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**Presentation: Tort Reform 2003**

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DR. ANAWIS: Tort reform engenders strong feelings in everyone today. Physicians blame lawyers for the high malpractice awards that drive up their malpractice premiums to often prohibitive levels, ending their medical careers prematurely. Insurance companies state the same simplistic rationale that malpractice awards are increasing premiums and driving their business into the ground. Lawyers cite poor insurance company investment practices with heavy losses following September 11th that are passed on to physician subscribers.

Some legislators are trying to pass new bills in the House and Senate. These bills target caps on non-economic damages and aim to regulate insurance companies. Non-economic damages are difficult to quantify and include pain and suffering and disfigurement. Awards by juries given for non-economic damages are unpredictable and vary from jury-to-jury given the same case profile. Economic damages are quantifiable and include lost wages and future earnings, the latter of which are reasonably estimated through actuarial tables.

The current malpractice crisis will not be solved with short-sighted or simplistic reasoning. The effort to legislate tort reform is not new, but rather, began in the mid-1970s and was again revived in the mid-1980s and 1990s following economic downturns. Insurance companies during those poor investment cycles spread their losses, as they are doing now, onto subscribing physicians. California was the pioneer, in 1975, by passing comprehensive tort reform and insurance regulation
(MICRA) to curb rapidly rising malpractice costs. Rates of malpractice insurance in California continue to rise but at an apparently more controlled rate as compared to the year-to-year doubling and tripling seen in other states. California is also unique in having had managed care since its inception in the 1930s with Kaiser, and was later joined by Cigna as key providers of health care for the state. While physicians’ salaries have been consistently lower for Kaiser and Cigna employees, these companies indemnify their physicians, thus, making the working conditions more acceptable. Clearly, it was to these large managed care organizations’ benefit to spearhead tort reform in an effort to control their costs and reap greater profits.

The hard facts are that while the U.S. probably has the most advanced and innovative approach to patient care, the delivery of the care has been in crisis for decades. Our emergency rooms are the port-of-call for patients who are uninsured with taxpayers left to cover considerable losses.

Tort reform may be beneficial but is not a panacea for our financially-challenged health care system. I stress that it is the delivery of medicine, (meaning the unstructured, patchwork of public, private and largely uninsured), that is the key problem. The actual care that each patient receives in this country is probably the best in the world.

Recent trends in malpractice awards have arguably had their effects on the costs of medical malpractice insurance. We will review data to support or reject this hypothesis and its potential effect on physicians and the delivery of medical care today.

The median national jury awards in medical malpractice cases doubled between 1995 and 2000 rising from $500,000 to $1,000,000. Similarly, median national settlements rose precipitously from $350,000 to $500,000 during the same five years. The current national government responded in July 2002 by issuing a report from the U.S. Department of Health and Human Services (HHS) entitled “Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System.” The government placed the blame for the rapid rise in health care costs directly on the shoulders of the legal system, citing a need to “curb excess litigation.” The paper stated:

“The cost of these [medical malpractice] awards for non-economic damages is paid by all other Americans through higher health care costs, higher health insurance premiums, higher taxes, reduced
access to quality care, and threats to quality of care. The system permits a few plaintiffs and their lawyers to impose what is in effect a tax on the rest of the country to reward a very small number of patients who happen to win the litigation lottery. It is not a democratic process.”

The HHS paper further states: “The malpractice system does not accurately identify negligence, deter bad conduct, or provide justice.” As a physician, I would argue that it is not the responsibility of the legal system to determine the quality of medical care, the existence of negligent care, or to deter what the HHS calls “bad conduct.” We as physicians need to do a better job at identifying and educating physicians who are not providing quality medical care. Hospital staffs and medical societies need to be more active in assuring that the highest quality of care is provided to patients. The purpose of the legal system is to provide a redress, a remedy, for the harms suffered by patients who do not receive care within an acceptable standard given our current technical abilities.

As for a “litigation lottery” in which rewards are implicitly present for the asking, plaintiffs’ attorneys are clearly aware of the real costs and probability of success. According to available data, plaintiffs lose more than 60% of jury trials. The average cost of bringing a case to trial is between $35,000 and $50,000.

