

Testimony of
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Testimony of the
American Hospital Association
before the
Senate Committee on the Judiciary
on
The Medical Liability Crisis and its Impact on Patient Care

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Mr. Chairman, I am George F. Lee, M.D., executive associate to the CEO at California Pacific Medical Center in San Francisco, an affiliate of Sutter Health. For more than 10 years I have been involved with hospital administration on a full-time basis. I am here today on behalf of the American Hospital Association's (AHA) nearly 4,700 hospital and health care system members, and our more than 31,000 individual members. We are pleased to testify before you concerning the harmful impact that excessive litigation is having on patient access to care, and the need for a national solution to the problem. This issue is of critical importance for hospitals, physicians, patients, and the communities we serve.

BACKGROUND

Mr. Chairman, the effects of the medical liability crisis are well known ... and every one of them hurts the ability of many patients to get the care they need in a timely manner. In many areas, physicians are packing up and leaving town because they simply cannot afford the skyrocketing costs of liability premiums. Hospitals and other facilities are closing down or curtailing important services, such as emergency rooms and the delivery of babies. Where these kinds of services are still available, not only are liability premiums driving up the cost of care, but defensive medicine ... the ordering of extensive tests and other services to cut down on the potential for a lawsuit should something go wrong ... drives up the cost of care.

Mr. Chairman, on any give day, there are more than 125,000 malpractice suits in progress against America's doctors and hospitals. Many of them will lead to awards so high as to make us question how anyone can survive in the health care field. For example, in Texas, where they do everything big, there was a claim of \$268 million. Many states see claims of \$100 million and more. These kinds of unlimited verdicts have serious consequences. They make it very difficult to afford being able to go to court. They dramatically increase the cost of settling a case. In short, unlimited judgments require unlimited premiums.

And here is a very telling statistic: There is no correlation between the presence or absence of medical negligence and the outcome of malpractice litigation.

A survey that the AHA did of its members earlier this year found that, for the previous two years, more than 20 percent of the hospitals in crisis states (crisis states as identified by the American Medical Association as of March of 2004 include: PA, WV, NV, MS, WA, OR, TX, AR, MO, GA, FL, IL, NC, KY, OH, NY, CT, NJ, WY), had seen their liability premium rates double. Sixty-four percent reported they had been forced to take on more risk by raising their deductibles or self-insuring, for example. More than half reported their community had lost physicians. And 39 percent of hospitals in those states reported having lost specialty coverage for any period during the past 24 months, most of them due to liability concerns. Recently, St. Paul's, one of the largest providers of liability insurance, withdrew from the market, further exacerbating the problem.

An AHA TrendWatch report from 2002, researched by the Lewin Group on behalf of the AHA, documented that health care providers across the nation are becoming increasingly concerned about their ability to find affordable medical liability insurance, and that patient access to care has been undermined. The report suggests that the current crisis is likely to be more complicated than medical liability insurance problems that occurred in the 1970s and 1980s, stating that the factors influencing the wide geographic differences in premiums include the following:

- ? State regulations
- ? Characteristics of physician organizations
- ? Local culture and legal practices
- ? Differences in the costs of defending claims
- ? Population size and degree of competition among insurers in the market

The TrendWatch report also stated that the exit of large insurers such as St. Paul's from a market could push premium rates up and make coverage harder to find. "In response," says the report, "physicians may leave for another market and hospitals may need to alter the services they provide."

Indeed, insurers faced heavy losses when declining returns on investment exposed them to expenses that were significantly above premiums collected. In addition, large jury awards, which often set the standard for settlement awards, began to put upward pressure on premiums. Some large insurers became insolvent and no longer offered medical liability insurance. In short, insurance capacity evaporated.

In addition to experiencing serious increases in the cost of health care liability insurance, hospitals are coping with a workforce shortage; private, Medicare, and Medicaid payments that do not cover the cost of providing care; and redoubled disaster preparedness efforts. These additional burdens are threatening hospitals' ability to appropriately staff emergency departments, recruit new physicians to high-risk specialties, deliver babies, and provide other services communities depend on.

In the book "Ghost Soldiers," by Hampton Sides, a veteran of the Battle of Bataan describes how "the defense of Bataan devolved into a brutal war of attrition - a war ... of consumption without replenishment." It is just such a circumstance that confronts our nation's hospitals and physicians. Without intervention by Congress, we could find ourselves unable to address the basic health care needs of our communities. Congress must help hospitals and physicians find a solution to

skyrocketing medical liability premiums so that we can continue to provide the right care, at the right time, in the right place; 24 hours a day, seven days a week.

The current medical liability system is a costly and ineffective way of resolving health care liability claims and compensating injured patients.

It is well documented that the United States has the world's most expensive tort system, with tort costs over the past 50 years outpacing growth in the United States' economy by a factor of four. Such growth has not translated into efficiency. According to the General Accounting Office (GAO), 43 percent of insurance defense costs are spent on claims that have no merit. Other studies show that many claims with merit are never filed.

