the judgment or settlement?

Ms. HOLLIER. That goes to the attorney, sir.

Mr. GINGREY. It goes to who?

Ms. HOLLIER. The attorneys.

Mr. GINGREY. OK. Thank you and I see my time is expired. I yield back.

Mr. PITTS. Chair thanks the gentleman. Now recognizes the Ranking Member from California, Mr. Waxman for 5 minutes of questions.

Mr. WAXMAN. Thank you very much, Mr. Chairman. I think medical malpractice is a real problem. I don't think the system is a very good one. People who should be compensated when they are hurt are often not because their cases are not attractive enough for a lawyer to take on. Some people are overcompensated. There is not justice in the system and this has been a perplexing issue for many, many years.

In California, we adopted a law that—called MICRA which has been the law that many other States are emulating and a good part of the bill H.R. 5 is based on MICRA. But I have a question about whether we ought to be doing this at the Federal level. States have tried different approaches. There is no perfect approach to this unless you want to say it is about the providers. Providers will never be responsible even when they are negligent or even in reckless. I don't think that makes any sense. I don't like some of these caps. Frankly it is such a low cap and hasn't been expanded so that—$250,000 seems to be an inadequate compensation for people who are going to live the rest of their lives disfigured and in pain.

So I think it is still a State matter because the States have jurisdiction over insurance. The States have jurisdiction over licensure. One of the ways to deal with doctors who commit malpractice is to—is for—to have their peers under State law do something about it. That is a State matter. All States have already examined this issue of medical reform, liability reform and they have their own different systems, but we want to now in this bill preempt the whole matter and make it a one size fits all. That is why the National Conference of State Legislatures has written to express its strong bipartisan opposition to H.R. 5, and Mr. Chairman, I would like to ask unanimous consent to put their letter into the record.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

April 4, 2011

Congressman Joe Pitts
Chairman, Health Subcommittee
420 Cannon HOB
Washington, DC 20515

Congressman Frank Pallone
Ranking Member, Health Subcommittee
237 Cannon Building
Washington, DC 20515

RE: H.R. 5, the "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2011."

Dear Chairman Pitts and Ranking Member Pallone:

On behalf of the National Conference of State Legislatures, we are writing to express strong, bipartisan opposition to the passage of the latest federal medical malpractice legislation, H.R. 5, the "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2011," pending before the United States House of Representatives.

Medical malpractice, product liability and other areas of tort reform are areas of law that have been traditionally and successfully regulated by the states. Since the country's inception, states have addressed the myriad of substantive and regulatory issues regarding licensure, insurance, court procedures, victim compensation, civil liability, medical records and related matters. In the past two decades, all states have explored various aspects of medical malpractice and products liability and chosen various means for remedying identified problems. Over the past several years, states have continued to revise and refine their medical malpractice laws and procedures.

NCSL has a longstanding Medical Malpractice policy that was initially passed in 2006 and was renewed in 2009. Our Medical Malpractice policy explicitly and firmly states that, "American federalism contemplates diversity among the states in establishing rules and respects the ability of the states to act in their own best interests in matters pertaining to civil liability due to negligence." That diversity has worked well even under the most trying and challenging circumstances. The adoption of a one-size-fits-all approach to medical malpractice envisioned in H.R. 5 and other related measures would undermine that diversity and disregard factors unique to each particular state.

Federal medical malpractice legislation inappropriately seeks to preempt various areas of state law. All 50 states have statutes of limitations for medical malpractice suits. All 50 states have rules of civil procedure governing the admissibility of evidence and the use of expert witnesses. Many states have caps on noneconomic damages and limitations on attorney's fees in medical malpractice cases.

NCSL studied this issue in 2005 when the last iteration of H.R. 5 was being considered by the U.S. House of Representatives. Our review included assessing whether circumstances had

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developed or were so unique that only federal action could provide an adequate and workable remedy. We again examined recent state actions, policy options and experiences. We discussed at length how various proposed or anticipated pieces of federal legislation fared against NCSL's core federalism goals. Those questions included: (1) whether preemption is needed to remediate serious conflicts imposing severe burdens on national economic activity; (2) whether preemption is needed to achieve a national objective; and (3) whether the states are unable to correct the problem. **The resounding bipartisan conclusion was that federal medical malpractice legislation is unnecessary.**

NCSL's opposition will extend to any bill or amendment that directly or indirectly preempts any state law governing the awarding of damages by mandatory, uniform amounts or the awarding of attorney's fees. Our opposition also extends to any provision affecting the drafting of pleadings, the introduction of evidence and statutes of limitations. Furthermore, NCSL opposes any federal legislation that would undermine the capacity of aggrieved parties to seek full and fair redress in state courts for physical harm done to them due to the negligence of others.

Thank you for your consideration of our concerns. For additional information, please contact Susan Parnas Frederick (202-624-3566) or Jennifer Arguinzoni (202-624-8691) in NCSL's Washington, D.C. office.

Respectfully,

Assemblyman William Horne, Nevada
Chair, NCSL
Committee on Law and Criminal Justice

Representative Jerry Madden, Texas
Immediate Past Chair, NCSL
Committee of Law and Criminal Justice

CC: Members of the U.S. House Committee on Energy and Commerce, Subcommittee on Health

Mr. WAXMAN. Ms. Doroshow, am I correct in my statement that States are trying different things out?

Ms. DOROSHOW. That States——

Mr. WAXMAN. Are doing different things on their own?

Ms. DOROSHOW. Well, yes, they have for 35 years.

Mr. WAXMAN. Now Section 11 of this bill spells out to the extent to which State medical liability laws would be abolished or prevented from being enacted in the first place, in other words preempted. Ironically, the title of this section is State Flexibility and Protection of State's Rights but it preempts the States if they don't follow the Federal model.

Professor Wolfman, can—what would this Section 11 mean for existing or potential State medical liability reform laws?

Mr. WOLFMAN. Well, essentially it is essentially one way preemption. What it does is it preempts States. For instance if a State had a law saying or a policy that you know the jury can determine what is appropriate noneconomic damages that would be preempted. But if a State had a provision that was more punitive in my view, you know a $200,000 cap, that would not be preempted.

Mr. WAXMAN. That would——

Mr. WOLFMAN. One way.

Mr. WAXMAN. There is a provision in this bill that says if it—if there is greater protection in healthcare providers and healthcare organizations——

Mr. WOLFMAN. That is correct.

Mr. WAXMAN [continuing]. That would not be preempted.

Mr. WOLFMAN. That is absolutely correct.

Mr. WAXMAN. But the bill goes on to preempt State laws to protect consumers?

Mr. WOLFMAN. That is correct. It is one way.

Mr. WAXMAN. That is a one-way preemption. California's law has worked as I understand it to hold down insurance premium from malpractice, but that also seems to have been part of the insurance reforms adopted by the State. I don't know if any of you—Ms. Doroshow, you have lived in California over——

Ms. DOROSHOW. Yes. What——

Mr. WAXMAN. Is that an accurate statement?

Ms. DOROSHOW. It is the Prop 103 insurance regulatory law that passed in 1988 that is primarily responsible for that. Yes, for controlling rates in California.

Mr. WAXMAN. Do you know if any evaluation has been done of the California medical situation to see whether it has stopped excessive practice in medicine or defensive medicine?

Ms. DOROSHOW. In——

Mr. WAXMAN. Or is defensive medicine practiced in California the same as other places?

Ms. DOROSHOW. As well as Texas. I mean, it—when you enact these caps and other tort reforms it has absolutely no effect on that issue. I mean, how could it? You are just limiting one small measure of damages and in a case it is not is going to change somebody's practice. And I think that is generally what has been true. It certainly was true according to a very well-known article about Texas, McAllen, Texas in the New Yorker Magazine where they talked to some cardiologist and sat down and said they acknowl-

edged the $250,000 cap had practically wiped out law suits in that State and yet they were still practicing the same kind of tests. And they attributed it—admitted that it was due to overutilization, having nothing to do with the legal system.

Mr. WAXMAN. I would like my colleagues that support this bill which may well be almost all the Republicans, maybe all of them. I still think there are states' rights and states' prerogatives, and this really tramples on all of that. And that troubles me a lot. All answers to questions are not found in Washington, DC. Yield back my time.

Mr. PITTS. Chair thanks the gentleman and now recognizes the gentleman from Kentucky, Mr. Guthrie for 5 minutes of questions.

Mr. GUTHRIE. Thank you, Mr. Chairman. My friend from Texas said who is left out in the cold and what is fair for the patient. And in the terms of access to legal representation and you would have to say perhaps that there would be if you limit fees—obviously if you are going to limit price, price controls—you know people are going to in turn to that business as often. But the question as I have listened to the Texas story and I can tell you about Kentucky is what is fair for the patient in term of access to healthcare? I mean, that is the issue that we have. I believe if I am correct 22 rural counties gained OB–GYNs and 10 counties had an OB–GYN that did not have. In my situation I have three children. If I had a fourth, we couldn't have the same doctor who delivered the first three because he doesn't practice OB because of medical malpractice specifically for that. Two hospitals in my hometown, one doesn't do OB anymore because of medical malpractice. Now there is a hospital across town you can go to, but if you get into rural parts of Kentucky, it—you can't—and it is part of the eastern part of the State you have to drive a couple hours to Lexington. You know about disproportionate effect on the poor. Not that middle class and upper middle class people don't have to drive 2 hours, but they can afford it a lot easier than somebody that is poor.

And I am telling you if you give free healthcare to somebody in parts of my State they are not going to be able to go to a doctor unless they drive 2 or—over 2 hours because of access to medical care. An OB–GYN that I am very close to has to pay $105,000 for healthcare OB–GYN practice in Kentucky. So that is why we are losing people practicing.

So even if you admit and I think you would have to if you are a person that doesn't believe in—if you—economics and you said the free market of price controls would perhaps limit some people to big awards, the overall—what we have to look at and Ms. Doroshow, is it a fair argument to look at to say well, what about the access? Because you know some people are arguing that tort reform didn't change the issues in Texas. You know the evidence seems to say they did, but I can tell you we are losing OB–GYNs. If it is not tort reform for some reason in Kentucky and it is the access to care not something that we as policymakers have to make decisions when we—what is fair for one patient—maybe access to the legal. What is fair for one patient—access to care.

Ms. DOROSHOW. Well, I would point you to page 23 of my written testimony where it describes study after study after government study showing that medical malpractice issues have absolutely

nothing to do with the access to care argument. And frankly, if the argument is that insurance rates are too high as they have been three times in the last 30 years as we have gone through this cyclical market, the solutions to that problem lie with the insurance industry. They should not be solved on the backs of injured patients. And we are dedicated. We have an organization called Americans for Insurance Reform that is dedicated to try to help get some control over the property, casualty insurance industry. That is one of the least regulated industries in the country. They are exempt from anti-trust laws and that is something that Congress could do is to get rid of the anti-trust exemption that——

Mr. GUTHRIE. What about the Texas situation? The Texas—didn't—I am asking. I am not trying to lead you in a way or Mr. Wolfman, did Texas malpractice reform not lower premiums? Is that—are you thinking it was something outside of? Because they didn't put caps in control.

Ms. DOROSHOW. Texas—right after the law was passed in 2003, Texas insurers went in for between a 35 and 65 request for rate hikes. That is because we are in a hard market in this country. It was happening in every State in the country. In 2006, rates stabilized everywhere in the country. In every State in the country no matter whether they passed these laws or not and that simply as——

Mr. GUTHRIE. But so the access in these rural counties in Texas—was it, you don't think——

Ms. DOROSHOW. The access to the rural counties—look in 2007 there is a big Texas Observer article called "Baby I Lied." It was all about how misrepresenting the medical societies word in terms of where the access was going to improve in those rural counties and they were not—they had not improved. And I would also point you to this very important study by Charles Silver, David Hymen, Bernard Black, the impact of the 2003 medical malpractice and its cap on physicians supply. Basically the account——

Mr. GUTHRIE. I am not cutting you off because I don't want to hear it and I——

Ms. DOROSHOW. Well, this is——

Mr. GUTHRIE [continuing]. Understand——

Ms. DOROSHOW. This is the actual analysis of what happened to physician supply in Texas. The——

Mr. GUTHRIE. But I know we are losing OB–GYNs in Kentucky and rural part and maybe there are lots other but as a doctor, I know you just—what you said. I am not trying to cut you off because I don't want to hear it. I just want to give Dr. Hollier—I guess you have 20 seconds to say that.

Ms. HOLLIER. Thanks. Ranks of rural obstetricians increased by 27 percent. Imagine yourself 9 months——

Mr. GUTHRIE. Because of malpractice or that is the question that—that is this——

Ms. HOLLIER. Yes.

Mr. GUTHRIE. You are not denying the increase, right, Dr. Doroshow?

Ms. DOROSHOW. Yes, I am denying it.

Mr. GUTHRIE. You are denying that it increased? OK.

Ms. DOROSHOW. According to this study, population went up 2 percent. OB–GYNs went up 1.6 percent annually since the cap passed.

Mr. GUTHRIE. But we have OB–GYNs in Bowling Green. The question is we don't have then in some county——

Ms. DOROSHOW. Well there are dual problems that are very common in every single State. The way to fix that problem is to provide incentives for doctors to go into those areas not to cap damages for the entire State.

Mr. GUTHRIE. But they did in Texas. That is the question. Thanks. I yield back.

