

TESTIMONY OF

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WASHINGTON, D.C.**

BEFORE THE

**SUBCOMMITTEE ON HUMAN RIGHTS AND WELLNESS
OF THE COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES**

REGARDING:

***Dying for Help: Are Patients Needlessly Suffering Due to the High Cost of
Medical Liability Insurance?***

ON

OCTOBER 1, 2003

Mr. Chairman, Representative Watson, and Members of the Subcommittee, thank you for inviting me to speak today on behalf of the American Tort Reform Association (ATRA).

ATRA is a Washington, DC-based membership association of more than 300 large and small businesses, physician groups, nonprofits, and trade and professional associations having as its mission the establishment of a predictable, fair, and efficient civil justice system through the enactment of legislation and through public education.

Introduction

There is no doubt that the American healthcare system is the finest in the world. We have the best doctors, hospitals, and medical schools. American pharmaceutical companies are the engine of innovation in creating life-saving medicines. America has conquered polio, developed cures for serious diseases that were once death sentences, and created technologies and therapies that have not only improved the American people's health, but also the world's.

Unfortunately, we also know that our healthcare system costs are a major issue for consumers and elected officials, with annual costs increasing at double digit rates. This increase threatens the very greatness of our healthcare system, and ultimately the American people's access to world class medical care. While elected officials at the federal and state level discuss possible solutions to this problem, be they medical savings accounts or a single-payer healthcare system, one of the contributing factors to the healthcare cost problem is the crisis in our medical liability system. ATRA believes that Congress should consider reforms to our medical liability system as one of the critical elements to reform our healthcare system.

The Problem: The Current Medical Liability System Is Inadequate

An effective medical liability system should provide predictability and fairness, guided by the over-arching principle of fairly compensating those who are truly injured by medical negligence.

Unfortunately, our medical liability system comes up short.

In our system, costs are escalating astronomically. According to *Jury Verdict Research*, a national verdict reporting service, the median medical liability verdict in 2001 was \$1,000,000. The mean verdict was \$3,902,058, an increase of 34 percent from 1998. As a result of this system, it was reported that in 2001 doctors practicing medicine in twelve states saw physicians' insurers raise their rates by more than 25 percent. Eight states saw rate increases by more than 30 percent.¹ As the *Sacramento Bee* correctly noted, healthcare costs and patient access are inextricably linked, "Every dollar in higher awards to people injured in malpractice will mean one less dollar available for care."²

In addition to sharp escalation in costs, however, the medical liability system is highly inefficient.³ Prompt and full compensation to injured plaintiffs are the exception and not the rule. A full 70 percent of medical liability claims result in no payment to the plaintiffs. These claims, on average, cost \$66,767 to adjudicate, further driving up healthcare costs.⁴

In addition to being expensive and inefficient, the system does a poor job of promoting patient safety. Only 1.53 percent of patients injured by medical error file claims and most claims that are filed do not involve medical

¹ See AMERICAN MEDICAL NEWS, January 7, 2002.

² *Opinion*, SACRAMENTO BEE, June 5, 1999, at B6.

³ Fifty-eight cents from every dollar recovered goes to administrative and defense costs, as well as attorney's fees. See COUNCIL OF ECONOMIC ADVISERS, WHO PAYS FOR TORT LIABILITY CLAIMS? AN ECONOMIC ANALYSIS OF THE U.S. TORT LIABILITY SYSTEM 9 (April 2002).

⁴ See Karen Ignagni, *The Malpractice Mess; Runaway Litigation Is Plaguing Doctors and Hampering Patients*, THE CHARLOTTE OBSERVER, January 21, 2002, at 12A.

malpractice.⁵ Such a system plainly fails to serve the interests of all parties to litigation.

Negative Policy Implications of the Status Quo

Doctors routinely order unnecessary tests and procedures to guard against the possibility of litigation in the aftermath of a bad outcome. According to a study published in the *Quarterly Journal of Economics*, the excess cost of defensive medicine contributes \$50 billion annually to the cost of our healthcare system.⁶ Through programs such as Medicare and Medicaid, the federal government pays tens of billions of dollars to pay the costs associated with defensive medicine. According to a recent HHS report, between \$28.6 and \$47.5 billion per year in taxpayer funds is spent indirectly subsidizing this system.⁷ These increased costs in a financially overburdened healthcare system reduces both the access to and quality of healthcare. The root of this problem is an unpredictable litigation system where the volatile nature of jury verdicts provides no clear signals and predictability to healthcare providers and insurers.