THE NEED FOR A FEDERAL SOLUTION

To cope with the problem, several states have enacted medical liability reform bills. But we strongly believe that the only way to successfully deal with this growing problem is to address it at the national level. The federal government pays for nearly half of the health care delivered in this country. Standards of care are national. And defensive medicine costs our nation more than \$100 billion a year.

I would like to specifically focus on the strong need for federal reform that is based on the reforms we implemented in California, which stands as a model for the nation. The AHA believes that the California-style reforms enacted under the Medical Injury Compensation Reform Act (MICRA) of 1975 and reflected in legislation that is languishing in Congress should be adopted at the federal level. I served on one of the committees that developed the language for that law. For more than 25 years, MICRA has demonstrated that patients' rights can be protected at the same time that medical liability costs are reduced.

The goals of MICRA were simple, and they have been met:

- ? A sustainable insurance system providing full indemnification of actual loss
- ? More money for injured patients
- ? Faster settlements
- ? Preservation of access to medical care without impeding access to courts for truly injured patients
- ? Society does not incur double costs
- ? Assures money is available at the time it is needed

The bipartisan Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act, has been passed by the House but continues to run up against a roadblock in the Senate. The HEALTH Act contains MICRA-style provisions that can help make this happen at the national level.

Limits on non-economic damages: The HEALTH Act limits the amount a plaintiff could receive for pain and suffering to \$250,000. Such a ceiling on these non-economic damages restores stability to the insurance market. All economic losses and/or costs are paid in full. Such a cap provides affordable coverage, and ensures that health care providers can buy coverage. It does not affect a plaintiff's ability to be fully compensated for economic damages such as medical expenses or lost wages.

Limits on contingency fees: Under the current health care liability system, patients awarded compensation are often shortchanged. Money that should go toward their long-term care goes instead to their attorneys. This is because, traditionally, attorneys in liability cases are paid through contingency fees, which provide the attorney a percentage of the plaintiff's award. Percentage limitations should be applied to attorneys' fees. The HEALTH Act limits the attorney's share to 40 percent of the first \$50,000 of a plaintiff's award, 33.3 percent of the next \$50,000, and lower percentages for higher amounts.

Periodic payments: In cases where the court decides that the plaintiff will incur future damages over \$50,000, the HEALTH Act allows the award to be paid over time. Periodic payments would allow compensation to be made in intervals rather than a lump sum, permitting settlements to be geared to a plaintiff's needs over the course of his or her life. In addition, because periodic payments can be funded through an annuity, future needs can be fully met at a considerably lower cost to the health care system.

A fair share rule: The "joint and several" rule allows any defendant to be liable for the entire amount of an award, regardless of how small that defendant's share of the fault may be. As a result, the rule generally punishes a co-defendant (or a sole defendant) who is fully insured or has substantial assets - the so-called "deep pocket" defendant. For some providers, this removes any incentive to carry full liability insurance coverage. By establishing a fair share rule in health care lawsuits, each party is liable solely for its share of damages and not for the share of any others. In cases with multiple defendants, the HEALTH Act proposes that defendants can be held liable for only their share of the damages.

Collateral source reform / halt double recovery: In cases where plaintiffs sue for medical expenses and loss of income, the HEALTH Act allows doctors and insurance companies to inform juries if the expenses had already been paid by an insurance company.

The California experience under the MICRA law has proven to be more equitable to the medically injured. While the number of health care liability claims brought by medically injured plaintiffs in California, on a per capita basis, is the same as before MICRA, the compensation actually paid to those medically injured in California is higher after MICRA than before. Total awards in California have kept pace with inflation.

And million-dollar verdicts are down. In California, the number of million-dollar verdicts per 1,000 physicians stands at 1.3 ... less than the national average of 1.92. That's a far cry from New York, for instance, where the number is 3.71.

The average medical liability insurance premium in California is now about \$14,000 a year ... a far cry from the nearly \$24,000 a year, adjusted for inflation, being charged in 1976. Another improvement: in California the average time to settlement is now 1.8 years ... for states without caps on non-economic damages, cases go on for almost two and a half years. And patients benefit directly, instead of attorneys. Before MICRA, a patient's portion of a \$1 million settlement was about \$600,000. Under MICRA, that percentage has jumped to \$800,000.

The AHA also supports a uniform statute of limitations in health care liability cases and the continued development of successful conflict resolution programs. Bringing liability claims to

court is often inefficient and costly and renders unpredictable results. Nontraditional approaches such as alternative dispute resolution systems can play an important role in reforming the health care liability system.

CONCLUSION

Patients, hospitals and physicians need Congress to enact the HEALTH Act to prevent even more hospitals from being forced to shut down or curtail services, to prevent physicians from doing the same, and to ensure that patients can get the care they need when they need it. Hospitals want to continue providing the type of health care that saves patients' lives and improves their quality of life, but skyrocketing medical liability premiums and awards too often tie their hands.

MICRA-style provisions as embodied in the HEALTH Act won't make the tort system perfect, but they will create stability and fairness for patients, physicians and hospitals.

I appreciate the opportunity to testify before your committee today. The hospital and physician communities look forward to working with you to ensure that important medical liability reforms ... like those in MICRA ... are enacted at the federal level.