

Statement
of the
American Medical Association
to the
Subcommittee on Wellness and Human Rights
Committee on Government Reform
U.S. House of Representatives

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

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Good afternoon, Mr. Chair. My name is John Nelson, MD, MPH. I am the President-elect of the American Medical Association (AMA) and an obstetrician-gynecologist from Salt Lake City, Utah. On behalf of the physician and medical student members of the AMA, I appreciate the opportunity to appear before you today to discuss how our nation's medical liability litigation system is seriously threatening patients' access to quality health care.

THE CRISIS

Escalating jury awards and the high cost of defending against lawsuits, even meritless ones, have caused medical liability insurance premiums to reach unprecedented levels. As insurance becomes unaffordable or unavailable, physicians are being forced to relocate, close their practices, or drop vital services—all of which seriously impede patient access to care. Emergency departments are losing staff and scaling back certain services such as trauma units. Many obstetrician-gynecologists and family physicians have stopped delivering babies, and some advanced and high-risk procedures (such as neurosurgery) are being postponed because physicians can no longer afford or even find the liability insurance they need to practice.

Throughout 2003, the medical liability crisis has not waned. In fact, it is getting worse. Access to health care is now seriously threatened in 19 states, up from 12 states in 2002.¹ In many other states a crisis is looming—a crisis that not only threatens access to quality medical care, but also stifles medical and scientific innovation, inhibits efforts to improve patient safety, discourages new treatments and procedures, heaps billions of dollars in additional costs upon a health care system already strained to the breaking point, and places lives at risk. Virtually every day for the past two years there has been at least one major media story on the

¹ See attached map of medical liability crisis states.

plight of American patients and physicians as the liability crisis reaches across the country. The attached sample of media reports illustrates the problems faced by patients and physicians in some of these states—problems many other states will face if effective tort reforms are not enacted.

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as, or even more, devastating to patients and their families as an injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation. This compensation should include, first and foremost, full payment of all out-of-pocket “economic” losses. The AMA also believes that patients should receive reasonable compensation for intangible “non-economic” losses such as pain and suffering and, where appropriate, the right to pursue punitive damages.

Unfortunately, our medical liability litigation system is neither fair nor predictable. Transformed by high-stakes financial incentives, it has become an increasingly irrational “lottery” driven by open-ended damage awards for unquantifiable non-economic damages. Studies have concluded that the only significant predictor of payment to plaintiffs in a medical liability case was disability, and *not* the presence of an adverse event due to negligence.² In other words, in our medical liability litigation system, injuries often lead to settlements or jury awards even when there is no negligence.

As the U.S. House of Representatives has recognized by passing H.R. 5, the HEALTH Act, on March 13, 2003, the time for action is past due. Physicians across the country are making decisions now, and more and more patients are wondering, “Will my doctor be there?” We must bring common sense back to our courtrooms so that patients have access to their emergency rooms, delivery rooms, operating rooms, and physicians’ offices. This is why the AMA has worked so hard to seek passage of H.R. 5 in the House, and why we continue to join with numerous other members of a broad-based coalition known as the Health Coalition on Liability and Access (HCLA) to seek passage of similar legislation in the Senate.

THE LITIGATION SYSTEM IS CAUSING THE CRISIS

The primary cause of the growing liability crisis is the unrestrained escalation in jury awards that are a part of a legal system that in many states is simply out of control. Several reports have been published since the mid-1990s indicating that increases in jury awards lead to higher liability premiums. Additionally, in the last year a growing number of federal government and private sector reports show that increasing medical liability premiums are being driven primarily by increases in lawsuit awards and litigation expenses. These reports, outlined below, clearly show that the medical liability litigation system in the United States has evolved into a “lawsuit lottery,” where a few patients and their lawyers receive astronomical awards and the rest of society pays the price as access to health care professionals and services is reduced.

² Troyen A. Brennan, Colin M. Sox & Helen R. Burstin, *Relation between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 N. ENG. J. MED. 1963, 1963 (1996).

