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MEDICAL MALPRACTICE AND NATIONAL HEALTH CARE REFORM

Public Citizen's Congress Watch

August 1993

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MEDICAL MALPRACTICE AND
NATIONAL HEALTH CARE REFORM

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QUALITY HEALTH CARE
STATEMENT OF PRINCIPLES

WHEREAS, the medical lobby is urging the President and Congress to restrict the legal rights of patients injured or killed by medical malpractice;

WHEREAS, medical malpractice liability costs are a minuscule portion of overall health care costs, totaling less than one percent of national health care costs -- and in states that have restricted malpractice rights, health care costs have continued to rise;

WHEREAS, restrictions on medical liability will not address problems of health care affordability or availability, they will have a devastating effect on the ability of most malpractice victims to receive full compensation and hold negligent doctors accountable;

WHEREAS, medical malpractice restrictions will do nothing to address the epidemic of malpractice that takes an estimated 80,000 lives every year, but will reduce the money paid to victims of medical malpractice, who are already vastly undercompensated, and benefit overcompensated negligent medical providers and insurers.

WE OPPOSE RESTRICTIONS ON THE LEGAL RIGHTS OF HEALTH CARE CONSUMERS.

* Capping noneconomic damages is unfair, hurts the most seriously injured victims, and discriminates against women, children and senior citizens;

* Mandatory periodic payments result in inadequate compensation to injured victims and benefit the wrongdoer at the expense of the injured victim; and

* Abolition of the collateral source rule reduces the amount of money wrongdoers must pay, weakening the deterrent effect of the malpractice system.

WE SUPPORT MEASURES TO IMPROVE THE QUALITY AND SAFETY OF MEDICAL CARE IN THE UNITED STATES.

* Create consumer access to reliable information about negligent providers, such as that provided by the taxpayer-funded National Practitioner Data Bank -- currently closed to the public;

* Strengthen state medical boards' disciplinary functions; require recertification and performance audits for doctors and stronger regulation of hospitals;

* Mandate reporting of substandard performance to disciplinary authorities at state and federal levels;

* Establish risk management programs and improve physician training, licensing and recertification; and

* Support retention of the Clinical Laboratory Improvement Act of 1988 -- passed after public outcry over shoddy lab work in analyzing Pap smears for cervical cancer -- now under attack by the AMA.

WE SUPPORT PRO-CONSUMER COST-CONTAINMENT MEASURES.

* Reform the malpractice insurance system in order to ensure sensible underwriting practices, lower premium costs, and reward the safe practice of medicine with lower premiums; and

* Prohibit physician self-dealing and other financial and ethical abuses.

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Introduction
The Real Medical Malpractice Crisis

The real malpractice "crisis" is the extent of medical malpractice.

There is a virtual epidemic of medical malpractice in this country. Between 150,000 and 300,000 Americans are injured or killed each year by doctor negligence that occurs in hospitals. An estimated 80,000 deaths, twice the number of highway fatalities, occur annually due to doctor negligence. This number does not even include the thousands more who are injured and killed outside of a hospital setting.[1]

There is no "avalanche" of malpractice suits: only 1 in 8 patients who are victims of malpractice ever file a claim against their health care provider and only 1 in 16 malpractice complaints that are filed result in payment of damages to the victim.[2] If anything, too few victims of malpractice file claims.

Medical malpractice costs are an insignificant part of total health care costs.

In 1991, total health care costs were about $750 billion; medical malpractice insurance premiums were about $4.8 billion, or 0.6 percent of total health care costs.[3] Therefore, limiting consumers' access to the court system will not alleviate the serious economic issues surrounding current health care reform.

The current medical malpractice system may save money in the health care system because of its deterrent effect. According to Patricia Danzon of the Wharton School, even under a pure economic analysis, the tort liability system would justify its costs if it deterred even a relatively small proportion -- 20 percent -- of medical injuries.[4]

There is no evidence that so-called "defensive medicine" would be reduced by restricting medical malpractice laws.

"Defensive medicine" has never been objectively defined or quantified, and its causes have not been identified. Advocates of limiting victim's access to court argue that "defensive medicine" -- medical practices that are not in the best interest of the patient, but are performed to avoid liability -- is driving up health care costs.

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[1] Brennan, Troyen and others, "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I," New England Journal of Medicine, February 7, 1991.

[2] Id.

[3] "Medical Malpractice Insurance: 1985-1991 Calendar Year Experience," National Insurance Consumer Organization, March 1993.

[4] Danzon, Patricia M., Medical Malpractice: Theory, Evidence and Public Policy, Harvard University Press, 1985.

However, so-called "defensive medicine" may simply be good, careful medicine: telling patients more about risks, obtaining more referrals, keeping better patient records, taking better initial histories from patients, scheduling more followup visits, improving communication with patients, and studying professional literature more regularly. A patient's decision to sue her doctor is usually based on her patient-doctor relationship, according to the Texas Medical Association. Based on a survey of 200 doctors who had practiced for 20 years without a malpractice suit, the TMA recommended a close relationship and better communication between doctor and patient as the best insurance against malpractice claims.

In 1992, the Congressional Budget Office testified before Congress on proposed malpractice law reforms and concluded:

> Moreover, if the system of medical malpractice liability were modified, the resulting change in national health expenditures would be uncertain, and, if any reductions occurred, their magnitude would be small. In fact, much of the care that is commonly dubbed "defensive medicine" would probably continue to be provided for reasons other than concerns about malpractice.

In addition, much care labeled "defensive medicine" may be the result of physician self-dealing - profitable referrals for testing at facilities in which the doctor has a financial stake. The New England Journal of Medicine reported that physicians with ownership interests in diagnostic testing equipment and facilities order 4.0 to 4.5 times more tests than those physicians without such financial interests.

According to a recent study released by the National Liability Reform Coalition, a group backed by the AMA and other medical groups, "comprehensive" restrictions on the rights of medical malpractice victims will save only between $4 and $9 billion per year.[5] If you add those savings to malpractice premiums, at most, limiting the malpractice system would save between $9 and $14 billion per year -- or between 1.125 percent and 1.75 percent of total health care costs. But more important, the Coalition's study found that defensive medicine is a difficult concept to define because there are a variety of reasons why a physician might perform services that are not warranted, including financial incentives, patient expectations, and lack of current clinical information. The report concludes, "The wide range of potential motives, which are also likely to overlap in many cases, make it virtually impossible to isolate the contribution of defensive medicine costs."

The doctor discipline system, controlled by the medical community, is abysmal.

Negligent and incompetent doctors are rarely disciplined or removed from practice.At most, about 0.5 percent of the nation's doctors face any sanctions from their state medical boards each year. On average, only 3.44 serious disciplinary actions are taken for every 1,000 doctors.[6]

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[5] "Estimating the Cost of Defensive Medicine", Lewin-VHI, Inc., January 27, 1993.

[6] VanTuinen, Ingrid; McCarthy, Phyllis; Wolfe, M.D., Sidney M.; and Barne, Alana; "Comparing State Medical Boards," Public Citizen Health Research Group, January 1993.

State medical boards may take more than two years to even investigate complaints of doctor incompetence or misconduct, allowing the doctor to continue to treat other patients all during this time.

Studies conducted over the past ten years have found that a small number of physicians are responsible for most medical malpractice payouts. By reducing incidents of negligence by those few doctors, much malpractice injury can be avoided.

Malpractice insurance reform would ensure sensible underwriting practices, and lower premium costs.

While malpractice insurance premiums represent a minuscule part of total health care costs, physicians in certain specialties, such as obstetricians and gynecologists, sometimes pay very high insurance premiums. The subcategories currently used by insurance companies result in high premiums for certain specialties. Insurers should be prohibited from micro-categorizing specialists, a practice that drives up premium costs for specialists and creates groups so small that the risks are not effectively spread.

In order to differentiate high-risk doctors from the rest of the pool, insurance companies should charge rates based on a physician's own experience with malpractice lawsuits. This would ensure that doctors with histories of negligent behavior would pay more, and doctors with clean records would be rewarded with lower rates.

Limiting the legal rights of victims will not lower health care costs; we should not try to cure the economic problems facing the health care system on the backs of seriously injured victims of medical malpractice. The most humane and effective way to lower medical malpractice costs is to limit the incidence of physician negligence and thereby reduce the number of malpractice victims.

I. The Medical Lobby's Medical Malpractice Proposal: A Critique

President Clinton is seriously considering proposals, long-advocated by the medical lobby, to restrict the legal rights of patients injured or killed by medical malpractice. The medical lobby claims that limiting compensation to malpractice victims will lower costs in the health care system. In fact, medical malpractice costs are a minuscule portion of overall health care costs, and in states that have restricted malpractice rights, health care costs have continued to rise.

The model for the medical lobby's campaign is a controversial California statute known as the Medical Injury Compensation Reform Act, or MICRA. The law was enacted by the California Legislature in 1975 in response to rapidly-increasing medical malpractice insurance premiums. The powerful insurance and physicians' lobbies told legislators that medical malpractice lawsuits and jury awards were responsible for the higher premiums.

What has been California's experience? MICRA has restricted compensation of malpractice victims, and limited their access to the legal system. It has not lowered health care costs in California, it has not reduced "defensive medicine", and it has primarily benefitted profiteering insurers and dangerous doctors.

Key Provisions of MICRA:[7]

Limitation on Compensation of Injured Victims: Places a cap of $250,000 on the amount of compensation paid to malpractice victims for their "non-economic" injuries, such as sterility, loss of sexual organs, blindness or hearing loss, physical impairment, disfigurement, and pain.

The MICRA cap is not adjusted for inflation. In order to provide the same level of compensation in today's dollars, the cap would need to be approximately $630,000.[8] Though health care costs have risen dramatically since 1975, compensation for non-economic damages has been frozen by the statute.

Abolition of the Collateral Source Rule: Requires the malpractice victim's health insurance, or taxpayer-subsidized government health care programs, to pay the victim's medical expenses, rather than the doctor or hospital responsible for the malpractice. MICRA accomplishes this by abolishing the "collateral source rule" and by prohibiting the health insurance company or government agency from using the subrogation process to obtain reimbursement from the wrongdoer.

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[7] Rosenfield, Harvey "California's MICRA: Profile of a Failed Experiment in Tort Law Restrictions," Voter Revolt, pp. 3-6.

[8] Based on consumer index as published by the U.S. Dept. of Labor, Bureau of Labor Statistics, cited in "California's MICRA: Profile of a Failed Experiment in Tort Law Reforms", Harvey Rosenfield, p. 3.

Periodic Payment Schedule: Permits defendant found liable for malpractice, at the defendant's request, to pay jury-ordered compensation on an installment basis if the award equals or exceeds $50,000. If the victim dies earlier than expected, the defendants, rather than the family of the deceased, retain the balance of what they owe. If the victim requires a lump sum payment, for example to purchase expensive medical equipment, the victim is out of luck.

Mandatory Arbitration: Allows health care providers to insist that patients agree to mandatory arbitration and waive their right to a jury trial as a condition of receiving treatment.

Statute of Limitations: Imposes a short statute of limitations for medical malpractice cases. Victims must file a malpractice suit within three years after the date of injury, or one year after the discovery or when the injury should have been discovered, whichever occurs first. Actions by a minor under the age of 6 years must begin within 3 years or before her 8th birthday, whichever provides a longer period. There have been many instances in which malpractice involving children has not readily been detected or for which no action is taken initially because the family is unfamiliar with the legal system. Such cases are precluded by the statute of limitations.

Limit Plaintiff's Attorney's Fees: Sets a sliding contingency fee scale for plaintiff attorneys representing victims of medical malpractice, in order to discourage attorneys from taking severe and difficult to prove malpractice cases. The fees are limited to 40 percent of the first $50,000 recovered; 33.3 percent of the next $50,000; 25 percent of the next $100,000; and 15 percent of any amount exceeding $200,000. MICRA does not limit the fees of the defendant's lawyers.

California's Experience:

MICRA Has Not Significantly Lowered Health Care Costs

Intensive research based on statistics from health care providers, government agencies and insurance companies demonstrates that while MICRA has restricted compensation of malpractice victims, and limited their access to the legal system, it has not lowered health care costs in California. Health care costs in the state are as high, and by some measures higher, than the national average. California's consumer price index for medical care has grown faster than national health care costs since 1975,[9] and the rate of growth in California is accelerating compared to the U.S. In short, California is experiencing the same, if not a more destabilizing, health care crisis than the nation is facing.

From 1986 through 1990, the amount insurance companies estimated they would have to pay out for medical malpractice claims in California amounted to about one-half of one

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[9] Rosenfield, p. 7.

percent of the total health expenditures each year. This was only .14 percentage points lower than the rate for the nation as a whole. The "savings" from applying the California restrictions nationally in 1991 would have amounted to about $1 billion, a tiny fraction of the nation's aggregate health care outlay of $751 billion.

MICRA Has Not Reduced So-Called "Defensive Medicine."

For example, the rate of Caesarean sections - a procedure which is routinely said to be performed because of physician's fears of malpractice suits - is about the same in California as it is nationwide.

MICRA has Primarily Benefitted Profiteering Insurers and Dangerous Doctors

Insurance companies which sell malpractice liability coverage to doctors and hospitals are the chief beneficiaries of MICRA. While MICRA has limited the amount malpractice insurers must pay out in claims, insurers have not reduced premiums commensurately. Data reported by the insurance industry show that in California, insurers were dramatically overcharging for malpractice coverage in the mid-1980s, until newly imposed regulation of the property-casualty industry began lowering premiums in recent years.

In 1990, malpractice insurance companies operating in California paid out only thirty six cents in claims for every premium dollar they took in. Malpractice insurers' operating profits in California were a staggering 40 percent of premiums in that year.[10]

Negligent or incompetent health care providers are the other group which has benefitted from MICRA. Recognizing that limiting malpractice victims' tort rights would undermine the deterrent effect of the legal system and lead to more malpractice, the California Legislature modified the state's doctor disciplinary system when it enacted MICRA. However, the Board of Medical Quality Assurance, controlled by doctors, has come under severe criticism by consumer advocates and state legislators for failing to adequately police the medical profession. An undercover investigation by state law enforcement officials determined that the Board had destroyed thousands of complaints against doctors. It has rarely acted to punish doctors for negligence, incompetence or other improper behavior.

Furthermore, where malpractice insurance premiums have been reduced, doctors have not passed the reduction onto their patients in the form of lower health care costs.

MICRA is Not the Solution to the Health Care Crisis

While some in the Clinton Administration apparently think it makes good politics to adopt the California statute and assuage the powerful American Medical Association, it is

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[10] Rosenfield, p. 15.

important to understand the facts: restrictions on tort suits by medical malpractice victims will not diminish the nation's health care crisis, or even appreciably affect the cost of health care. As borne out by the California experience, such restrictions place profound burdens on disabled individuals who have been victimized by medical incompetence or negligence and reduce the deterrence effect on future physician and hospital recklessness.

If the Clinton health care reform proposal incorporates the key provisions of MICRA, it will not address problems of health care affordability or availability, and it will have a devastating effect on the ability of most malpractice victims to receive full compensation and hold negligent doctors accountable for their actions. As the following critique explains, a MICRA-style plan would preserve full legal rights only for the rich, a startling result in a health care bill designed to provide access to high quality medical care for all.

Critique of the Medical Lobby's Proposal

A. Caps on Pain and Suffering

The proposal: Place a federally-imposed cap on non-economic damages[11], or require or encourage the states to set such a cap.

Capping non-economic damages is unfair, hurts the most seriously injured victims, and discriminates against injured women, children and senior citizens.

Twenty states already have a cap on non-economic damages in medical malpractice cases; eight of these states also cap economic damages. In nine other states, caps on damages have been declared unconstitutional. The amount of the caps vary from state to state, but they are usually set at $250,000 and above (although some proposals would place the cap as low as $100,000). Caps on pain and suffering awards in these ranges affect only the most severely harmed victims -- those who are permanently or catastrophically injured by doctor negligence, and the families of those who have been killed -- since only the most seriously injured individuals ever receive over $250,000 in non-economic damages.

What is worse, capping non-economic damages aggravates an existing serious deficiency in personal injury lawsuits -- the most seriously injured victims are usually undercompensated even where there are no damage caps. In fact, studies show that the

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[11] Noneconomic damages are intended to compensate for intangible injuries, such as severe pain, the loss of a loved one, sterility, loss of sexual organs, blindness or hearing loss, physical impairment, disfigurement, and other losses of enjoyment of life. Intangible values are routinely recognized, quantified and awarded by U.S. courts. For example, courts award monetary damages for the value of corporate good will, art work and the right to maintain the view from a penthouse apartment. Economic damages, the other type of legal damages, compensate for out-of-pocket expenses, such as wage loss and doctor bills.

larger the loss, the greater the marginal undercompensation.[12]

Furthermore, it is misguided to separate pain and suffering and other "intangible" damages from other types of damages. Compensation for non-economic loss is compensation for real loss, and should be treated in the same manner as damages for out-of-pocket expenses. For example, a woman who loses her ability to ever bear children, a youngster whose childhood is stolen away because of prolonged illness or injury, or parents who lose their children, all suffer losses that deserve compensation, even if the loss does not result in direct financial expense.

Finally, placing limits on non-economic damages has discriminatory results because it targets a very specific population -- low or non-wage earners. In other words, those most adversely affected by caps would be women, children and the elderly -- people who generally will not have high wage loss in the event of death, serious injury or illness.

Placing caps on damage awards is unnecessary, because jury awards in malpractice cases are not excessive.

Duke University Law School's Medical Malpractice Project recently completed a study which attempted to review every malpractice suit filed in North Carolina between July 1, 1984 and June 30, 1987 -- 895 cases. The project also collected information on more than 300 other cases filed in a sample of North Carolina counties between July, 1987 and December, 1990. The study found that medical malpractice juries do not award excessive damages.

Only 117 of the cases reviewed in the study went to trial.[13] Of these, the plaintiff prevailed on the issue of liability in just one out of five, or 21 cases. There were only four large jury awards in these 21 cases, ranging in size from $750,000 to $3.5 million (subsequently reduced to $2.9 million). These judgments were awarded in cases involving severe brain damage, permanent paralysis and brain damage, death from suffocation by an intubation tube improperly placed, and a child who suffered brain damage at birth.

After these cases, the next highest jury award was $300,000. The study found that the average damage award in cases that plaintiffs won was $367,737. But this number was much inflated by the four large awards discussed above. The median or midpoint award, on the other hand, was only $36,500.