Mr. PITTS. Chair thanks gentleman and recognizes gentlelady from California, Mrs. Capps for 5 minutes.

Mrs. CAPPS. Thank you, Mr. Chairman. As I touched on in my opening today I believe that in order to solve the issues of rising malpractice costs, we can't ignore one of the major issues here which is reducing the incidents of malpractice, bringing down the astounding number of costly medical errors that claim 98,000 lives a year. I want to be clear many of these deaths would be wholly preventable through the adoption of simple measures like increased focus on communication between doctors and nurses, appropriate staffing levels as increasing the use of simple but effective checklists.

To that end, I join with my colleague Mr. Holt on—in introducing the Medical Checklist Act of 2010 in the 111th Congress. Checklists have long been used in commercial aviation as well as the number of other fields to ensure that complicated procedures are performed safely. They have been used because they work and their increased use in medical centers—settings is one way to improve patient test—safety. In your testimony, Ms. Doroshow, you spoke of the importance of focusing on patient safety and highlighted how one study in obstetrics department was able to reduce medical errors in claims by 99.1 percent by instituting a department wide program focused on ways that they can improve patient care; for example, establishing new drug protocols, improving communications between medical staff. What kind of incentives do you believe prompted the implementation of this systemic approach to improving patient safety? Do you think this kind of program could be replicated in other hospitals or other branches of medicine?

Ms. DOROSHOW. Absolutely and in fact it is not the only—it is New York Presbyterian Cornell Medical Center study beginning in 2002. At the request of the insurance carrier for this hospital, they implemented these things and as you said claims—everything went down. But it is not the only situation where that has been repeated. We also had somebody testify before, a task force I was on from a Boston hospital the same kind of results. It is extraordinarily successful at reducing errors and claims in compensation payments.

Mrs. CAPPS. And then real quickly in your reading of H.R. 5 is there anything that improves on patient protection measures that reduce the instance of medical errors?

Ms. DOROSHOW. No, absolutely not.

Mrs. CAPPS. OK. Well, I think this is an area where all of us can agree that this kind of approach, these innovative approaches are—

is worth learning from. I want to turn now to Dr. Kachalia. In your testimony, you described your review of the current evidence regarding the effective liability reform measures such as those contained in H.R. 5, you say for example there is not enough evidence to evaluate the impact of caps on the overall quality of care. I found the paper that you did in 2008 very interesting. You wrote that with regard to problems of liability costs and quality, there is a growing awareness and this is a quote from your statement—your letter. "Traditional tort reform measures such as caps on noneconomic damages will not solve them." You go on to say that "There is also increasing recognition that such measures do little or nothing to make care safer. Would you agree then, Dr. Kachalia, that the grants program included in the Affordable Care Act that permits States to conduct pilot projects to test some of these methods is a sensible first step before we enact sweeping legislation that would impose a batter of tort reform provisions on all States? And kind of a yes or no, because I will...

Mr. KACHALIA. So——

Mrs. CAPPS. Actually, I have time.

Mr. KACHALIA. So yes, I actually think the grants program that is being contemplated is a great thing because as we look to improve our liability system we should be looking to see how we can improve the quality of the safety of the care that we deliver at the same time. So as we—I think there is general recognition also that we need to fix the premium problem. We need to fix this issue with excessive economic awards, but at the same time there is no reason we couldn't package this with other measures that will also help with safety. So I think a grants program to investigate and give us more data on how to fix these problems is all—would be a welcome thing.

Mrs. CAPPS. And to corroborate that, Ms. Doroshow, the Affordable Care Act does include grants and encourage States to experiment with various methods to address medical liability in their State. Of course in keeping with the way that we have always treated medical as a State and not a Federal issue, do you want to comment on the same kinds of programs that you have seen where States are kind of testing the waters to see if there are programs that they can implement at the State level?

Ms. DOROSHOW. Yes, I mean a number of grants were made by HHS and we are waiting to see the results of those. Most of them are very focused on patients safety which I think is the correct way to go in solving this problem.

Mrs. CAPPS. Thank you. And I yield back my time but I ask unanimous consent to insert in the record a letter from the Consumer Watchdog that clearly shows that caps alone did nothing to decrease medical malpractice premiums by the study.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

April 5, 2011

Chairman Fred Upton
Ranking Member Henry Waxman
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

California is the only state in the nation where the impact on doctors' medical malpractice insurance premiums of both strong insurance rate regulation and strict medical liability limits can be directly compared.

H.R. 5 would severely limit the rights of patients who are victims of medical negligence. Arguments for the bill rely on incontrovertible errors in the understanding of California's experience. We are writing to set the record straight. Insurance reform, not liability limits, lowered malpractice insurance premiums in California.

The October 2009 Congressional Budget Office letter on medical malpractice predicts that limits on patients' legal rights will lower health care costs by 0.5%, and that 40% of those savings will come from direct reductions in medical malpractice insurance premiums. California's experience reflects the failure of such limits to produce the anticipated premium reductions.

In 1975 the California legislature approved the Medical Injury Compensation Reform Act (MICRA). MICRA imposed most of the medical liability limits proposed in H.R. 5, including a $250,000 cap on non-economic damages, modification of the collateral source rule, sliding scale limits on attorney fees and periodic payments of damages.

For the 13 years following the enactment of MICRA, medical malpractice insurance premiums in California rose 450% to an all-time high, according to premium data provided to the National Association of Insurance Commissioners.

In 1988 voters approved the insurance reform ballot measure known as Proposition 103. The law required a 20% rollback of insurance premiums for virtually all property and casualty insurers, including medical malpractice insurers, and subjected insurance rates to "prior approval" regulation that requires insurance companies to open their books and get approval for any rate change before it takes effect. It prohibits insurance companies from passing on to policyholders excessive executive salaries, profits, and administrative expenses.

In the first three years after Proposition 103 was enacted malpractice premiums fell 20%, then stabilized even as premiums across the country continued to fluctuate.

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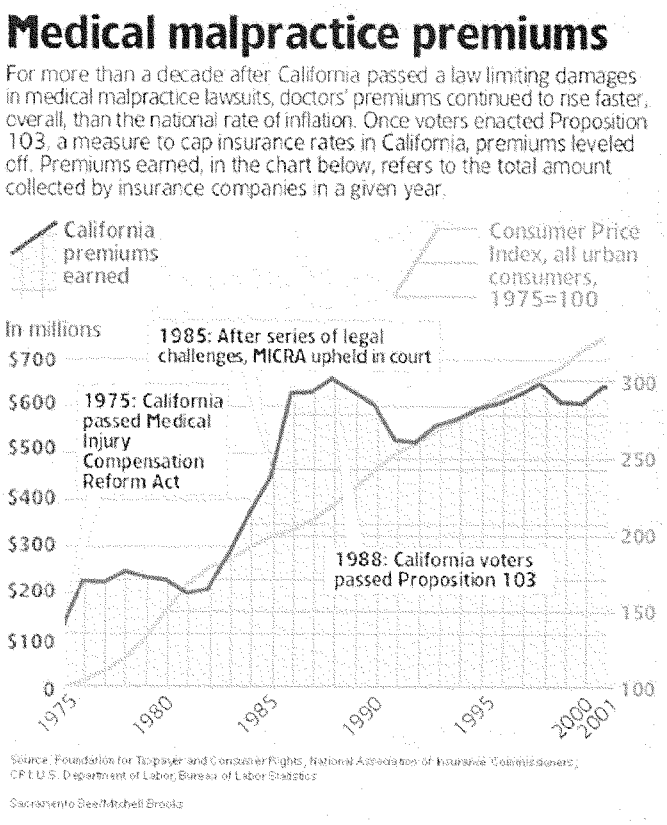
These savings are illustrated in an analysis of California medical malpractice premiums by the Sacramento Bee:



Property-casualty insurance companies in California eventually issued over $1.4 billion in refund checks under Proposition 103's rebate provision, and medical malpractice insurance companies were the first in the state to voluntarily comply. The state's top three medical malpractice insurance companies paid more than $60 million in refunds.

Proposition 103 also allows any member of the public to intervene and challenge excessive rate increases. Consumer Watchdog has used this intervenor process to prevent $66 million in unjustified rate hikes for doctors and other medical professionals since 2003.

In the years prior to enactment of Proposition 103, California's severe malpractice liability limits did nothing to limit doctors' ever-inflating malpractice insurance premiums. Only when strong insurance reform was enacted did malpractice premiums fall, then stabilize.

Consumer Watchdog has worked for decades with California patients who are twice injured: first by medical negligence, and again by a legal system that denies them justice. These facts about the experience in California should make clear that efforts to lock patients out of the courtroom will ultimately fail to provide the reductions in health care costs proponents seek.

I can be reached at (202) 629-3043 to answer any questions you may have.

Sincerely,

Carmen Balber
Washington DC Director
Consumer Watchdog

Mr. PITTS. Chair now recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes.

Mr. SHIMKUS. Thank you, Mr. Chairman. This is a really great hearing. I have been a Member since '96. We have dealt with this numerous times. And it is not an easy issue, and so I appreciate all the folks at the panel. First, Mr. Chairman, I would like to submit into the record two articles. One November 14, 2010; March 9, 2011, New York Times, and I don't know who this was. And it——

Mr. PITTS. Without objection.

[The information follows:]

November 14, 2010

Investors Put Money on Lawsuits to Get Payouts

By BINYAMIN APPELBAUM

Large banks, hedge funds and private investors hungry for new and lucrative opportunities are bankrolling other people's lawsuits, pumping hundreds of millions of dollars into medical malpractice claims, divorce battles and class actions against corporations — all in the hope of sharing in the potential winnings.

The loans are propelling large and prominent cases. Lenders including Counsel Financial, a Buffalo company financed by Citigroup, provided $35 million for the lawsuits brought by ground zero workers that were settled tentatively in June for $712.5 million. The lenders earned about $11 million.

Most investments are in the smaller cases that fill court dockets. Ardec Funding, a New York lender backed by a hedge fund, lent $45,000 in June to a Manhattan lawyer hired by the parents of a baby brain-damaged at birth. The lawyer hired two doctors, a physical therapist and an economist to testify at a July trial. The jury ordered the delivering doctor and hospital to pay the baby $510,000. Ardec is collecting interest at an annual rate of 24 percent, or $900 a month, until the award is paid.

Total investments in lawsuits at any given time now exceed $1 billion, several industry participants estimated. Although no figures are available on the number of lawsuits supported by lenders, public records from one state, New York, show that over the last decade, more than 250 law firms borrowed on pending cases, often repeatedly.

The rise of lending to plaintiffs and their lawyers is a result of the high cost of litigation. Pursuing a civil action in federal court costs an average of $15,000, the Federal Judicial Center reported last year. Cases involving scientific evidence, like medical malpractice claims, often cost more than $100,000. Some people cannot afford to pursue claims; others are overwhelmed by corporate defendants with deeper pockets.

A review by The New York Times and the Center for Public Integrity shows that the inflow of money is giving more people a day in court and arming them with well-paid experts and elaborate evidence. It is helping to ensure that cases are decided by merit rather than resources, echoing and expanding a shift a century ago when lawyers started fronting money for clients' lawsuits.

But the review shows that borrowed money also is fueling abuses, including cases initiated and controlled by investors. A Florida judge in December ordered an investment banker who orchestrated a shareholder lawsuit against Fresh Del Monte Produce to repay the company's legal expenses, ruling that the case should not have reached trial.

Such financing also drains money from plaintiffs. Interest rates on lawsuit loans generally exceed 15 percent a year, and most states allow lawyers that borrow to bill clients for the interest payments. The cost can exceed the benefits of winning. A woman injured in a 1995 car accident outside Philadelphia borrowed money for a suit, as did her lawyer. By the time she won $169,125 in 2003, the lenders were owed $221,000.

Lawyers are not required to tell clients that they have borrowed money, so the client may be unaware that there is financial pressure to resolve cases quickly. Lenders also seek detailed information about cases, which can jeopardize client confidentiality. A federal judge in Delaware ruled in June that a company suing Facebook for patent infringement had to show Facebook documents that its lawyer had shared with a lender.

Citing these issues, critics of lending for lawsuits say the practice should be banned.

"It sends shivers down the spines of general counsels all across the globe," said Lisa A. Rickard of the Institute for Legal Reform, an arm of the United States Chamber of Commerce.

But proponents, who argue that people often need help to fight corporations, have won a series of victories in state courts and legislatures in recent years, overturning old laws that prohibited investments in lawsuits.

"If you want to use the civil justice system, you have to have money," said Alan Zimmerman, who founded one of the first litigation financee companies in 1994, in San Francisco, now called the LawFinance Group. "If there's less money, you'd have less litigation. But then you'd also have less justice."

A Case in Point

A legal battle between residents of a faded Texas factory town and the BNSF Railway, the nation's second-largest railroad company, highlights what some see as the benefits and others see as the excesses of lawsuits driven by borrowed money.

Somerville, Tex., 80 miles northwest of Houston, has hosted the noxious work of treating wood to make railroad ties for more than a century. The railroad runs through the town, dividing a small grid of residential streets from the lumber yard and treatment plant where stacks of wood are soaked in preservatives.

Dennis L. Krueger crossed the tracks to begin work at the factory the week after he graduated from the local high school, in 1974. Three decades later, he was found to have a malignant skin

cancer that his doctor said was most likely caused by prolonged exposure to creosote, the tar oil in which the ties are soaked.

