

HR 4600 Will Harm Patients & Enrich Only Insurers

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In an age where expanding patients' rights has become a national demand, HR 4600 would dramatically contract patients' rights across the nation. This anti-consumer legislation will shield HMOs and providers they influence from legal accountability to the patient for harm they cause.

HR 4600 will deny innocent victims of medical negligence both adequate compensation for their injuries and legal representation for legitimate claims. It will confer substantial financial benefits only on malpractice insurance companies, not the average physician. To the extent that staff model HMOs indemnify their staff and facilities, as the nation's largest HMO does, HR 4600 will also protect HMOs from liability for the harm they cause to patients. The evidence comes from California, where the model for HR 4600 has had these consequences. Under California's restrictions, malpractice insurers have consistently paid out in claims less than 50% of the premiums they have taken in and made excessive profits. Despite limitations on victims, California doctors' malpractice premiums have been consistent with the national average.

The failed model for this legislation was enacted in California in 1975 as the Medical Injury Compensation Reform Act, or MICRA. In recent years, Californians have been confronted with MICRA's devastating human impact and its failure to achieve its financial goals. The California legislature has tried twice in the last four years to remove MICRA's limits, but have been unsuccessful in the face of lobbying by the insurance industry.

First my testimony will explain the impact of the MICRA provisions also contained in HR 4600 and their draconian consequences for innocent patients. Then, I will address MICRA's impact on malpractice premiums and how insurers in California have seen the only substantial profits from MICRA.

Like HR 4600, MICRA provisions:

- Place a \$250,000 cap on the amount of compensation paid to malpractice victims for their "non-economic" injuries.
- Eliminate the "collateral source rule" that forces those found liable for malpractice to pay all the expenses incurred by the victim.
- Permit those found liable for malpractice to pay the

compensation they owe victims on an installment plan basis. -Impose a short "statute of limitations" on malpractice victims (generally three years). -Establish a sliding scale for attorneys fees which discourages lawyers from accepting serious or complicated malpractice cases.

I have been contacted over the last ten years by hundreds of patients who are innocent victims of medical malpractice, then further victimized by these MICRA restrictions. The actual experiences of these patients shows the cruel consequences of each MICRA restriction also contained in HR 4600.

Capping Medical Malpractice Victims' Compensation Causes Innocent Patients More Pain And Suffering: Like HR 4600, MICRA places a cap of \$250,000 on the amount of compensation paid to malpractice victims for their "non- economic" injuries, no matter how egregious the malpractice or serious the harm.

The MICRA cap is not adjusted for inflation. In order to provide the same level of compensation in today's dollars, the cap would have to be approximately \$800,000. Put another way, the \$250,000 MICRA cap has decreased in value since 1975, when compared to the Consumer Price Index, to approximately \$70,000. Though health care costs -- hospital charges, medical fees, etc. -- have risen dramatically since 1975, compensation for non-economic damages has been frozen by the statute.

Non-economic injuries include pain, physical and emotional distress and other intangible "human damages." Such damages compensate for severe pain; the loss of a loved one; loss of the enjoyment of life that an injury has caused, including sterility, loss of sexual organs, blindness or hearing loss, physical impairment, and disfigurement.

Applying a one-size-fits-all limit to non-economic damages objectifies and erases the person, considering them as a fixed "thing" for the purposes of law, so that there is no recognition of the uniqueness of their suffering. There is no quicker way to strip an individual of their humanity than to fail to recognize their suffering.

My personal bias on this point springs from the experiences of a friend who today is twelve years old. Steven Olsen is blind and brain damaged because, as a jury ruled, he was a victim of medical negligence when he was two years old. He fell on a stick in the woods while hiking. Under the family's HMO plan, the hospital pumped Steven up with steroids and sent him away with a growing brain abscess,

although his parents had asked for a CAT scan because they knew Steven was not well. The next day, Steven Olsen came back to the hospital comatose. At trial, medical experts testified that had he received the \$800 CAT scan, which would have detected a growing brain mass, he would have his sight and be perfectly healthy today.

The jury awarded \$7.1 million in "non-economic" damages for Steven's avoidable life of darkness and suffering. However, the jury was not told of a two decade old restriction on non-economic damages in the state. The judge was forced to reduce the amount to \$250,000. The jurors only found out that their verdict had been reduced by reading about it in the newspaper. Jury foreman Thomas Kearns expressed his dismay in a letter published in the San Diego Union Tribune.