Recent Federal Government Reports

Congress' Joint Economic Committee (JEC) determined in a May 2003 study that a key driver of medical liability insurance premium increases is the recent surge in the size of damage awards in lawsuits. The JEC stated that the medical liability system affects access to health care by increasing the cost of health insurance, which reduces the number of Americans with health insurance—especially for employees of small businesses. In fact, the JEC stated that when medical liability litigation increases the cost of health insurance, low-wage workers suffer the most. The JEC also determined that the medical liability system impacts access to health care by reducing the supply of health care professionals available to provide medical services.

On March 3, 2003, the U.S. Department of Health and Human Services (HHS) released its second major report on the medical liability crisis. In this report HHS stated that “The crisis we face . . . is caused by our expensive litigation system, which often finds liability on a random basis and increasingly imposes very large judgments for non-economic damages.” HHS also reports that the medical liability system affects access to care by making medical liability insurance premiums unaffordable or unavailable to many physicians, making it more difficult for Americans to find care. HHS lists numerous accounts of physicians and hospitals affected by soaring medical liability insurance premiums.

Further, the 2003 Congressional Budget Office study on H.R. 5 (108th Congress), which includes a limitation on non-economic damages, asserts that:

CBO's analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 5 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law.

Recent Private Sector Reports

Evidence that the litigation system is broken, and that the medical liability crisis is growing, is further established in a study released by Tillinghast-Towers Perrin on February 11, 2003. Tillinghast reported that “The cost of the U.S. tort system grew by 14.3% in 2001, the highest single-year percentage increase since 1986,” which is “equivalent to a 5% tax on wages.” This is the only study that tracks the cost of the U.S. tort system from 1950 to 2001 and compares the growth of tort costs with increases in various U.S. economic indicators. Some of the key findings of this study are stunning:

- The U.S. tort system is a highly inefficient method of compensating injured parties, returning less than 50 cents on the dollar to people it is designed to help and returning only 22 cents to compensate for actual economic loss.

- Medical malpractice costs have risen an average of 11.6% a year since 1975 in contrast to an average annual increase of 9.4% for overall tort costs, outpacing increases in overall U.S. tort costs.

The study also adds that “These trends continued in 2002, with no sign of abatement in the near future.” In a press release accompanying this study, a Tillinghast principal stated that, “Absent sweeping tort reform measures, we expect most of these trends to continue in 2003 and beyond.”

In a 2001 report by Jury Verdict Research, data show that in just a one-year period (between 1999 and 2000) the median jury award increased 43 percent. Further, median jury awards for medical liability claims grew at 7 times the rate of inflation, while settlement payouts grew at nearly 3 times the rate of inflation. Even more telling, however, is that the proportion of jury awards topping \$1 million increased from 34 percent in 1996 to 52 percent in 2000. More than half of all jury awards today top \$1 million, and the average jury award has increased to about \$3.5 million.

GAO CONFIRMS THE CAUSE

In the summer of 2003, the U.S. General Accounting Office (GAO) released two reports related to America’s medical liability crisis.³ These reports address several separate but related issues. The first report, released in June 2003, confirms that, since 1999, medical liability premiums skyrocketed in some states and specialties—and increasing settlements and jury awards (“paid claims”) are the primary drivers for these increases. The second report, released in August, confirms that America’s medical liability crisis is causing access to health care problems in high-risk medical specialties and in select locations throughout America. In the five states studied by the GAO, all previously identified by the AMA as liability crisis states, the GAO found health care access problems. The GAO reports also confirm what the AMA has long held to be true—tort reform works. Medical liability premiums in states with strong caps on non-economic damages grew at a slower rate than states without caps on non-economic damages.