Is there a relationship between malpractice suits and rising medical malpractice insurance? In the past year, physicians across America have responded to the precipitous rise in their malpractice insurance. In July 2002, doctors in Las Vegas closed the main trauma center for 10 days because many physicians could no longer afford insurance. The nearest level one trauma center was five hours away. Some surgeons’ insurance premiums increased to $200,000 from $40,000 the previous year. Re-opening of the trauma center was only possible because some surgeons agreed to work as temporary government employees, thus, capping their liability for non-economic damages in potential cases of malpractice.

In the past six years, Mississippi juries awarded $1 million or more in 100 cases. In the fall of 2002, most cities in Mississippi with populations under 20,000 had no physicians willing to deliver babies due to high malpractice insurance costs. As a result, the Mississippi legislature called a special session and passed tort reform.
On January 1, 2003, surgeons in West Virginia took a 30-day leave of absence to protest rising malpractice insurance premiums. All three neurosurgeons in the city of Wheeling moved. One-third of all general surgeons in Wheeling also moved away. Blue Cross/Blue Shield, the state’s largest insurance carrier, raised premiums to employers providing coverage to employees between 20%-90% compared with the previous year’s rates.

On February 3, 2003, 70% of New Jersey’s 22,000 physicians participated in a work “slowdown.” The result was that elective surgeries were cancelled. Routine office visits were also cancelled. All emergency conditions, however, were treated.

The four states just discussed do not have caps on non-economic damages. According to the *Medical Liability Monitor*, the data available clearly demonstrates that malpractice insurance across all medical specialties in states with caps is significantly lower than malpractice insurance in states without these caps. According to *Survey of PIAA Companies* (July 2002) and *ASPE Review of Articles* (2000-2002), in 2001, states with non-economic damage caps of $250,000 or less averaged a 15% increase in malpractice rates compared with the previous year. States with caps of $350,000 or less averaged a 12% increase. This is compared to states without caps which on average had a 44% increase in malpractice premiums over the preceding year. Illinois, for example, had over a 30% increase in malpractice rates between 2000 and 2002 while Virginia had a 75% increase.

In addition to significantly higher malpractice rates in states without caps resulting in work “slowdowns,” certain high-risk specialties in medicine keenly felt the impact of sky-rocketing malpractice rates. Three critical areas of medicine have been hit with the highest malpractice insurance raises: neurosurgery, general surgery, and obstetrics/gynecology.

According to *Medical Liability Monitor*’s “Trends in 2001 Rates for Physicians’ Medical Professional Liability Insurance” of October 2001, in California, where malpractice caps were instituted nearly thirty years ago, the lowest obstetrics/gynecology rates are found which range from $23,000 to $72,000 per year. The highest rates are in Florida ranging from $143,000 to $203,000. In Illinois, rates vary from a low of $89,000 to a high of $110,000. General surgery malpractice premiums in California range from $14,000 to $42,000 compared with
the highest state, again in Florida, ranging from $63,000 to $159,000. Illinois general surgery premiums vary from $50,000 to $70,000.

Without obstetricians, the lives of future generations and mothers are placed at unreasonable risk. This past year, three of the ten highest nationwide jury verdicts (given all types of cases) were all obstetrical cases. All three cases involved children born with cerebral palsy (still a poorly understood condition). All three cases occurred in New York state. The verdicts ranged from $81 million to $94.5 million. These large awards are bound to result in higher malpractice premiums for obstetricians at least in New York state, if not nationally, and may result in an exodus of obstetricians from New York.

Beyond the risks to unborn lives, the malpractice crisis has profoundly affected the existing lives of patients needing neurosurgeons. Within the past year, 19% of neurosurgery malpractice premiums rose 100%. Half of premiums increased by more than 50%. In a nationwide poll last year, 43% of neurosurgeons planned to or considered discontinuing high-risk surgical procedures in order to lower their liability insurance rates. Twenty-nine percent of neurosurgeons considered retiring while 19% considered relocating.