Other studies have come to similar conclusions. A U.S. General Accounting Office study

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[12] Saks, Michael J., "Malpractice Misconceptions and Other Lessons About the Litigation System," The Justice Journal, Volume 16, Number 2 (1993); U.S. General Accounting Office, Product Liability: Verdicts and Case Resolution in Five States, 1989.

[13] Vidmar, Neil, "The Unfair Criticism of Medical Malpractice Juries," Judicature, October/November, 1992. According to the study, about 40 percent of the cases were terminated without any payment, and about 50 percent were settled -- only about 10 percent, or 117, were decided by a jury.

found that the median malpractice payment in 1984 was $18,000, and that 69 percent of victims received less than $50,000.[14] Furthermore, the study found that any increases in settlements could be attributed to the rise in health care costs. According to the report, between 1981 and 1984, the average malpractice verdict increased at an annual rate of 3.9 percent, yet health care costs increased 11.8 percent.

B. Abolishing the "Collateral Source Rule"

The proposal: Abolish the "collateral source" rule, or provide for an automatic offset of collateral source benefits.

The collateral source rule ensures that defendants are held responsible for all the harm that they caused, but it does not result in "double payments" to injured victims.

The collateral source rule prohibits defendants charged with negligence from informing the jury that the plaintiff has other sources of compensation, such as health insurance or government benefits, including Medicare and Medicaid. The purpose of this long-established rule is to ensure that the defendant is held responsible for the full cost of the harm that the defendant caused.

The collateral source rule does not result in "double payments" to injured victims because of another legal doctrine, known as "subrogation." Under subrogation rights -- which are applicable to virtually all health insurance policies, government programs, and workers' compensation systems -- the third party payor of a health or job loss benefit has the legal right to take funds from a malpractice award to reimburse itself for payments it has already made to the malpractice victim. The collateral source rule, in conjunction with subrogation rights, ensures that wrongdoers pay for the full amount of the harm they cause, and that victims do not receive double payments for their injuries.

Abolition of the collateral source rule, or offsets to damage awards of collateral source payments, reduces the amount of money wrongdoers must pay, weakening the deterrent effect of the malpractice system.

By definition, when juries reduce the damage award by the amount of collateral source payments received by the victim, defendants pay less. In effect, responsibility is shifted to the victim, who purchased the insurance coverage, to the victim's insurer, and/or to taxpayers. And when negligent parties are relieved from bearing the full cost of their wrongdoing, the deterrent effect of the entire system is weakened.

C. "Periodic Payments" at the Request of the Defendant

The proposal: Require payments to be made on a periodic basis upon the request of the defendant.

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[14] U.S. General Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984, April 1989.

Mandatory periodic payments result in inadequate compensation to injured victims.

Allowing defendants to force injured victims to accept damage awards in installments, rather than as a lump sum, can deny victims needed compensation. Very often, medical malpractice victims need larger sums of money initially, or as time goes on, to pay for past bills, unanticipated medical expenses, renovations to their homes (e.g., wheel chair ramp, hallways and doorways widened), and expensive medical equipment. In addition, most often periodic payments schedules make no adjustments to account for inflation generally, or changes in the cost of medical care specifically. Finally, if a victim dies earlier than expected, dependent family members are left without needed income and wrongdoers are relieved of their obligation to pay for the damages they caused.

Mandatory periodic payments benefit the wrongdoer at the expense of the injured victim.

Periodic payments allow the negligent provider or its insurance carrier to control, invest and earn interest upon the victim's compensation year after year. By structuring payments through annuities, or other investment mechanisms, defendants may end up paying just a fraction of the damages awarded at trial. Furthermore, if the defendant enters bankruptcy or simply ceases to pay, the victims are forced to return to court and engage in another lengthy legal proceeding. The longer the insurance company refuses to pay, the more investment income it can earn. And if the insurer holds out long enough, the victim may die, and the remainder of the award reverts back to the wrongdoer.

Where periodic payments work to the advantage of <u>both</u> parties, they are frequently entered into voluntarily -- it is not fair or necessary to force plaintiffs into a payment schedule at the option of the defendant.

Very often, both parties to a lawsuit agree to structured settlements, in which the plaintiff receives payments in installments. When agreed to as part of a negotiation, these settlement agreements can be beneficial to plaintiffs and defendants. But it is not fair, nor necessary, to lock plaintiffs into installment payments against their will.

D. Placing a Cap of One-Third on Plaintiffs' Attorneys' Fees

The proposal: Cap plaintiffs' attorneys' fees at one-third of the jury award.

If plaintiffs' attorneys' fees are subject to federal price controls, defendants' attorneys' fees should also be regulated.

Plaintiffs in medical malpractice cases almost always hire their attorneys on a contingency fee, in which the attorney does not get paid unless the plaintiff prevails. Then the attorney is paid a percentage of the damage award -- usually one-third. Plaintiffs in medical malpractice cases lose more than half the time. Therefore, attorneys must be paid enough in the remaining cases to make up for the cases in which they receive nothing. While, in general, plaintiffs' attorneys should not receive more than one-third of any damage award, it is true that some attorneys charge as much as fifty percent. This practice is best

sanctioned on the state level, by bar associations or other legal oversight body.

If plaintiffs' attorneys' fees are to be regulated on the federal level, it is only fair for defendants' fees to be regulated as well. This is especially true because defendants, who bill by the hour, have tremendous incentives to delay and drag out cases in order to hike up their fees. If there is a need to control plaintiffs' attorneys' fees, that need is even greater for defense lawyers.

Capping plaintiffs' contingency fees could encourage attorneys to charge by the hour, rather than on a contingency fee. This would be prohibitively expensive for most consumers, effectively locking them out of the courthouse doors.

The Medical Lobby's Proposal Benefits the Rich

Each of these provisions, taken on their own, harms injured victims. However, in combination, this proposal would be devastating to the medical malpractice system, virtually eliminating the vast majority of cases. Upon close examination, it becomes clear that the only people who would benefit from malpractice cases under this proposal would be high-wage earners who are out of work for a period of time due to medical malpractice.

Damages in personal injury case are generally made up of three components:

- non-economic damages
- medical expenses
- lost wages

Under a MICRA-like plan, non-economic damages would be capped, reducing this as an incentive to bring a lawsuit. The proposal would also reduce damage awards by the amount of health benefits paid for by the victims' insurer. If the Clinton health care proposal provides health insurance for all, then medical bills will cease to be an element of damage awards. This leaves lost wages as the major component of damage awards.

In practice, the result will be that high-salaried individuals will be able to obtain an attorney to bring malpractice cases because the high potential damage award would make it worth the attorney's while. However, most cases brought by the middle class, the poor, children, the elderly, and women who work in the home would not promise high enough damages to attract attorneys to take the cases. This is because their "intangible," noneconomic damages would be capped, and their health care bills -- paid for by the universal coverage promised by the Clinton health care plan -- would be subtracted from the damage award. **It is outrageous, indeed, that a health care plan designed to benefit the vast majority of the public would rob from most people the fundamental right to a jury trial, reserving that right only for the rich.**

II. The National Practitioner Data Bank

What is the National Practitioner Data Bank?

The National Practitioner Data Bank ("Data Bank")[15] was created in order to protect health care consumers from unethical and incompetent doctors. The Data Bank is a clearinghouse which collects information from state medical boards, hospitals and other institutions on medical malpractice payments and adverse professional actions involving physicians, dentists, and other health care providers.

Opened in 1990, the primary purposes of the National Practitioner Data Bank are: 1) to restrict the ability of incompetent health care providers to move from state to state without discovery of their substandard care or professional misconduct and, 2) to encourage, through the granting of immunity, peer review participants to report incompetent providers or providers engaging in professional misconduct.

Three types of disciplinary actions must be reported to the Data Bank, including those taken against a practitioner's license by a state medical or dental board; certain restrictions on clinical privileges resulting from peer review activity in a hospital, HMO or nursing home; and adverse actions against membership in a professional society. In addition, insurers and others making malpractice payments on behalf of a health care provider must report those payments and the circumstances involved. This requirement applies to both completed lawsuits where the plaintiff won damages and those settled without a formal judgment from the court.

Since 1990, the Data Bank has collected nearly 60,000 reports, the bulk of which are for medical malpractice payments.[16] The remainder of the reports involve adverse actions relating to licensure, clinical privileges and professional society memberships.[17] Access to the information in the Data Bank is limited to hospitals, state medical boards, professional associations and government agencies. Hospitals are required to query the Data Bank to check on new applicants for medical staff membership or clinical privileges. Hospitals must also query the Data Bank every two years with respect to existing medical staff members and doctors with clinical privileges. Hospitals are not, however, required to act upon the information they receive.

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[15] The National Practitioner Data Bank ("Data Bank") was authorized by Title IV of the Health Care Quality Improvement Act of 1986 (P.L. 99-660) and is administered by the Health Resources and Services Administration, a division of the U.S. Department of Health and Human Services.

[16] Statement of Lawrence H. Thompson, Assistant Comptroller General, Human Resources Division, "Medical Malpractice: Experience with Efforts to Address Problem," GAO, May 20, 1993, p. 5.

[17] Id.

Consumers Do Not have Access to the Data Bank

Consumers and their physicians do not have access to the information stored in the Data Bank. Consumers seeking information about providers from whom they intend to seek medical care and physicians seeking to make referrals are generally left to their own devices to determine providers' track record. The Data Bank could be the most powerful resource to assist consumers in making informed health care "purchasing" decisions. A Data Bank query would inform a consumer whether the provider at issue had been the subject of disciplinary actions in more than one state, had restrictions on or loss of hospital privileges set by the provider's own peers and/or had made payments for multiple malpractice claims.

Patients need a full range of data in order to make informed decisions in choosing health care providers. This is especially important in the current health care reform climate which emphasizes consumers' role in the "marketplace." "To make a system with significant role for market forces work, you need [public access to] the kind of information in the data bank,"[18] says Representative Ron Wyden (D-OR).

Physicians and others acting as "agents of patients need this information in order to make conscientious referrals to other providers." According to Dr. Lynn Soffer, "It's essential to me that the HMO and hospitals where I work and receive care are able to check on the records of my colleagues as thoroughly as possible."

Given the high incidence of deaths caused by medical negligence in the United States each year -- estimated at 80,000 annually -- the selection of a health care provider is literally a life or death decision. According Representative Wyden, the sponsor of the legislation creating the Data Bank, "[i]t ought to be the goal of health reform to get [Data Bank information] out [to the public] in an easily accessed, understandable, readily digestible fashion."[19]

No consumer would willingly choose to be treated by a health care provider who has a record for providing substandard medical care. By having access to information which identifies incompetent providers, consumers will be able to avoid becoming victims of malpractice.

The elimination of incompetent providers will benefit not only the consumer, but the health care system as a whole through the reduction of the direct and indirect costs associated with malpractice.

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[18] Greg Rushford, "Data Bank Has a Deficit", Legal Times, April 22, 1991, p. 1

[19] Edward Felsenthal, "Doctors Oppose Public Access to Malpractice-Case Data," Wall Street Journal, May 18, 1993, quoting, Rep Ron Wyden (D-OR).

The AMA Calls for the Data Bank to be Closed

In 1989, AMA Executive Vice President James Todd said that the AMA would "do whatever we can to make the [data bank] a useful activity." However, in response to recent consumer demands for public access, the American Medical Association (AMA) has called for the abolition of the Data Bank. According to Todd, efforts to open the Data Bank to the public must be motivated by "[p]eople who have a generic dislike of physicians"[20] as opposed to health care consumers trying to protect their health and their lives. The AMA argues that opening the Data Bank would place information in the "wrong hands" -- consumers' hands. Physicians argue that consumers are incapable of understanding the information they would obtain from the Data Bank, a condescending and inaccurate appraisal of consumers' ability to decide what is best for themselves. Denying health care consumers access to Data Bank information is unconscionable, as it subjects consumers to unreasonable and unnecessary risks.[21]

Safeguards are currently in place to limit unwarranted harm to provider's reputations. Providers must be notified of all reports filed against them and are afforded an opportunity to dispute the reported information. If the report is upheld following the dispute resolution process, the provider may submit an explanation to be inserted in her Data Bank file. Also, reporters of false or inaccurate information are subject to criminal penalties. The Data Bank legislation stipulates that payment in settlement of a claim should not be construed as a presumption of malpractice.

More Reporting - Not Less - Should Be Required

Given the vital importance of information on substandard medical care, contributions to the Data Bank by individuals and entities possessing such information cannot be discretionary, but must be mandatory with stiff penalties being meted out for the failure to report as required. Legislation has been drafted which would establish more stringent and broader reporting requirements.

Reporting Loopholes Must Be Closed

Efforts to evade the Data Bank's reporting requirements threaten to undermine the Data Bank's effectiveness as an agent for consumer protection and as an indicator of a compromised practitioner for hospital and medical board reviewers. Currently, doctors can avoid the reporting requirements of the 1986 law if their attorney has their name dropped from the suit before it is settled.[22] Increasingly since the inception of the Data Bank,

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[20] Id.

[21] The only information possessed by the Data Bank which should not be released, except to the relevant patient or provider, is patients' identities.

[22] Rushford, p. 1.

defendants demand that malpractice plaintiffs agree to drop specifically-named practitioners as a term of settlement and settle the case against the hospital or clinic as the sole defendant. Thus, no individuals are represented by the settlement payment, and no report to the Data Bank is required. While not technically illegal, this practice blatantly violates the spirit of the law in which Congress mandated that malpractice payments made on behalf of health care practitioners be reported to the Data Bank for both settled and adjudicated cases. Congress clearly did not intend to allow insurers or defense attorneys to make unilateral decisions about whether a given defendant "should" be reportable.

To protect the public health and welfare, it is urgent that:

- the information currently deposited with the Data Bank be made available to consumers;
- the AMA's self-interest proposal to close the Data Bank be defeated; and
- the reporting requirements of the Health Care Quality Improvement Act of 1986 not be subverted by settlement manipulated agreements.

III. An Affirmative Quality of Care Agenda

The American health care system is in crisis and needs restructuring. Currently, over 37 million Americans have no health insurance, while another 65 million are underinsured and receive only minimal medical care. Beyond the critical issue of access to health care, however, are serious concerns about the quality of care that many Americans receive. Substandard medical care may result in additional medical care, serious illness or injury or even death, all adding to the nation's overall health care costs. Any attempt to restructure and lower costs of health care financing and delivery must seize the opportunity to improve the quality of care at the same time.

Limiting the legal rights of malpractice victims will not lower health care costs or improve health care quality. The most humane and effective way to lower medical malpractice costs is limit the occurrence of malpractice.

A. Improve the Quality and Safety of Medical Care.

▸ Create consumer access to reliable information about negligent providers, such as that provided by the taxpayer-funded National Practitioner Data Bank -- currently closed to the public. The National Practitioner Data Bank provides the best source of information on the disciplinary record of physicians, including state and federal disciplinary actions, hospital and professional society sanctions, and malpractice settlements and judgments. Due to pressure from the medical lobby, the information in the data bank is not available to the public or to other doctors seeking to make referrals;

▸ Strengthen state medical boards' disciplinary functions; require recertification and performance audits for doctors and stronger regulation of hospitals. The current doctor discipline system, controlled by the medical community, is abysmal. Negligent and incompetent doctors are rarely disciplined or removed from practice. At most, about 0.5 percent of the nation's doctors face any sanctions (many for financial, not malpractice, abuses) from their state medical boards each year. State medical boards may take more than two years to even investigate complaints of doctor incompetence or misconduct, allowing the doctor to continue to treat other patients all during this time;

▸ Mandate hospital and peer reporting of substandard performance to disciplinary authorities at state and federal levels;

▸ Establish risk management programs and improve physician licensing and recertification; provide more information to physicians through the development and dissemination of outcomes research, practice guidelines and continuing medical education; and

▸ Support retention of the Clinical Laboratory Improvement Act of 1988 -- passed after public outcry over shoddy lab work in analyzing Pap smears for cervical cancer -- now under attack by the AMA.

B. Promote Pro-Consumer Cost-Containment Measures.

▸ Reform the malpractice insurance system in order to ensure sensible underwriting practices, lower premium costs, and reward the safe practice of medicine with lower premiums. The subcategories currently used by insurance companies result in high premiums for some specialties. Insurance companies should be required to more effectively spread risk by placing all physicians in larger pools. In addition, insurance companies should charge rates based on a physician's own experience with malpractice lawsuits, thereby ensuring that doctors with histories of negligent behavior would pay more, and doctors with clean records would be rewarded with lower rates; and

▸ Prohibit physician self-dealing and other financial and ethical abuses. The New England Journal of Medicine reported that physicians with ownership interests in diagnostic testing equipment and facilities order 4.0 to 4.5 times more tests than those physicians without such financial interests. Approximately one-quarter of the medical labs in this country are owned wholly or in part by physicians who refer their patients to those labs.

C. Oppose Restrictions on the Legal Rights of Health Care Consumers.

▸ Capping noneconomic damages is unfair, hurts the most seriously injured victims, and discriminates against women, children and senior citizens;

▸ Mandatory periodic payments result in inadequate compensation to injured victims and benefit the wrongdoer at the expense of the injured victim;

▸ Abolition of the collateral source rule reduces the amount of money wrongdoers must pay, weakening the deterrent effect of the malpractice system; and

▸ Any caps on attorney's fees must include defense attorneys and must not create prohibitive barriers to plaintiffs retaining counsel on a contingency basis.

IV. "Defensive Medicine"
A Critique of the Medical Lobby's Claims

The term "defensive medicine" usually refers to medical care that does not benefit the patient, and is done to avoid perceived risk of medical malpractice claims. The medical industry has long argued that restrictions on the legal rights of malpractice victims will reduce the amount of "defensive medicine" that is practiced, and thus, will lower costs in the health care system. In fact, there is no reliable evidence that unnecessary procedures are caused by the fear of lawsuits, nor that malpractice restrictions will reduce the amount of unnecessary care that is delivered. In truth, no one really knows what "defensive medicine" is or what causes it.

"Defensive Medicine" Cannot Be Measured

Physicians have many motivations for ordering a particular test or procedure. It is therefore impossible to discern which "unnecessary" practices were solely motivated by the fear of malpractice claims. Motivations for procedures which may not be cost-justified include: patient preferences, the medical culture's emphasis on doing everything possible for a patient, scheduling convenience, institutional requirements, financial incentives, premature use of new medical technologies, and delayed response to new clinical information.