We appreciate the GAO's efforts and note that it, like others who have tried to quantify the medical liability crisis, found that data sources are difficult to locate, inconsistent, and often lagging. We would hope that instead of looking at this work as a one-time project, the GAO will continue to gather data over time so that the impact of the current crisis can be measured. In some fields, such as economic forecasting, the fact that an event has occurred is not determined until after it is over. For example, workers who lose their jobs know that the economy is bad, but a recession is often not declared until after it is over. We cannot afford the luxury of waiting until the liability crisis is over to declare a crisis and take action. Too many patients will be hurt.

³ U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (June, 2003); and *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (August, 2003).

Among its general findings, the GAO confirmed that:

- Increased losses on claims are the primary contributor to higher medical liability premium rates. (GAO 03-702, p.15)
- Premiums were higher (GAO 03-702, p.14) and grew more quickly (GAO 03-836, p.30) in states without non-economic damage caps than in states with non-economic damage caps.
- Physician responses to medical liability pressures in the five crisis states have reduced access to services affecting emergency surgery and newborn deliveries. (GAO 03-836, p.5)
- Similar examples of access reductions attributed to medical liability pressures were not identified in the four non-crisis states. (GAO 03-836, p.5)
- Insurers are not charging and profiting from excessively high premium rates. (GAO 03-702, p.32)
- None of the insurance companies studied experienced a net loss on investments. (GAO 03-702, p.25)

While verifying that the liability crisis has affected access to health care services, the GAO made several determinations in its August report relating to the extent of the liability crisis that the AMA believes do not accurately reflect the severity of the current crisis in real time. Numerous changes to the GAO methodology would strengthen the basic findings of this report. Among the data sources, measures, or analytical methods that could be improved are the following:

- *Examination of all crisis states.* The GAO only examined five of the 19 crisis states. The current medical liability crisis is far more widespread, extending to an additional 14 states as well.
- *Appropriate measurement of physician mobility.* Physician counts were based on state licensure data, which do not accurately reflect the number of physicians practicing in a given location. Actual physician practice location information must be used instead.
- *More accurate counts of physicians by specialties and local markets.* Physician/population ratios that aggregate physicians across local markets and specialties obscure the significant market-specific or specialty-specific changes in the supply of physicians and availability of critically important medical services.
- *Use of multi-payor data to accurately measure access to health care services that Medicare data alone do not capture.* Utilization statistics based exclusively on data from a single payor (Medicare) exclude data for obstetric and emergency care, and fail to capture the impairment of access among other vulnerable populations, such as Medicaid patients.
- *Use of current source of data to capture the magnitude of the access problem in real time.* The GAO accorded no weight to current sources of data which reflect the magnitude of impairment of patient access today.

In addition to our general comments on both of the GAO reports, the AMA has particular concerns relating to the August report. While the GAO verified many examples of impaired access to critical health care services, several of the GAO's conclusions do not logically follow from its analysis, including the following:

The GAO claims that access to care problems are not widespread.

The GAO's measurement of access problems is incomplete. The report uses Medicare claims data to examine changes in the utilization of medical services. Medicare data are inadequate to identify changes in obstetric services because a vast majority of Medicare eligible beneficiaries are beyond reproductive age. Limitations in the data also preclude an assessment of changes in emergency room services. Therefore, the report significantly understates the impact of rising liability insurance premiums because it does not examine the two clinical areas of patient care in which impairment of patient access has been the most severe—obstetric and emergency room services.

To date, the AMA, in conjunction with its federation of state medical associations, has identified 19 states in a liability crisis. The GAO investigated access problems in only five of those states. In each of those states it found examples of reduced access to hospital-based services. We believe that the GAO would have found similar access to care problems if it had examined the other 14 crisis states. In fact, the GAO did not identify any access problems in the four non-crisis states it examined. Therefore, the GAO's conclusion that access to care problems are not widespread is not substantiated.

The GAO concludes that access problems were largely limited to rural areas where there are other factors present that contribute to access to care problems.