Mr. Krueger, who is 54 but looks much older, reduced by manual labor and medical treatment, is suing the railroad for damages, claiming that BNSF failed to provide basic safety equipment or to warn workers that the federal government had linked creosote with skin cancer. He recalled cleaning the inside of the treatment tanks wearing no safety gear except steel-toed boots and mule-skin gloves.

"I got so high off that stuff I'd be laughing one minute and crying the next minute," said Mr. Krueger, sitting at the local Dairy Queen beneath old photographs of factory workers. "I've got a 2-year-old grandson. My goal was to live to 101. What I'd like is a fair shake from the railroad for missing out."

Mr. Krueger's lawsuit is financed by investors he has never met. His lawyer from Houston, Jared R. Woodfill, has borrowed more than $3.5 million from a New York hedge fund run by Stillwater Capital Partners, in a deal arranged by the litigation finance specialist Oxbridge Financial Group, also based in New York.

Mr. Woodfill first drove to Somerville in 2000 to meet with a former factory worker who has since died of skin cancer. He said that his work on that worker's case, which BNSF agreed to settle in 2003, convinced him that toxic emissions from the factory had poisoned the town's air, water and land.

Mr. Woodfill, who is 42 and the chairman of the Republican Party in Harris County, is empathetic and well-spoken. He found a ready audience in Somerville, which has declined with the railroad industry. The population peaked in the 1930s. About 1,700 people still live in the timeworn residential section, but automation has further reduced employment at the factory, and a quarter of the households now live in poverty. Residents with a wide range of health problems embraced the idea that the factory was responsible.

Mr. Woodfill signed up workers with skin cancer, like Mr. Krueger, and those with gastrointestinal cancers that he says can be caused by the chemicals used at the factory. He also signed up Somerville residents who never worked at the factory but had developed cancers. And he signed up property owners with no health problems, arguing that the value of their property had suffered.

About 400 people sued the railroad — almost a quarter of the town's residents.

Oxbridge spent several months reviewing the cases before agreeing to arrange the financing, sending lawyers to Texas to look at documents and to question Mr. Woodfill and his partners. Stillwater Capital is charging about 16 percent annual interest.

"But for a hedge fund, I couldn't afford to take on a railroad," Mr. Woodfill said.

BNSF's general counsel, Charles Shewmake, said the company had carefully reviewed claims brought by its former workers and decided they had no merit. He said the claims by Somerville residents who did not work at the factory were "physically impossible and without any scientific basis."

Company executives were outraged when they learned that a hedge fund was backing the lawsuits, Mr. Shewmake said. He said that BNSF had been forced to spend millions of dollars mounting its courtroom defense and defending its reputation.

"They're stirring up cases that don't need to be in the courthouses," he said.

An Opportunity for Lenders

Lawsuit lending is a child of the subprime revolution, the mainstream embrace of high-risk lending at high interest rates that began in the early 1990s.

Mr. Zimmerman, the founder of the LawFinance Group, practiced law for more than two decades before moving into finance in California in 1992. A lawyer friend called to ask if he would lend to a client who had won a sexual harassment lawsuit. The woman's former employer had appealed, and she needed money for living expenses or she would be forced to take a smaller settlement.

Mr. Zimmerman invested $30,000 in the case; the former employer almost immediately dropped the appeal and paid out the verdict. Mr. Zimmerman made $20,000.

"I said: 'That's an interesting way to make money. Is there a way to turn that into a business?' " he recalled. The company he created has since invested more than $350 million in litigation.

Others in the lending business saw the same opportunity at about the same time, including a mortgage salesman in Buffalo; a subprime auto lender from Nashville; and a Las Vegas man who had been convicted of threatening borrowers who failed to repay his previous business, Wild West Funding.

By the late 1990s, several of those companies were also making loans to lawyers. Plaintiffs needed small sums for living expenses; their lawyers needed much larger sums to mount cases, and they had few other options. Banks make loans against assets, and law firms generally have little property to pledge as collateral.

The new lenders jumped into the void. LawFinance's slogan is "We do what banks won't."

The industry's great innovation, and still its defining trait, is the willingness to lend based on the potential value of unresolved cases.

The roughly one dozen major lenders tend to cultivate an image of conservative prudence. Counsel Financial, which bills itself as the largest, with more than $200 million in outstanding loans to law firms, shares a suburban office building outside Buffalo with an insurance firm.

But the work sits somewhere between banking and gambling. Lenders employ experienced lawyers to judge the strength of cases. They consult databases showing the results of similar lawsuits, just as appraisers value homes based on recent sales. A corporate defendant may have a history of battling personal injury claims; or juries in a specific county may have a history of siding with local employers. Then they place their bets. Counsel will invest up to $10 million in a law firm.

The returns can be lucrative. Counsel Financial charges 18 percent annual interest. "If firms have access to lower-cost financing, our first comment back to them is that you really shouldn't be talking to us," said Paul R. Cody, president of Counsel Financial. "We're not going to be competitive" with the interest rates charged by banks.

Law firms are generally obligated to repay loans even if they lose. In reality, however, firms that make less than expected often struggle to make the required payments, and a number of firms that borrowed from Counsel Financial have filed for bankruptcy protection.

Increasingly, banks are making lawsuit loans, too. During the lending boom of the last decade, companies including Citigroup, Commerce Bank of New Jersey and Credit Suisse provided financing for lawsuit lenders. More recently, some banks have started cutting out the middlemen. Deutsche Bank recently refinanced one of Counsel's largest clients, the New York firm Napoli Bern Ripka. TD Bank, which absorbed Commerce, lends to lawyers and plaintiffs.

The founders of LawCash, a Brooklyn lender, won a charter from New York in 2006 to establish Esquire Bank, the first American bank to specialize in the business of financing lawyers and lawsuits.

Defendants on the Defensive

A recent Nevada case illustrates one reason many companies are troubled by the rise of financing: They fear that investors will move from supporting to producing lawsuits.

Steven and Roz Flans left Los Angeles in 2004 for Sun City Anthem, a sprawling retirement community of 7,000 one-story homes, from ranches to mansions, at the edge of the Las Vegas basin. When the gas fireplace stopped working during their third winter in the desert, the couple contacted their home builder, Del Webb.

"We called and said, 'We have a minor problem,' " Mr. Flans recalled. "And they said: 'We can't talk to you. You're suing us!' "

It emerged that the Flanses had accepted a free home inspection the previous year from a company, MC Mojave Construction, that had papered their neighborhood with brochures. They said they did not realize that the forms they signed authorized MC Mojave to sue Del Webb on their behalf for the money to correct any problems.

By 2008, MC Mojave had initiated more than 500 lawsuits against Del Webb. The company acted as an investor, providing inspection reports to the Las Vegas law firm that handled the cases in exchange for a share of any winnings.

Del Webb sued MC Mojave, arguing that Nevada law prohibited fomenting and investing in lawsuits. Jacque Petroulakis, a company spokeswoman, said that Del Webb would have fixed legitimate problems under its warranty policy, and that the lawsuits served solely to make money for MC Mojave and the law firm.

"They were throwing people into litigation that many of them never anticipated or wanted," Ms. Petroulakis said.

MC Mojave did not return calls for comment, but in court filings, it called the Nevada law "medieval" and said it should not be enforced. The company said it was providing a service at the request of the homeowners.

This year, a federal judge barred MC Mojave from initiating further lawsuits, ruling that Nevada law indeed prohibits such investments.

But a growing number of states have eliminated similar laws.

The Massachusetts Supreme Judicial Court started the trend in 1997, citing a "fundamental change in society's view of litigation — from a social ill, which, like other disputes and quarrels, should be minimized, to a socially useful way to resolve disputes."

South Carolina, Texas and Ohio are among the states that have followed.

Stephen C. Yeazell, a law professor at the University of California, Los Angeles, and a leading historian of the civil justice system, said the trend was likely to continue. He said there was little legal justification for allowing lawyers to pay for cases but barring third parties from doing so. "This is another step in leveling the playing field between plaintiffs and defendants," Mr. Yeazell said.

Gathering Plaintiffs

Anthony Flammia, a former New York City police officer who spent three months working in the wreckage of the World Trade Center, did not learn that his lawyers had borrowed money to pursue his claim of compensation for health problems until he received a bill for $828.93 in interest charges.

Mr. Flammia left ground zero at the end of 2001 for a job with a suburban police department. A few years later, a passer-by found him asleep in his patrol car. His health had been deteriorating, and the episode prompted him to visit a free clinic established to treat ground zero workers for the consequences of inhaling dust. He was found to have sleep apnea and scarring in his lungs. In 2007, he passed out after inhaling smoke at a house fire and was forced to retire.

Lawyers led by Napoli Bern Ripka sued the City of New York and a host of agencies and companies on behalf of more than 9,000 ground zero workers. When Mr. Flammia signed up as a client, the paperwork included a general notice that the lawyers might borrow money to pursue the case, and that they might bill clients for the interest.

Mr. Flammia said he did not see the general warning, and there was no further notice as the lawyers borrowed more than $35 million.

In June, the city and other defendants agreed to settle the case for up to $712.5 million. The workers have until Tuesday to approve the settlement. Workers received letters detailing how much they would receive, and how much the lawyers would keep to cover the costs of pursuing the case.

Among the costs billed to clients was $6.1 million of the $11 million in total interest payments, which the law firms said reflected the share of the borrowed money covering the workers' expenses.

Lawsuit lenders, including Counsel Financial, encourage lawyers to bill clients. They advertise in trade magazines that lawyers can borrow money free if the client is paying the interest. Bar associations in most states, including New York, condone the practice.

Paul J. Napoli, one of the lead lawyers representing the ground zero workers, said that the firm needed money to pursue the case, that the loans were taken at the lowest available interest rates and that clients were properly notified.

"We followed the rules. Do people want to have it sky-written over their house every day?" Mr. Napoli asked. "They didn't read it. Or maybe they didn't care at the time. At what point do people have a self-responsibility to read something and be bound by it?"

But Mr. Flammia and other workers said they had not agreed that the law firm could pay for its work by borrowing money at their expense.

"If I'm ever involved in a lawsuit again, I'm going to be very careful and read every document line by line," Mr. Flammia said. "I'm also going to find a lawyer who is acting on my behalf and not to line their own pockets."

The judge overseeing the case, Alvin K. Hellerstein of the Federal District Court of Manhattan, ordered the lawyers to swallow the cost.

Judge Hellerstein acknowledged that the charges were legal, but said that the lawyers already were earning enough from the case. He said that it was not clear that clients had understood or approved the decision to borrow, and that it was clear that clients had no control over how the money was spent.

The workers, Judge Hellerstein said, "want to have the fruits of this settlement not diminished by an effort of lawyers to finance much of the way that they work this case."

A War of Attrition

The residents of Somerville, Tex., have yet to win a trial.

The case of Linda Faust, who never worked at the railroad plant, was the first to reach court, in 2008. She had stomach cancer.

The jury deliberated three days before deciding that BNSF was not responsible.

The following year, a jury ruled against Dennis Davis, a former worker at the factory with pancreatic cancer.

Mr. Woodfill's nine-lawyer firm, Woodfill & Pressler, has spent more on the Somerville cases than any of its previous litigation. Win or lose, it must repay Stillwater, the hedge fund that is bankrolling the cases. Mr. Woodfill said he remained confident that the cases could be won. He is appealing the two losses and preparing for a third trial next year.

He drove through Somerville recently on his way to meet with clients, rolling down the windows so the smell of the factory came into the car. "They're hoping to spend us into the ground and make us go away, but we're not giving up," he said.

Mr. Shewmake of BNSF said the company was braced to continue fighting the cases until Stillwater ran out of patience.

"Right now," he said, "I'd say it's starting to look like a bad investment decision."

The New York Times
City Room
Blogging From the Five Boroughs

MARCH 9, 2011, 11:10 AM

One Person's 'Special Interest' Is Another's 'Stakeholder'

By THOMAS KAPLAN

There were once simpler times in Albany, when a special interest could be described as a special interest and — at least linguistically — that was the end of it.

Like his predecessors, Gov. Andrew M. Cuomo has spent plenty of time deriding special interests since he took office two months ago. But for the hospitals and labor unions whose representatives he appointed to a committee charged with making sharp cuts to the state's Medicaid program, he has taken to affixing another label: "stakeholder."

That euphemism prompted some eye-rolling among old Albany hands. But this week, a consumer group tried to turn Mr. Cuomo's verbiage against him, arguing that his "stakeholders" were, by their very nature, in violation of state law guarding against conflicts of interest among public officials.

The group, the Center for Justice and Democracy, which opposes the Medicaid committee's proposal to limit medical malpractice claims, sent a letter to the state's Commission on Public Integrity on Tuesday seeking an investigation.

Their claim is complicated, but it boils down to the notion that the members of the Medicaid committee — "stakeholders," in Cuomo-speak — should be considered "public officers" under state ethics laws. Such officials, if serving on a state advisory board, are forbidden to vote on anything that "directly affects his or her specific employer," according to an ethics commission opinion that the group cited in its letter.

Among the so-called stakeholders whose employers they said would directly benefit from the malpractice cap are several hospital officials as well as Jeffrey A. Sachs, a close friend of Mr. Cuomo's whom the Center for Justice and Democracy and other groups have criticized for not fully disclosing his consulting clients, which include major New York hospitals.