A. "Defensive medicine" may be quality medicine. Many of the practices which doctors themselves classify as defensive are often identified with quality medical care. Doctors allege that the fear of liability causes them to order more diagnostic tests, stick with the safest treatments, give patients more information about treatment risks, and keep complete records. Additional testing may at times lead to improved quality through earlier and more accurate diagnoses. Efficient documentation and more patient contact can also improve quality at minimal cost to the health care system. Fear of liability motivates many doctors to practice better quality medicine.

B. Experts themselves disagree 40 percent of the time as to what is appropriate care. Reviewing medical records alone in an attempt to determine whether a practice is cost-justified is insufficient since it does not consider patient outcomes and satisfaction over long periods.

C. The amount of unnecessary surgery has been vastly overestimated. The Rand Corporation reports that unnecessary bypass surgery is performed at the rate of only 2.4 percent rather than the previously reported 14 percent, and the number of equivocal bypasses was only 7 percent rather than the previously reported 44 percent.

"Defensive Medicine" Does Not Prevent Malpractice Claims

Physicians claim that they perform unnecessary and costly procedures -- so-called "defensive medicine" -- to avoid malpractice lawsuits. But, a very small minority (approximately 15 percent) of malpractice claims are based upon improper diagnoses caused by failure to perform additional tests and procedures. In fact, the overwhelming majority of medical

malpractice claims result from mismanagement and errors in the procedures themselves. Since performance errors are one of the most common bases for malpractice claims, performing unnecessary procedures serves to increase the risk of liability rather than lessen it. Mandated quality assurance and risk management programs, practice guidelines and more effective doctor licensing and discipline procedures are the most effective ways to reduce malpractice claims because they reduce the incidence of malpractice.

A. The malpractice liability system is underutilized, not overutilized. Physicians greatly overestimate the risk of having a malpractice suit filed against them. At most, only 10 percent of injuries resulting from medical negligence result in the filing of a claim and only 40 percent of those claims result in compensation to the victim through the tort liability system.

B. Practicing "defensive medicine" in order to avoid the very small risk of a medical malpractice suit is ineffective. Since the majority of malpractice is the result of errors in procedures, more unnecessary tests will only increase the chance of a claim.

C. The liability system serves an important role by identifying incompetent physicians and dangerous work environments. Most malpractice is committed by either incompetent physicians, competent but overworked physicians who commit occasional acts of negligence, or physicians of above-average competence who perform difficult procedures. The liability system helps to identify incompetent physicians, who might otherwise pass the medical board disciplinary system, and encourages competent physicians and hospitals to adjust workloads to prevent abusively long hours of medical practice. Highly-skilled physicians are already adequately compensated for their exposure to liability.

D. The most effective way for doctors to reduce malpractice claims is to provide better patient contact. A Texas Medical Association survey of physicians who had practiced more than twenty years without having a malpractice claim filed against them provided the following advice for avoiding lawsuits: develop positive patient relations, listen patiently, be available and polite, stay on time, keep patient expectations in line, include the patient in the decision-making, be straightforward about accidents and bad results, document your work, avoid the obvious high risk situation, and obey the golden rule. Indeed, according to James S. Todd of the AMA, having a good bedside manner reduces the likelihood of a suit being filed even if the physician commits malpractice.

Unnecessary Care is Often Motivated by Financial Incentives

It is more likely that unnecessary tests are performed for financial gain rather than to avoid the extremely remote risk of a malpractice claim. While unnecessary tests do not reduce malpractice suits, they do increase physician income.[23] The New England Journal of Medicine reported that physicians with ownership interests in diagnostic testing equipment and facilities order 4.0 to 4.5

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[23] *See generally*, Cooper, Mark N., "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs, Offensive Profits", Consumer Federation of America, October 1991.

times more tests than those physicians without such financial interests. Approximately one-quarter of the medical labs in this country are owned wholly or in part by physicians who refer their patients to those labs. A recent study found that 40 percent of doctors in Florida had financial investments in medical labs or other testing facilities.[24]

A. Although much can be achieved by low-tech medicine and personal contact, high-tech tests are more lucrative and less time-consuming. Sophisticated technology and expensive medical procedures form the "economic lifeblood" for doctors and hospitals.

B. Self-referrals pushed up costs by 110 percent for physical therapy, 26 percent for psychiatric services and 31 percent for MRIs in California. A recent California study of workers' compensation cases reported that "self-referring" or "self-dealing" physicians charge more per test by a factor of 1.6 to 6.2 times. Physicians have no incentive to keep costs low since they are essentially purchasing the services from themselves with health insurance carriers and others picking up the bill.

Unnecessary and Expensive Medical Care is Often Caused By Inadequate Physician Training and Education

A. Experts cannot agree among themselves what procedures are appropriate. The AMA, Rand Corporation, and a consortium of academic medical centers are developing practice guidelines in order to give physicians better information on treating the nation's most prevalent diseases. James Todd of the AMA correctly noted that "[y]ou can't give a treatment just because it is available. You just give it when its indicated."

B. New technologies are put into use before research is completed regarding appropriate and cost-justified use. The indiscriminate use of new and very costly technologies without a true understanding of their appropriate use is cited by many experts as a primary cause of health care cost escalation.

C. Unnecessary care is also caused by deficiencies in medical education and by the marketing environment for medical care. The Congressional Budget Office reported, "[m]edical education has typically given little emphasis to cost-conscious decision-making. The marketing environment for medical care may encourage use of high-technology equipment, insofar as the availability of such equipment helps health care institutions to attract both physicians and patients." A GAO report found that technological advances have led some hospitals to participate in a medical "arms race." The use of practice guidelines and the dissemination of treatment outcome data should assist physicians in making more appropriate and cost-effective decisions.

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[24] Supplee, Curt, "Florida Reviews Ownership of Clinics," The Washington Post, August 9, 1991.

The AMA Admits Defensive Medicine is Impossible to Quantify

According to an AMA-backed study, "comprehensive" restrictions on the rights of medical malpractice victims will save only between $4 and $9 billion per year, or, at most, 1 percent of total health care costs. The same study admits that defensive medicine is virtually impossible to define. The report concludes:

> "...defensive medicine is a difficult concept to define. There are a variety of reasons why a physician might perform services that are not warranted, including financial incentives, patient expectations, and lack of current clinical information. The wide range of potential motives, which are also likely to overlap in many cases, make it virtually impossible to isolate the contribution of defensive medicine costs."[25]

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[25] "Estimating the Cost of Defensive Medicine", Lewin-VHI, Inc., January 27, 1993.

The Myth of Medical Malpractice

Says Nader: If Anything, Too Few Claims Are Filed. Reform Must Not Restrict Victims' Rights.

By Ralph Nader

Just last month, the First Lady, Hillary Rodham Clinton, in her capacity as the head of the President's Health Care Task Force, met with the American Medical Association and assured those present, "[W]e will offer a serious proposal to curb malpractice problems for all of you."

Just what are the "malpractice problems" that doctors face?

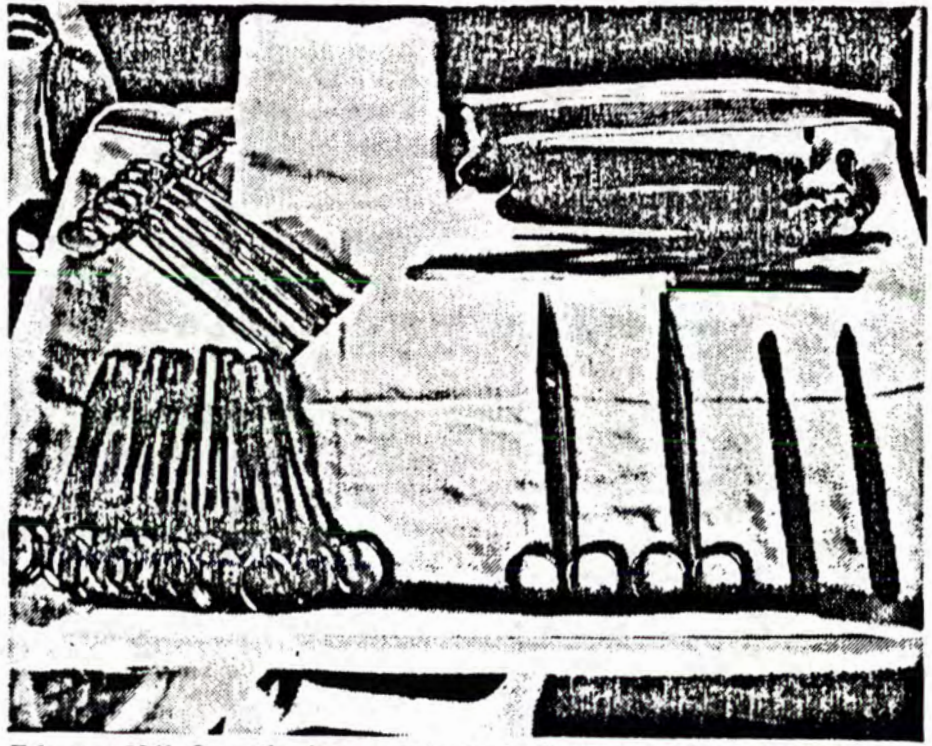
I know what "malpractice problems" patients face: an epidemic of careless medicine that results in an estimated 80,000 deaths and at least 230,000 significant injuries every year.

In fact, medical malpractice is the largest cause of person-to-person fatal violence in the US, exceeding both street homicide and vehicle fatalities combined, according to Census Bureau statistics. National health care reform presents an ideal opportunity to address the cause of medical malpractice and greatly diminish the tremendous pain, suffering, and cost associated with its consequences.

Yet the Administration appears interested in protecting the medical industry from its so-called "malpractice problems." The powerful medical industry lobby claims malpractice suits are a major force behind the nation's skyrocketing health care costs.

In private meetings, the AMA has been pressuring the White House to adopt its proposal, based on California's malpractice liability legislation, the Medical Injury Compensation Reform Act (MICRA).

MICRA places a $250,000 cap on non-economic awards; eliminates the collateral source rule that forces those found liable for malpractice to pay for all of the expenses incurred by the victim; and permits those found liable for malpractice to pay the compensation they owe victims on an installment basis, regardless of inflation and the needs of the victims.



February 1942. Operating instruments are sterilized at an Arizona hospital.

The influential medical lobby wants to reduce the legal rights of Americans without a shred of evidence that this will reduce overall health care costs. MICRA has not reduced health care costs in California. Instead, it has provided a windfall for insurance companies, as well as physicians and hospitals guilty of malpractice.

The real crisis is the rate of medical malpractice in the US. For victims and their families, medical malpractice is more than an abstract issue of public policy, such as enterprise liability, mandatory dispute resolution, or certificates of merit. It is about life and death and the quality of life and sustenance for those who survive malpractice.

Joyce Palso of Orange County, Calif., nearly died after suffering five episodes of heart failure, a stroke, six hospitalizations, and open-heart surgery due to the negligence of her surgeon. She now lives with a mechanical heart valve and takes medication to thin her blood.

Joyce explains the true effect of MICRA: "While I was fighting for my life in the hospital, California began to implement MICRA.... Well, when I got out of the hospital, I could not even find a lawyer to take my case because of the cap on damages imposed by MICRA. Despite the fact that I almost died, my damages were so severely limited by this law that reputable attorneys in the area had discontinued handling medical malpractice cases." Most politicians don't want to hear real-life stories like that of Joyce Palso; their leftover consciences have been PAC-marked.

The real crisis is the rate of medical malpractice in the United States.

In addition to creating hurdles to legal representation, a federal law based on MICRA would hurt the most seriously injured victims and discriminate against injured women, children, and senior citizens.

Capping non-economic damages hurts only the most injured victims — those who were permanently or catastrophically injured by doctor negligence and the families of those who have been killed — since only the most seriously injured individuals ever receive more than $250,000 in non-economic damages.

The $250,000 cap has been heavily eroded by inflation since 1975 when MICRA was enacted. In order to provide the same level of compensation in today's dollars, the cap would have to be approximately $630,000.

Capping non-economic damages dis-

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Ralph Nader is founder of Public Citizen, a consumer advocacy and public policy watchdog group.

Why MICRA Didn't Work in California

Continued from page 37

criminates against injured women, children, and senior citizens — low or non-wage earners — people who will not have high-wage loss in the event of death, serious injury, or illness.

If federal legislation limiting medical liability passes, it will usurp a system of state common law that has evolved prudently over 200 years. The compassionate application of this common law has deterred unsafe medical practices, disclosed dangerous practitioners to the public, and expanded respect for human life.

The fiscal challenge posed by universal health care cannot be resolved by limiting the rights of persons victimized by medical malpractice. These costs are an insignificant part of total health care costs.

In 1991, total health care costs were about $750 billion; medical and hospital malpractice insurance premiums were about $4.8 billion, or 0.6 percent of total health care costs.

In 1976, California passed MICRA. Yet, in 1990, California had the second highest per capita health care costs in the nation. In fact, the medical malpractice system may save money in the health care system because of its deterrent effect on reckless practices.

Although the medical industry argues that "defensive medicine" — what it defines as medical practices that are not in the best interest of the patient but are performed to avoid liability — is driving up health care costs, there is no evidence that so-called defensive medicine would be reduced by restricting medical liability.

"Defensive medicine" has never been objectively defined nor quantified, according to the Office of Technology Assessment. Defensive medicine may simply be good, careful medicine: telling patients more about risks, obtaining more referrals, keeping better patient records, and improving communication with patients.

In addition, much care labeled "defensive medicine" may be billings-driven or the result of physician self-dealing — profitable referrals for testing at facilities in which the doctor has a financial stake. There is no "avalanche" of malpractice suits: only one in eight patients who are victims of malpractice ever files a claim against a health care provider, and only one in 16 malpractice victims receives any compensation from his or her perpetrator.

If anything, too few victims of malpractice file claims. It would be legislative malpractice for the President and Congress to restrict malpractice victims' rights in the face of the overwhelming evidence that the malpractice liability system should be strengthened, not weakened.

There are affirmative, pro-consumer, and cost-containing steps that can be taken to address medical malpractice:

1. Improve consumer access to reliable information about negligent practitioners, including public access to the taxpayer-funded National Practitioner Data Bank.

The data bank provides the best source of information on the disciplinary record of physicians, including state and federal disciplinary actions, hospital and professional society sanctions, and malpractice settlements and judgments.

Due to pressure from the medical lobby, the information in the data bank is not available to the public or to other doctors seeking to make referrals. Opening the data bank to the public will help inform consumers to avoid those practitioners who commit the majority of malpractice.

2. Strengthen the state medical boards' disciplinary functions. The current doctor discipline system, controlled by the medical community, is abysmal. Negligent and incompetent doctors are rarely disciplined or removed from practice.

At most, about 0.5 percent of the nation's doctors face any sanctions (many for financial, not malpractice, abuses) from their state medical boards each year. State medical boards may take more than two years even to investigate complaints of doctor incompetence or misconduct, allowing the doctor to continue to treat other patients during this time.

3. Reform the malpractice insurance industry through measures that would ensure sensible underwriting practices and lower premium costs.

The subcategories now used by insurance companies result in high premiums for some specialties. Insurance companies should be required to spread risk more effectively by placing all physicians in larger pools. In addition, insurance companies should charge rates based on a physician's own experience with malpractice lawsuits, thereby ensuring that doctors with histories of negligent behavior would pay more.

4. Establish risk-management programs, as Harvard-affiliated hospitals have done, and improve training, licensing, and recertification of physicians. More information should be made available to physicians through the development and dissemination of outcomes research, practice guidelines, and continuing medical education.

The President's desire to placate the powerful players in the health care industry has already jeopardized the reforms that would cut the fat, fraud, and profiteering from the health care industries.

If the Clinton Administration chooses to restrict malpractice victims' rights as part of its health care plan, it would be nothing more than a callous move designed to win the support of the medical lobby at the expense of seriously injured patients.

Such a course of action will weaken the public support that is crucial to the success of any health care plan and will generate a level of protest that will surprise the inside-the-Beltway pundits.

Capping non-economic damages discriminates against women, children, and senior citizens.

A word to the patsies of health care reform

THE VIEW FROM HERE

SIDNEY ZION

LONG before Bill Clinton took the oath, the word was out: The victims of medical malpractice would be the prime patsies in Hillary Rodham Clinton's health care package.

I shook it off as a sick joke. "Tort reform," that code lingo for the Bad Doctors Protection Program, was the promise of Bush-Quayle, the ticket that ran around the country flailing at the trial lawyers in their "tassled loafers" and stretch limos. Clinton was accused of selling out to these shysters who had managed to ruin the medical profession and run up our insurance bills.

Clinton took their money and made them promises. But these promises were the stuff of common decency and (I thought) the product of his Yale Law School education, which, if it taught him (and Hillary) anything, it was that the one thing the health care system didn't need was more insulation for doctors, hospitals and insurance companies.

It appears that I was dead wrong. If the Clinton Administration has its way, the doctors will have a license to kill and maim that none of them would have dreamed possible under a second Bush Administration.

Medical malpractice is one of the leading causes of death and serious injury in the U.S., dwarfing such high profile killers as AIDS and drunk driving. The Joint Commission on Accreditation of Health Care Organizations reported that there are some 100,000 preventable deaths due to medical injury annually nationwide.

> ***Medical malpractice dwarfs such high profile killers as AIDS and drunk driving.***

Since AIDS was discovered, we have lost a grand total of 180,000 Americans. On the roads, alcohol accounts for about 20,000 lives per year.

We can never do enough to find a cure for AIDS. But at least we are trying. And the public is informed on a daily basis about how to prevent it and what we are and aren't doing to get rid of it.

And surely we get the message about drunk driving — a message delivered through funding by the liquor industry. Not to mention secondary smoke, now labeled a carcinogen by the Environmental Protection Agency on hotly contested statistics that claim no more than 5,000 lives a year.

We have virtually suspended the Bill of Rights to catch drinkers on the highways. And we have set children against parents and brothers against sisters in our great crusade for a smoke-free society.

About malpractice we are told next to nothing — except that we ought to get these lousy ambulance chasers off the backs of Marcus Welby M.D.

And yet, as intractable as AIDS has been, and drinking and smoking, that's how easy it would be to curb medical malpractice.

First, expose the problem: let's bring all the power of government behind an informational campaign.

However, most people think it is an oddity unless they think it can't happen to them. I was that way until my daughter Libby died in a hospital emergency room, which I'm aware make me less than an objective observer. Once we let them know that it kills four times as many people as drunk drivers and geometrically more than secondary cigarette smoke, and how many times more folks than AIDS — well, the cure will follow as night from day.

It is called law. If doctors kill or maim you, they must answer to the law as any other citizen. And this can range from disciplinary proceedings to criminal prosecutions, depending on the severity of the negligence.

