

TESTIMONY OF

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WASHINGTON, D.C.**

BEFORE THE

**SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES**

**REGARDING:
*Current Issues Related to Medical Liability Reform***

ON

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Mr. Chairman, Representative Brown, 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 the Physicians Insurers Association of America, a trade association composed of 50 insurance companies owned by doctors and dentists, the median medical liability jury award nearly doubled from \$157,000 in 1997 to \$300,000 in 2003.¹ The average award also increased from \$347,134 in 1997 to \$430,727 in 2002.² The growth in settlements followed this trend, with the median settlement increasing from \$100,000 in 1997 to \$200,000 in 2002.³ Average settlements increased from \$212,861 in 1997 to \$322,544 in 2002.⁴

In addition to sharp escalation in costs, however, the medical liability system is highly inefficient.⁵ 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.⁶ Of the 5.8 percent of claims that do go to a jury verdict, defendants won 86.2 percent of the time, with an average cost to defend such lawsuits of \$87,720 per claim.⁷

¹ PHYSICIANS INSURERS ASSOCIATION OF AMERICA, PIAA CLAIM TREND ANALYSIS: 2003 ed. (2004) [hereinafter "PIAA TREND ANALYSIS" (2004)].

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ Fifty-eight cents from every dollar recovered goes to administrative and defense costs, as well as attorneys' 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).

⁶ See PIAA TREND ANALYSIS (2004), *supra* note 1.

⁷ *Id.*

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 malpractice.⁸ 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.⁹ 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.¹⁰ These increased costs in a financially overburdened healthcare system reduce both the access to and quality of healthcare. The root of this problem is an unpredictable litigation system in which 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

⁸ 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)”].

⁹ David Kessler and Mark McClellan, *Do Doctors Practice Defensive Medicine?* QUARTERLY JOURNAL OF ECONOMICS, May 1996, at 387-388.

¹⁰ See HHS REPORT (2002), *supra* note 8, at 7.

improvements in patient safety. For example, the American Hospital Association has reported that 45 percent of hospitals have lost physicians and/or reduced coverage in emergency departments due to the medical liability crisis.¹¹ Stories about individual physicians are equally compelling. For example, after serving 30 years as medical director for Forsyth County Emergency Medical Services of North Carolina, Dr. Lew Stringer resigned his position in 2003 due to the lack of availability of affordable malpractice insurance.¹² And in Missouri, family physician Dr. Donald Maples closed his practice after serving the community of Kirksville for 14 years because of the high cost of his medical liability insurance. Commenting on his experience, Dr. Maples said, “I expected to be here until I was in my mid-60s, but the reality is that I can no longer really truly afford to do this.”¹³

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.¹⁴ According to the American Medical Association (AMA), 20 states are in the midst of a healthcare liability crisis, while another 25 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. The public has taken notice, as well. According to a nationwide survey commissioned by the Health Coalition on Liability and Access, 82 percent of Americans believe doctors are leaving their practices due to unaffordable malpractice premiums caused by excessive litigation.¹⁵

¹¹ AMERICAN HOSPITAL ASSOCIATION, PROFESSIONAL LIABILITY INSURANCE SURVEY (2003).

¹² WINSTON-SALEM JOURNAL, June 3, 2003.

¹³ KTVO, April 30, 2004.

¹⁴ See HHS REPORT (2002), *supra* note 8, at 4.

¹⁵ See Health Coalition on Liability and Access, available at [http://www.hcla.org/factsheets/2004-HCLA-Poll-\(Fact%20Sheet\).pdf](http://www.hcla.org/factsheets/2004-HCLA-Poll-(Fact%20Sheet).pdf).

For example, on January 10, 2005, Mercy Hospital of Wilkes-Barre, Pennsylvania, stopped delivering babies because of the retirement of several OB/GYNs due to the high cost of medical liability insurance.¹⁶ Pennsylvania has been hit hard by the medical liability crisis, with a 2004 poll suggesting that one in four patients have changed doctors in the Keystone state due to the medical liability crisis.¹⁷

In early January, President Bush visited Southern Illinois to discuss the medical liability crisis. The President pointed out that Madison and St. Clair Counties¹⁸ had lost about 160 doctors over the last two years due to the medical liability crisis.¹⁹ High-risk specialists have been particularly hard hit; in 2004, the last two brain neurosurgeons in Southern Illinois resigned their posts at Neurological Associates of Southern Illinois because their malpractice insurance premiums were approaching \$300,000.²⁰

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. As Congress contemplates a legislative remedy, ATRA believes that any such legislation should apply to all defendants in healthcare actions. Doing so will ensure that all parties in a claim are treated equitably in the civil justice system.

¹⁶ WILKES-BARRE CITIZENS VOICE, January 8, 2005.