A spokesman for the public integrity commission, Walter C. Ayres, said it received the complaint and was reviewing it.

The Cuomo administration, meanwhile, did not respond happily to the complaint. James Introne, Mr. Cuomo's deputy secretary for health, described it as "one of the most absurd stunts" that was advanced by a group that he described as "devoted to fighting against tort reform of any and all kinds and is closely allied with the trial lawyers."

The Medicaid committee members, he said in a statement, were simply "doing what they were asked to do, namely, represent their own interests as part of a stakeholder process."

Mr. Introne also accused the Center for Justice and Democracy of hypocrisy, noting that the group was included on a task force about medical malpractice that Gov. Eliot Spitzer created in 2007. "By the Center's own analysis, they are guilty," Mr. Introne said.

It is worth noting that the "stakeholder" mantra is not a creation of Mr. Cuomo, though he certainly has embraced it. Mr. Spitzer used the term when he announced his medical malpractice task force. And it was used liberally by officials in Wisconsin — including Mr. Cuomo's Medicaid director, Jason A. Helgerson — when they embarked upon a similar process to make Medicaid cuts two years ago.

But its use in New York has seemed to reach a new height under Mr. Cuomo. In the past two months, a cursory search finds more than 100 Albany-related articles that indulged the governor and used the term "stakeholder." For the same period last year, when Gov. David A. Paterson was in office, the word pops up in only a handful of stories.

Shortly after Mr. Introne released his statement, the Center for Justice and Democracy released its own statement asking Mr. Introne to produce a sworn affidavit stating, effectively, that the so-called stakeholders do not actually have a financial stake in the malpractice proposal. (Hospital officials, for the record, said last week that the proposal would eventually yield hundreds of millions of dollars in annual savings.)

"If there has been no such benefit, we would be happy to reconsider our position," the group's executive director, Joanne Doroshow, said. "If not, we will await the commission's findings."

"And by the way," she added, "after you apply the facts to the law, that sound you'll hear is the steel trap closing on you."

For whatever merits the Center's legal argument may hold, their letter to the ethics also raises a philosophical question, and one that could be considerably harder to arbitrate. After all, if a stakeholder does not actually have a stake, is he or she still a stakeholder? And, if not, what are they?

Perhaps, say, a special interest?

Center for Justice and Democracy Complaint

Our political reporters, and occasional guests, offer you a peek inside Albany and City Hall. Check back every Wednesday.

Mr. SHIMKUS. It addresses an issue of loaning money, in essence usury and rates within the States. Let me read the paragraph: "Large banks, hedge funds and private investors hungry for new and lucrative opportunities are bankrolling other people's lawsuits, pumping hundreds of millions of dollars into medical malpractice claims, divorce battles and class actions against corporations—all in the hope of sharing in the potential winnings." So they are using medical issues and there is a—actually, there really is a debate now in States and whether this is a State issue or Federal issue I am still going to try to reconcile that debate. It has been raised up, but States are—we are involved with credit card rates now here nationally. States are involved in loan sharking and payday loan issues and rates, so I would like to submit that. And I have got some other things, but Dr. Tippett, you are a neurosurgeon? Is that correct?

Mr. TIPPETT. Yes, sir, I am a neurosurgeon.

Mr. SHIMKUS. And in Illinois we have gone on and off of medical liability reforms and we just had one. It just got overruled by the Supreme Court. Now we are kind of in limbo until we see if anything else could pass. Before the last passage of State Liability Reforms we did not have a single neurosurgeon south of Springfield, Illinois, which is parts of 52 counties. Now as a practitioner of that specialty that is a danger sign,s wouldn't you think?

Mr. TIPPETT. Absolutely. You talk about—everybody's talking about what do we want to do about patient safety and I am thinking when you don't have someone there to take care of the patient it is not very safe. If you have got to travel 500 miles to get to see a doctor, that is not safe.

Mr. SHIMKUS. Fifty-two counties, yes.

Mr. TIPPETT. We are all for patient safety, but you have to have the physician access.

Mr. SHIMKUS. Yes, reclaiming my time. Fifty-two counties is a third of the State of Illinois, and at that time we would have to airlift folks who are in critical acts—I mean to airlift them 100, 150 miles maybe to New York—not New York to St. Louis, Dens Sens, maybe Paducah, to other places who had across the State line who had neurosurgeons because they had lower—and that is why I think if you hear the testimony of some of the members' concerns, we are from rural districts. We are from districts that have problems with access to care and that is where our passion for this debate comes from. So I just—I will put that on the table.

The other thing I found interesting, Ms. Doroshow, and I appreciate your testimony. I appreciate you raising this issue of Dr. Lora Ellenson and the quotes in there and the story. Because I think if I ask this question to everyone—this is the doctor who has the disabled son that wants a judgment to be made to pay for the care of that son for the rest of his life. No one at this panel would disagree with that. Would you? Would you, Dr. Hollier? Would you disagree?

Ms. HOLLIER. Would not disagree.

Mr. SHIMKUS. Ms. Doroshow, would you disagree?

Ms. DOROSHOW. Would not.

Mr. SHIMKUS. Yes, Dr. Kachalia? You wouldn't disagree. Mr. Wolfman?

Mr. WOLFMAN. No.

Mr. SHIMKUS. Dr. Tippett?

Mr. TIPPETT. Absolutely not.

Mr. SHIMKUS. So no one would disagree with it. There is something that we can all agree upon. Now this debate is really about—and I am not a lawyer, OK, and sometimes I wish I was and sometimes I am glad I am not—but this is the issue of the second part of a medical liability claim which is pain and suffering. Now, this is in the issue because the Governor of New York is trying to cap pain and suffering at $250,000. Is that correct, Ms. Doroshow?

Ms. DOROSHOW. That is—no. I mean, that was——

Mr. SHIMKUS. Yes, that was in the story that you used it for?

Ms. DOROSHOW. No, that is over it. That was withdrawn.

Mr. SHIMKUS. OK, but it was.

Ms. DOROSHOW. That was withdrawn.

Mr. SHIMKUS. But it was——

Ms. DOROSHOW. It was the hospitals that were on a refined scheme that——

Mr. SHIMKUS. All right, do I want to read the story that you quote in your—do I want to read the story?

Ms. DOROSHOW. Well——

Mr. SHIMKUS. The story——

Ms. DOROSHOW. Since I wasn't involved in it——

Mr. SHIMKUS. OK. I don't want to fight this.

Ms. DOROSHOW [continuing]. I can——

Mr. SHIMKUS. The story is based on Cuomo had proposed capping at $250,000. That is part of the story that you used. And I don't want to go on that fight, but that is what raised this story was her concern of Governor Cuomo's.

Ms. DOROSHOW. Well——

Mr. SHIMKUS. Now the issue was this. Mr. Chairman, the time is mine. The time is not the ranking member of the full committee's, and I ask for my 15——

Mr. PITTS. Shimkus——

Mr. SHIMKUS [continuing]. Seconds returned based upon the disruption by the ranking member.

Mr. PITTS. You may proceed.

Mr. SHIMKUS. Thank you, Mr. Chairman. Now the issue is this, that in a court case what we should have—there is economic damages that should be recovered. This issue of pain and suffering is what is driving this. Now in California, one economic damage case recovered $96 million. So this debate is about the pain and suffering aspect that actuarially insurers can never quantify because there is no cap. Thank you, Mr. Chairman. I yield back my time.

Mr. PITTS. Chair thanks the gentleman and recognizes the gentleman from New York, Mr. Weiner, for 5 minutes.

Mr. WEINER. Thank you, Mr. Chairman. You know, I think that Mr. Gingrey's question earlier should inform our debate about who should make these decisions. Now Mr. Gingrey suggested in his questions that you should or he should, when in fact we have a history of jurisprudence in this country that empowers our constituents to make these decisions, that they are smart enough to send Mr. Gingrey to Congress, they should be smart enough to sit on a jury. Or alternatively they should be smart enough to pass State

laws. It is interesting that in Mr. Gingrey's explanation of Constitutional authority for this bill, he writes the Constitutional authority in which this legislation is based is on Article I, Section VIII, Clause III of the Constitution as healthcare related lawsuits are activities that affect interstate commerce. If that is the explanation for trumping tort law in the States where does—so we can take this book—this is New Jersey's law and say that apparently Congress knows better. So we are going to trump State law. Like there is not a Federal tort regime now. It is basically they are in the individual States. It is the right of the States. The Tenth Amendment of the Constitution reserves this for the States. Why stop there? If we are not going allow the State to make health-related tort laws, then who is going to decide? I am impressed with Mr. Wolfman—and, by the way, I am not a lawyer, but if we ever had a law firm Wolfman and Weiner, I mean, we would just—I am serious, we would just get clients just on the sheer intimidation factor. But perhaps you can talk a little bit about the idea that there are some areas of the law that we reserve for the States and the effect that this would have on the regime of State tort law because frankly, we could really go to every extreme. You really could say that every court case can be decided in this room theoretically. I mean, if you are going to say, if you are going to trump State tort laws for this, where does it stop? Is there no line that you don't cross? I mean, I thought that part of the ethos of this new Congress was respect for the Constitution. I mean, this basically tramples on the Tenth Amendment worse than anything I have seen in awhile. You want to comment on that, Mr. Wolfman?

Mr. WOLFMAN. Yes, Mr. Weiner, that—first of all you are right that the tort system has been traditionally one in which the State has had plenary authority. And let me just add and I think that this goes to the point that was asked to me earlier. What this bill does, it not only trumps the States, but it does it in entirely a one-way direction. So in other words, what it does is it is—it pretends that the State system will continue to exist and it only imposes Federal law when it undermines the rights——

Mr. WEINER. Right.

Mr. WOLFMAN [continuing]. Of people who are harmed. And that is—and let me make one other point. Now it is one thing to waive around a $96 million punitive—pain and suffering judgment. There is a big difference between 250,000 and 96 million. That is what we are talking about. We are talking about the people who have to live for the rest of their lives with disfigurement, phantom pain, blindness—$250,000?

Mr. WEINER. Well, and then there is the other question that I think is at the foundation and it is worth having a conversation here about. Who gets to make the decision? If you are patient in rural Georgia in Mr. Gingrey's district and you want a jury of your peers to hear your case or you are a doctor or you are a hospital and you want a jury of your peers to hear the case, under this law effect—under this proposal, effectively that jury is meaningless. If that jury comes to the conclusion and there are smart people in Georgia. There are smart people in Mr. Gingrey's district and they hear the evidence and they draw a certain conclusion, they are now going to be told that actually it doesn't really matter. That exercise,

your State legislator that passed that law doesn't matter. The State legislature that approved it and the Governor that signed it—doesn't matter. That jury that sat—doesn't matter. The witnesses that were called—doesn't matter. The victim himself, his or herself doesn't matter as it relates to Georgia. It only matters as it relates essentially to big Washington. You are saying it is going to be in the Federal judicial system. And I would say that it is very hard for anyone to call themselves small government or respectful of the Constitution or concerned about states' rights and support the Gingrey measure. Because what you are really saying is all of those things we have heard about. Even the Texas law could theoretically be trumped tomorrow because we can just change the limit or change a word and suddenly Texas laws are thrown out. I mean, we have all these law books that are filled with what people have done. The Code of Virginia—all these different laws that were passed and now we are going to say that no, it is Washington that is going to make that decision. I, for one, find that offensive to the Constitution of the United States.

Mr. PITTS. The gentleman's time is expired. The Chair recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minutes for questions.

Mr. CASSIDY. Thank you. I will first by—end up by quoting or at least summarizing the gist of Mr. Weiner's speech from yesterday saying that we can't rely on State insurance commissioners to create standards because otherwise, I think I remember him saying, somebody in one State will define the lowest common denominator and there was a basic obligation of the people who set the kind of rules in which there needs to be rules of the road. So it seems a little contradictory. That said, Mr.—Dr. Kachalia, I enjoyed your brief, if you will. I am a physician so it is—I don't want to insult you by calling it a brief, no offense to the attorneys. But it was well-referenced. I like that. I also have here a chapter from a textbook on healthcare economics. And it is saying stuff that frankly I find very disturbing. Let us see, less than half of malpractice insurance premiums, one third of 1 percent of total healthcare, but less than half of malpractice healthcare premiums are returned to victims of negligence and the remainder is spent on overhead and legal fees. So it is less than half. I mean, the medical loss ratio in PPACA for insurance companies is 85–15 percent. This is something like 55 going to overhead and 45 not. That is disturbing. It also goes on to say that there is limited evidence. Mr. Gonzalez suggested that the purpose as did you, Ms. Doroshow, the purpose of malpractice is the deter bad physicians, but this article goes on to say that there is limited evidence that bad physicians are removed through the malpractice system. Any comments upon that?

Mr. KACHALIA. If I can start, so starting with the overhead costs I do think that is one of the biggest problems that we have in our current system with the way the litigation process works you often have the need for expert testimony on both sides.

Mr. CASSIDY. So just to summarize that is money not going to victims of malpractice, it is money going to overhead?

Mr. KACHALIA. Correct.

Mr. CASSIDY. OK. Continue.

Mr. KACHALIA. Correct. And so this is one of the problems that we have noted in the system because there—we advocate it shows that there is a need for reform in this regard because it takes way too long and it is much too expensive to adjudicate claims. So that if we——

Mr. CASSIDY. If we have somebody who is a victim of malpractice, a sponge is left in the belly, then really there is a length of time before that is adjudicated, the patient gets relief, begins to get the extra dollars she may need for her recovery and an ordinate amount is consumed in overhead? Fair example?