New York is now ranked 49th in the country in disciplining bad doctors, according to Ralph Nader's Public Citizen Health Research Group. Five years ago, we ranked 16th.

What we need is an independent commission in every state to enforce discipline and for district attorneys to start enforcing the law of criminal negligence on doctors. One prosecution of a criminally negligent doc — apart from well-publicized cases like the abortion butcher — would do more to cure malpractice than all the studies in the world.

Instead, we get Hillary Rodham Clinton at the American Medical Association convention, bringing the medics to their feet with a "serious" promise to "curb malpractice problems" and cut down jury verdicts.

Who won the election, anyway?

Sidney Zion is an author and journalist.

The New York Times

6/14/93 p. A12

First Lady Offers Doctors A 'Bargain' on Health Plan

By ROBERT PEAR
Special to The New York Times

CHICAGO, June 13 — In a speech to the American Medical Association today, Hillary Rodham Clinton proposed "a new bargain" in which the White House would limit malpractice lawsuits, relax regulation of medical laboratories and free doctors from burdensome Government supervision if the doctors supported President Clinton's effort to overhaul the nation's health-care system.

Mrs. Clinton said doctors must take the lead in cracking down on incompetence, negligence and other abuses by practicing physicians. In return, she said, the Administration would try to protect the "clinical autonomy" of doctors, reduce paperwork and remove legal obstacles to self-regulation of the medical profession.

Speaking to an audience of more than 3,000 at the annual meeting of the A.M.A. here, Mrs. Clinton said doctors could not regain "trust and respect and professionalism" without completely changing the operation and structure of the nation's health-care system.

She told the doctors what they wanted to hear on many issues, including medical malpractice, but she generally avoided issues on which the President disagreed with the association. The organization, for example, opposes Mr. Clinton's plan to establish national limits on all health-care spending, public and private, and is deeply concerned about various price controls that have been considered by the White House.

"Over the last decade," Mrs. Clinton said, "our health-care system has been under extraordinary stress. That stress has begun to break down many of the relationships that stand at the core of the health-care system. That breakdown has, in turn, undermined your profession in many ways, changing the nature and rewards of practicing medicine."

Holding out an olive branch to the A.M.A.

Accordingly, she said, "we have to work harder to renew trust in who doctors are and what doctors do."

Mrs. Clinton was head of the President's Task Force on National Health Care Reform, which was supposed to develop a legislative proposal by May 3 to control health costs and guarantee insurance coverage for all Americans. The plan, now expected sometime before the end of September, has been delayed by the complexity of the work and by the fact that Mr. Clinton has been preoccupied with the politics of budget legislation now pending in Congress.

Mrs. Clinton did not say how the Administration would pay for its proposals. But she did say, "We will try to include prescription drugs in the comprehensive benefit package for all Americans, including those over 65 on Medicare."

She also tried to allay doctors' concerns that Mr. Clinton wanted the United States to follow Canada, Germany or other countries where the government plays a larger role in medicine.

An American Solution

"We have looked at every other system in the world," Mrs. Clinton said. "We have concluded that what is needed is an American solution for an American problem, by creating an American health-care system that works for America."

Under the President's plan, she said, patients would be able to choose their doctors, and doctors would be able to choose the health plans for which they worked. In addition, she said, doctors would have "the option of being part of more than one plan at the same time," even though the health plans will compete with one another.

Mrs. Clinton expressed sympathy for members of her audience. "I know that many of you feel that as doctors you are under siege in the current system," she said. "And I think there is cause for you to believe that, because we are witnessing a disturbing assault on the doctor-patient relationship."

Mrs. Clinton received warm applause when she said, "I can understand how many of you must feel when instead of being trusted for your expertise, you are expected to call an 800 number and get approval for even basic medical procedures from a total stranger.

Malpractice caps and less red tape in return for doctors' support.

No Mention of Price Gouging

She added: "The result of this excessive oversight, this peering over all of your shoulders, is a system of backward incentives. It rewards providers for over-prescribing, over-testing and generally overdoing, and it punishes doctors who show proper restraint and exercise their professional judgment in ways that those sitting at the computers disagree with."

Mrs. Clinton did not attack price gouging and profiteering in the health-care industry, as she did in a speech to a labor union on May 26. Rather, she pleaded with doctors to forge "a new bargain" with her today.

"We need to remove from the vast majority of physicians these unnecessary, repetitive, often unread forms and instead substitute more discipline, more peer review, more careful scrutiny of your colleagues," Mrs. Clinton said. "Let us remove the kind of micromanagement and regulation that has not improved quality and has wasted billions of dollars."

Dealing With Malpractice

Specifically, Mrs. Clinton said, "We have to simplify and eliminate the burdensome regulations" imposed on medical laboratories. Congress required such regulations several years ago after Federal investigators found that some laboratories were failing to detect clear evidence of cancer and other deadly diseases. But doctors have asserted that they will be unable to perform certain laboratory tests in their offices under the new rules, so patients will suffer.

As part of the new bargain, Mrs. Clinton said, "We will offer a serious proposal to curb malpractice problems." She did not give details. But White House officials said they were considering proposals that would require arbitration of claims and would limit payments to victims of malpractice and their lawyers. The limits would apply, in particular, to damages for "pain and suffering" caused by a doctor's negligence.

In a telephone interview, Ralph Nader, the consumer advocate, denounced these proposals. "They will alienate grass-roots citizen groups that Clinton was counting on to support his overall health-care plan," Mr. Nader said. "These malpractice proposals would strip vulnerable patients of the meager rights they have now, and the proposals will depreciate Hillary Clinton's most important asset: knowledgable compassion for consumers."

The Washington Post

White House Considers AMA's Prescription For Malpractice Relief

By Dana Priest
Washington Post Staff Writer

Faced with vigorous opposition from physicians' and hospital groups, the Clinton administration has retreated from its recently stated position on medical malpractice reform and instead is considering changes advocated by the American Medical Association, White House officials said yesterday.

Three weeks ago, the chair of the White House's malpractice reform working group publicly said that "enterprise liability" would be the centerpiece of the reform package. Under that system, patients could sue the health plans that treat them, but not their individual doctors.

But White House officials said yesterday that enterprise liability had been scrapped because reaction to the idea "was not affirmative."

Instead, the White House now plans to propose a more traditional approach favored by the AMA and the Bush administration.

While the details are still to be worked out, the new proposal includes limits on some malpractice awards for pain and suffering, caps on some attorney fees, mechanisms for alternative dispute resolution and the possibility of paying awards in installments instead of a lump sum.

It is unclear how much flexibility the states would be given to implement malpractice reform.

First Lady Hillary Rodham Clinton will address the AMA's annual conference in Chicago Sunday and is likely to refer to the administration's new direction then.

Consumer groups, which have lobbied the administration not to weaken patients' legal leverage over physicians, are likely to oppose the new approach. "This is the AMA's wish list, which is anathema to the consumer movement," said Pamela Gilbert, director of Public Citizen's Congress Watch. "If there are costs to be saved, why pick on the most vulnerable. [This approach] is cruel, it doesn't work and it lets the doctors off the hook."

Malpractice reform is an emotional issue for both physicians and the public. Most health policy experts, however, do not believe it is a major contributor to rising health costs. There are no definitive estimates of the number of deaths and injuries caused by malpractice. One frequently cited Harvard University study calculated that 80,000 people are killed each year and another 230,000 injured by physician negligence.

The AMA estimates that doctor and hospital malpractice premiums will total $9.2 billion this year.

The AMA was pleased by news of the administration's change of heart. "It's gratifying when they realize the medical profession is united on an issue and more importantly when the profession is right on the issue," said James S. Todd, AMA executive vice president. "They also increasingly realize that if the health care reform plan is going to work, it's got to have the support of those who provide the care."

The administration reportedly fears a rebellion by organized physicians and is worried that they might throw their support behind an alternative reform package under development by congressional Republicans.

Last week, 69 medical speciality groups sent a letter to Hillary Clinton opposing enterprise liability. Last Saturday Todd and two members of the AMA board of trustees met with White House health adviser Ira Magaziner to discuss the matter.

The White House has been prodding physicians to accept some voluntary controls on their fees as part of its cost-containment strategy. Todd said that no deal had been struck. But when asked what physicians consider to be their "bottom line" concerns on any health reform package, he did not mention physicians' reimbursement.

Last month former vice president Dan Quayle argued in a Wall Street Journal opinion piece for the same malpractice reform measures as those the White House is now considering.

"Since the Clinton administration has come around to admitting there is a problem, there still is a chance that it will offer workable solutions," Quayle wrote. "But it will take much more than Clinton's enterprise-liability placebo."

Public Citizen

Buyers Up • Congress Watch • Critical Mass • Health Research Group • Litigation Group

Ralph Nader, Founder

August 24, 1993

Ms. Melanne Verveer
Office of the First Lady
The White House
Washington, D.C. 20500

Melanne

Dear ~~Ms.~~ Verveer,

As President Clinton finalizes his health care proposal, we strongly urge you not to restrict the legal rights of victims of medical malpractice. There is no factual or public policy rationale for restricting consumers' legal rights. In addition, the most commonly proposed malpractice liability restrictions are arbitrary and fundamentally unfair to the most severely injured victims of medical malpractice.

Instead, we encourage you to pursue a course which will enhance our currently weak system of doctor discipline and information disclosure and expand consumers' access to the civil justice system.

We have enclosed background materials on medical malpractice in the context of national health care reform. Please feel free to call us if you need further information.

Sincerely,

Pamela Gilbert

Pamela Gilbert
Director
Congress Watch

Mern Horan

Mern Horan
Staff Attorney
Congress Watch

Enclosures

215 Pennsylvania Avenue SE • Washington, D.C. 20003 • (202) 546-4996 • FAX: (202) 547-7392

June 29, 1993

President Bill Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Clinton:

We are gravely disturbed to learn that you are seriously considering proposals, advocated by the American Medical Association, the insurance industry and other business interests, which would limit the legal rights of consumers who become victims of medical malpractice.

We are writing to you today because we believe that such restrictions, if included in your national health care proposal, would lead to widespread consumer opposition -- including our own -- to the entire proposal, depriving it of the public confidence that is critical to its success, both in Congress and in the nation.

According to reliable sources, your proposed medical malpractice restrictions are apparently based on a California statute known as the Medical Injury Compensation Reform Act (MICRA). The proposal would:

(1) Limit the compensation for "human injuries" which doctors, hospitals and other health care providers would have to pay to patients injured by their malpractice, no matter how egregious the malpractice nor how incompetent the practitioner.

(2) Force consumers, businesses and taxpayer-financed health care plans to subsidize the malpractice caused by negligent doctors and hospitals, by requiring victims' health insurance plans to pay for harms caused by malpractice, rather than the provider responsible for the malpractice.

(3) Allow negligent doctors and hospitals to refuse to pay the compensation ordered by a jury in full and immediately. Instead, those found guilty of negligence would be allowed to hold on to the money they owe the victim and pay in installments. If the victim dies earlier than expected, the wrongdoer, or its insurance company, keeps the balance owed.

While the powerful American Medical Association's position on your health care plan will no doubt influence the outcome in Congress, we urge you to consider the extensive literature and studies which demonstrate that restrictions on the rights of victims of medical malpractice benefit only the insurance industry and the small proportion of health care providers who are responsible for most of the malpractice in the nation.

<u>Limits on malpractice lawsuits and settlements or jury awards will have no appreciable impact on the nation's health care costs.</u> The soaring cost of health care, and the millions of

Americans who are denied access to it, are the problems we had understood it was your intention to solve. Numerous studies -- including one which examines the impact of the California law upon which your proposal is said to be based -- show that malpractice restrictions will not reduce health care costs.

The study of California's law shows that the state's restrictions on the legal rights of malpractice victims have primarily benefited insurance companies and negligent providers. They have not lowered California's health care costs, which are as high, and by some measures higher, than the national average, and have grown nearly twice as fast as the inflation rate since 1985.
The study, *California's Micra: Profile of a Failed Experiment in Tort Law Restrictions, Voter Revolt (June 1993),* is attached.

There is a malpractice "crisis" in the nation, and it is the widespread prevalence of malpractice. An estimated 80,000 Americans die from medical negligence each year -- nearly twice as many as are killed on the highway in auto accidents. According to a landmark study, over 85 percent of the instances of malpractice are not the subject of litigation. "We do not now have a problem of too many claims; if anything, there are too few," was the conclusion of *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, The Report of the Harvard Medical Practice Study to the State of New York, March 28, 1990.

The malpractice epidemic has been abetted by the abysmal failure of the medical disciplinary system to track down and remedy malpracticing practitioners (The report *Comparing State Medical Boards*, Public Citizen Health Research Group, January, 1993 is attached).

California's medical disciplinary system, established to "protect" patients from malpractice in lieu of the deterrence previously provided by the tort system, has been discredited as a shill for the industry it is supposed to regulate. (See An Initial Report on the Physician Discipline System of the Board of Medical Quality Assurance, Robert Fellmeth, Center for Public Interest Law, 1989).

The proposals to limit the rights of malpractice victims are inconsistent with your campaign promises, particularly your emphatic promotion of individual responsibility. The proposals would absolve medical providers of the duty, concern and caution that they, like all others in society, owe to the rest of us, backed by the right to go to court. Laws which diminish the responsibility of doctors and hospitals for the treatment they provide will simply lead to more malpractice and higher costs.

Moreover, access to high quality medicine -- a major concern of the White House -- is eviscerated by a scheme which allows negligent physicians to evade responsibility for their actions. The right to choose one's own doctor is worthless if patients are to be deprived of their ability to insist on the highest quality medical care and the elementary right not to become the victim of negligence.

Indeed, the proposed restrictions fly in the face of what should be a key component in your administration's national health care plan: reforms guaranteeing the highest quality of health care. To guarantee that universal health care is not more than a sham, your proposal must include provisions to protect all Americans against the human devastations of malpractice and other abuses.

Most Americans, regardless of political affiliation, welcomed your commitment to an overhaul of our nation's grossly expensive and inefficient health care system. Each of the undersigned organizations has worked hard in Washington and across the United States to reform the health care system.

But if the price of your effort is a trade-off that bargains away the rights of the most seriously injured to hold the responsible parties accountable in order to gain the political support of the medical lobby, we believe few in the nation will think it worth the cost.

A reformed national health care system must reflect, in every detail, humanity and compassion. Limiting the compensation of victims of malpractice is incompatible with the values upon which health care reform must be based if it is to succeed. We regret to say that we will not be able to support any plan if it is so fatally flawed.

Sincerely,

Gene Kimmelman
Consumer Federation of America

Laura Wittkin
National Center for Patients' Rights

Elma Holder
National Citizens' Coalition for Nursing Home Reform

Linda De Benedictis
New England Patients' Rights Group

Robert Wages
Oil, Chemical and Atomic Workers' Union

Charles Inlander
People's Medical Society

Joan Claybrook
Public Citizen

Terry McBride
Safe Medicine for Consumers

Harvey Rosenfield
Voter Revolt

Public Interest Research Groups (PIRGs):

Chuck Malick
Colorado

Kiki Dunton
Connecticut

David Simon
Florida

Diane Brown
Illinois

Josh Kratka
Massachusetts

Dan Pontious
Maryland

Tom Geiger
Michigan

Chris Lockwood
Missouri

Andrew Igregas
New Jersey

Blair Horner
New York

Karen DeCamp
Ohio

Jon Stubenval
Oregon

Sheila Ballen
Pennsylvania

Rebecca Levinson
Washington

Anne Ditzler
Wisconsin

March 29, 1993

President Bill Clinton
First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Clinton and Mrs. Clinton:

We are gravely disturbed to learn that the White House is seriously considering proposals, advocated by the medical lobby, which would limit the legal rights of consumers who become victims of medical malpractice.

As described in the New York Times (3/9/93), the proposals would:

(1) Limit the compensation negligent doctors, hospitals and insurers would have to pay to patients injured by their malpractice, no matter how egregious the malpractice or how incompetent the practitioner. This punishes the most grievously injured victims.

(2) Force consumers, businesses and taxpayer-financed health care plans to subsidize the malpractice caused by negligent doctors and hospitals, by requiring health insurance plans to pay for harms caused by malpractice.

(3) Allow negligent doctors and hospitals to refuse to pay the compensation ordered by a jury in full and immediately. Instead, those found guilty of negligence would be allowed to hold on to the money they owe the victim and pay in installments.

(4) Discourage patients from pursuing claims in court. As it stands now, only one in ten victims of malpractice ever pursues a claim. Reform efforts should focus on <u>increasing</u> the number of victims who bring claims for compensation, rather than discouraging the claims that are currently brought.

Taken together, these proposals would completely preempt the protective consumer rights carefully developed by state legislatures and courts over the preceding two hundred years. And for what reason? To assuage the medical lobby, which complains that malpractice lawsuits are responsible for the high cost of health care in our country. However, numerous empirical studies dispute this self-serving contention:

* Malpractice premiums and malpractice claims have nothing to do with the soaring cost of health care, which is the political problem the medical industry is desperately trying to dodge. The

premiums paid by doctors and hospitals for malpractice insurance are approximately 0.6% of health care costs in the United States (A.M. Best's Loss Development Reserve (1991); Health Care Financing Administration, Office of the Actuary (October 2, 1991)), and obviously have nothing to do with soaring health care costs, which are a function of charges by doctors, hospitals, insurance companies and drug companies. The medical lobby likes to blame the threat of lawsuits for the expense of what it calls "defensive medicine," but this is merely a convenient scapegoat for the medical industry's own desire to reap excessive profits. Most of what the medical lobby calls "defensive medicine" is not performed for the purpose of evading lawsuits. (Economic Implications of Rising Health Care Costs, Congressional Budget Office (1992)).

* Consumer Reports' 1992 book, How to Resolve the Health Care Crisis: Affordable Protection for <u>All</u> Americans, notes that, "malpractice claims are in a downward swing. The rate of claims has declined steadily since the peak of the last 'crisis' in 1985." While the number of malpractice claims per capita went down in the early 1980's, (National Center for State Courts, 1986) malpractice insurance premiums have increased by 30 percent (Report on Profitability by Line by State, National Association of Insurance Commissioners (NAIC), 1986, 1991) -- proof that rates are wildly excessive. Since many of the same private insurance companies that sell malpractice liability policies also sell health insurance coverage, efforts to cut malpractice premiums -- like efforts to cut health care costs generally -- threaten the profits delivered by the "pass-through" system and are bitterly resisted. The medical profession's target ought to be the insurance industry, whose unjustified price-gouging has led to huge profits (Report on Profitability by Line by State, National Association of Insurance Commissioners (November, 1991)), and not consumers.