¹⁷ See Pennsylvania Economy League, available at <http://www.issuespa.net/polls/point/10295/10281/>.

¹⁸ The American Tort Reform Foundation published an analysis of the worst trial court jurisdictions in the country, known as “Judicial Hellholes[®]” where the law is applied in a systematically unfair and unbalanced manner, generally against defendants. Madison County is ranked as the number one Judicial Hellhole in the United States, with Saint Clair County being ranked as number two. The 2004 Judicial Hellholes report is available at <http://www.atra.org/reports/hellholes/report.pdf>.

¹⁹ *President Discusses Medical Liability Reform*, available at <http://www.whitehouse.gov/news/releases/2005/01/print/20050105-4.html>.

²⁰ UPI, February 25, 2004.

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 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.²¹ 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.²² 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. For example:

²¹ See Californians Allied for Patient Protection, MICRA Information, July 1, 1995, at 10.

²² 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 differ 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.

- From 1976 through 2002, malpractice premiums in California rose 245 percent. In the rest of the country, premiums increased 750 percent;²³
- 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;²⁴ and
- 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.²⁵

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.²⁶ For example:²⁷

- A Los Angeles area internist pays \$13,808; an internist in Chicago pays \$38,424, and in Miami pays \$69,310;
- A Los Angeles area general surgeon pays \$40,436; a general surgeon in Chicago pays \$102,700, and in Miami pays \$277,241; and
- A Los Angeles OB/GYN pays \$66,100; an OB/GYN in Chicago pays \$147,540, and in Miami pays \$277,241.

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.

²³ See American Medical Association, *Medical Liability Reform-Now!*, December 3, 2004, at 40.

²⁴ See The Doctors' Company, *What is MICRA?*, available at <http://www.thedoctors.com>.

²⁵ See Californians Allied for Patient Protection, *MICRA: A Successful Model for Affordable and Accessible Health Care*, available at <http://www.micra.org>.

²⁶ 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.

²⁷ Rates are for 2004, \$1/\$3 million coverage as reported by MEDICAL LIABILITY MONITOR. Los Angeles rates reported from SCPIE Indemnity Co., Chicago rates reported from Illinois State Medical Ins. Services, Inc., and Miami rates reported from First Professional Insurance Company.

Recent Examples of Reforms: Mississippi and Texas

Over the last two years, Mississippi and Texas passed significant medical liability reform legislation to rein in skyrocketing malpractice premiums. In July 2004, Mississippi Governor Haley Barbour signed House Bill 13, comprehensive civil justice reform legislation, which contained significant medical liability reform provisions. One of the key provisions was a \$500,000 limit on noneconomic damages in medical liability cases. Positive results are already being seen as the Medical Assurance Co. of Mississippi, which insures approximately 60 percent of doctors in Mississippi, did not raise base premium rates for 2005.²⁸ The story is much the same in Texas. In the summer of 2003, Governor Rick Perry signed House Bill 4, comprehensive civil justice reform legislation containing meaningful medical liability reform, including a \$750,000 limit on noneconomic damages (\$250,000 per healthcare provider). As a result, the largest medical malpractice provider in the state, the Texas Medical Liability Trust, lowered rates by 12 percent for 2004 and an additional 5 percent for 2005.²⁹ According to Lieutenant Governor David Dewhurst, 13 new companies have started writing policies in Texas.³⁰ The recent experiences of both Mississippi and Texas confirm that MICRA-style reforms have a positive impact in reining in medical malpractice rates.

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.

²⁸ See HATTIESBURG AMERICAN, October 10, 2004, at 8.

²⁹ See HOUSTON CHRONICLE, September 21, 2004, at 5.

³⁰ *Id.*

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 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.”³¹

In addition, more than 60 percent of physicians obtain insurance through physician owned and operated companies.³² 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 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.

³¹ Raghu Ramachandran, Brown Brothers Harriman & Co., *Did Investment Affect Medical Malpractice Premiums?* (January 2003).

³² 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).

A 2003 Government Accounting Office (GAO) study examined the impact of the medical liability system on access to healthcare. The report acknowledged that states that limit noneconomic damages have enjoyed a lower rate of increase in medical liability insurance rates than states with more limited reforms.³³ As our opponents are quick to point out, however, the report also alleged that there is little evidence to suggest that states with no limits on damages have a healthcare access problem.³⁴

The report is incomplete. GAO examined only a limited number of states, 5, and not the entire 18 then 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 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. And these reforms should apply to all defendants in litigation. 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

³³ See GOVERNMENT ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 5 (August 2003) [hereinafter "GAO Report" (2003)].

³⁴ See GAO Report (2003), *supra* note 33, at 5.

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.