Mr. KACHALIA. That can be a fair example although unless people are starting to settle much more quickly, but if they—if the provider chooses not to settle, yes, that is a fair example.

Mr. CASSIDY. OK. So Mr. Gonzalez's point that we are actually using the malpractice system to drive physicians out who shouldn't be practicing, do you think that is valid? Does that work?

Mr. KACHALIA. I don't remember his exact example but I am not sure that the medical malpractice system—because we don't see as many claims as one would expect for the amount of error that occurs. It may not necessarily be sending the right signal to all of the providers we want to send it to. I do think that to some extent it does impact people and does drive some accountability because people do worry about being sued. And I do think there is some accountability——

Mr. CASSIDY. Now, that accountability though—I am a physician, so one of the general surgeon says that when he goes to the emergency room it used to be a history and physical form. Now it is a history, physical, and CT scan form.

Mr. KACHALIA. Right.

Mr. CASSIDY. Because folks are so afraid if you come in with a headache you could have had the headache for 10 years, you are getting a CT scan. I see Dr. Tippett nodding his head. I think $1,000 test with lots of radiation, but that way if you are sued you have got the CT scan. In fact, fair to say it also drives some of that practice, too.

Mr. KACHALIA. I think it is fair to say it drives defensive practices and also drives accountability at the same time. The question is which one is being—which one is winning the battle so to say?

Mr. CASSIDY. Now, I also read in this article from an academic textbook that only 2 percent of negligence victims file claims, but 6 percent of patients who are not victims of negligence file claims. That is incredible. Dr.—Mr. Wolfman is looking kind of surprised. I can find the exact reference and I can show the chapter. But that apparently people who aren't victims of negligence 6 percent of the time file malpractice claims. Dr. Tippett, how would that impact your practice?

Mr. TIPPET. Well, it—I mean, you had the perfect example. You can't get into or out of my office without having an MRI scan these days and it is not because you need one necessarily when you come in, but because when we see a patient in the office we think of a differential diagnosis rather than just to that one thing like treat a simple back pain for a few weeks to see if they are going to get better because there is one in a thousand chance that patient may have a tumor in their spine we get an MRI scan. That is unneces-

sary, increasing the cost of medicine. It doesn't need to be done, but nevertheless it is exactly what occurs in every ER and every doctor's office in this country.

Mr. CASSIDY. I am sorry. I am out of time. I had a question for you, Ms. Doroshow and I forgot—one question, Dr. Hollier, why is it Hollier, not Hollier as in Louisianans?

Ms. HOLLIER. It is Hollier, sir.

Mr. CASSIDY. Thank you very much. I just—warms my heart.

Mr. PITTS. Chair thanks the gentleman. Recognizes gentlelady from Illinois, Ms. Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Dr. Tippett, you just said that you perform unnecessary procedures?

Mr. TIPPETT. That is not what I said.

Ms. SCHAKOWSKY. Yes, you used the word unnecessary.

Mr. TIPPETT. No.

Ms. SCHAKOWSKY. We could go back and ask for a reading of the transcript, but you said that——

Mr. TIPPETT. Unnecessary at that particular time.

Ms. SCHAKOWSKY. Uh-huh.

Mr. TIPPETT. It is a necessary procedure in the differential diagnosis that I mentioned earlier, so it is not unnecessary. It is the question of timing. My point was——

Ms. SCHAKOWSKY. But you are saying—now you are saying it is unnecessary because I want to know if you—when you do that you order—if you order something that is medically unnecessary do you also bill Medicare and Medicaid for or private insurance for this work?

Mr. TIPPETT. I don't order tests that are unnecessary.

Ms. SCHAKOWSKY. Excuse me?

Mr. TIPPETT. I don't order tests that are unnecessary.

Ms. SCHAKOWSKY. Well, OK, you said it was absolutely unnecessary. I wanted to just——

Mr. TIPPETT. At that particular time. I am sorry I was trying to be brief in my comments——

Ms. SCHAKOWSKY. Yes, exactly.

Mr. TIPPETT [continuing]. And I did not add to the——

Ms. SCHAKOWSKY. You said no one leaves your office without getting an MRI because—and the implication was because you want to avoid litigation. And what I am asking you if you are billing Medicare, Medicaid, or private insurance for these procedures that you view to be unnecessary.

Mr. TIPPETT. I didn't say I viewed them to be unnecessary.

Ms. SCHAKOWSKY. You did.

Mr. TIPPETT. I said—no, ma'am, I did not finish the sentence earlier when I said that test wasn't necessary at that particular time.

Ms. SCHAKOWSKY. No, you didn't. OK.

Mr. TIPPETT. It is a necessary test to determine whether or not someone has a tumor was my entire——

Ms. SCHAKOWSKY. Yes, I actually wanted to start what I was saying until I heard that disturbing sentence—those disturbing remarks that actually I think there might be a way that we could be on the same side with doctors. This is not a war between doctors and lawyers. This is about people that get hurt. Now what—it is so interesting to me that injured patients become the focus. And we

are going to take it out on them rather than looking at the insurance companies. And why it is that you who have maybe never been sued and doctors, the small number who actually may engage in dangerous behavior that causes patients to be injured, why you are asked to pay the similar insurance? I—there is—it doesn't— I don't believe there is experience rating in medical malpractice insurance. Is that true, Ms. Doroshow?

Ms. DOROSHOW. Right, it is rated by specialty primarily now.

Ms. SCHAKOWSKY. You know which really, I think is unfair. All of us want to see that obstetrician gynecologist, and neurosurgeons are able to practice where they want to practice without and without any distinction from the bad actors that are in those professions. And we all admit that there have to be those. So what I wanted to ask Mr. Wolfman or Ms. Doroshow, will capping damages, that is actually making sure that the real victims lead to lower rates?

Ms. DOROSHOW. Well, if history is any guide at all, it absolutely won't. You look at State after State. Missouri for example, Maryland both had severe caps in the mid-80s. They experienced very severe insurance crises in the early part of the 2000s. Missouri's rates went up 121 percent. This is true in every State. Ohio passed caps. The insurers immediately went in; asked for rate hikes. Oklahoma the same thing. Mississippi the same thing. In Texas they would be—after 2003 the cap passed. The insurers immediately went in for rate hikes. Until the market stabilizes and it happens everywhere in the country irrespective of a State's tort law. States will—rates will continue to go up. That is an insurance problem that needs to be fixed.

Ms. SCHAKOWSKY. Exactly and I think that we are absolutely looking in the wrong direction and if we want to help doctors to be able to in their view afford to practice where they want to practice, to say to people whose lives have been permanently altered that the burden is now going to be on you. And by the way, $250,000 which was a number decided in California years and years ago would be a million dollars now. So we are not even talking about a situation where we are going to be able to people—to have people restore their lives. I think if we could work together on figure—on pointing our finger in the right direction that this is an insurance problem—it has already been stated that most people, and you stated it yourself, Dr. Kachalia, that not as many injured people actually file claims. A very small percent do because you know it is laborious, it is expensive, it is hard to do.

Mr. KACHALIA. It is not as if you want me to comment, but I do think there is a premium problem, but there is also the issue of the emotional cost of a suit that gets attached and the behaviors that result from it. So it is not just all about premiums.

Ms. SCHAKOWSKY. Well, there is a lot of emotion attached to having the wrong breast removed or yes. Um-hum.

Mr. PITTS. The gentlelady's time has expired. Chair now recognizes my colleague from Pennsylvania Dr. Murphy for 5 minutes.

Mr. MURPHY. Thank you, Mr. Chairman. A few questions here. First, Mr. Wolfman, I am trying to understand this—how this works. Is there a correlation between unlimited noneconomic dam-

ages and unlimited punitive damages in improvement in healthcare?

Mr. WOLFMAN. I think the answer to that is yes with one caveat. I mean, that——

Mr. MURPHY. Do—was there a study that you could refer us to? I would have actually looked to see that. I am not looking for you to—I am not going to put you on the spot with a guess.

Mr. MURPHY. There are. There are some famous studies on punitive damages that show some relationship. I just—with the word unlimited, but yes and I can get those to the committee.

Mr. MURPHY. I mean, I am not talking about a single award that is given in a case, but I mean overall?

Mr. WOLFMAN. Yes, yes.

Mr. MURPHY. You think you can do that for us? Thank you. So in other words feel that when we have the ability for higher damages or punitive damages not economic damages we could—expect to see overall improvement in healthcare driven by that factor separate from other things?

Mr. WOLFMAN. As I understand what you are saying I think the answer is yes and I can get that to the committee.

Mr. MURPHY. OK. Now, is there also a correlation then between the more an attorney gets paid and an improvement in healthcare?

Mr. WOLFMAN. I think the answer to that is yes and no and I think it is not an easy answer that what I—the point I was making about lawyer compensation through our contingent fee system is that if you have rates that are driven by the Congress of the United States that are way below the market which is what this bill does you are not going to attract lawyers to take important difficult cases. You are not going to get the best lawyers on the most difficult cases particularly the cases for instance older people who have no wage income, people whose income so to speak would decide——

Mr. MURPHY. And the attorney wouldn't have the money to really advance this case. I understand that point.

Mr. WOLFMAN. Right, that is the problem. So it——

Mr. MURPHY. You have a delay—this goes back——

Mr. WOLFMAN. Your correlation that you are talking about I—with all respect doesn't ask the right question.

Mr. MURPHY. Well, I mean——

Mr. WOLFMAN. The question is whether the market is going to attract people to take difficult cases.

Mr. MURPHY. It is important because then you would have the justice delayed is justice denied issue. Well, let us talk about that market. I know in Pennsylvania we have some serious problems with attracting neurologists and OB–GYNs to the market. And for some of the physicians here perhaps some of you can enlighten me on this, but I know when I have seen in States they list the number of people who have a medical degree or license in that State. My understanding they will look at all licenses including the residents and interns, semi-retired physicians and even those who may still have a license in Pennsylvania but have moved down to South Carolina or somewhere else to retire in. Is that correct? Can anybody—I see some heads nod that is correct.

Mr. TIPPETT. That is correct.

Mr. MURPHY. I also hear from some top medical schools—I am on the faculty of the University of Pittsburgh School of Medicine. I should disclose that—the Department of Pediatrics. And one of the things I hear from some other departments is for example, they will have an entire class year after year of graduates from a top level residency program in OB–GYN and not a single one of those residents remains in Pennsylvania. So I go to this question then if we don't have OB–GYNs and I have friends of mine who are neurologist say they have spent years trying to attract a neurologist to join their practice. I have some neurologists here in front of us. If you don't have enough people to treat patients, what does that do in terms of delaying care? Anybody answer that for me or enough OB–GYNs in a practice to delay—does that affect care?

Ms. HOLLIER. Absolutely. If you don't have available obstetrician gynecologists care is definitely affected. Imagine being 9 months pregnant in Blanco County that had no obstetricians prior to the passing of——

Mr. MURPHY. And why don't they want to stay in that State?

Ms. HOLLIER. OB–GYN doctors do want to stay in the State of Texas.

Mr. MURPHY. But what are—is the cost of medical liability insurance part of that overall concern in one State versus another and they can leave and go to another State?

Now I go back to Mr. Wolfman's comment at the crux of not going forward with H.R. 5 as you affect the marketplace. So I ask the physicians, does this affect the marketplace to not deal with this issue? Dr. Tippett?

Mr. TIPPETT. Well, absolutely.

Mr. MURPHY. Dr. Kachalia, does that affect the marketplace?

Mr. KACHALIA. I mean I will reiterate. I think we need reform. It is going to help the marketplace.

Mr. MURPHY. Ms. Doroshow, you have a comment you want to make?

Ms. DOROSHOW. Well, you know Michelle Mello from Harvard actually did a study of Pennsylvania doctors and compared access to care in Pennsylvania before and after the most recent liability insurance crisis when rates went up.

Mr. MURPHY. Um-hum.

Ms. DOROSHOW. And found there is no connection whatsoever.

Mr. MURPHY. Between amount of physicians?

Ms. DOROSHOW. It is in my——

Mr. MURPHY. Yes, I appreciate that. I was a State Senator at the time and that is why I was saying that point before.

Ms. DOROSHOW. You should take a look at that study.

Mr. MURPHY. If they count the number of physicians available in Pennsylvania, look at all licenses and that is a distorted statistic. I just want information, the truth, and it is—but I appreciate and Mr. Wolfman if you could get me those studies I would really be grateful. Thank you. I yield back.

Mr. PITTS. Chair thanks the gentleman and now recognizes the Ranking Member Emeritus, Distinguished Gentleman from Michigan, Mr. Dingell for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy. Professor Wolfman, you described in your testimony the sad story of

Diana Levine who lost her arm as a result of an inadequate labeled drug. Here is a case of noneconomic damages and it is—we find it quite overwhelming. The lady in question was a musician by trade. Without her arm it is doubtful she will ever be able to return to her profession. She found as you indicated a small town Vermont lawyer who took the manufacturer all the way to the Supreme Court. In fact, I was one of those who joined a number of my colleagues in signing an amicus curiae Brief in support of the Levine case. I find it haunting as her lawyer hesitatingly admitted that her case might never have brought to court had a $250,000 noneconomic damages cap been in place. Obviously it isn't every day that cases are taken all the way to the Supreme Court, and I hope it isn't every day that people suffer the kind of loss that she suffered.