* If there is a malpractice "crisis" in the nation it is the widespread prevalence of malpractice, 88% of which is never the subject of litigation ("We do not now have a problem of too many claims; if anything, there are too few." (Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York" The Report of the Harvard Medical Practice Study To the State of New York, March 28, 1990)), abetted by the abysmal failure of the medical disciplinary system to track down and remedy malpracticing practitioners (Report Comparing State Medical Boards, Public Citizen Health Research Group, January, 1993).

* Restrictions on malpractice victims' tort rights in several states have only succeeded in depriving injured patients of needed compensation or even the ability to hire a lawyer. Moreover, restrictions on the rights of malpractice victims has done nothing to contain health care costs. In California, a

similar package of restrictions did not lower malpractice premiums, and many doctors were forced to set up their own insurance companies. In the meantime, California's medical disciplinary system, established to "protect" patients from malpractice, has been discredited as a shill for the industry it is supposed to regulate. (An Initial Report on the Physician Discipline System of the Board of Medical Quality Assurance, Robert Fellmeth, Center for Public Interest Law, 1989).

There is nothing new in these proposals, certainly nothing that could be the product of a legitimate inquiry such as that promised by the White House in describing the present Task Force process. Astonishingly, they are the identical recycled special interest inhumanities put forward by then President George Bush and Vice President Dan Quayle as part of their discredited effort to place business wrongdoers beyond the reach of American courts and to allow the wrongdoers to escape accountability to those harmed by their actions. That the Bush/Quayle proposals would resurface as the product of the administration's health care proposal is surprising and disturbing for several reasons.

First, these onerous recommendations are inconsistent with your campaign promises, particularly your emphatic promotion of individual responsibility. The proposals would absolve medical providers of the duty, concern and caution that they, like all others in society, owe to the rest of us, backed by the right to go to court. Laws which diminish the responsibility of doctors and hospitals for the treatment they provide will simply lead to more malpractice and higher costs.

Second, access to high quality medicine -- a major concern of the White House -- is eviscerated by a scheme which allows negligent physicians to evade responsibility for their actions. The right to choose one's own doctor is worthless if patients are to be deprived of their ability to insist on the highest quality medical care and the elementary right not to become the victim of negligence.

Indeed, the proposed restrictions fly in the face of what should be a key component in your administration's national health care plan: reforms guaranteeing the highest quality of health care. To guarantee that universal health care is not more than a sham, your proposal must include provisions to protect all Americans against the human devastations of malpractice and other abuses. Specifically, we have proposed a series of reforms to reduce the incidence of malpractice, summarized as follows:

* Recertification of doctors and stronger regulation of medical facilities. No national health care plan can work if it is not backed by national minimum standards for medical care to protect patients against medical mishaps. A major component of such protection is a program to periodically ensure that medical

providers continue to meet necessary standards for practice through examinations and performance audits.

* Expanded access to information about negligent providers. A stronger federal role is much needed in tracking down malpracticing providers, beginning with allowing the public access to the taxpayer-funded National Practitioner Data Bank, which gathers information on actions taken against negligent doctors. Additionally, all evidence of substandard performance -- loss of hospital admitting privileges, for example -- should be reported to disciplinary authorities at the state and federal level for their evaluation.

* Stronger federal and state disciplinary authority. In most states, the disciplinary system is a failure, often controlled by the industry it is supposed to regulate. The federal government should provide greater resources to state disciplinary boards and prohibit links between such agencies and the medical lobby.

* Eliminate costly self-dealing and other financial abuses. Many physicians and hospitals are involved in self-dealing arrangements with laboratories, medical imaging centers and other facilities. These relationships are highly lucrative for members of the medical lobby but are a major cause of skyrocketing costs. Patients cannot afford the ethical and financial price.

* Criminal sanctions for misuse of prescription drugs and unnecessary surgery. The sanctions of the civil justice system often are insufficient to deter and punish misconduct such as unnecessary surgery or prescriptions that threaten the health of patients and impose an unacceptable cost on the health care system. Such abuses should be punished by criminal sanctions.

* Reform the insurance system to reward the safe practice of medicine. Another way to motivate safe medicine is to prohibit insurers from engaging in underwriting practices that punish good doctors. Presently, insurers define sub-categories of specialties so narrowly that only a handful of doctors qualify; because there are too few practitioners to spread the risk broadly, premiums are excessive. Such sub-categories should be collapsed into unified pools in which all physicians participate. However, insurers should be forced to treat malpractice insurance policyholders the ways many states increasingly treat motorists: those who have a good record with no claims are entitled to lower premiums. By "experience rating" physicians, insurers will reward the safe practice of medicine and penalize recidivist medical practitioners whose negligence or incompetence are killing over 80,000 Americans a year in hospitals alone. (This figure is based on a conservative projection of the findings of "Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York" The Report of the Harvard Medical Practice Study To the State of New York, March 28, 1990).

Our proposals place the focus of reform efforts squarely where it belongs: on the need to prevent and punish malpractice, not limit the rights of its victims.

Americans hope that the health care proposal developed by the White House will be one which "puts people first," as you have promised. But many citizens are increasingly concerned that the process which has been established to develop the plan will put the special interests first. The report that the White House is considering the medical lobby's proposals appears to justify that fear.

Our alarm is compounded by the apparent reasoning behind the proposals floated in the news media: that doctors and hospitals must be given a political reward in the form of diminishing the legal rights of their harmed patients in exchange for accepting the health care reforms that your administration seeks to deliver. The suggestion that medical patients who become victimized by negligent doctors and hospitals should be denied their right to put their case before a jury just because the wealthy medical practioners are going to have to limit their fees is macabre.

We ask that you advise the health care task force members that the long-held legal rights of medical patients are not on the table for compromise, that they should direct their attention to preventing the costly and tragic incidence of medical malpractice that is so widespread, and they and you publicly assure consumers that their rights will not be limited. We stand ready to provide you with extensive information on the issues addressed in this letter and we would like to meet with you at your earliest convenience to discuss these matters in greater detail.

Sincerely,

Ralph Nader

Charles Inlander
President
People's Medical Society

Cathy Hurwit
Legislative Director
Citizen Action

Robert Wages
President
Oil, Chemical and Atomic
Workers International Union

Pamela Gilbert
Director
Public Citizen's Congress
Watch

Consumer Federation of America

Consumers Union

March 29, 1993

President Bill Clinton
First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Clinton and Ms. Clinton:

We are concerned that the White House is seriously considering proposals, advocated by the medical lobby, which would limit the legal rights of consumers who become victims of medical malpractice.

Contrary to the claims of the medical/insurance communities, there is no factual or public policy basis for restricting consumers' legal rights beyond the limitations states have imposed in their medical malpractice laws. The most commonly proposed "malpractice reforms" (e.g., caps on pain and suffering, limits on punitive damages, shortened statutes of limitation, restricted expert testimony, denial of trial-by-jury, expanded immunity from legal challenge) are arbitrary and fundamentally unfair to the most severely injured victims of medical negligence.

By reducing financial penalties for the most egregious medical misbehavior, these "malpractice reforms" would reduce market incentives to promote the highest quality of medical care at the lowest price. In addition, any potential financial savings from changes in malpractice law are minuscule in the context of the overall health care budget (i.e., elimination of all malpractice costs would save $5-10 billion per year). Finally, the cost of legal awards has declined in recent years.

Although reliable nationwide malpractice data have never been compiled, a mixture of national, state and regional studies reveal the following facts:

* The number of malpractice claims has declined since 1985. Between 1985 and 1989, A.B. Best found a 19 percent reduction in claims filed.[1]

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[1] A.B. Best's Aggregates and Averages, 1990, Schedule P, Part 1F.

* Malpractice insurance premiums have been falling. Data from A.B. Best show a 7.6 percent nationwide reduction in malpractice premiums from 1989-1991.[2]

* Most of what is described as "defensive medicine" (i.e., ordering excessive tests and procedures) may simply be physician self-dealing. When doctors have a financial stake in testing facilities, CFA's research shows that twice as many tests are ordered at prices up to 40 percent higher than charged by independent labs.[3] According to a recent study published in the New England Journal of Medicine, this self-referral by physicians who send patients to facilities they own may add $40 billion each year to our health care budget for needless and excessive medical treatment.[4] Eliminating this wasteful treatment is more likely than caps on pain and suffering to save money[5] and reduce "defensive medicine".

* A very small percentage of negligent behavior results in the filing of a malpractice claim. According to the Harvard Medical Practice Studies,[6] of the 3.7 percent of hospitalization's in New York in 1984 that involved "adverse events," about one-quarter of the "adverse events" involved negligent behavior and only 1.5 percent of these negligent acts resulted in the filing of a malpractice claim. A similar study in California showed that only ten percent of the injuries caused by negligence resulted in the filing of a malpractice claim.[7]

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[2] Best's Review, 1992 at 30.

[3] Dr. Mark N. Cooper, "Physician Self-Dealing For Diagnostic Tests in the 1980s: Defensive Medicine v. Offensive Profits," CFA, Presentation to National Institute on Clinical Laboratory Reimbursement and Policy, Oct. 3, 1991.

[4] Harvard Magazine, March - April 1993 at 15.

[5] The Lewin - VHI report shows that limits on pain and suffering, expert testimony, statutes of limitations, etc. would only save $4.3 billion once implemented, and $35.8 billion over 5 years. However, even these small savings are suspect, given that the report does not control for self-dealing.

[6] A. Russell Locatio, et. al., "Relations Between Malpractice Claims and Adverse Events Due to Negligence," The New England Journal of Medicine, Vol. 325 No. 4, July 25, 1991.

[7] Danzon, Medical Malpractice: Theory, Evidence and Public Policy, Cambridge, MA, Harvard University Press, 1985.

Despite these facts, we recognize that there is a perceived problem with malpractice awards and that much could be done to improve the adversarial legal process to benefit consumers. We therefore urge you to consider promoting balanced alternative dispute resolution mechanisms that offer malpractice victims an opportunity to receive adequate compensation without pursuing costly litigation. As more data are gathered on the effectiveness of dispute resolution systems, it will be possible to address legitimate concerns about our legal system without denying consumers their right to full compensation for injuries resulting from medical negligence.

Sincerely,

Gene Kimmelman
Consumer Federation of America

Linda Lipsen
Consumer Union

-MEMORANDUM-

TO: Ira Magaziner, Bob Berenson, Kathy Hastings
FROM: Pamela Gilbert, Director, Congress Watch
Mern Horan, Staff Attorney, Congress Watch
Linda Lipsen, Legislative Director, Consumers Union
Gene Kimmelman, Legislative Director, Consumer Federation of America
DATE: April 30, 1993
RE: Medical Malpractice

Thank you for taking the time to meet with us to discuss medical malpractice. As you may know, for over ten years, our three organizations have worked together to oppose efforts by product manufacturers and others to restrict the legal rights of injured victims. Therefore, although we attended separate meetings with you, we thought it would be most efficient to follow our usual practice and send you one memo from all three of our organizations. The purpose of this memo and the attached supporting materials is to record and clarify our joint position on the various topics covered in our discussions. Please feel free to call us with any additional questions or comments you may have. We are eager to continue this dialogue in the hope that we can agree on proposals that will achieve the goals we all share: reduce the incidence of malpractice; improve doctor discipline; compensate more victims of malpractice; and make the medical malpractice system more efficient and less costly.

I. The importance of the civil justice system.

The civil justice system serves four goals:

* compensates victims;

* provides safety incentives;

* punishes and deters reckless, knowing or repeated misconduct; and

* provides a mechanism to discover and disclose information about negligent, reckless or knowing misconduct.

Although the first two goals are the ones most frequently cited as the purposes of the civil justice system, in reality, these are not the strongest characteristics of our legal system. In fact, very few victims of medical malpractice are ever compensated through the legal system, and the most seriously injured are most often undercompensated. Furthermore, the virtual epidemic of medical negligence in the U.S. today (between 150,000 and 300,000 deaths and serious injuries

every year)[1] is strong evidence that the legal system does not provide sufficient incentives for delivering high-quality medical care.

In contrast, we believe that the civil justice system plays a more effective and irreplaceable role in accomplishing the last two goals listed above. We have found no substitute for our constitutionally-mandated jury system when it comes to ferreting out the truth about an incident, assigning fault and personal responsibility, and assessing compensation and punishment. This right -- to go before a jury of your peers to seek justice when you believe that you have been harmed by the acts of another -- should not be curbed by governmental action. In fact, the government should be working to enhance citizens' access to the courts, through increased funding and other measures.

We believe that alternative mechanisms to the court system are appropriate if they more fairly and more efficiently accomplish the compensation and safety incentive goals of the system as long as the civil justice system remains available and unrestricted. We are eager to work with you to develop voluntary and nonbinding alternative dispute resolution mechanisms that will compensate more people, more fairly and efficiently. We believe that if the alternative mechanisms meet these criteria, they will be freely chosen by both sides of most disputes, thereby reducing the number of costly lawsuits without restricting the right to a jury trial.

In addition, Public Citizen has worked for many years on doctor discipline and quality of care issues, and we are pleased that you are interested in including such measures in your health care proposal. For your information, we have enclosed our most recent draft proposal on quality of care.

II. Enterprise liability.

Enterprise liability is an entirely new concept for us, and as far as we know, it is as yet untried. Therefore, it is difficult for us to assess whether enterprise liability for medical malpractice cases will benefit consumers until we have a chance to review an actual proposal. We have, however, a number of suggestions and concerns that we believe must be addressed in any enterprise liability scheme:

1. Doctor Discipline

By removing doctors from personal liability in medical malpractice lawsuits, enterprise liability will weaken current incentives to practice safe medicine. We understand that some people believe that enterprise liability will actually increase the oversight of medical care by hospitals and HMOs because of the increased liability that will be faced by those entities. We

[1] "Comparing State Medical Boards," Public Citizen Health Research Group, p. 15, January, 1993.

are concerned, however, that this will not be true in many instances. For example, very often, doctors who commit repeated malpractice are also big moneymakers for hospitals. We question whether hospitals in such situations will deem it to be in their best financial interest to take disciplinary action against those doctors. Therefore, it is imperative that the enterprise liability scheme include a vastly improved system for disciplining doctors who practice negligent or substandard medicine.

We have enclosed Comparing State Medical Boards, a study by Dr. Sidney Wolfe and the Public Citizen Health Research Group, that lists recommendations for improving quality of care systems. In addition, as we mention above, we have enclosed a draft quality of care proposal that we recently developed.

2. Substantive and Procedural Standards

We are concerned that under an enterprise liability scheme, liability standards for hospitals and other institutions may develop differently from the rules that are now in place for physician liability. For example, whereas doctors are usually held to a high national standard of care, we fear that hospitals and HMOs may be held to a lower standard. The enterprise liability proposal must make clear that when a doctor is alleged to have committed malpractice, the lawsuit will proceed under traditional substantive and procedural rules for physician liability, even though the entity being sued is the hospital or the health plan.

3. Malpractice Insurance

If health plans or hospitals are to be liable for all the malpractice committed by their doctors, they must have adequate insurance to cover their liability. The enterprise liability plan must include a requirement that the enterprise carry a minimum amount of liability insurance.

III. Alternative Dispute Resolution (ADR)

Studies show that only about one in ten victims of malpractice ever even bring a claim for compensation, and only about one in twenty-five receive compensation. A major reason for this poor record is that malpractice lawsuits are lengthy, costly, and very difficult to bring and win. This is particularly true for victims with "small" claims -- approximately $50,000 and less -- who often cannot find an attorney willing to bring a complicated medical malpractice suit on a contingency basis. ADR mechanisms that provide fair compensation, at lower cost and more quickly would be a great benefit to many consumers: those who do not have meaningful access to the courts today; those whose cases do not require the powerful discovery capabilities of a trial; and those who do not seek public accountability.

To date, there has been very little experience with ADR in the medical malpractice context, and what experience there is has met with mixed reviews.[2] Medical malpractice claims that are contested are, by their nature, complicated, fact-specific cases that usually depend on the testimony of outside experts. The very character of these cases makes them difficult to bring in a setting other than a courtroom.

There have been some positive experiences with ADR and medical malpractice, particularly at Duke University under Tom Metzloff, although Metzloff has found ADR to be resource-intensive. **If states or health alliances are allowed to design their own ADR plans, it is critical that the federal law establish minimum standards so that the ADR systems that are set up further appropriate goals and do not cut off access to the courts.** We believe that it would pose an enormous conflict of interest if the Accountable Health Plans (AHPs) were to design the ADR mechanism because of the likelihood that the AHP will be a defendant in many medical malpractice cases. This is particularly true under a system of enterprise liability where the AHPs would be the defendant in almost every case.

The federal ADR guidelines should:

1. Require that the ADR be voluntary and nonbinding on both parties. Studies show that mandatory ADR systems do not work -- the parties usually end up going straight to court when the ADR is completed, adding to the cost and delay in the system. But in order for ADR to be truly voluntary, there must be informed consent by both parties. Consent cannot be adequately informed if consumers must choose ADR at the time that they pick their health plan -- before there has been a malpractice injury. **The choice must come after the injury occurs.**

First, the decision to use ADR depends very much on the facts of the individual case -- the type of injury, the alleged malpractice that took place, and the difficulties of proof. Second, most consumers are not knowledgeable about the legal system or its alternatives, nor do they expect to be victims of malpractice (presumably, they would pick another health plan if they thought they were opting for malpractice as part of the bargain). Third, the choice of whether

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[2] Data collected on Maryland's mandatory nonbinding arbitration system from 1976 to 1990 provides no evidence that such a system has been a "success...as compared to ordinary litigation." (Arizona State Law Journal, Volume 23, 1991). The Yale Law & Policy Review reported that any impact generated from the Maryland program "seems largely negative" and that similar experimentation with mandatory mediation in Wisconsin also had a negative impact, inhibiting negotiation and resulting in 92 to 97 percent of its claims being abandoned or heading toward the state courts. (Yale Law & Policy Review, Volume 10, 1992). Finally, Michigan's voluntary, binding arbitration, instituted in 1975, has resulted in few resolved claims and in increasing malpractice insurance premiums. (Medical Malpractice, General Accounting Office, December 1990.)

to pick ADR usually should be made in consultation with a lawyer, or other knowledgeable expert. At the point of picking a health plan, the average consumer will not have a lawyer to consult. (Although, you can be sure that the health plan and hospital will consult with plenty of lawyers before opting for a particular type of ADR.)