Imagine that you have a brain tumor or have suffered a stroke and no neurosurgeon is available to care for you. In Mississippi and West Virginia, this very thing happened as patients lost the “gold hour,” meaning the time in which the optimal care can be delivered, because no neurosurgeons were available. Once this time is lost, even if another neurosurgeon is eventually found, it is often too late to help the patient have the best outcome or benefit at all because the blood flow and nutrition to the brain has been cut off for too long and specific portions of the brain are dead.

In addition to physicians and state citizens, insurance carriers have responded to the medical malpractice crisis. Since December 2001, St. Paul Insurance, previously the largest malpractice carrier in the U.S., discontinued underwriting policies. As of January 1, 2003, ISMIE, the insurance branch of the Illinois State Medical Society, no longer underwrites new malpractice policies. MIXX, PHICO, and Frontier Insurance Group all left the market last year. Nearly all companies underwriting nursing home policies are leaving the business. The nursing home insurance crisis has had its greatest impact on Florida’s elderly population. The average cost of insuring one skilled nursing home bed in Florida averaged $11,000 per year last year. Nursing homes are unable to pay such high costs and still remain in business.
The federal and state governments have responded to these crises in medicine by a number of legislative proposals. Currently, three federal House bills and one Senate bill have been proposed to control malpractice costs.

House Rule 321, the “Common Sense Medical Malpractice Reform Act of 2003,” proposes the following: 1) alternative dispute resolution for all health care liability except vaccine-related or Public Health Services Act applications, 2) a statute of limitations on filing suits of one year with a maximum of three years, 3) non-economic damage caps of $250,000, 4) punitive damages of double compensatory damages or $250,000 (whichever is greater), 5) periodic payments if damages exceed $50,000, 6) allowance of evidence of collateral source payments, and 7) limitations on contingency fees.

The second bill, House Rule 485, the “Federal Medical Malpractice Insurance Stabilization Act of 2003,” targets insurance companies in an effort to control costs. The bill proposes that the Secretary of Health and Human Services would establish and oversee a fund. This national fund would automatically reinsure companies and underwriters of malpractice insurance coverage for all claims exceeding $250,000.

The third bill is House Rule 446, the “Emergency Medical Liability Insurance Commission Act.” This bill seeks to appropriate $2 million to form a committee to “investigate and determine whether a causal relationship exists between skyrocketing malpractice insurance premiums, rising jury awards, decreased accessibility and affordability of health care and the increase in the number of physicians moving, quitting or retiring.” It does not make sense to take $2 million of taxpayer money to gather data that is readily available on the internet or through government agencies while wasting more time to confirm that a crisis in medicine exists today.

The final bill is Senate proposition 352 the “Medical Malpractice Insurance Anti-trust Act of 2003.” This bill aims to remove the advantages given to insurance companies through exemption from anti-trust regulations. The bill states that nothing in the “McCarran-Ferguson Act shall be construed to permit commercial insurers to engage in any form of price-fixing, bid rigging, or market allocations in connection with the conduct of business of providing medical malpractice insurance.” Why should insurance companies not compete with one another as all other businesses do in order to allow consumers the best product at the lowest prices?
As the federal and state governments seek to control spiraling malpractice insurance costs via statutory caps on non-economic damages, a number of challenges in the case law will have to be addressed. Federal challenges include: 1) equal protection, 2) due process, both substantive and procedural, and 3) 7th Amendment right to a jury trial. Federal equal protection challenges have been decided by the judicial standard of review. Caps on non-economic damages have been found unconstitutional when either strict scrutiny or intermediate scrutiny has been applied. When the rational basis test is used, caps have been held constitutional. In seeking to uphold damage caps, proponents should argue that caps act as effective legislation aimed at ensuring adequate health care at reasonable costs. Proponents should encourage the court to defer to legislation to uphold caps.

By contrast, opponents of caps under equal protection arguments should stress that caps deny an important substantive right of recovery to plaintiffs harmed by medical errors. Caps on damages also place greater burdens on the most seriously injured plaintiffs, those plaintiffs who are elderly or unemployed, and therefore, will not receive significant economic damages to offset their loss.

Federal due process arguments take the form of both substantive and procedural due process claims. Under previous case law, substantive due process arguments have been analyzed by courts using the "reasonableness" test. Proponents under substantive due process have argued that there is a reasonable relationship between caps and the predictability of malpractice premium rates once high jury awards are eliminated.