We viewed video of Steven, age 2, shortly before the accident. This beautiful child talked and shrieked with laughter as any other child at play. Later, Steven was brought to the court and we watched as he groped, stumbled and felt his way long the front of the jury box. There was no chatter or happy laughter. Steven is doomed to a life of darkness, loneliness and pain. He is blind, brain damaged and physically retarded. He will never play sports, work, or enjoy normal relationships with his peers. His will be a lifetime of treatment, therapy, prosthesis fitting and supervision around the clock. . . Our medical-care system has failed Steven Olsen, through inattention or pressure to avoid costly but necessary tests. Our legislative system has failed Steven, bowing to lobbyists of the powerful American Medical Association (AMA) and the insurance industry, by the Legislature enacting an ill-conceived and wrongful law. Our judicial system has failed Steven, by acceding to this tilting of the scales of justice by the Legislature for the benefit of two special- interest groups. . . . I think the people of California place a higher value on life than this.

When in San Diego, I often visit Steven and his family. Their struggles are unfathomable to me. In 2001, Steven had 74 doctor visits, 164 physical and speech therapy appointments, and three trips to the emergency room. And his parents say that was a good year because Steven was not hospitalized. Steven's mother Kathy had to leave her job because caring for Steven is a full time job. She has to struggle constantly with the school district for Steven to receive special education classes. One day, Steven ate part of a light bulb, not an uncommon problem for children with brain injuries. He has to be watched constantly. Insurance executives that seek to limit jury

awards for the individual's pain and suffering claim society must do so to save money. Yet these executives typically make millions every year without any of Steven Olsen's pain and suffering. Limiting their responsibility for the pain of individuals reduces not only the corporation's accountability, but the worth of the individual to that of a mere object.

Last week, Kathy Olsen said this about Steven: It has been 10 years ago this month when Steven came home from a 5-month life changing stay at the hospital. He was only 2 years old. When he went into the hospital no one asked his party affiliation. He was a casualty of the system. The system that he had no say in. Which lawmakers were looking out for him? Now with all his disabilities he will never see, do things that the average person gets to do in their lifetime, or vote in an election. Please look out for all the Steven Olsen's in this great country. Don't let this happen over and over again.

Other California patient cases similar document how the \$250,000 cap on compensation has further victimized innocent victims. Patients with permanent injuries are limited to \$250,000, even when juries award significantly more compensation, tangible "economic" damages exist (but are unidentified by juries), and unforeseen "economic" costs arise later.

Harry Jordan, a Long Beach man, was hospitalized to have a cancerous kidney removed but the surgeon took out his healthy kidney instead. A jury awarded Jordan more than \$5 million dollars, but the judge was required to reduce the verdict to \$250,000 due to California's cap on "non-economic" damages - plus a mere \$6,000 in "economic costs". Jordan, who lived for years on 10% kidney function, could no longer work, though the jury (which lawfully can not be notified about the "non-economic" cap) did not take this into account. Jordan's court costs -- not including attorney fees -- amounted to more than \$400,000 and his medical bills, that arose after frequently being denied by insurers, totaled more than \$500,000. He paid \$1700 per month in health insurance.

Arbitrary caps on "non-economic" compensation unfairly discriminate against the suffering of women -- who typically sustain injuries due to medical negligence, such as laceration of the uterus or loss of a new born during child birth, that do not carry high "economic" price tags but involve significant loss. Injuries sustained by homemakers are also unvalued, because they have no "wage loss." Caps not only deny women victimized by medical malpractice fair compensation and legal

representation for their injuries, but subject women to repeat offenders and have been undeterred.

San Andean Terry McBride lost her unborn baby and her fertility at the hands of a negligent doctor who had injured at least 25 women before her, causing the unnecessary deaths of their babies and the affliction of Cerebral Palsy to 2 children.

California's "non-economic" compensation cap restricted McBride to less than \$250,000 for the loss of her child's life and her own sterilization (because she suffered no wage loss due to her injuries). The award was even insufficient to cover the cost of an expensive new procedure seeking to restore her fertility.

Arbitrary caps on "non-economic" compensation unfairly discriminate against the littlest victims, children -- who can not prove significant future wage loss and whose families cannot realistically estimate the expenses they are to incur over the course of a life time.

A six year old Northern California girl paralyzed by negligent medicine was restricted to 250,000 in compensation for her lifetime due to California's "non-economic" cap because she could not prove any future wage loss.

Caps on "non-economic" compensation devalue the lives and health of low income patients. Caps on pain and suffering discriminate against the suffering of low income people whose "economic" basis -- wages -- are limited. A strictly "economic" evaluation based on wages devalues what victims will create or produce in the future, their quality of life, as well as an injury's impact on their ability to nurture others. For instance, a laborer may lose his arms due to the exact same act of medical negligence as a corporate CEO, but the CEO would be able to collect millions and the laborer would be closely limited to the \$250,000 cap. A housewife similarly would be limited to the cap no matter the physical or emotional depths of her injury. Caps assign greater value to the limbs and lives of some people than the limbs and lives of others.