Finally, we do not want to require consumers to choose a form of dispute resolution at the time they choose a health plan for the same reason we do not want consumers to have to understand, evaluate and select the individual components of their health care benefits package. As we understand it, one of the goals of a basic benefits package is to protect consumers from having to make health care choices that are beyond their expertise. The same is true for legal rights, which are equally mysterious to the average consumer, and cannot be judged without the help of an outside expert. Therefore, the choice must come after the injury occurs, when the consumer has an opportunity to consult with a lawyer.

In addition to being voluntary, ADR must be nonbinding. Both parties should always have the option of going to court if they feel that the ADR has been unfair, the decision was wrong, or the damages were inappropriate. If, on the other hand, the ADR is perceived as a just process that gives both sides a fair and complete hearing, it is unlikely that either side will choose to continue litigating.

2. Encourage consumers with "small" damages to file claims. It is often very difficult to obtain an attorney to bring a medical malpractice case if the damages are too small (the cut-off is about $50,000). ADR mechanisms should be designed to make it easier for victims with small claims to recover their losses. This could be done with a lower burden of proof, abbreviated discovery, limited trial time and reducing the number of experts.

3. Preempt state laws that prohibit ADR.

IV. Affidavit of Doctor

A common complaint of the medical community is that sympathetic victims with serious injuries bring frivolous or baseless medical malpractice cases. When this occurs, even if the doctor ultimately prevails, doctors complain of the time and resources they must spend to defend the case. One reform that seems to work to weed out nonmeritorious medical malpractice cases is a requirement that, before the case can go forward, the plaintiff file an affidavit from an expert stating the expert's opinion that the claim has merit.

V. Capping Attorneys Fees

We believe that an attorney's contingency fee should never be more than one-third of the award. On the other hand, it is important to set the fee high enough to encourage lawyers to take medical malpractice cases. A sufficient attorney's fee is particularly important in medical malpractice cases, which are time-consuming, expensive, and risky. In fact, malpractice victims

lose more than half their cases. When this happens, contingency fee attorneys do not get paid. Therefore, the attorneys must make up that lost income through their other cases -- this need to highly compensate attorneys in successful cases to make up for the cases that lose is the reason that consumers support the apparent "windfall" that attorneys get in some big dollar contingency fee cases.

In general, we believe that policing the contingency fee arrangement between consumers and their lawyers should be the role of disciplinary authorities. Capping contingency fees will not reduce the overall cost of an individual lawsuit. The only cost reduction comes when the fee is set so low that fewer malpractice cases are brought. Since there are far too few malpractice cases being brought today in relation to the amount of malpractice being committed, we would vigorously oppose caps that led to this result.

Finally, any provision to limit attorneys' fees must apply to both sides -- plaintiff and defense. This is critical to ensure fair treatment for all parties. In fact, excessive fees are a bigger problem on the defense side than on the plaintiff's side. Defense attorneys, paid by the hour, are often the root of delay tactics, frivolous motions, and other costly procedural maneuvers. It is also important to remember that any restrictions on damage amounts (e.g., collateral source rule, caps) will further reduce the attorney's contingency fee, increasing the possibility that the attorney will not find it cost-effective to bring the lawsuit.

VI. Caps on damages

We are unalterably opposed to placing caps on pain and suffering damages.

First, capping pain and suffering damages would penalize only those victims who have been catastrophically or permanently injured, their families, and the families of those who have been killed -- a small, but tragic, group. For example, high pain and suffering awards go to parents whose babies are killed in childbirth, patients who lose their fertility, and permanently disfigured or disabled victims. And studies show that, under current laws without caps on damages, the most seriously injured victims are already vastly undercompensated. Even if capping pain and suffering damages would save the health care system money -- an assertion that is not borne out by experience -- why would we cut costs on the backs of our most vulnerable and devastated citizens, who are already being undercompensated?[3]

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[3] While malpractice juries are alleged to be incompetent, erratic, biased against doctors and prone to giving unwarranted damage awards, research has proven otherwise. The American College of Physicians found that unjustified jury awards were "uncommon" and that awards were in fact most closely related to the degree of doctor negligence, not the degree of injury. ("The Influence of the Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims", Mark I. Taragin, Annals of Internal Medicine, Volume 117, No. 9, November 1, 1992.) Despite much attention to the small number of million dollar verdicts,

Second, capping pain and suffering damages discriminates against women, children, the elderly, and others who do not make high salaries. In effect, by treating pain and suffering as less important than lost income, you are saying to the mother who has just lost a child, or her ability to bear children in the future, that her loss is less deserving of compensation than the lost income of a wealthy executive who has been a malpractice victim. To illustrate the kinds of devastating pain and suffering that can be caused by malpractice, we have enclosed a transcript of a recent Prime Time Live about Dr. Namihas, who sexually and physically abused hundreds of female patients over a twenty year period. After you read the transcript, ask yourself if the Administration or the Congress, sitting here far removed in Washington, DC, is qualified to decide how much compensation each of those women deserves. We have also enclosed a Pulitzer Prize-winning series that ran in the Indianapolis Star which recounts the stories of the plight of malpractice victims who live under a regime of restrictive medical malpractice laws.

Third, there is no evidence that capping pain and suffering awards will reduce costs.[4]

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research has shown that damage awards are directly related to economic loss. (Medical Malpractice: Theory, Evidence and Public Policy, Patricia Danzon, Harvard University Press, 1985; "Valuing Life and Limb: Scheduling 'Pain and Suffering'", Bovbjerg, Sloan & Blumstein, 35 Northwestern Law Review 908, 1989.)

Studies have also repeatedly found plaintiff-win rates to be as low as 14% ("Report on Awards for Noneconomic Loss", Patricia Danzon, Medical Malpractice Policy Guidebook, 1985) and 32% ("Jury Verdicts in Medical Malpractice Cases", Stephen Daniels, American Bar Foundation, 1989). In addition, Duke University researchers examined 2,000 malpractice cases and found that the median malpractice award was $36,500. The same study found that juries were not biased against doctors, but if anything, were biased against the plaintiffs and their lawyers. ("The Unfair Criticism of Medical Malpractice Juries", Neil Vidmar, Judicature, Oct/Nov 1992.)

[4] A report issued in March 1993 by the Coalition for Consumer Rights found that there is no indication that enacting tort reform is positively correlated with lower health care costs. States with the lowest per capita health care spending are less likely than average to have enacted caps on damages: only 30 percent of the ten states spending the least in health care have enacted limits on recovery of damages; 55 percent of the remaining 40 states have such a statute. (see enclosure "False Claims: The Relationship Between Medical Malpractice ''Reforms' and Health Care Costs", Andrea Durbin, Coalition for Consumer Rights, March 1993)

The 1986 Government Accounting Office (GAO) study on the impact of specific tort changes on malpractice claims found that claims and insurance costs still rose despite limits on patients' access to compensation. The GAO report examined six states that enacted limits on medical malpractice claims in the 1970's. Between 1980 and 1986, these states experienced increased premiums for general practitioners from 58% to 335% and for ob/gyns from 116% to 547%. Between 1983 and 1985, U.S. hospitals experienced a 76% increase in annual costs per bed for malpractice insurance. In the six tort reform states examined, annual costs per hospital

To begin with, there is no clear evidence that caps reduce malpractice insurance premiums. More often, caps increase insurance company profits because payouts are reduced, yet premiums are not. Even where premiums have stabilized or been reduced, there is no evidence that the savings is passed on to the consumer to make health care more accessible or more affordable. In fact, California, which doctors cite as having the model malpractice law, has the second highest health care costs in the country. The enclosed report on malpractice insurance by the National Insurance Consumer Organization shows that insurance premiums are relatively high in California, payouts are very low, and profits are high.

It is true that many states already cap medical malpractice damages, so that, currently, damage awards may depend on where the injured victim lives or where the malpractice took place. Furthermore, many states have draconian laws that cap economic as well as non-economic awards. We recognize these inequities, but we remain opposed to federal damage caps, even if they were accompanied by some preemption of more restrictive state laws. First, we are not too bothered by the discrepancies among the states. U.S. citizens live with differences in legal rights, remedies and doctrines in different states in a wide variety of situations -- criminal laws, traffic rules and sanctions, drug laws, family law, etc. That is part of our system of federalism, and we are in general support of state autonomy in areas of state concern. Second, while we would like to override draconian laws that intrude on consumer rights, we are troubled that such preemption would not survive through the Congress. This could leave us with a situation in which Congress defeats preemption of anti-consumer state laws, while voting for federal caps on damages for states that do not already have them. To avoid this horrendous result, which is well within the realm of possibility, we strongly urge President Clinton not to endorse federal caps on damages in any formulation.

VII. Periodic payments

We acknowledge that it is often in the injured consumer's best interest to spread out their compensation payments so they receive them as they are needed. However, by the same token, injury victims may need a large lump sum payment up front, to pay for past bills, or large one-time expenses, such as making necessary renovations on their home or purchasing expensive medical equipment. Ordinarily, this decision should be left to the parties to decide in each case. Where damage awards are large, it might be appropriate to establish a preference in favor of periodic payments that leaves open an option for lump sum payments where they are necessary or desireable. In addition, we would support preempting state laws that do not allow periodic payments so that the injured party can have a choice, but we oppose mandatory periodic payments at the option of the defendant.

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bed ranged from 33% to 141%. ("Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms", U.S. General Accounting Office, 1986.)

VIII. Malpractice insurance reform

While malpractice insurance premiums represent a minuscule part of total health care costs, it is true that physicians in certain specialties, such as ob/gyns and surgeons, sometimes pay very high insurance premiums. Malpractice insurance reform would ensure sensible underwriting practices, and thereby lower costs to doctors.

Insurance companies should be required to more effectively spread risk by placing all physicians in a unified pool. Currently, the subcategories used by insurance companies result in high premiums for certain specialties. In order to differentiate high-risk doctors from the rest of the pool, insurance companies should charge rates based on a physician's own experience with malpractice lawsuits. This would ensure that doctors with histories of negligent behavior would pay more, and doctors with clean records would be rewarded with lower rates.

On a more general note, when developing malpractice reforms, it is always critical to keep your goals in mind, and then make sure that the reform will achieve those goals. This is especially important if the ultimate goal is to save money because experience shows that malpractice restrictions do not reduce health care costs. Despite passing one of the nation's most restrictive medical malpractice laws, the Medical Injury Compensation Reform Act ("MICRA"), California's health care costs have continued to rise much beyond the rate of inflation.[5]

In addition, if you look at malpractice insurance premiums, the entire malpractice system costs less than .6% of all health care costs.[6] So, even if you eliminated the whole system, you would barely make a dent in total health care costs. And saving money will not bring health care costs down unless the savings are passed on to consumers, which has not been the experience in states that have passed "tort reform." To ensure savings, there must be a requirement that malpractice insurers lower their rates, and that doctors pass these savings on to their patients. Otherwise, you will only have served to make doctors and insurance companies richer at the expense of injured patients.

Finally, we want to appeal to you to meet with malpractice victims before you decide on any kind of malpractice reform. We know you have talked to all parties in the health care industry, to trial lawyers and to consumer advocates. The only ones missing are the people who would be most affected by your proposal -- victims of medical malpractice. We would be happy to help put together a meeting with victims at your earliest convenience.

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[5] Department of Labor, Bureau of Labor Statistics, CPI - All Urban Consumers, cited in "MICRA in Perspective," Memorandum, January 1992.

[6] "Medical Malpractice Insurance, 1985-1991 Calendar Year Experience," National Insurance Consumer Organization, March, 1993.

We would like to discuss these comments with you whenever you are available. As we stated, we are eager to keep up this dialogue, and to work with you to reform the malpractice system while preserving victims' rights and enhancing health care quality. Thank you for considering our views.

Enclosures:

* "Comparing State Medical Boards," Public Citizen Health Research Group, January, 1993.

* "Rx for Abuse," Primetime Live, ABC News, April 1, 1993.

* "A Case of Neglect: Medical Malpractice in Indiana," Joseph Hallinan and Susan Headden, The Indianapolis Star, June 24-26, 1990.

* "False Claims: The Relationship Between Medical Malpractice 'Reforms' and Health Care Costs," Coalition for Consumer Rights, March, 1993.

* "Medical Malpractice Insurance: 1985-1991 Calendar Year Experience, " National Insurance Consumer Organization, March, 1993.

* "Judiciary Suffers Racial, Sexual Lack of Balance," Bill Clinton, The National Law Journal, November 2, 1992.

National cpr

Center for Patients' Rights
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Tel. (212) 979-6670 • Fax (212) 982-3036

June 17, 1993

Ms. Hillary Rodham Clinton
The White House
Washington D.C. 20500

Dear Ms. Clinton:

Three months ago, I wrote you to ask you to meet with me and members of an organization I direct, the National Center for Patients Rights, the largest medical malpractice victims support group in the country. While I did not receive a response from you, I did receive a cordial reply from the Health Care Task Force declining my request and asking that I share any additional views in writing. I write this letter not only to explicate our views, but to ask once again that we be provided an opportunity to meet directly with you.

Members of our organization are flying to Washington from around the country during the week of June 21 to meet with elected officials for the purpose of expressing our first-hand views on medical malpractice reform. These individuals, for whom each day is another test of their ability to cope with the results of medical tragedy, are sacrificing much to make the trip. But if news reports are accurate, there is no one in Washington who is speaking for the victims of medical malpractice, while the perpetrators are well represented. Thus, we must speak for ourselves.

While we understand the enormous pressures you and the Task Force face in attempting to solve our national health care crisis, we remain extremely concerned with the attitude, seemingly widespread in Washington, that the issue of medical malpractice is merely a battle between doctors and lawyers. The people who will be most negatively affected by federal tort restrictions are the hundreds of thousands of victims of medical malpractice who already have only limited legal access to correct the permanent harms caused by negli-

gence. For these individuals, whose basic rights are now the subject of a cavalier academic debate, the impact could be as profound as the malpractice itself.

Moreover, the "reforms" under consideration apparently do not include sufficient measures to prevent future medical malpractice. As I stated in my earlier letter, I fear that the health care reform initiatives being discussed place medical malpractice prevention at the bottom of the list, while malpractice liability reform is at the top.

Any health plan proposed by the White House must reflect compassion and humanity or it will not win the public support crucial to its success. As victims whose lives have been profoundly and irrevocably altered by medical malpractice, we ask that you provide us with an opportunity to speak directly with you so that your health care plan can benefit from our experiences.

In order to make the necessary arrangements for a meeting during June 29 or 30, we ask that you let us know of your decision by Wednesday, June 23. Thank you.

Sincerely,

Laura Wittkin

Laura Wittkin Executive Director

June 17, 1993

Ms. Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C.

Dear Ms. Clinton:

We have followed the work of your health care task force with heightened anticipation. We are encouraged that the Administration is pursuing efforts to make health care available to all Americans; yet, we are concerned that a serious affliction of health care consumers is not being given the attention it deserves. We refer, specifically, to the many victims of medical malpractice.

News reports have been filled with details of meetings of your task force with every imaginable interest group on this issue, save one: consumers who have suffered grave harm at the hands of physicians. Doctors, insurance companies, attorneys, hospitals, HMOs, and many other participants in the health care industry have been given the opportunity to plead their case for financial protection. Medical malpractice victims, however, have been ignored.

For the 80,000 Americans who are killed each year just in hospitals by negligent, incompetent or criminal providers, and the estimated 230,000 or more who are significantly injured, medical malpractice is about more than abstract issues of public policy, such as enterprise liability, mandatory alternative dispute resolution, or certificates of merit. It is about life and death, and about the quality of life and sustenance for those who survive malpractice.

The victims of malpractice deserve the same opportunity to plead their case -- in person -- as has been given those with a financial stake in the outcome of your deliberations.

Enclosed is a letter from Laura Wittkin, of the National Center for Patients' Rights, requesting a meeting with you. Laura's organization represents more than 10,000 victims of medical malpractice. Laura herself is a victim. She and several members of the NCPR will be in Washington the week of June 28, 1993 to meet with members of Congress and the news media.

We respectfully request the opportunity to meet with you during that week. In attendance would be

ourselves, Laura Wittkin, and several members of her organization. We are confident that you will find the presence and reasoned presentation of these Americans well worth your time and attention.

Sincerely,

Ralph Nader
P.O. Box 19312
Washington, DC 20036
202-387-8034

Pamela Gilbert
Director,
Public Citizen's
Congress Watch

NATIONAL INSURANCE
CONSUMER ORGANIZATION

Immediate Release
March 24, 1993
For info contact:
Bob Hunter (703) 549-8050

MEDICAL MALPRACTICE PREMIUMS TOTAL SIX-TENTHS OF ONE PERCENT OF AMERICA'S HEALTH CARE COST

Washington, D.C... A major new study of the costs of medical malpractice has been submitted to President and Mrs. Clinton by Ralph Nader and the National Insurance Consumer Organization. The study shows that the cost of medical malpractice premiums to America's doctors and hospitals amounted to just six-tenths of one percent in 1991 of the cost of health care (unchanged from 1985). The claims paid out and reserves for future claims have fallen in half -- from eight-tenths of one percent in 1985 to four-tenths of one percent in 1991.

"The idea that medical malpractice costs have driven up the cost of health care in America is absurd," said Ralph Nader, the consumer advocate, at a press conference held here today. "Even if medical malpractice lawsuits were abolished, there would be savings of only six-tenths of one percent of health care costs but the return cost, in removing the incentive to safe medical practice, would be great. Against this background, purely defensive medicine is itself a form of malpractice -- physically and economically."

"It is stunning that, when measured against the growth in health care costs, the cost of medical malpractice claims have fallen by 45.2% between 1985 and 1991," said actuary J. Robert Hunter, President of the National Insurance Consumer Organization and former Federal Insurance Administrator under Presidents Ford and Carter. "On the other hand, insurance overhead costs have risen as fast as health care inflation and are truly excessive. Insurer profits are high, particularly in states that have enacted restrictions on victim's legal rights," Hunter said.

"As President and Mrs. Clinton near their decision on health care reform, they should avoid federally reducing the legal rights of Americans under state laws. There is also concern that price caps and other restrictions on access to justice will lead to deteriorating care and grave injustice to the most seriously injured victims of medical and hospital malpractice. Only by fully allowing lawsuits for victims of injurious care will Americans benefit from the deterrent impact of such accountability against bad medicine," Nader stated. "Cutting back medical malpractice protections will inevitably lead to grave public doubts about health care quality," he said.