Impact On Physicians

The current costs of the litigation system impose burdens on taxpayers and individual physicians. This compromises innovation in delivering improvements to patient safety. The result is a medical liability system that is too costly, offers little deterrent value, and, at best, does little to promote improvements in patient safety. For example, after 25 years of doing biopsies, lumpectomies, mastectomies and other breast surgery, Cleveland General Surgeon Dr. Joan Palomaki closed her practice on June 30, 2001, the day before

⁵ See OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING MEDICAL COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 11 (Jul. 24, 2002) [hereinafter “HHS REPORT (2002)”].

⁶ David Kessler and Mark McClellan, *Do Doctors Practice Defensive Medicine?* QUARTERLY JOURNAL OF ECONOMICS, May 1996, at 387-388.

⁷ See HHS REPORT (2002), *supra* note 5, at 7.

the price she pays for medical liability insurance would have jumped 80 percent, to about \$45,000 a year. Had she chosen to stay in medicine, Dr. Palomaki says she would have had to clock 1,000 office visits - about half a year's work - just to cover the cost of insurance.⁸ And, in Mississippi, Gulf Coast vascular surgeon Dr. Alton Dauterive and his partner closed down their practice after they were scheduled to see their combined premiums double to \$180,000 -- the second year in a row premiums would have doubled.⁹ The irrationality of the system is too often driven by a litigation culture that is motivated by the pursuit of high verdict claims rather than by fair recovery for true medical negligence and the promotion of stability that benefits physicians, insurers, and most importantly, patients.

Patient Access to Healthcare is Compromised by Current Liability System

A survey of physicians showed that over 76 percent believed malpractice litigation affected their ability to provide quality healthcare.¹⁰ According to the American Medical Association (AMA), 19 states are in the midst of a healthcare liability crisis, while another 23 states show problem signs that indicate a crisis is imminent. ATRA believes that this litigation environment has resulted in many physicians stopping the practice of medicine, abandoning high-risk parts of their practices, or moving their practices to other states. President Bush summarized the situation in his State of the Union Address in January saying, "Because of excessive litigation, everybody pays more for health care, and many parts of America are losing fine doctors."¹¹

For example, on July 3, 2002, the only Level-1 trauma center in Las Vegas temporarily closed when trauma surgeons were unable to obtain insurance. As a

⁸ See Roger Mezger, *Insurance Costs Force Doctors To Quit*, THE CLEVELAND PLAIN DEALER, February 18, 2002 at A1.

⁹ See David Tortorano, *Surgeons Set Walkouts Over Insurance*, THE SUN HERALD, January 21, 2003.

¹⁰ See HHS REPORT (2002), *supra* note 5, at 4.

¹¹ *The President's 2003 State of the Union Address, Presented to the U.S. Congress, U.S. Capitol, Washington* (January 28, 2003) (statement of George W. Bush).

result, patients with serious injuries were to be flown to similar facilities in California and Arizona. Fortunately, the center reopened when the Governor temporarily reclassified trauma center physicians as government employees.¹² The Nevada Legislature later enacted modest reforms in response to this situation.

In December 2002, Doctors Hospital of Sarasota (Florida) closed its obstetrics unit. Deliveries were shifted to other area hospitals, including Sarasota Memorial which already had difficulty covering emergency room specialists, such as neurologists.¹³ Statewide, 43 percent of counties in Pennsylvania have reached or are close to reaching a shortage of primary care physicians.¹⁴ These examples are by no means unique; other states, such as Arizona, Georgia, Mississippi, and New Jersey also have experienced problems.

Solution

Fortunately, there are proven policy changes that Congress can enact to abate this liability crisis. These laws can ensure Americans will continue to enjoy high quality medical care. At the same time, these reforms will protect the rights of patients in cases of true medical negligence.

In fact, the solution to the medical liability problem was devised over 25 years ago in California with reforms called the Medical Injury Compensation Reform Act, better known as MICRA. Like much of the United States today, California experienced a medical liability crisis in the early 1970s. By 1972, a sharp increase in litigiousness ensured that California medical malpractice insurance carriers were paying claims well in excess of dollars that they collected

¹² See Joelle Babula, *Liability Concerns: Trauma Center Closes; ERs Gear Up*, LAS VEGAS REVIEW JOURNAL, July 4, 2002, at 1A.

