



American Tort Reform Association

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**Statement of Sherman Joyce, President
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**Submitted to the Patient Safety and Medical Liability Reform National Advisory
Council (NAC) Subcommittee Meeting**

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This statement is being submitted by the American Tort Reform Association (ATRA). ATRA is the only independent national organization dedicated exclusively to civil justice reform through public education and enactment of legislation. ATRA's membership includes physician groups, non-profits, small and large companies, as well as state and national trade, business, and professional associations.

BACKGROUND

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. A balanced system also helps to promote access to health care, deters harmful practices, and reduces the cost of wasteful "defensive medicine." The current system comes up short.

The current medical liability system, with its high costs and unpredictability, compromises the delivery of quality patient care. It does so by limiting access to medical providers and life-saving medical specialties; deterring the innovation and use of beneficial medicines, medical devices, and therapies; and unnecessarily increasing health care costs.

Medical liability awards are rising swiftly. The median medical liability jury award nationally nearly tripled from \$157,000 in 1997 to \$487,500 in 2007, with average award amounts rising from \$347,134 in 1997 to \$637,134 in 2006, according to the Physicians Insurers Association of America (PIAA), a trade association composed of insurance companies owned by doctors and dentists. Medical liability premiums in many states, including Pennsylvania, New Jersey and Connecticut, are at levels more than double those of just a few years ago.

Doctors confronted with the exorbitant cost of medical liability insurance have scaled back their practices, moved to states with more favorable liability climates, or stopped practicing altogether. This problem is particularly acute in high-risk specialties. For example, 23% of neurosurgeons no longer treat brain tumors, 75% no longer operate on children, 44% limit the types of patients they treat, and 71% stopped performing aneurysm surgery, according to a 2004 survey by the American Association of Neurological Surgeons and Congress of Neurological Surgeons. The American Medical Association reports that 1 in 12 obstetricians who have reported changes in their practice as a result of the risk or fear of professional liability claims have stopped delivering babies. Eighty nine percent of OB-GYNs have had at least one liability claim

against them, with an average of 2.6 claims per obstetrician, according to a 2007 study by the American College of Obstetricians and Gynecologists.

Tort lawsuits against manufacturers of federally regulated prescription medicines and medical devices discourage innovation of new products (e.g., contraceptives, AIDS vaccines) and can even lead to the removal of beneficial products from the market (e.g., morning sickness drug Benedectin, acne medication Accutane). They also can result in inappropriate state-court imposed warnings about supposed product risks that conflict with federally mandated warnings, that are not grounded in good science, or that result in “over-warning” which causes doctors not to prescribe or patients not to use beneficial products, sometimes with serious adverse consequences to public health.

At the same time, the medical liability system does little to make services and goods safer. The system is supposed to provide incentives for parties most able to prevent and reduce risks to do so, but that can only happen when the responsible parties are aware of the risk of liability and can take corrective steps. When liability is applied haphazardly, or imposed retroactively on behavior that was lawful and appropriate at the time, the deterrent aspect of the medical liability system does not work. Instead the system drives up the costs of goods and services to incorporate the costs of legal liability, and encourages wasteful, unnecessary practices to avoid liability. The cost of defensive medicine adds to the already sky-high cost of our healthcare system – from \$99 billion to \$179 billion per year, according to an American Medical Association 2005 update of a 2003 HHS report.

Compensation for medical liability plaintiffs is often delayed. It takes nearly three years for a medical malpractice case to get to trial, according to the Bureau of Justice Statistics. More than 60 percent of liability claims against physicians are dropped, withdrawn or dismissed without payment. However, even these cases have a price, costing an average of more than \$18,000 to defend in 2007. And in those cases that go to trial, physicians are found not negligent in over 90 percent of cases—yet spend more than \$100,000 per case to defend them.

PROVEN SOLUTIONS

Fortunately, there are proven policy changes which HHS should study that would abate the medical liability crisis. These laws can ensure Americans will continue to enjoy high quality medical care, while at the same time protect the rights of patients in cases of true medical negligence. ATRA believes that any such reforms to decrease unnecessary lawsuits and lower system costs should apply to all parties in healthcare actions. Doing so will ensure that all parties in a claim are treated equitably in the civil justice system. Reforms should not simply increase the potential legal liability of one set of health care defendants while decreasing the potential legal liability of another.

CALIFORNIA

California developed an excellent solution to the medical liability problem with the enactment of the Medical Injury Compensation Reform Act (MICRA). MICRA’s centerpiece is a single limit of \$250,000 on noneconomic damages – but there are no limits on a claimant’s economic losses. 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.

Evidence indicates that MICRA's success has stabilized insurance rates in California by limiting overall damages and by substantially diminishing the unpredictability of judgments. According to the National Association of Insurance Commissioners, from 1976 through 2005, malpractice premiums throughout the country increased by 1,045% -- except in California, where the increase was 322%. Physicians in California pay substantially less for their malpractice insurance than their colleagues in non-reform states. For instance, a Los Angeles area OB-GYN pays \$89, 953 while an OB in Dade County, FL, pays \$214, 893. General surgeons in Los Angeles pay \$68,007, while they would pay \$104,054 in Suffolk County, NY.

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.

TEXAS AND MISSISSIPPI

Mississippi and Texas recently passed medical liability reform legislation to rein in skyrocketing malpractice premiums. According to the Wall Street Journal, Mississippi's 2004 reform package featuring a \$500,000 limit on noneconomic damages has resulted in malpractice premium decreasing 30% to 45%. The story is much the same in Texas, where a 2003 reform package that includes a \$750,000 total limit on noneconomic damages (\$250,000 per healthcare provider) has resulted in the largest medical malpractice provider in the state, the Texas Medical Liability Trust, decreasing premiums 31.3%; the Blanco County News reported earlier this year that 76 counties have witnessed a net increase in emergency room physicians. The recent experiences of both Mississippi and Texas confirm that MICRA-style reforms have a positive impact in reining in medical malpractice rates.

NEW AND INNOVATIVE SOLUTIONS SHOULD BE EXPLORED

In addition to examining proven solutions, ATRA supports and urges HHS to consider pilot projects that would measure the effectiveness of new and innovative policy solutions that have been proposed by legal scholars and academics that would provide prompt compensation for injured patients, provide a stable malpractice insurance market for doctors, and just as importantly, enhance patient safety.

Specifically, HHS should consider funding pilot projects that would assess the effectiveness of specialized Health Courts, an alternative dispute resolution mechanism championed by Common Good, and supported by many in the medical community, including the AMA.

HHS also should consider funding projects that focus on an "early offer of settlement" process, which, according to the Health Coalition on Liability and Access (HCLA), would allow defendants to make a financial offer covering the claimant's HCLA believes such a system would realize significant savings from the elimination of noneconomic damages and lower attorneys' fees that result from the speedier resolution of cases. Finally, HHS also should consider funding projects that encourage and assure the use of relevant and reliable expert evidence in medical liability cases, to discourage the use of so-called

“junk science” and ensure that expert witnesses have legitimate expertise in the area of medicine or science in question.

CONCLUSION

The goal of promoting greater patient safety begins with ensuring access to healthcare, particularly specialists who treat those with the most serious injuries and illnesses. Medical liability reform is a key component of ensuring that patients have access to providers and it helps in the important effort to reduce unnecessary costs. Thank you for allowing ATRA to comment.