121 N. Payne Street
Alexandria, Virginia 22314
(703) 549-8050

The 15 page NICO study, Medical Malpractice Insurance: 1985-1991 Calendar Year Experience showed that in 1991, the latest available data, premiums totalled $4.9 billion, claims totalled $2.7 billion, insurance expenses totalled $2.6 billion, investment income totalled $2.4 billion and after-tax profit to insurers totalled $1.4 billion.

Copies of the NICO study are available for $10, which includes postage and handling, by writing NICO at 121 N. Payne Street, Alexandria, VA 22314.

The National Insurance Consumer Organization (NICO) is dedicated to educating the consumer on buying insurance wisely to save money. NICO undertakes public policy research on key insurance issues and is an advocacy group that monitors the insurance industry with respect to consumers' rights.

MEDICAL MALPRACTICE INSURANCE

1985-1991 CALENDAR YEAR EXPERIENCE

A Report By

The National Insurance Consumer Organization

MARCH, 1993

121 N. Payne Street
Alexandria, Virginia 22314
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MEDICAL MALPRACTICE INSURANCE

1985-1991 CALENDAR YEAR EXPERIENCE

A REPORT BY

THE NATIONAL INSURANCE CONSUMER ORGANIZATION

As the nation debates National Health Insurance, there has been much discussion of the role/cost of Medical Malpractice insurance. This report analyzes the costs of Medical Malpractice insurance over the last seven years, a period which represents the maximum data on rate of return on net worth published by the National Association of Insurance Commissioners (NAIC). The report focuses particular attention on the most recent period, Calendar year 1991, data for which became available from the NAIC in December, 1992.

In this analysis, we will look at these issues:

* Cost of Medical Malpractice Insurance to doctors and hospitals;
* Breakdown of the underlying expenses
  - Claims Incurred
  - Insurance Company Expenses
  - Investment Income
  - Insurance Company Profits
* Implications for National Health Insurance Policy

<u>Sources of Data - Method - Definitions</u>

The attached Exhibits show the total national experience for Medical Malpractice Insurance for all insurance companies licensed to write in the United States. These data do not

include self-insured hospitals or "off-shore" unlicensed insurers. The data were compiled by the NAIC from Annual Statements of financial data required to be filed with them by the insurance companies. These Annual Statements are subject to audit by the individual states and are sworn as to their accuracy by officials of the filing insurance company.

The data shown is "direct" experience; that is, before considering the impact of reinsurance. "Direct" experience is the total of actual premiums that insured doctors and hospitals paid throughout the nation. Thus, this is the experience from the perspective of the insurance buyers. The insurance companies results will be somewhat different because the insurance companies secure reinsurance to "lay off" part of the risk so that, in years of high losses, the reinsured or "net" result is better than the "direct" result; in years of low losses the opposite is true.

The time series information is from 1985 to 1991, the longest period of data available from NAIC on rates of return on net worth. The seven years is also roughly the length of a typical insurance cycle and therefore should capture typical high and low profit years.

Certain terms must be defined. Most important is "Losses Incurred". This is the sum not only of claims paid by insurers to doctors and hospitals but includes the insurers' estimates of what they expect to pay out in the future on both claims they know about and even those they do not yet know about. This

latter reserve, on the unknown claims, is the so-called "Incurred-But-Not-Reported", or IBNR, reserve.

Premiums Earned are the premiums paid in by doctors and hospitals that the insurers have "earned" through the passage of time. For example, if a policy costs $120 and has been in effect one month, the insurer has earned 1/12 of $120 or $10. When premiums paid in by doctors and hospitals are going up, premiums earned are lower than premiums paid in; when premiums paid in by doctors and hospitals are going down, premiums earned are higher.

Expenses include defense attorney costs, overhead costs and state taxes.

Dividends shown in the attached exhibits are those paid back to doctors and hospitals as refunds of excessive premium charges.

Underwriting Profit deducts losses incurred, expenses and dividends from earned premiums.

Investment Income is the money that insurance companies make from investing reserves on claims and unearned premiums as well as investing net worth (net worth is also called "retained earnings"). For a line, such as Medical Malpractice, where claims reserves are held for a long period prior to payment of claims to victims, investment income is large. Lines such as these are called "Long-Tail" lines as opposed to such "Short-Tail" lines as Fire insurance where claims are paid off quickly.

Retained Earnings is the net worth backing up the business, overwhelmingly obtained from earnings in earlier years.

Return on Net Worth is the profit divided by the retained

earnings.

Analysis

1. Cost of Medical Malpractice Insurance

In 1991, doctors and hospitals paid $4,862,170,000 in premiums for medical malpractice insurance coverage in the United States of America (see Exhibit 1). The State-By-State costs ranged from $7,927,000 in Rhode Island to $699,493,000 in New York (see Exhibit 2). While these costs have risen over the past seven years -- from $2,660,985,000 in 1985 to $4,862,170,000 in 1991 -- the costs have declined from the 1989 high of $5,119,518,000 and are lower than the amount doctors and hospitals spent in 1988 (see Exhibit 3).

The 1985 to 1991 reported premium increase is 82.7% or 10.6% per year. Adjusted for inflation, the real seven year increase is between 44.6%, adjusted for all items CPI and 17.2%, adjusted for medical care inflation (see Exhibit 3).[1] In other words, the increases are:

	As Reported	Adjusted for All Items CPI	Adjusted For Med. Inflation
1985-1991 Change	+ 82.7%	+ 44.6%	+ 17.2%
Annual Change	+ 10.6	+ 6.3	+ 2.7

Medical Malpractice insurance premiums have risen over the past seven years, with all of the increase in early years. In recent years medical malpractice insurance premiums have fallen

[1] NICO believes the most important "real" increase is that adjusted by medical care inflation since, in the context of the National Health Insurance discussion, that is the relevant measure (i.e., is this cost changing in a way that lowers or raises health care costs).

so that, in 1991, costs were below 1988 costs. Even so, the premium costs have risen faster than inflation, even faster than medical care inflation (by 2.7% per year).

As a percentage of total health care costs in 1991, Medical Malpractice insurance premiums represent less than one percent (six-tenths of one percent) of costs, unchanged over the period studied. (See Exhibit 4.)

In the next section, we will look at what underlying costs drove this premium increase.

2. Underlying Expenses

(A) Losses Incurred

In 1991, the National Medical Malpractice Insurance Losses Incurred were $2,708,229,000, or 55.7% of Premiums Earned (see Exhibit 1). Losses ranged from a low of - $15,214,000 in Oregon (the negative "loss" is a result of significant reductions in previously established excessive reserves in the state) to $541,408,000 in New York (see Exhibit 2).

Losses Incurred over the 1985 to 1991 period have fallen from $3,206,487,000 in 1985 to $2,708,229,000 in 1991, a drop of 15.5% (see Exhibit 3). Adjusted to real terms by adjusting for inflation, the drop in incurred losses is even more significant, viz:

	As Reported	Adjusted for All Items CPI	Adjusted For Med. Inflation
1985-1991 Change	- 15.5%	- 33.1%	- 45.2%
Annual Change	- 2.4	- 4.7	- 6.4

Thus, Medical Malpractice Insurance Losses Incurred have fallen sharply over the past seven years, although there was a reported increase from 1985 to 1987. Indeed, the reserves for medical malpractice were overstated by $1.4 billion at year end 1990 when an additional year of data on those claims was reviewed.[2]

A very important finding of this study is that costs of Incurred Losses, as percentage of health care costs has fallen in half over the period of study -- from eight-tenths of one percent in 1985 to four-tenths of one percent in 1991 (see Exhibit 4).

(B) Insurance Company Expenses Incurred

In 1991, insurance company expenses for writing Medical Malpractice insurance were $2,508,880,000, excluding state premium taxes of $136,140,000 (see Exhibit 1). Combined, the overhead costs were $2,645,020,000 or 54.4% of premium. These costs, which represent over 50% of premium income, are a very inefficient level of costs. We have not shown the state-by-state insurance company expenses on Exhibit 2, because the NAIC uses national expenses to estimate state costs. The NAIC does not maintain insurance company expenses on a state-by-state basis in the Annual Statement.

In the period 1985 to 1991, insurance company expenses rose from $1,612,557,000 in 1985 to $2,645,020,000 in 1991, an increase of 64.0% (see Exhibit 3). Adjusted to real terms by

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[2] Aggregates and Averages, A.M. Best and Co., 1992 Edition, Page 119.

reflecting inflation the increase is:

	As Reported	Adjusted for All Items CPI	Adjusted For Health Care Inflation
1985-1991 Change	+ 64.0%	+ 29.9%	+ 5.2%
Annual Change	+ 8.6	+ 4.4	+ 0.8

This means that insurance company expenses rose at about the same rate as health care inflation during this period. The increase in costs was somewhat faster than health care inflation through 1987 but slowed to somewhere below it since.

PROFIT

In 1991, insurers writing Medical Malpractice insurance in the United States earned a return of $1,419,750,000 or 15.9% of net worth. (See Exhibit 1). This is the profit after dividends (returns of excess premiums) to doctors and hospitals of 4.2% (over $200 million). Investment Income amounted to almost 50% of premium, due to the very "long-tail" this line has in its loss reserves. Economists have testified in insurance rate matters that returns of 13 - 16% on net worth are appropriate for this line of insurance.

It should be noted that the rate of return on sales (i.e., premium) is 29.2% (see Exhibit 1). The reason this translates into a return of 15.9% on net worth is either because the actual net worth backing up this business is excessive (i.e., retained earnings of $8,929,270,000) or the NAIC estimate of net worth has allocated too much net worth under their formula (the NAIC report is based on an assumption that, for each dollar of premium in the medical malpractice line, insurers have $1.84 backing up the

transaction). According to studies undertaken by the California Department of Insurance, properly capitalized insurers should hold only about $1.00 of net worth for every $1.00 of premium for this line of insurance. Had insurers not retained so much previous profit (or the NAIC used a more reasonable allocation), America's medical malpractice insurers return on net worth would have been 29.2%, a remarkably high return which is almost double the profit required to reward the risk of underwriting medical malpractice insurance.

State-by-state profits ranged from a loss of $37,368,000 in Texas to a gain of $354,999,000 in California. In terms of percentages, the biggest loss was in the District of Columbia where the loss was 21.2% of net worth (31.6% of sales); the largest profit was in Oregon where the return on net worth was +65.9% (119.2% of sales). (See Exhibit 2.) In the six states that undertook tort reform studied by the General Accounting Office, profits in 1991 averaged 122% above the national average, implying possible insurer profiteering in these states.[3]

Over the entire time that the NAIC has kept profit or net worth data, 1985 - 1991, the return on net worth for writers of Medical Malpractice has been 14.4% (see Exhibit 3). Profit shows the expected cyclical pattern with a low in 1985 and a high in

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[3] Arkansas, California, Florida, Indiana, New York and North Carolina. Source: Medical Malpractice, Six States Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms, U.S. General Accounting Office, December, 1986. Profits averaged 46.1% of premiums in these states vs. 20.8% in the other states, averaging 29.2% countrywide.

1989. This is a normal, reasonable profit. However, if net worth was established at less redundant, more economically appropriate levels, returns over the period would have been about twice that needed to attract capital.

IMPLICATIONS FOR NATIONAL HEALTH INSURANCE POLICY

Medical Malpractice is a tiny fraction of health care costs in America. In 1991, it represented just six-tenths of one percent of such costs, unchanged from 1985. Incurred Losses represented only four-tenths of one percent of these costs, half of the 1985 level. Although premiums have risen slightly faster than health care inflation over the past seven years, the incurred losses have fallen by almost 50% over that time relative to health care inflation. Premiums have turned down in recent years reflecting the declining claims costs. Insurer overhead expenses represent half of premiums. These expenses could and should be reduced significantly. Investment income also represents half of premiums and is very significant in this long tail line. Profits of insurers appear to have been fair on the reported net worth basis of NAIC but are excessive when adjusted to more realistic capitalization assumptions. In several states, profits appear grossly excessive.

At six-tenths of one percent of health care system costs to cover all aspects of the cost of medical injury -- medical malpractice premiums are low. The current system appears to be an excellent and reasonably priced approach to protect Americans from faulty medical care, a system that, if maintained, would

give assurance that President Clinton's reform of health care would not result in improper or harmful health care. How else, for less than one percent of overall costs, can America fund the cost of medical negligence and create a strong incentive for safe delivery of health care? While insurance company expenses and profits appear to have been excessive and premium costs should be further reduced, the system works in a generally efficient way to protect Americans from medical negligence.

Exhibit 1

MEDICAL MALPRACTICE INSURANCE
COUNTRYWIDE RESULTS OF INSURANCE COMPANIES

CALENDAR YEAR 1991

	Dollars	% of Premium
Premiums Earned	$ 4,862,170,000	100.0%
Losses Incurred	2,708,229,000	55.7
Defense Attorneys\Other Claim Costs	1,687,173,000	34.7
Overhead, Sales Expense	821,707,000	16.9
Total Ins. Company Expenses (excluding State Taxes)	2,508,880,000	51.6
State Taxes	136,140,000	2.8
Dividends to Doctors, Hospitals	204,211,000	4.2
Underwriting Profit	- 695,290,000	- 14.3
Investment Income	2,367,877,000	48.7
Federal Tax	257,695,000	5.3
Total Profit	1,419,754,000	29.2

		% of Net Worth
Retained Earnings (Net Worth)	$ 8,929,270,000	100.0%
Return on Net Worth	1,419,754,000	15.9

Source: Report on Profitability, By Line, By State, 1991; December 1992, National Association of Insurance Commissioners.

Exhibit 2, Sheet 1

MEDICAL MALPRACTICE INSURANCE
STATE-BY-STATE RESULTS OF INSURANCE COMPANIES

CALENDAR YEAR 1991

State	Premiums Earned (000)	Losses Incurred (000)	Loss Ratio	Profit (000)	Profit As A % Sales	Profit As A % Net Worth
Alabama	$ 84,979	$ 20,480	24.1%	$ 47,758	56.2%	37.2%
Alaska	13,731	2,609	19.0	5,575	40.6	39.8
Arizona	107,812	54,445	50.5	25,767	23.9	14.6
Arkansas	23,135	12,932	55.9	4,789	20.7	11.7
California	529,059	47,615	9.0	354,999	67.1	37.7
Colorado	65,543	23,989	36.6	16,143	28.5	24.2
Connecticut	103,224	34,373	33.3	63,483	61.5	29.6
Delaware	20,068	19,566	97.5	- 2,850	-14.2	- 6.9
D.C.	37,612	39,380	104.7	- 11,885	-31.6	-21.2
Florida	241,421	110,088	45.4	62,769	26.0	19.7
Georgia	134,604	59,899	44.5	50,342	37.4	19.0
Hawaii	16,066	11,118	69.2	- 321	- 2.0	- 1.2
Idaho	14,837	252	1.7	9,511	64.1	53.2
Illinois	289,811	243,731	84.1	17,968	6.2	3.1
Indiana	34,174	13,362	39.1	17,976	52.6	25.6
Iowa	44,120	16,986	38.5	18,398	41.7	25.5
Kansas	32,544	1,562	4.8	23,432	72.0	49.4
Kentucky	58,212	30,736	52.8	13,331	22.9	15.1
Louisiana	50,850	23,340	45.9	17,696	34.8	20.9
Maine	28,883	20,045	69.4	2,657	9.2	5.3
Maryland	107,893	36,899	34.2	48,768	45.2	23.0
Massachusetts	31,127	24,061	77.3	249	0.8	0.5
Michigan	169,347	107,705	63.6	39,966	23.6	12.0
Minnesota	62,903	31,640	50.3	16,795	26.7	17.8
Mississippi	22,132	8,875	40.1	8,255	37.3	22.3
Missouri	112,915	59,055	52.3	28,567	25.3	16.3
Montana	16,613	6,578	39.6	5,349	32.2	24.9
Nebraska	17,972	3,176	17.7	11,233	62.5	35.9
Nevada	25,250	13,130	52.0	5,732	22.7	14.0
New Hampshire	10,253	5,229	51.0	3,455	33.7	18.1
New Jersey	241,892	219,154	90.6	- 9,434	- 3.9	- 2.0
New Mexico	15,161	10,400	68.6	349	2.3	1.7
New York	699,493	541,408	77.4	295,886	42.3	13.3
N. Carolina	91,687	56,296	61.4	9,902	10.8	7.8
N. Dakota	12,764	3,689	28.9	6,905	54.1	32.8
Ohio	246,063	134,350	54.6	48,228	19.5	13.4
Oklahoma	59,666	26,372	44.2	11,695	19.6	21.2
Oregon	48,144	- 15,214*	-31.6*	57,388	119.2	65.9

* This is due to significant reduction of excessive reserves in the state.