It is well documented that access to care is more problematic in rural areas than in urbanized areas. Many rural areas suffered from physician shortages prior to the recent escalation in liability premiums. It is precisely in those areas where access is already threatened that one would first notice the impact of physicians' relocation or curtailment of certain services.

Health care access problems do not have to affect every part of a state to create crisis conditions. Health care by its nature is local, where a loss of just one or a few physicians or other health care providers in a community can have a traumatic impact on the availability of health care services in that community. Mrs. Leanne Dyess, a recent witness before House and Senate committee hearings, found this out when her husband was rushed to the closest hospital after he suffered severe head injuries in a car crash. On that night, that hospital did not have the necessary specialist on duty to treat her husband's injuries because physicians in the community had been forced to close their practices due to the liability crisis. By the time her husband was airlifted to a hospital with the proper staff it was too late—he suffered permanent brain damage.

The GAO states that it was unable to substantiate all of the claims of physician relocation, practice closings, or retirement.

We are heartened to learn that some hospital departments were able to find temporary solutions to what is likely to be a long-term problem. Nevertheless, many reports of physician relocation, practice closings, and retirement were confirmed and, as the GAO reported, have had a significant impact on patient access to care.

The AMA has verified that, in at least one instance, the GAO relied on inaccurate interpretations of the information it was provided in making this assertion. In particular, the GAO reported it was unable to substantiate a report that Collier and Lee counties in Florida lost all of their neurosurgeons because the GAO found five neurosurgeons practicing in each county. In fact, the information provided to the GAO stated there were no “pediatric” neurosurgeons in those two counties, an important distinction indicative of the lack of critical access for all local children.

Some of the GAO’s conclusions are not supported by its facts. For example, the GAO cites a litany of examples where patients’ access to health care has been limited in Mississippi, but then relies solely on licensure data—an inappropriate indicator of physician mobility—to assert that there is not an access problem.

In several cases, the GAO implies that (a) because state-level physician to population ratios from state licensing data have remained largely unchanged, or that (b) because the number of physicians departing a state accounts for a small percentage of physicians licensed in the state, that access to care has not been affected.

Relying on the total number of licensed physicians in a state to track physician mobility is inappropriate. According to James Thompson, MD, President and CEO of the Federation of State Medical Boards of the U.S. (FSMB):

The number of licensed physicians in a state is not an accurate measure of whether patients have adequate access to health care. Physicians may reduce their practice, stop treating high-risk patients, or stop practicing altogether and still maintain their license. Also, the number of licensed physicians is not an accurate indicator of the distribution of those physicians in underserved areas. Licensed physicians may work in administrative, academic or other settings where they may not have a clinical practice. Also, many retired physicians maintain a license. Information in the Federation of State Medical Boards’ database shows that approximately 60% of physicians are licensed in more than one state which indicates that they are licensed in states where they do not maintain a full-time or part-time practice.

The state licensing board data that the GAO examined runs through 2002, and therefore do not capture changes in physician location that occurred in 2003. Moreover, the decision to retire or relocate is a complicated one in which physicians must weigh their duty to their patients against the financial viability of their medical practice. It is not a decision made lightly, or made overnight. We expect to see the rate of physician retirements and relocation increase over time if premiums continue to escalate.

The GAO's method of measuring physician supply and potential access to care is not appropriate. Access problems are specialty and locality specific and are completely obscured when one looks at state-level physician to population ratios that aggregate physicians across specialties and local markets. Similarly, the number of high-risk sub-specialists that depart from any locality would likely account for only a small percentage of physicians in the state.

The GAO concludes that the cost of defensive medicine cannot be reliably estimated.

Research published in peer-reviewed journals on economics suggests that the reduction in defensive medicine from the adoption of direct tort reforms would reduce selected hospital expenditures by 5% to 9%.⁴

The GAO criticizes reports that extend an estimate of the cost of defensive medicine from data on selected hospital services provided to Medicare patients (it says that results from Medicare data cannot be generalized). Yet, the GAO bases its own conclusion that patient access has not been affected on a widespread basis on the same Medicare data.