Alternatively, opponents of caps under substantive due process arguments should provide the court with qualitative evidence, meaning hard numbers, to undermine the argument that statutory caps are reasonably related to the health care crisis. Procedural due process arguments are unlikely to invalidate caps unless jury determinations of the merits of the cause of action are pre-empted.

The final federal challenge to statutory caps is the 7th Amendment right to a jury trial. The court's scope of interpretation of this right determines the case outcome. Where the right to jury trial is narrowly interpreted, caps have been upheld. The reasoning upholding caps is that they are narrowly applied after the jury has already reached its verdict and corresponding recovery. If the right to jury trial is broadly interpreted, then caps have been held unconstitutional. By refusing to
enter the amount of a jury’s verdict, the court has invalidated the determination of fact.

On a state level, Illinois currently has some liability-containing measures in place but does not have caps on non-economic damages. Current regulations include having each defendant be jointly and severally liable. Illinois applies the collateral source rule as follows: the judgment is offset by 50% of lost wages and 100% of medical benefits received with the total judgment not being reduced by more than 50%. Attorneys fees are limited on the following scale of awards: 33.3% for the first $150,000, 25% for the next $850,000, and 20% for amounts greater than $1 million. Periodic payments may be elected at least 60 days prior to trial or with leave of the court. As many of you know, the lack of damage caps and soaring malpractice premiums in the state have led to physicians planning a protest next week in Springfield with a work stoppage proposed for all except emergency medical treatments.

State challenges to damage caps include: 1) the “open courts provision,” 2) the prohibition against “special legislation,” 3) the right to a jury trial, and 4) the separation of powers doctrine. The “open courts provision” guarantees the right of access to courts. The court’s determination under this provision hinges on whether the court accepts or rejects the need for an alternative remedy for the right to access. In other words, if the plaintiff is denied the right to use the courts for his or her grievance, then should they be provided an alternative to make up for this loss? Proponents of caps would argue that the right to sue for malpractice damages is not a fundamental right. Furthermore, limitations on claims are reasonably related to the state’s attempt to minimize costs and maintain medical services. Opponents of caps should emphasize that limitations on non-economic damages restrict a common law cause of action. In addition, caps are arbitrary and unreasonable when balanced against limiting recovery to the most deserving victims, those victims who are without substantial economic recovery due to advanced age or lack of employment. Finally, opponents of caps using the open courts provision should state that the legislature is failing to provide an adequate substitute remedy replacing the rights to recovery which are modified by caps.

The “special privilege” clause prohibits granting unique rights or immunities to an individual or class. This clause effectively mirrors the federal equal protection argument. Proponents of caps argue that the class of malpractice victims is treated equally because they receive
identical caps. Caps are also reasonably related to the medical malpractice crisis because they aim to contain costs.

By contrast, opponents of caps argue that health care providers are being granted a special privilege of limited liability by virtue of capping damages. Again, recovery of damages to the most severely injured would be arbitrarily limited.

A separation of powers proponent would state that by entering awards in excess of caps, the court is invading legislative powers. Opponents of caps would counter by saying that the legislature is interfering with court determinations of law.

Having reviewed the current state of federal and state law and the response of physicians and the impact on the delivery of medical care, I would like to summarize with solutions that I feel are the most viable. Each element of our health care system must be active and take responsibility. Physicians must establish better mechanisms to evaluate patient outcomes and improve clinical practice. Insurance companies should be required to limit assets placed in high-risk investments so that their losses are not passed on to physicians in the form of higher insurance premiums. Anti-trust legislation exempting insurance companies should be repealed. In addition, competition amongst insurance companies can be encouraged by state-sponsored start-up insurers in the effort to boost competition and drive down costs.

Finally, if caps are permitted, then the legal system must provide adequate review and potential for bypassing rulings when victims of catastrophic outcomes are inadequately compensated due to limitations on non-economic damages. The $250,000 cap cited by federal bills and some state statutes was imposed in California in 1975 and must be adjusted periodically as the cost of living increases. There are no simple solutions to our current medical malpractice crisis, but we possess extraordinary tools and intellect and can build an even better and more efficient medical system to serve our nation.