Exhibit 2, Sheet 2

State	Premiums Earned (000)	Losses Incurred (000)	Loss Ratio	Profit (000)	Profit As A % Sales	Profit As A % Net Worth
Pennsylvania	228,266	233,288	102.2	- 33,099	-14.5	- 7.5
Rhode Island	7,927	935	11.8	6,064	76.5	39.6
S. Carolina	8,542	5,757	67.4	1,298	15.2	8.4
S. Dakota	9,982	1,777	17.8	5,790	58.0	41.1
Tennessee	118,135	29,179	24.7	41,584	35.2	22.2
Texas	214,757	211,536	98.5	- 37,368	-17.4	- 9.4
Utah	24,858	13,722	55.2	2,759	11.1	9.4
Vermont	12,593	4,143	32.9	6,032	47.9	27.7
Virginia	76,537	35,360	46.2	27,859	36.4	18.9
Washington	104,323	23,264	22.3	51,640	49.5	39.2
W. Virginia	34,595	38,400	111.0	- 6,435	-18.6	- 8.6
Wisconsin	74,812	36,583	48.9	22,892	30.6	18.4
Wyoming	8,118	5,001	61.6	187	2.3	2.0
Puerto Rico	16,750	8,459	50.5	2,864	17.1	14.2
USA	$4,862,170	$2,708,229	55.7%	$1,419,754	29.2%	15.9%

Source: Report on Profitability, By Line, By State, 1991, December, 1992; National Association of Insurance Commissioners

Exhibit 3, Sheet 1

MEDICAL MALPRACTICE INSURANCE
MULTI-YEAR REVIEW OF EXPERIENCE (1985-1991)

As Reported

Cal. Year	Premium Earned*	Losses Incurred*	Loss Ratio	Ins. Co. Expenses*	Expense Ratio	Return on Net Worth
1985	$ 2,660,985	$ 3,206,487	120.5%	$ 1,612,557	60.6%	- 5.2%
1986	3,808,105	3,537,730	92.9	1,831,699	48.1	11.2
1987	4,550,493	3,726,854	81.9	2,206,989	48.5	12.6
1988	5,067,749	3,638,644	71.8	2,341,300	46.2	17.2
1989	5,119,518	2,723,583	53.2	2,513,683	49.1	22.4
1990	4,930,786	2,657,694	53.9	2,682,348	54.4	17.4
1991	4,862,170	2,708,229	55.7	2,645,020	54.4	15.9
Total	$30,999,806	$22,199,221	71.6%	$15,833,596	51.1%	14.4%

Premiums Earned: Reported and Constant Dollars

Cal. Year	Reported Premiums Earned*	CPI All Items Index**	CPI Medical Index**	Constant $ Prem. Earned All Items Adjusted*	Constant $ Prem. Earned Medical Adjusted*
1985	$ 2,660,985	1.000	1.000	$ 2,660,985	$ 2,660,985
1986	3,808,105	1.016	1.075	3,748,135	3,542,423
1987	4,550,493	1.074	1.146	4,236,958	3,970,762
1988	5,067,749	1.099	1.221	4,611,237	4,150,491
1989	5,119,518	1.154	1.315	4,436,324	3,893,170
1990	4,930,786	1.210	1.434	4,075,030	3,438,484
1991	4,862,170	1.263	1.559	3,849,699	3,118,775

Losses Incurred: Reported and Constant Dollar

Cal. Year	Reported Losses Earned*	CPI All Items Index**	CPI Medical Index**	Constant $ Losses Incurred All Items Adjusted*	Constant $ Losses Incurred Medical Adjusted*
1985	$ 3,206,487	1.000	1.000	$ 3,206,487	$ 3,206,487
1986	3,537,730	1.016	1.075	3,482,018	3,290,912
1987	3,726,854	1.074	1.146	3,470,069	3,252,054
1988	3,638,644	1.099	1.221	3,310,868	2,980,052
1989	2,723,583	1.154	1.315	2,360,124	2,071,166
1990	2,657,694	1.210	1.434	2,196,441	1,853,343
1991	2,708,229	1.263	1.559	2,144,283	1,737,157

Insurance Company Expenses: Reported and Constant Dollar

Cal. Year	Reported Insurer Expenses*	CPI All Items Index**	CPI Medical Index**	Constant $ Expen. Incurred All Items Adjusted*	Constant $ Expen. Incurred Medical Adjusted*
1985	$ 1,612,557	1.000	1.000	$ 1,612,557	$ 1,612,558
1986	1,831,699	1.016	1.075	1,802,853	1,703,906
1987	2,206,989	1.074	1.146	2,504,943	1,925,819
1988	2,341,300	1.099	1.221	2,130,391	1,780,456
1989	2,513,683	1.154	1.315	2,178,235	1,911,546
1990	2,682,348	1.210	1.434	2,216,817	1,870,536
1991	2,645,020	1.263	1.559	2,094,235	1,696,613

* 000 deleted

** July of each year; 1985 = 1.000; Source: Telephone call to Bureau of Labor Statistics, Consumer Price Index Hotline, March 2, 1993.

Source of Insurance Data: Report on Profitability, By Line, By State, years indicated, National Association of Insurance Commissioners.

Exhibit 4

MEDICAL MALPRACTICE INSURANCE

IMPACT OF MEDICAL MALPRACTICE INSURANCE ON HEALTH CARE

Year	(1) Health Care Costs*	(2) Med. Mal. Earned Prem.	(3) (2)/(1)	(4) Med. Mal. Incurred Losses	(5) (4)/(1)
1985	$422,600,000	$ 2,660,985	0.6%	$3,206,487	0.8%
1986	454,900,000	3,808,105	0.8	3,537,730	0.8
1987	494,200,000	4,550,493	0.9	3,726,854	0.8
1988	546,100,000	5,067,749	0.8	3,638,644	0.7
1989	604,300,000	5,119,518	0.8	2,723,583	0.5
1990	675,000,000	4,930,786	0.7	2,657,694	0.4
1991	751,800,000	4,862,170	0.6	2,708,229	0.4

* Source: Health Care Finance Administration, Telephone Call of March 3, 1993.

Note: All dollar figures 000 deleted.

Public Citizen

Buyers Up • Congress Watch • Critical Mass • Health Research Group • Litigation Group

Ralph Nader, Founder

October 19, 1993

Ms. Melanne Verveer
Office of the First Lady
The White House
Washington, D.C. 20500

Dear Ms. Verveer,

We are very disappointed that the Clinton health care proposal has not addressed the epidemic of medical malpractice, but has chosen instead to restrict patients' legal rights in the event of malpractice. Despite the shocking fact that 80,000 deaths are caused by medical negligence annually in hospitals alone, the Clinton health care plan is silent on how to improve the nation's oversight of hospitals and physicians.

President Clinton highlighted "responsibility" as a cornerstone of health care reform in his speech to the nation. In contrast, the current provisions on medical malpractice will diminish deterrence and cost-shift the expense of medical negligence from the negligent provider to the health care system. These proposals will reduce the liability exposure and accountability of negligent doctors and hospitals, thereby causing fewer bad doctors to be identified or removed from practice, and diminishing the incentive for hospitals to improve or correct medical safety problems. In other words, these medical malpractice proposals will lead to a predictable increase in avoidable deaths, injuries, and sicknesses, outcomes which are antithetical to the stated goals of the Clinton health care reform plan.

Currently, American consumers are insufficiently protected by a weak system of medical quality control. National health care reform presents a unique opportunity to affirmatively address the colossal problem of medical malpractice and negligible regulation of health care providers. While "quality assurance" provides a gross filter which can gradually improve aggregate quality of care nationally, it will not regulate the profession to identify and discipline individual negligent providers or terminate a doctor's privileges, when necessary. We must incorporate a strong physician regulatory and disciplinary system in our national health care plan and we must not curtail the legal rights of consumers victimized by negligent doctors.

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Enclosed is our response to the Clinton Working Group Draft provisions on quality of care and medical malpractice. We have also enclosed a powerful letter to the Wall Street Journal from a victim of medical negligence. Please feel free to contact us for further information.

Sincerely,

Pamela Gilbert
Director
Congress Watch

Mern Horan
Staff Attorney
Congress Watch

cc: Vice President Albert Gore Jr.
Melanne Verveer
Thurgood Marshall, Jr.
Ira Magaziner
Bob Boorstin
Mike Lux
Judith Feder
Peter Edelman
Philip Lee
Heather Booth
Frank Hunger
George Phillips
Cindy LeBow
Webster Hubbell
Nancy McFadden
Jeff Eller
Walter Zellman

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Ralph Nader, Founder

RESPONSE TO THE WHITE HOUSE PROPOSAL ON MEDICAL MALPRACTICE

Public Citizen, a national consumer advocacy organization founded by Ralph Nader, provides the following analysis of the medical liability provisions of the Clinton Administration's health care proposal, and we offer an alternative proposal to respond to the needs of consumers rather than the claims of the medical industry.

The Clinton medical malpractice plan has integrated most of the elements of California's anti-consumer Medical Injury Compensation Reform Act (MICRA) - the "AMA wish list" -including elimination of the collateral source rule; periodic payments for defendants; mandatory ADR; and limits on plaintiffs' attorneys' fees without a corresponding limitation on defense attorneys' fees. With the exception of the proposed "repeat offender" provision, this plan penalizes injured persons while rewarding physicians.

Moreover, because these proposals will result in fewer suits and a reduction in the liability exposure and accountability of negligent doctors and hospitals, they will result in fewer bad doctors being identified or removed from practice, and less incentive for hospitals to improve or correct medical safety problems. In other words, these proposals will lead to a predictable increase in deaths, injuries and sickness -- not to mention completely avoidable costs.

Hard-won health care consumer protections should not be used as crass bargaining chips in order to gain the support of the medical industry. We are very disappointed that this plan chooses to reduce consumers' access to justice while it ignores the unique opportunity posed by national health care reform to promote essential quality of care provisions and confront the current epidemic of medical malpractice.

I. THE WHITE HOUSE PROPOSAL ON MEDICAL MALPRACTICE CLINTON'S PLAN ROLLS BACK PATIENT'S RIGHTS

The following is a summary of the White House draft medical malpractice provisions, as well as our response to these provisions.

♦ **Permit those found liable for malpractice to pay the compensation they owe victims on an installment plan basis.**

Periodic payments at the option of the defendant are unfair and unnecessary. Periodic payments: (1) can result in inadequate compensation to injured victims due to large, immediate medical bills, unaccounted for inflation, and early death which relieves the

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wrongdoer from payment of the balance of the award; (2) benefit the wrongdoer, who may control, invest and earn interest on the balance of the award, at the expense of the injured victim; and (3) structured settlements can be entered into voluntarily when they work to the advantage of both parties.

♦ **Eliminate the "collateral source rule" that forces those found liable for malpractice to pay all the expenses incurred by the victim.**

The collateral source rule prohibits defendants charged with negligence from informing the jury that the plaintiff has other sources of compensation such as health insurance or government benefits. The purpose of this long-established doctrine is to ensure that the jury holds the defendant responsible for the full cost of the harm the defendant caused. Abolition of the collateral source rule reduces the amount of money that the defendant must pay, weakening the deterrent effect of the malpractice system and shifting the cost of the defendant's negligence from the malpractice insurer to the to the victim (who paid a premium for the health insurance), the victim's insurer, and/or taxpayers. This proposal, which shifts costs onto health insurance, is antithetical to the cost containment goals of national health care reform.

♦ **Require mandatory, nonbinding Alternative Dispute Resolution (ADR) in the event of medical malpractice.**

Although this provides for nonbinding ADR, the mandatory nature of the provision creates an additional layer of bureaucracy for a medical malpractice victim to maneuver before she can get to court, increasing both cost and delay. Moreover, ADR proceedings do not offer the normal protections provided by the judicial system to neutralize imbalances between the parties, including the presence of an impartial judge who is guided by the substantive law. In addition, medical malpractice ADR procedures must not be established and controlled by the health care plan itself, as the health care plan will most often be a defendant in medical malpractice cases, a clear conflict of interest.

♦ **Place a 1/3 cap on plaintiffs' attorneys' fees with no corresponding limitation on defense fees.**

This provision is entirely unbalanced and reflects the overall perspective of punishing consumers while rewarding physicians. If plaintiffs' attorneys' fees are subject to federal price controls, defendants' attorneys' fees should also be regulated.

♦ **Create a Medical Liability Pilot Project on Practice Guidelines, allowing introduction of the practice guidelines as an affirmative defense in medical malpractice cases.**

Under this system, a physician able to demonstrate that his or her professional conduct or treatment complied with the practice guidelines would not be held liable for medical malpractice. If practice guidelines are available as an affirmative defense in medical malpractice cases, they must also be available for the plaintiff to use, so that failure to meet the standard established by the practice guidelines should create a presumption of negligence. of negligence.

♦ **Mandate that the Department of Health and Human Services promulgate regulations to expose "repeat offenders" of medical malpractice.**

Public Citizen has long advocated opening the taxpayer funded National Practitioner Data Bank (NPDB) to the public. Created in order to protect health care consumers from unethical and incompetent doctors, the NPDB is a clearinghouse which collects information from state medical boards, hospitals and other institutions on medical malpractice payments and adverse professional actions - but unfortunately it is not open to the public. Currently, consumers seeking information about providers from whom they intend to seek medical care are left to their own devices to determine a providers' track record. The Data Bank could be one of the most powerful resources to assist consumers in making informed health care "purchasing" decisions. The AMA has always opposed public access to the NPDB and has recently accelerated their attack on the Data Bank, calling for its abolition.

Further information on the following provisions, also included in the Clinton Plan, is necessary in order to provide a meaningful critique:

♦ **Create a Pilot Project on Enterprise Liability.**

♦ **Require a Certificate of Merit from a physician before a lawyer can file a medical malpractice lawsuit.**

II. PUBLIC CITIZEN'S MEDICAL MALPRACTICE PROPOSAL
A BETTER SOLUTION: IMPROVE THE QUALITY OF CARE

National health care reform must include provisions promoting the highest quality of health care for all Americans. Universal coverage and cost control, while essential, can be rendered worthless if consumers are subjected to shoddy care and cut off from compensation for medical negligence or incompetence.

A. Improve the Quality and Safety of Medical Care.

♦ **Create consumer access to reliable information about negligent providers**, such as that provided by the taxpayer-funded National Practitioner Data Bank -- currently closed to the public. The National Practitioner Data Bank provides the best source of information on the disciplinary record of physicians, including state and federal disciplinary actions, hospital and professional society sanctions, and malpractice settlements and judgments. Due to pressure from the medical lobby, the information in the data bank is not available to the public or to other doctors seeking to make referrals;

♦ **Strengthen state medical boards' disciplinary functions**; require recertification and performance audits for doctors and stronger regulation of hospitals. The current doctor discipline system, controlled by the medical community, is abysmal. Negligent and incompetent doctors are rarely disciplined or removed from practice. At most, about 0.5 percent of the nation's doctors face any sanctions (many for financial, not malpractice, abuses) from their state medical boards each year. State medical boards may take more than two years to even investigate complaints of doctor incompetence or misconduct, allowing the

doctor to continue to treat other patients all during this time;

♦ **Mandate hospital and peer reporting of all evidence of substandard performance to disciplinary authorities** at state and federal levels;

♦ **Establish risk management programs and improve physician licensing and recertification**; provide more information to physicians through the development and dissemination of outcomes research, practice guidelines and continuing medical education; and

♦ **Support retention of the Clinical Laboratory Improvement Act of 1988** -- passed after public outcry over shoddy lab work in analyzing Pap smears for cervical cancer -- now under attack by the AMA.

B. Promote Pro-Consumer Cost-Containment Measures.

♦ **Reform the medical malpractice insurance system** in order to ensure sensible underwriting practices, lower premium costs, and reward the safe practice of medicine with lower premiums. The subcategories currently used by insurance companies result in high premiums for some specialties. Insurance companies should be required to more effectively spread risk by placing all physicians in larger pools. Insurance companies should charge rates based on a physician's own experience with malpractice lawsuits, thereby ensuring that doctors with histories of negligent behavior would pay more, and doctors with clean records would be rewarded with lower rates; and

♦ **Prohibit physician self-dealing and other financial and ethical abuses.** The New England Journal of Medicine reported that physicians with ownership interests in diagnostic testing equipment and facilities order 4.0 to 4.5 times more tests than those physicians without such financial interests. Approximately one-quarter of the medical labs in this country are owned wholly or in part by physicians who refer their patients to those labs.

C. Increase Access To The Courts

♦ **States should establish binding alternative dispute resolution systems for medical malpractice claims under $50,000.** Since malpractice lawsuits are almost always brought under a contingency fee arrangement, in which the plaintiff's attorney is paid by a portion of the award, victims with relatively small damages are often unable to find attorneys to take their cases. Their lawsuits are simply too expensive to bring for the potential fee generated by a smaller claim. The small claims procedure must be less expensive and more streamlined than litigation to make it useful.

For more information, contact:
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Malpractice Damage Caps Won't Help

David McIntosh's Sept. 22 Rule of Law column, "Without Malpractice Reform, Forget Health-Care Reform," touted Indiana as the model for medical malpractice laws. In particular, Indiana's cap on damages was held out as the sure-fire way to harness escalating health care costs. Nothing could be further from the truth. In 1989, I suffered an injury as a result of a medical procedure that has left me disabled and in a wheelchair with continual medical expenses and unable to work.

In 1975, I was one of the lobbyists for the insurance industry who fought to enact Indiana's law and cap. We used arguments to play on fears that are now being used to force taxpayers to pick up the tab for what others have done wrong. We argued that caps would lower health care costs, would keep malpractice premiums low and would encourage physicians to stay in Indiana to provide health care to our citizens. We were wrong then and those same arguments are wrong now.

Between 1980 and 1990, health care costs in Indiana increased 139.4%, according to the Families USA Foundation, a public interest group. This increase indeed is appalling, but Indiana's rise in spending is even higher than the national average of 138.7%. If Indiana's damage caps have "worked wonders," as the column states, then why have health care costs in Indiana outpaced the national average?

The simple truth is that the damage caps enacted in Indiana have not controlled health care spending because the two issues are not related. A Congressional Budget Office report last year illustrates this by showing that medical malpractice litigation represents less than 1% of total health care spending in the U.S. There is no reason to believe that malpractice litigation accounts for a higher percentage of Indiana's health care costs than the national study revealed.

In 1980, Indiana ranked 32nd among the states in per capita health care spending, according to the consulting firm Lewin/ICP. In 1990, 15 years after Indiana passed its malpractice law, after the damage caps had ample time to work their magic, Indiana was still 32nd in per capita health care spending. Clearly, damage caps have had no effect on controlling health care spending in Indiana.

While it is true that Indiana's doctors pay less than physicians in other states for malpractice insurance, this is only half the story. Malpractice premiums paid to the insurance companies are artificially low in Indiana. Malpractice insurers only write up to $100,000 of coverage. Negligently injured patients who are entitled to more than $100,000 must look to Indiana's state-run excess compensation fund. Depending on when the malpractice occurred, the patient can receive up to an additional $400,000 or up to an additional $650,000 for compensation. (A brain-damaged baby, who can require more than $3 million of lifetime health care services, will quickly eat up that award and become dependent upon the taxpayers for survival.) Where does the money to pay the potential $400,000 to $650,000 come from? As it turns out, it is funded by a surcharge on—you guessed it—Indiana doctors. Consequently, doctors' true malpractice costs are not accurately reflected until doctors' malpractice insurance premiums and surcharges are added together. It is noteworthy that the surcharges have ballooned from 10% in 1975 to 125% in 1990.

Doctors have not flocked to Indiana because of damage caps and apparently low insurance premiums. According to the 1991 Statistical Abstract of the United States, Indiana has 45 fewer physicians per 100,000 residents than the national average. Further, the Indiana Medical Association says half of the graduates of the Indiana University School of Medicine leave the state upon graduation.

Even if damage caps did result in lower malpractice costs for doctors, the idea that this would reduce costs to the health care consumer is not true. When the medical establishment cuts its costs for malpractice insurance—whether in the form of private insurance premiums or surcharges—it pockets the difference.

Damage caps will not reduce health care spending in the U.S., nor will lower malpractice costs for doctors result in lower health care costs. Instead, damage caps are only an attempt by the insurance and medical establishments to gain special treatment at the expense of the taxpayer and the severely injured patients. President Clinton, to his credit, has not been conned into believing that damages caps are the salvation of our health care system's ailments.

FRANK CORNELIUS
Indianapolis

Wall Street Journal
October 13, 1993
p. A23