Now, Professor Wolfman, can you provide some other examples of the types of cases that you have seen dealing with FDA approved drugs and medical devices?

Mr. WOLFMAN. Yes, I can, Representative Dingell, and what I would like to do is if I could direct your attention to my testimony and I will just—I know the time is short, so but beginning at page 12 of my testimony I talk about a number of other examples and one that I think is similar to the problem of Ms. Levine is the case of Karen Bartlett. She took an anti-inflammatory drug and these were in the same family of drugs as cause terrible problems and were taken off the market, the NSAID drugs. She ended up having all these complications including blindness. I think it is just awful and it is described in some detail, page 14 of my testimony. But the defense put up by the company was—required 50 pretrial motions, 50 motions during trial. She had to hire four expert witnesses, a pharmacologist, a burn surgeon, economist, a life care planner and then there was another 50 post trial motions after the verdict came in. Now, no rational lawyer could take that case given the enormous amount of noneconomic damages.

Mr. DINGELL. First off the preparing of the Briefs and the appearing of the filing of the papers and paying witness fees and a wide array of other things, the cost of that had to be astronomical.

Mr. WOLFMAN. Right. And so—and yes she got a significant noneconomic damage award, $16 million, but she is going to live blind her whole life. But the point is is that no rational lawyer knew the result going in, no rational lawyer would take that meritorious case if the limit was $250,000. It is very—it is much easier to attack these kind of awards after the fact and that is the economic problem, the economic problem in looking at it from an after the fact perspective.

Mr. DINGELL. Thank you very much. Now, Dr. Kachalia, you work as a physician at Brigham and Women's Hospital and Harvard Medical School. I am interested in your perspective on this legislation. Does capping of liability of pharmaceutical companies protect physicians from lawsuits?

Mr. KACHALIA. So, the question is in regard to how I feel about the capping with the?

Mr. DINGELL. Yes, does it—does capping of the liability protect you from lawsuits? Yes or no.

Mr. KACHALIA. Well, if you look at the data here, it seems that the capping liability does not seem to lower the number of claims, so it may not protect us from lawsuits.

Mr. DINGELL. Just—I have limited time. Yes or no?

Mr. KACHALIA. No.

Mr. DINGELL. All right, it seems that making drug companies less responsible would not help doctors. With—is it your opinion that this would interfere with your deciding what medication is best for your patient? Yes or no?

Mr. KACHALIA. Is my question what—I am sorry. Could you repeat the question one more time?

Mr. DINGELL. Well, it may-it is my view that capping of these risks may actually encourage drug companies to withhold safety data that you could use to best determine what medication is necessary for your patient. Is that a correct assumption on my part or not?

Mr. KACHALIA. I mean it is a possibility any time you cap a company's liability.

Mr. DINGELL. Thank you. Thank you. Now, well, thank you. I notice my time is up. Thank you, Mr. Chairman.

Mr. PITTS. Chair thanks gentleman. The chair will now recognize the Vice-Chair of the Full Committee, gentlewoman from North Carolina Mrs. Myrick for 5 minutes.

Mrs. MYRICK. Thank you, Mr. Chairman. I would like to ask a question to Doctors Tippett and Hollier. Is that correct? Can you speak to the savings to the overall system that would result if a national medical liability law like H.R. 5 went into effect? And I ask that because there have been estimates that defensive medicine costs our Nation up to 200 billion a year. And according to the Congressional Budget Office's recent publication Reducing the Deficit Spending and Revenue Options, comprehensive medical liability reform would reduce the budget deficit by $62 billion over 10 years. Dr. Tippett, you want to?

Mr. TIPPETT. Well, I think that—I think that figure tells us that it is difficult to quantitate the exact amount. And I can only speak to my own personal knowledge. I see it happen every day in which tests are ordered that as I said earlier if given proper time if you weren't forced to do so because of your fears that someday if you didn't think of every possible diagnosis you wouldn't have ordered that test. But maybe I see patients all the time that I am trying to operate on and they have to have a cardiology clearance when everybody knows they don't really need a cardiology clearance but it is because of some mild thing, an EKG. I mean, you could go on and on. There is a huge cost and I see every day that increases the cost to you and me and to everyone else who tries to pay but because of a fear of being sued.

Mrs. MYRICK. Dr. Hollier?

Ms. HOLLIER. Representative Myrick, I think H.R. 5 would produce important cost savings. What we have seen in Texas after the passage of liability reform is that a number of healthcare systems had had significant liability savings and they have reinvested those savings in new technology, in patient care, and in patient safety initiatives.

Mrs. MYRICK. Do you think the current medical professional liability system makes you a better or a safer doctor by acting as an incentive to practice good medicine? Both of you again.

Mr. TIPPETT. Shall I go first? Well, I think the perfect example and I have heard over and over today how if you get—have these lawsuits then it is going to get rid of the bad doctors in the system. And I think about a pole that we just did among the leaders of neurosurgery in the United States. One hundred of our best cream of the cream leadership in neurosurgery almost all of them academics, 25 percent had been sued between four and seven times for liability. Twenty-five percent—does that mean we need to get rid of all of those 25 percent? Are they bad doctors? Well, obviously not. They handle the complex cases. They take care of the most difficult patients. It is absurd.

Mrs. MYRICK. Yes, that is a challenge in our community, too with our neurosurgeons in particular when—because it is a large hospital that does handle very complicated cases and not just—I mean, nothing is run of the mill when it comes to your brain and neurology et cetera, but it is a real concern. And we are seeing people who are—some of my friends who are in their late, maybe mid-50s and they are telling me over and over again both in OB–GYN and neurology or neurosurgeons that they are going to retire and we are losing—we stand a really strong shot of losing some really good top notch doctors. And doesn't mean that others will take their place, but they are telling me that the younger people aren't coming into their professions. And so there is this you know, what are we going to do to service the population? And that really is where I am coming from when I talk about is there a way to bring this under control so we don't have some of the so called defensive medicine. I appreciate your time and being here today. Thank you all. And I yield back.

Mr. PITTS. Chair thanks——

Mr. BURGESS. Will you yield?

Mr. PITTS. Go ahead.

Mrs. MYRICK. Yes.

Mr. BURGESS. I thank the gentlelady for yielding. Ms. Doroshow, I need to ask you a question about your testimony about McAllen, Texas. I am aware of Dr. Gandhi's article. I don't know if you are aware and I apologize for not having it here, but he has written a subsequent article where he questions some of his own conclusions on that. But because of the article that Dr. Gandhi wrote a couple of years ago I went to McAllen, Texas, and visited with the doctors down there. The question before me was are doctors in McAllen, Texas over utilizing in order to overbill Medicare? And I think what Dr. Gandhi thought—found in his subsequent relook was that it is the publicly financed systems of medical care, Medicare, Medicaid, SCHIP which seem to be prone to this type of difficulty. You rarely see Aetna, Cigna, and United sending wheelchairs to patients who don't need them. So something about the precertification process was helpful there. But the other thing and the reason that medical liability reform was important in the equation was nobody practiced in McAllen prior to 2003. The reason there are so many urological procedures done now in McAllen is they hadn't had a urologist for over a decade. There was a lot of

pathology that had gone undiagnosed and untreated. So it is not just a simple equation as these sometimes draw. The President I know ahs made a big deal of this that Texas proves that medical liability reform does not bring down costs. I would say those two statements are true, true, and unrelated. McAllen is a different location because of some of the problems that were brought because of medical liability. Thank you, Mr. Chairman. I will yield back.

Mr. PITTS. Chair thanks the gentleman and recognizes the gentleman from Kentucky, Mr. Whitfield, for 5 minutes for questions.

Mr. WHITFIELD. Thank you, Mr. Chairman. I want to thank the witnesses for being here today. We appreciate your taking time to discuss this with us. Since I was not here, maybe you have already covered this and if you have that will be fine, but it is my understanding that many medical students when they are looking for their specialty that one of the considerations that they look at is liability. And we know that a large percentage of OB–GYN physicians are sued. We know that neurosurgeons are sued and Dr. Hollier, you responded to that. Would you agree that that is an issue with—I mean, what I am concerned about we may be getting in some specialty areas that may have a shortage in the future perhaps.

Ms. HOLLIER. It is an important concern. I have been counseling medical students in conjunction with UT Houston Medical School for a number of years both before and after the liability reforms in Texas. Before the reforms, one issue that always came up in speaking with medical students was their concern about entering the field of obstetrics because of the medical liability. They were seeing practicing OB–GYNs having to close their offices and stop practicing obstetrics at very young ages and that is not a future that they wanted.

After the medical liability reforms, my counseling sessions are very different and medical students have a renewed interest in our specialty preserving the healthcare limit for the future.

Mr. WHITFIELD. Dr. Burgess, I would be happy to yield additional time if you would like it.

Mr. BURGESS. And I thank the gentleman for yielding. Dr. Tippett, you were starting to talk about patient safety a moment ago and how the impact of medical liability reform may in fact advance the cause of patient safety and just like you, I mean, I can recall multiple anecdotes from the past. But one of the most striking for me was my very first year in Congress. I wasn't on the Health Subcommittee of Energy and Commerce, I was on the Transportation Committee, because that is where doctors go when they come to Congress. And the chairman at that time was a gentleman from Alaska and one afternoon I found myself in Nome, Alaska, with the chairman and he had sort of a Chamber of Commerce luncheon. I was seated at a table of doctors and they were all excited about the fact that we might pass medical liability reform in Washington. And I said, so is it a problem here? They said it is an enormous problem. So I asked the gentleman sitting next to me what type of medicine do you practice? He said well, just like you I am an OB–GYN. And he said we can't get an anesthesiologist up here because of the problems with medical liability. I said wait a minute, Bubba, you can't practice OB–GYN without an anesthe-

siologist. What—forget an epidural in labor—what do you do if you have to do a C-section? He said we have to get them on an air ambulance and get them to Anchorage. I mean, that is 400 miles away, and this was in the middle of the summer and some of the worst weather I had ever seen in my life. I got to believe it is worse in the winter. How is patient safety advanced by putting a mother on an air ambulance to Anchorage, Alaska, from Nome? I mean, that is the sort of thing we are talking about. Is that not correct?

Mr. TIPPETT. Yes, sir, it certainly is. And you can go on from there. The trauma system in our country is so dependent on immediate, immediate availability of the critical specialties. You have seen that in your own body here in the last few months of what happens when you have the immediate availability of a neurosurgeon and others to take care of something like a head injury or a gunshot wound. If that goes away then you lose all of this. I applaud my dermatology colleagues but they really can't take care of a blunt gunshot wound to the brain when it comes in. And when we have medical students who are purely interested in going to dermatology now it really worries me. And when you have neurosurgeons who 68 percent of them are not doing Pediatric neurosurgery anymore it is not because they don't want to. It is because of the long problems that you have with statute of limitations and other things with taking care of child. It is a travesty.

Mr. BURGESS. Yes, sir, and you know in Texas right before we passed the reforms in 2003, the Dallas-Fort Worth area lost one of its two neurosurgeons because of the renewal for their liability premium. It was well into six figures. It was a fantastic amount of money. He said I can't do it. I am not. I am going to go work, get an academic medical center somewhere. We had one neurosurgeon. It put the entire trauma system of the Dallas-Fort Worth Metroplex at risk because one guy cannot cover an area of four million people 24 hours a day, seven days a week. And we were at risk of losing our trauma designation. So it—I mean, these are real world—patient safety isn't going to be advanced if that happens. Is that correct?

Mr. TIPPETT. That is absolutely correct. I can cite—I mean half the neurosurgeons in South Florida for example can't afford to have liability insurance. As we said here today they are having to self insure. And I talk to neurosurgeon after neurosurgeon. A young one goes down to Miami to practice and says I just can't take the emotional stress of not having liability. I mean you can imagine with the hatchet hanging over your head every day you just can't take it. And you could go on and on around the country. We are at great risk not only of having young people not go into the various specialties, but also having them limit their practice after they do. We have a big problem in neurosurgery now with neurosurgeons saying I am just going to become a spine surgeon. I am not going to take care of cranial problems. And it is purely because of this and other issues which we are talking about something to try to do something to correct that right now.

I keep hearing all of this about we don't have any evidence and I keep—I am a country neurosurgeon, but it looks to me like 35 years of experience in California is a pretty good example of how things work. And I haven't really seen a lot patient people leave

California because they didn't get $250,000 cap. And I also haven't seen plaintiffs' attorneys go away in California in the last 35 years. They all seem to be doing pretty well.

Mr. PITTS. The gentleman's time is expired. Chair recognizes gentleman from New Jersey, Mr. Lance for 5 minutes.

Mr. LANCE. Thank you very much. Let me just say that in New Jersey we really do not have medical malpractice insurance reform the way it exists in States like California and Texas. And we have among the highest health insurance costs in the nation. In some surveys we are really at the top which is of course extremely expensive for everyone—our residents and the business community. And this is an issue of great importance and I support what we are trying to do here. And I know that Dr. Burgess has other questions and Mr. Chairman, I would ask that my term-time be given to Dr. Burgess.