¹³ See Corry Reiss, *Malpractice Debate Now A Blame Game*, SARASOTA HERALD-TRIBUNE, January 13, 2003, at A1.

¹⁴ See Press Release, Pennsylvania Medical Society, *New Study Provides Evidence of Doctors Going, Going Gone from Pennsylvania* (June 11, 2003).

in premiums. The crisis continued to worsen. By 1975, two major malpractice carriers in Southern California notified physicians that their coverage would not be renewed. At the same time, another insurer announced that premiums for Northern California physicians would increase by 380 percent.¹⁵ In response to the crisis, then-Governor Jerry Brown called the California Legislature into special session to develop solutions. The result was MICRA.

Signed by Governor Brown in 1975, MICRA's centerpiece is a single cap of \$250,000 on noneconomic damages.¹⁶ Other provisions of MICRA include: (1) allowing collateral source benefits to be introduced into evidence; (2) permitting the periodic payment of judgments in excess of \$50,000; (3) allowing patients and physicians to contract for binding arbitration; and (4) limiting attorney contingency fees according to a sliding scale.

California – A Comparison

Evidence indicates that MICRA's success has stabilized insurance rates in California by limiting overall damages and by substantially diminishing the unpredictability – the volatility – of judgments.

- From 1976 through 1999, malpractice premiums in California rose 167 percent. In the rest of the country, premiums increased 505 percent;¹⁷
- Medical liability lawsuits in California settle on average in 1.8 years, while the same lawsuits in states without limits on noneconomic damages settle on average in 2.4 years -- 33 percent longer;¹⁸ and

¹⁵ See Californians Allied for Patient Protection, MICRA Information, July 1, 1995, at 10.

¹⁶ Noneconomic damages are monetary awards intended to compensate the plaintiff for subjective losses such as physical pain and suffering, mental anguish, loss of body function, disfigurement, or emotional distress. This differs from economic damages which are monetary awards intended to compensate the plaintiff for objective quantifiable losses such as property loss, medical expenses, lost wages, or lost or impaired future earnings capacity.

¹⁷ See *Patient Access: The Role of Medical Litigation Before a Joint Hearing of the United States Senate Judiciary Committee and Health, Education, Labor and Pensions Committee* (Feb. 11, 2003) (statement of Lawrence E. Smarr, President, Physician Insurers Association of America) [hereinafter "Smarr Statement"].

¹⁸ See The Doctors' Company, What is MICRA?, available at <http://www.thedoctors.com>.

- Medical liability lawsuits in California settle for an average of \$15,387; the same lawsuits in states without limits on noneconomic damages settle for an average of \$32,714 -- 53 percent more.¹⁹

While these figures make the case that MICRA has worked, an even more compelling argument for its success can be made by comparing malpractice rates for California physicians with their counterparts in other major metropolitan areas of states without MICRA-style reforms.²⁰ For example:²¹

- A Los Angeles area internist pays \$11,164; an internist in Chicago pays \$26,404, and in Miami pays \$56,153;
- A Los Angeles area general surgeon pays \$36,740; a general surgeon in Chicago pays \$68,080, and in Miami pays \$174,268; and
- A Los Angeles OB/GYN pays \$54,563; an OB/GYN in Chicago pays \$102,640, and in Miami pays \$201,376.

MICRA has ensured that those injured by medical negligence receive fair compensation, but it also has ensured that the market for medical liability insurance has remained stable and affordable. As a result, California has been largely immune from the liability crisis endemic to other states.²²

¹⁹ See Californians Allied for Patient Protection, MICRA: A Successful Model for Affordable and Accessible Health Care, available at <http://www.micra.org>.

²⁰ The Florida Legislature passed medical liability reform, CS SB 2-D, during special session in August 2003. The bill contained a high cap on noneconomic damages. CS SB 2-D became effective on September 15, 2003.

²¹ Rates are for 2002, \$1/\$3 million coverage as reported by MEDICAL LIABILITY MONITOR. Los Angeles rates reported from The Doctors Company, Chicago rates reported from ISMIE Mutual Insurance Company, and Miami rates reported from First Professional Insurance Company.