The GAO states that it could not determine the extent to which differences in claim payments across states are caused by tort reform laws, such as caps on non-economic damages.

Research published in peer-reviewed journals on economics shows that claim payments in states with caps are lower than in states without caps. These research articles offer the best evidence that caps work because they consider, and rule out, other competing explanations for why claim payments differ across states.

A recent study by two economists at the Agency for Healthcare Research and Quality (AHRQ) shows that between 1985 and 2000 physician supply increased at a faster rate in states that passed caps than in states that did not. This study is even more powerful than the recent examples verified by the GAO because it considers and rules out other competing explanations for why physician supply differs across states. Also, it uses data on where physicians' main practices are located rather than state licensure data.

Long-term premium stability in California, a state with a cap on non-economic damages, shows that caps help keep medical liability premium growth in check.

⁴ Daniel P. Kessler & Mark B. McClellan, *Do Doctors Practice Defensive Medicine*, Quarterly Journal of Economics, 111(2): 353-390 (1996).

According to data from the National Association of Insurance Commissioners, while aggregate medical liability insurance premiums in California increased by 182% over the 1976 to 2001 period, premiums in the rest of the United States increased by 569%.

Further, an examination of recent premium data by various governmental agencies, including the GAO, indicates that growth in claim payments and premiums has been much lower in states with caps on non-economic damages than in states without caps.

H.R. 5, A PRACTICAL SOLUTION

On March 13, 2003, the U.S. House of Representatives passed H.R. 5, the “Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act,” a bipartisan bill that would bring balance to our medical liability litigation system and bring stability to the medical liability insurance market. This legislation would ensure that all patients who have been injured through negligence are fairly compensated.

The major provisions of the HEALTH Act would benefit patients by:

- Awarding injured patients unlimited economic damages (e.g., past and future medical expenses, loss of past and future earnings, cost of domestic services, etc.);
- Awarding injured patients non-economic damages up to \$250,000 (e.g., pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in the bill;
- Awarding injured patients punitive damages up to \$250,000 or up to two times economic damages, whichever is greater;
- Establishing a “fair share” rule that allocates damage awards fairly and in proportion to a party’s degree of fault; and
- Establishing a sliding-scale for attorneys’ contingent fees, therefore maximizing the recovery for patients.

These reforms are not part of some untested theory—they work. The major provisions of the HEALTH Act are based on the successful California law known as MICRA (Medical Injury Compensation Reform Act of 1975). MICRA reforms have been proven to stabilize the medical liability insurance market in California—increasing patient access to care and saving more than \$1 billion per year in liability premiums—and have reduced the time it takes to settle a claim by 33 percent. MICRA is also saving California from the current medical liability insurance crisis brewing in many states that do not have similar reforms. In fact, as mentioned above, NAIC data shows that aggregate premiums in California increased by 182% over the 1976 to 2001 period, while premiums in the rest of the United States increased by 569%.

CONCLUSION

Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an erosion of access to care because their physicians can no longer find or afford liability insurance. States that have enacted reforms similar to those contained in H.R. 5 have experienced greater stability in their medical liability insurance premiums.

By passing H.R. 5, the U.S. House of Representatives has moved our nation one step closer to achieving meaningful medical liability reforms that would increase access to medical services, eliminate much of the need for medical treatment motivated primarily as a precaution against lawsuits, improve the patient-physician relationship, help prevent avoidable patient injury, and curb the single most wasteful use of precious health care dollars—the costs, both financial and emotional, of health care liability litigation.

The AMA will continue to advocate on behalf of patients and physicians for national reforms similar to those already passed by the House. America's patients are the ones who will suffer if the Senate does not act soon. This is a crisis, it is not waning, and without real reforms more patients will be unable to find a doctor to deliver a baby, perform life-saving trauma surgery, or provide other critical care to high-risk patients who need it most.

Thank you.