Mr. BURGESS. I thank the gentleman for yielding. Mr. Wolfman, you cite some rather dramatic examples in your testimony. I got to tell you administration of Phenergan entering a course of a therapeutic event is something I saw I don't know how many tens of thousands of times during my professional career. True enough there can be a rare but severe reaction which is what you mentioned in your papers. Stephens-Johnsons syndrome, a fixed drug eruption doesn't happen very often. When it does it is so dramatic you will never forget it. Is it possible to construct a system to help people who are harmed by the extremely rare outliers and not punish everyone else along the way?

Mr. WOLFMAN. I don't know the answer to, you know, everything that you might do to construct a person—perfect health care system with a perfect set of incentives, but let me just say this. Going back to the Phenergan issue, no question Phenergan is used, you know frequently. It was the method of administration that wasn't warned against. The company had evidence——

Mr. BURGESS. But to be fair there and we have another OB–GYN on the panel. I mean, I cannot tell you how many times I ordered the administration of Demerol and Phenergan intravenously for someone who was in pain.

Mr. WOLFMAN. Well, the FDA says it is not a good idea and the—one of the competitors of Wyeth said it was not—shouldn't be done, either. But I—the point is, is that these cases—I tried to be fair in my testimony. I put out five examples. You could use many others. Two of them went to defendants' verdicts. You know, the point was that these were all cases that were, you know, reasonable cases to the ball—all cases in the ballpark. None of those cases would have been brought if there was a $250,000 cap.

Mr. BURGESS. But it was reasonable not to bring a case, but these are cases that represented the extremes of incidents in medical practice.

Mr. WOLFMAN. Right.

Mr. BURGESS. Should we be legislating to the extreme? Is that the type of—is that the type of system that will yield the best, most cost effective result?

Mr. WOLFMAN. Well, I think the—again there is two questions there. One is, are you creating the proper incentives for the physicians? Also are you properly compensating the victim of the prob-

lem? I don't agree and we could be here all day saying that these were extreme situations. I think in these instances, for instance in Ms. Levine's situation you had a potentially very, very serious side effect that was greatly augmented by the way it was administered and she came into the hospital with a headache. So the risk benefit wasn't appropriately calculated in that situation because the company failed to warn about the method of administration.

Mr. BURGESS. Let me just interrupt you a second to Hollier—do you still give Demerol and Phenergan to women in labor?

Ms. HOLLIER. Yes, sir.

Mr. BURGESS. And is it sometimes administered through an IV?

Ms. HOLLIER. Yes, sir.

Mr. BURGESS. OK. I just wanted to make sure I hadn't missed——

Mr. WOLFMAN. No, no, no——

Mr. BURGESS. Shouldn't—hadn't missed something in the last 8 years.

Mr. WOLFMAN. No——

Mr. BURGESS. I appreciate the continuing of this case and I am going to mark that down as one of my——

Mr. WOLFMAN. With all respect, that—with all respect, that was the problem. Ms. Levine didn't get it through an IV. The testimony was clear even from the defendant's witnesses that if it had been administered through IV it was virtually certain that she would not have been harmed.

Mr. BURGESS. Let me ask you a question because you seem to have a beef with the Food and Drug Administration. And I will just tell you right now we are up against a significant problem in this country. The Food and Drug Administration has gotten so risk adverse that virtually nothing can get through. We heard from medical device manufacturers here in one of our other subcommittees the other day. There is an enormous amount of human suffering and the potential for curing disease that is essentially being left on the shelf in the pipeline going to other countries. Some panel—we have to work together to find a way to stop this top-heavy, top-down, centralized punitive activity that is going on at the Food and Drug Administration. And unfortunately from some of the testimony you provide us here today I don't see us moving in that direction. We have got to work past this. These are not people who are bringing devices to the market that want to harm someone. These are not companies that are developing spending millions of dollars on developing new medications to harm someone. They are trying to alleviate human suffering and cure problems and prevent problems, and we have made the landscape almost unnavigable for particularly the small device manufacturers. But I will speak with the pharmaceutical industry. And thank you, Mr. Chairman. I will yield back.

Mr. PITTS. Gentleman's time is expired. This has been an excellent panel. In conclusion I would like to thank all of the witnesses and the Members that participated in today's hearing. And I remind Members that they have 10 business days to submit questions for the record. Members should submit their questions by the close of business on April 20, and I ask that the witnesses all agree

to respond promptly to these questions. Thank you again for the excellent testimony, and this subcommittee is now adjourned.

[Whereupon, at 11:52 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement
Chairman Fred Upton
Subcommittee on Health Hearing on Medical Liability

Wednesday, April 6, 2011

Thank you for holding today's hearing on the cost of the medical liability system and proposals for reforming the system. I also would like to thank the witnesses for testifying today on this important subject.

First, the bad news. We have a dysfunctional medical liability system in this country, and this system has imperiled patient access and imposed tremendous costs, both on our health system and on the economy at large. The system has forced doctors out of practicing in certain specialties; it has caused trauma centers to close; and it has forced pregnant women to drive hours to find an obstetrician. The medical liability system imposes costs on the overall health system because of defensive

medicine. Studies have shown that defensive medicine costs our country approximately $200 billion a year. Because frivolous lawsuits drive up health care costs, they contribute to the difficulties faced by employers who struggle to remain profitable and create new jobs.

Now, the good news. Although Obamacare failed to meaningfully address medical liability reform and in fact may have made it worse, we have a solution for solving the problem. States that have adopted comprehensive medical liability reform have solved the problem in their states. Texas provides a great example. Because Texas adopted comprehensive reform in 2003, the state now has more obstetricians and lower medical liability premiums. It is time to bring comprehensive reform to the whole nation so we can solve this problem for our nation's patients and doctors.

I thank the Chairman for holding this hearing and taking the first step to fixing our nation's dysfunctional medical liability system. I yield back.

THE HONORABLE FRANK PALLONE, JR.

SUBCOMMITTEE ON HEALTH HEARING

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

Opening Statement

April 5, 2011

Mr. Chairman, I want to thank you for holding a hearing on something other than repealing the Affordable Care Act.

Although I don't support H.R. 5 in its current form, I do understand that medical malpractice and liability is a very real problem for doctors in my home state and the country. I have met with physicians who are faced with skyrocketing premiums, declining reimbursement rates and increasing overheard costs – which coupled together, are putting many of them out of business.

But let's not forget that medical malpractice reform also affects patients. Any true reform must take a balanced approach and include protections for the legal rights of patients. Medical malpractice in the Unites States has devastating consequences. It is the sixth leading cause of death in this country. In addition, a November 2010 study by the Office of the Inspector General of the Department of Health and Human services found that approximately 1 in 7 hospital patients experience a medical error, 44 percent of which are preventable, and these errors cost Medicare $4.4 billion per year.

That is why I supported the provisions of the Affordable Care Act which included five-year demonstration grants to states to develop, implement and evaluate alternatives to current tort litigations. These grants will be given to states that attempt to reduce medical errors and improve access to liability insurance. But I think we can all agree that more needs to be done.

Now, this is not the first time the Subcommittee has considered this important topic but we have made very little progress at reaching a solution. Over the years, there has been little effort on the part of Republicans to reach across the aisle and work with Democrats on a satisfactory solution to medical liability reform.

We've been through this same debate for years. This marks the ninth time that the House has considered a "medical malpractice" bill and the fifth time it has taken up this identical legislation. But time and again the measures we consider contain the areas in which we remain divided.

Although it's described as a "medical malpractice" measure, the bill before us today extends far beyond the field of malpractice liability, extending new tort protections to nursing homes, pharmaceutical, device and insurance companies and others. And I just simply cannot support a measure that has such broad implications.

Additionally, we cannot continue to consider the ridiculously low and arbitrary cap on non-economic damages. I think we all realistically know that $250,000 is an unworkable and unrealistic number. I even think that some of our doctors would agree and would be willing to negotiate on that number. Look, you cannot address true malpractice reform without controlling the rising premiums for insurance and putting a cap on non-economic and punitive damages does nothing to rein in those rising premiums.

We all can agree on the goal of improving patient safety and reducing medical errors. Furthermore, we all can agree that we need to reduce frivolous lawsuits. The more time we spend debating these same unworkable tenets of what the Majority sees as medical malpractice reform, doctors are closing up their practices and patients experience difficulties in accessing specialty care.

Surely, we can come to an agreement on the best way to accomplish these goals. H.R. 5 is not the golden ticket. I ask my colleagues to work with me on finding the right solution.

Thank you.

Statement from Representative John D. Dingell
House Committee on Energy and Commerce
Subcommittee on Health
"The Cost of the Medical Liability System Proposals for Reform, including H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011"
April 6, 2011

- Mr. Chairman, I thank you for holding today's hearing on a topic I find to be very important.

- We have heard President Obama, from Members on both sides of the aisle, doctors and patients alike, as well as other stakeholders that medical malpractice reform should be part of a broader discussion on our health system.

- But like every other piece of legislation we have seen from the Majority – H.R. 5 is a flawed attempt at medical malpractice reform.

- It provides special protections to drug and medical device companies, broadly preempts state laws designed to protect consumers and patients, limits the time period under which an injured patients can file a claim, and caps non-economic damages to $250,000.

- I have long believed that the process of good legislating should begin in the middle, which is why I believe we can and we must find a third way solution.

- The Department of Health and Human Services have launched the Patient Safety and Medical Liability initiative to increase patient safety, foster better communication between physicians and patients, and reduce liability premiums.

- In June 2010 this initiative made $25 million available for both planning and demonstration grants to research and test models for patient safety and medical liability reform.

- I applaud this initial step because I believe strongly that there is a lot we can learn from institutions across the country who have decided to lead the way in medical liability reform.

- I know that institutions can help lead the way from the good work of one of my own constituents - The University of Michigan Health Care system.

- From 1996 to 2006, the University of Michigan Health Care system saw malpractice claims reduced by 55 percent as a result of their policy of full disclosure and compensation for medical claims.

- UofM also saw a 61 percent decrease in legal defense costs. This common sense policy has not only had proven results, but it has encouraged and developed a change in the culture at UofM that puts honesty and patient safety first.

- While I look forward to seeing the results of these demonstration projects, I believe that we should use today's hearing not as a forum to promote H.R. 5's flawed attempt at reform, but rather as an opportunity to explore ways to work together in a bipartisan manner towards careful, balanced and targeted legislation that will serve the interests of both physicians and their patients, not medical malpractice insurance companies.

- I hope that today's dialogue can continue and that my friends on the other side of the aisle will work with me to achieve this goal.

I

112TH CONGRESS
1ST SESSION

H. R. 5

To improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 24, 2011

Mr. GINGREY of Georgia (for himself, Mr. DAVID SCOTT of Georgia, and Mr. SMITH of Texas) introduced the following bill; which was referred to the Committee on the Judiciary, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems

existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this Act to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions

have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of "defensive medicine" and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 3. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years

after the date of manifestation of injury unless tolled for any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 4. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this Act shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages,

if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a sepa-

rate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 5. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) Forty percent of the first $50,000 recovered by the claimant(s).

(2) Thirty-three and one-third percent of the next $50,000 recovered by the claimant(s).

(3) Twenty-five percent of the next $500,000 recovered by the claimant(s).

(4) Fifteen percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 6. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health

care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 7. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant

will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

(2) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

(c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT COMPLY WITH FDA STANDARDS.—

(1) IN GENERAL.—

(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product,

based on a claim that such product caused the claimant's harm where—

(i)(I) such medical product was subject to premarket approval, clearance, or licensure by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such medical product which caused the claimant's harm or the adequacy of the packaging or labeling of such medical product; and

(II) such medical product was so approved, cleared, or licensed; or

(ii) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with appli-

cable Food and Drug Administration statutes and regulations.

(B) RULE OF CONSTRUCTION.—Subparagraph (A) may not be construed as establishing the obligation of the Food and Drug Administration to demonstrate affirmatively that a manufacturer, distributor, or supplier referred to in such subparagraph meets any of the conditions described in such subparagraph.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a medical product approved, licensed, or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product. Nothing in this paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims against the manufacturer, distributor, or product seller of such medical product.

(3) PACKAGING.—In a health care lawsuit for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required

to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially out of compliance with such regulations.

(4) EXCEPTION.—Paragraph (1) shall not apply in any health care lawsuit in which—

(A) a person, before or after premarket approval, clearance, or licensure of such medical product, knowingly misrepresented to or withheld from the Food and Drug Administration information that is required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and is causally related to the harm which the claimant allegedly suffered; or

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or main-

taining approval, clearance, or licensure of such medical product.

SEC. 8. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments, in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this Act.

SEC. 9. DEFINITIONS.

In this Act:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term "alternative dispute resolution system" or "ADR" means a system that provides for the resolution of health care lawsuits in a man-

ner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term "claimant" means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term "collateral source benefits" means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income-disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term "compensatory damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term "compensatory damages" includes economic damages and non-

economic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term "contingent fee" includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term "economic damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term "health care lawsuit" means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organi-

zation, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term "health care liability action" means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term "health care liability claim" means a demand by any person, whether or not pursuant to ADR,

against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term "health care organization" means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term "health care provider" means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(12) HEALTH CARE GOODS OR SERVICES.—The term "health care goods or services" means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(13) MALICIOUS INTENT TO INJURE.—The term "malicious intent to injure" means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) MEDICAL PRODUCT.—The term "medical product" means a drug, device, or biological product intended for humans, and the terms "drug", "device", and "biological product" have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(15) NONECONOMIC DAMAGES.—The term "noneconomic damages" means damages for phys-

ical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) PUNITIVE DAMAGES.—The term "punitive damages" means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term "recovery" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term "State" means each of the several States, the District of Columbia, the

Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 10. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this Act does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this Act in conflict with a rule of law of such title XXI shall not apply to such action.