²² In addition to the 25-year legacy of success enjoyed by California, other states have acted. Just this year, 10 states passed reforms to their medical liability systems. On September 13, 2003 Texas, took the added step of amending its state constitution to permit limits on damages. Unfortunately, personal injury lawyers in other states continue to seek to have medical liability reforms “undone” by activist state Supreme Courts, as happened in 1997 and 1999 in Illinois and Ohio, respectively. For this reason, insurers are often reluctant to roll back rates until they are certain that a particular state’s medical liability statute will “survive” constitutional scrutiny, a litigation process that in California was not completed until 1985, a full ten years after MICRA was enacted.

Opponent Arguments Are Incomplete

Opponents of medical liability reform claim that the “access to healthcare” problem is a myth and that MICRA-style reforms are not the solution to rising malpractice premiums. One of the most common arguments they advance is that malpractice rates are increasing because insurance companies are making up for investment losses suffered in the stock market bubble in the late 1990s. They further argue that insurance carriers are gouging doctors with rate increases to boost profits.

A brief examination of the evidence, however, suggests otherwise. A report released by the investment and asset management firm Brown Brothers Harriman examined the investment mix of medical liability insurance carriers and the effect those investments had on premiums. The Brown Brothers report found no relationship between losses suffered by carriers in the stock market and rising premiums, “As medical malpractice companies did not have an unusual amount invested in equities and since they invested these monies in a reasonable market-like fashion, we conclude that the decline in equity valuations is not the cause of rising medical malpractice premiums.”²³

In addition, more than 60 percent of physicians obtain insurance through physician owned and operated companies.²⁴ These companies began to form in the 1970s when commercial carriers were exiting the medical liability insurance market due to unexpected losses, leaving healthcare providers no other options but to form their own insurance companies. These companies compete with commercial carriers and return excess revenue to policy holders, the owners of the companies. The contention that malpractice premiums are increasing in an effort to boost profits is, in essence, asking us to believe that a majority of doctors are “gouging” themselves and picking their own pockets. A reasonable

²³ Raghu Ramachandran, Brown Brothers Harriman & Co., Did Investment Affect Medical Malpractice Premiums? (January 21, 2003).

²⁴ See Smarr Statement, *supra* note 17.

examination can reach only one conclusion: medical liability insurance premiums are increasing because of higher costs and instability of our current litigation system, which does not allow carriers to accurately predict future losses and provide reasonable pricing of liability policies. Insurers price their product on cost and risk. It is logical to infer that a medical liability system that is more expensive and more volatile will necessarily be more expensive to insure.

Recently the Government Accounting Office (GAO) released a study examining the impact of the medical liability system on access to healthcare. The report acknowledges that states that limit noneconomic damages have enjoyed a lower rate of increase in medical liability insurance rates than states with more limited reforms.²⁵ As our opponents are quick to point out, however, the report also alleges that there is little evidence to suggest that states with no limits on damages have a healthcare access problem.²⁶

The report is incomplete. GAO examined only a limited number of states, 5, and not the entire 18 in crisis, as identified by the AMA at the time that the GAO conducted its examination. It has never been ATRA's position that the effects of the medical liability crisis are uniform. Many variables drive the crisis, including the type of medical specialty, the physician's location (urban, rural, or suburban), and the overall litigation environment of a particular region. In some areas and among some specialties, the effects of the current crisis are minimal; in other areas, and many other specialties, the effects of the crisis are profound.

Conclusion

Members of Congress should examine the medical liability system and assess the effects that current cost escalation and litigation will have on the future. ATRA believes such an examination inevitably leads to the conclusion

²⁵ See GOVERNMENT ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 6 (August 2003) [hereinafter "GAO Report (2003)."]

²⁶ See GAO Report (2003), *supra* note 25, at 5.

that the costs associated with the current system are unsustainable and that MICRA-style reforms must be enacted. Such reforms are in the best interests of patients, taxpayers, physicians, and plaintiffs. As Californians can attest, strong medical liability reforms create a system that strikes the correct balance between fairly compensating victims of medical negligence with a liability market that stabilizes premiums for physicians. This reform will go a long way toward enhancing and protecting access to healthcare. Lawmakers should not wait to act until a full-blown crisis is verified by a government report. It is the responsibility of elected officials to take remedial and, if necessary, preventive action to ensure that such a crisis never occurs.

Thank you for your attention, and I would be happy to answer any questions.