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this Act or otherwise applicable law (as determined under this Act) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this Act shall be deemed to affect

any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 11. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this Act preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this Act. The provisions governing health care lawsuits set forth in this Act supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this Act; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this Act (including

State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This Act shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this Act or create a cause of action.

(c) STATE FLEXIBILITY.—No provision of this Act shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this Act, notwithstanding section 4(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

This Act shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that

any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

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April 6, 2011

U.S. House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

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

The Physician Insurers Association of America (PIAA) commends Chairman Pitts, Ranking Member Pallone, and the distinguished members of the Subcommittee on Health for holding this hearing on medical professional liability (MPL) reform. Reform is clearly a critical issue for our nation's healthcare system, as it has been for many years. And it is also a critical issue for our federal budget. Therefore, it is imperative that it remain at the forefront of Congress' attention.

- **It Is Doctors Who Insure Doctors**
  The majority of doctors in the United States are insured by physician-owned and/or -operated specialty insurers, whose primary mission is to provide access to dependable and affordable liability coverage.

The PIAA is a trade association whose 58 domestic medical professional liability (MPL) insurers collectively insure approximately 60% of America's practicing physicians, hundreds of hospitals, and thousands of other healthcare providers (including dentists, podiatrists, and numerous other specialties). Unlike the multi-line commercial carriers, MPL insurance is the primary focus of the PIAA companies. The PIAA is also unique in that its member companies are *owned and/or operated by the same physicians and other healthcare providers that they insure*. This gives us a dual perspective: that of the MPL insurers and also of the healthcare providers that our members insure. As such, the solutions sought by the PIAA are ones that serve the best interests of MPL insurers, healthcare providers, and their patients as well.

This fact highlights the gross mischaracterization of the industry that is frequently made by opponents of MPL reform. While the personal injury bar regularly repeats its accusation that increases in insurance premiums result from insurers' price-gouging, the physicians who are insured by these companies know that these arguments are patently false. In order to believe that insurers are overcharging for premiums, one must also believe that the physician-owners of these companies are intentionally choosing to overcharge *themselves*. This notion defies simple common sense. Why would a physician who can set the price for a product that he also consumes opt to make that product unnecessarily expensive? The answer is, that they wouldn't—and they don't. While inherent volatility of the insurance cycle does affect insurers with relatively better and poorer years, overall, any profits that PIAA member companies make inure to the benefit of their policyholders.

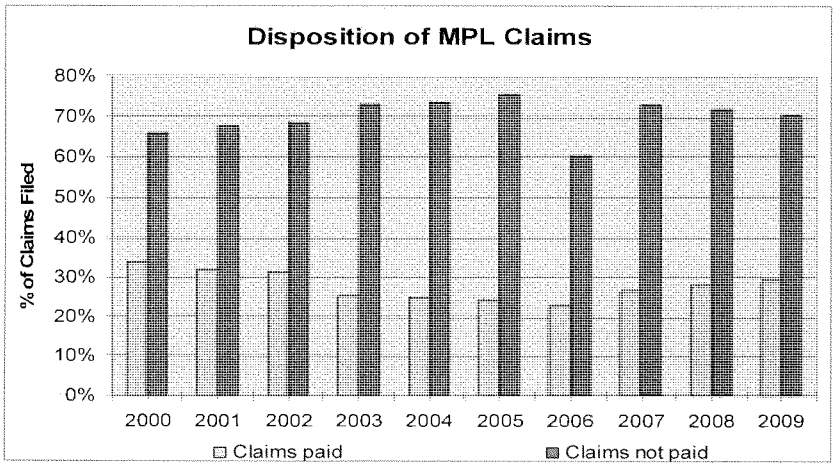
- **The Medical Liability System Is Broken**
  Neither doctors nor patients benefit from a system of rampant litigation. Only lawyers do, and thus they support a system that is fundamentally flawed and inefficient.

Our current system for assessing MPL is seriously flawed. Injured patients may have to wait for four years or more, on average, for their claim to be resolved after an alleged injury. And then, when they are compensated, substantial sums of *their* award/settlement money go to pay attorney fees and other litigation expenses, thereby depriving them of the funds that had been intended for their recovery. Unfortunately, no systematic data exists, but, it is widely believed that 40% or more of awards and settlements is paid to the plaintiff attorney, who also passes along the costs of prosecuting the claim. At the same time, doctors may be needlessly dragged through lengthy litigation, their reputations tarnished even when it is subsequently proven that they did nothing amiss (which is the case more than 80% of the time for claims resolved at verdict). Meanwhile,

personal injury lawyers insist there is nothing wrong with a system that wrongfully accuses doctors of negligence 70% of the time, and wastes years and vast sums of money resolving the remaining claims. While doctors, patients, and MPL insurers seek to fix the system, the personal injury bar, which stands to profit from it, steadfastly advocates for the status quo.

- **Most Medical Liability Claims Have No Merit**
  Every year, of all claims filed, more than twice as many are proven to have no substance, as compared with those that end in a payment. Nonetheless, the persisting accumulation of litigation needlessly clogs the courts and subjects healthcare providers to unnecessary stress and time away from caring for patients.

The overwhelming majority of claims that are filed against healthcare providers are demonstrated to have no merit and thus are dropped, withdrawn, or dismissed with no payment being made. According to the latest figures, over the last ten years, an average of 64% of all filed claims were dispensed in this manner. Even when a claim passes initial scrutiny, closer inspection still finds many that lack merit. Only 15% of claims that end in a jury verdict result in a verdict in favor of the plaintiff. The end result is that 70% of all claims filed are demonstrated to lack merit and result in no payment to the claimant.[1] (See chart.) These claims take a substantial toll on the physicians who are wrongly charged, in terms of emotional distress, loss of reputation, and time away from their practice.



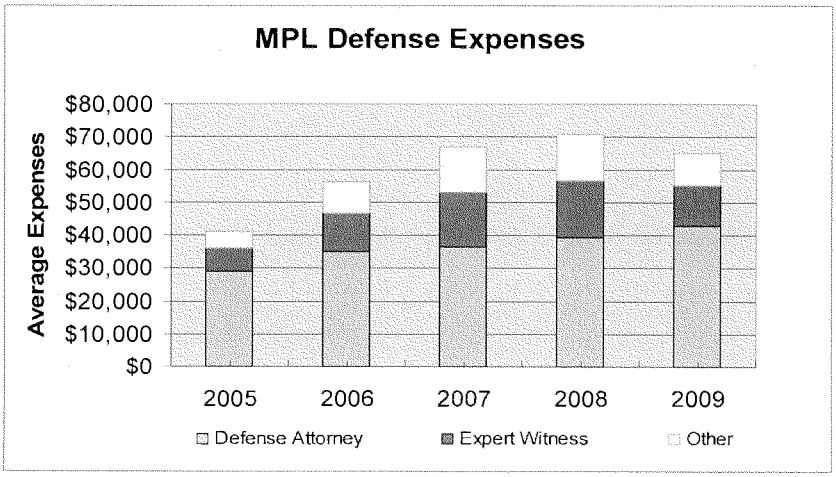
In addition, these meritless claims extract a significant financial toll on the MPL system. The average defense costs alone for a claim that is dropped, withdrawn, or dismissed total more than $26,000.[2] That's $26,000 for a claim shown to have had no merit. If a claim does proceed to

[1] Physician Insurers Association of America 2010 Claim Trend Analysis, 6c.
[2] *Id.*, at 6b-4.

trial, it may take as much as $140,000[3] to defend the doctor in those cases where the jury eventually finds that the claim lacks merit. These are funds that could otherwise have been used to pay a legitimate claim, support new patient safety initiatives, or provide a premium reduction. Instead, these healthcare dollars are simply squandered by a system that personal injury lawyers still maintain is effective.

- **Defense Costs Are Skyrocketing**
  MPL insurers must also contend with dramatically increasing costs to defend claims. These expenses are passed along to policyholders, thus increasing the costs for all doctors to do business, and increasing the overall cost of healthcare.

From 2005 to 2009, expert witness average expenses for a healthcare provider's defense increased by 78%, while defense attorney average fees increased by nearly 50%.[4] (See chart.) This is without factoring in whether or not a claim even has merit (costs for legitimate claims are substantially higher than those for meritless claims). These costs are then passed along to all healthcare providers, as higher MPL premiums. If something is not done to fix the MPL system, these costs will continue to rise.



- **Reforming the MPL System Will Help Patients**
  If MPL reforms are enacted, injured patients will be compensated more quickly and will receive a higher percentage of awards to cover their damages.

One claim made by the personal injury bar is that proponents of tort reform want to prevent severely injured patients from receiving compensation for their losses. In fact, nothing could be

[3] *Id.*, at 6a-4.
[4] *Id.*, at 5b.

further from the truth. The PIAA has never advocated for capping total compensation to victims of medical negligence, and in fact, we recommend reforms that specifically allow for full compensation of a victim's total economic losses.

However, we do advocate specific monetary caps on non-economic damages. Capping damages for pain and suffering—whose monetary value is obviously subjective and inherently immeasurable—in no way limits a victim's ability to be compensated for their actual economic losses. Lost wages, medical and rehabilitative expenses, in-home care services, etc., would still be fully compensated, as economic damages. A cap on non-economic damages brings a crucial measure of predictability to the MPL system. It lets patients and insurers evaluate the full extent of losses more quickly and accurately, and determine an arrangement for appropriate compensation. In addition, contrary to the trial bar's claims, caps on non-economic damages ensure that those with similar claims will be treated similarly throughout the MPL system—regardless of race, gender, age, work status or geographic location—thus ensuring equity in awards and settlements.

- **Tort Reform Will Put More Money in Patients' Hands**
  Personal injury lawyers retain a high percentage of the money that is intended to compensate victims of negligence. Restrictions on what attorneys could keep for themselves would help ensure that victims are fully compensated.

Estimates indicate that the contingency fee in an MPL claim is approximately 40% or more of the collected settlement or award. In addition, the attorney may also deduct expense costs, as well as additional litigation costs after assessing the contingency fee. So, a legitimate victim may receive as little as half of the settlement or award that had been determined as the requisite compensation for his loss. Unfortunately, we can only estimate this figure because, while everything is known about the defendant's costs because of provisions in state insurance regulations, nothing certain is known about the contingency fee practices of plaintiff attorneys except the little information gathered on an anecdotal basis. A structured fee arrangement, calculated according to the amount of the award, will ensure that more money goes to the plaintiff when appropriate—not into the coffers of his lawyer.

- **Federal Action Is Needed**
  State-by-state disparities in our MPL system result in reduced access to care, as physicians seek to avoid the most litigious states in favor of those that create a more conducive environment for practicing medicine. A federal template is needed to ensure that patients and doctors across the nation will operate within a similar framework when dealing with MPL claims. At the same time, it is possible to ensure that states have the flexibility necessary to address their unique circumstances.

In states like California and Texas, we have seen the gratifying success of MPL reform in maintaining or improving access to care and providing for a stable MPL insurance market. Unfortunately, in too many other states jurists prevented such legislation from taking effect. Last year, both Georgia and Illinois had vital reforms struck down. In Wisconsin, the court created an entirely new standard of review to justify its politically-influenced decision to overturn reforms it

had previously upheld.[5] Without federal reforms, too many states will continue to see the will of the people denied and critical MPL reforms blocked.

It is vital to note that the federal reforms we recommend not only protect the citizen's rights to adopt MPL reforms in their states, but also protect a state's right to establish its own unique reforms. The bipartisan legislation under discussion today (H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011) would merely establish a baseline of reform necessary to ensure a more stable MPL environment and maintain access to healthcare. In regards to most of the reform provisions now included in the legislation, states would be free to enact stronger legislation if their legislatures felt doing so was appropriate. For caps on noneconomic damages, the most widely debated reform, states would be free to set their cap at any amount or establish no cap at all. Far from infringing on states' rights, H.R. 5 clearly respects those rights while recognizing that MPL reform is a nationwide necessity.

- **Conclusion—the Status Quo Is Untenable**
  Our MPL system is broken. It does not work for the doctors it is supposed to oversee, nor does it serve the injured patients whom it is intended to help. Doing nothing is not an option.

Mr. Chairman, to put it bluntly, the current system of medical professional liability is not working. The average claim takes more than four years to resolve, and more than 70% of claims filed are found to have no merit at all and result in no payment to the plaintiff. Of the claims that are resolved, it is estimated that 50% of an award or settlement that is supposed to compensate a victim for his/her losses actually goes to pay attorney fees and other litigation costs. Some consumer groups, not fully grasping all of the complexities of MPL coverage and patient compensation, join the trial bar in advocating for the status quo. However, as the PIAA has explained herein, it is time for a change—and by this we do not mean tinkering around the edges. We do not need demonstrations projects that will not add new information about what is needed for MPL reform as were those in the Patient Protection and Affordable Care Act. We need federal reforms based on the demonstrable successes states such as California and Texas have achieved in overhauling their MPL systems.

[5] Ferdon v. Wisconsin Patients Compensation Fund, 2005 WI 125 (2005)

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