The five children of a 32-year old mother, who was unemployed and untrained (therefore had no 'economic' value), were left with merely \$250,000 to compensate all of them for their life time after the errors caused their mother's death during an emergency Caesarean section.

Caps make taxpayers foot the bill for malpractice. Malpractice victims

receive full compensation only for medical bills and lost wages. But those who are not wage earners -- such as seniors, women, and the poor -- have no other resource from which to pay for unforeseen medical expenses and basic needs. A cap forces malpractice victims to seek public assistance from state or federal programs funded by taxpayers.

A Los Angeles woman, who sustained severe jaw damage and slight brain damage from an HMO's misdiagnosis and refusal to treat her, was not represented by an attorney because she was limited in her recovery by California's cap. As the HMO did not pay for the damage it caused, and would not treat her, the woman was forced to receive government funded Medicare and Supplemental Social Security Income payments for her disability.

HMO Protection: Ending Deterrence To HMO Abuse: The nation's largest HMO, which is also California's largest HMO, is protected by MICRA's cap in California and staff model HMOs like it would be similarly shielded across the nation under HR 4600. Kaiser Permanente has hundreds of cases in its system every year in California for which it is liable for no more than \$250,000 in non-economic damages. In many cases, California 's cap system has limited the liability for egregious systemic error to an acceptable cost of doing business, permitting systemic medical negligence to continue undeterred. There is no incentive to systemic problems.

For example, Colin McCaffery was born too large, in Kaiser's Woodland Hills facility with only a nurse-midwife present -- although his parents urged that a physician be there because their other children had been born large. As a cost cutting practice, the HMO did not routinely assign doctors to be present during child birth, except for "high risk"cases. Because the nurse -midwife lacked the skill to properly guide Colin out of the birth canal, he was crippled, losing movement in his arms and torso -- a rare condition know as Erbs Palsy resulting only from botched deliveries. Due to California's cap on recovery, Colin's family settled for only \$250,000 -- not enough to compensate Colin or make Kaiser change its practice. Colin's father stated after the case the HMO "still does not provide the option for a doctor when delivering babies. At a clinic for Colin, I saw over 50 babies, all under the age of two, clinging to their parents. None of them were smiling. They all had Erbs Palsy. One little girl around one had such a sad look to her. Her arms, both of them, just dangled lifelessly by her side. " Other similar cases of seriously injured or dead newborns due to the child birth system

have emerged in California, but they typically cost Kaiser no more than \$250,000, so there is little incentive for the HMO to change its system.

A recent account from the Los Angeles Times of systemic problems with overcrowding in Kaiser's emergency room show how un-addressed deficiencies have led to many patient deaths from similar circumstances (Charles Ornstein, "Cases Reveal Lapses in Kaiser Emergency Care," Los Angeles January 2, 2002 p.A1) MICRA's cap dramatically limited the HMO's liability in these cases so there was no incentive to change its practices over a ten year period. As the article points out, recently the California Department of Managed Health Care fined Kaiser \$1.1 million for these same systemic problems. "In justifying a \$1.1- million fine against Kaiser, state regulators cited three patient deaths and said the cases demonstrated a pattern of problems in emergency care that has put the HMO's 6 million California members at risk," the Times reported. "Similar problems showed up in at least nine other cases since 1995. . .in which arbitrators found Kaiser liable for patient injuries or deaths." Had MICRA's shield not protected the HMO, perhaps Kaiser would have had an incentive to change its practices. Under MICRA, deterrence to wrongdoing at Kaiser has been removed.

For HMOs like Kaiser, the \$250,000 cap in MICRA and in HR 4600 allows negligence without consequence. Deterrence to wrongdoing is especially important at HMOs. Arbitrarily applying one-size- fits-all caps to systemic wrongdoing lets HMOs know there is a financial limit to how much they will pay no matter how egregious and irresponsible their conduct. This is carte blanche in many cases to throw caution to the wind.

Ironically, proponents of HR 4600 claim it will limit "defensive medicine" procedures. The Congressional Office of Technology Assessment reported in July 1994 that "defensive medicine," procedures purported to be driven by physicians' fears of lawsuits, account for only 8% of medical procedures and may in fact constitute merely preventative, high quality health care. As the OTA stated, fear of lawsuits can often simply make those with the least incentive to be cautious exhibit more caution. This is precisely the incentive HMOs and their doctors and hospitals now need.

Periodic Payments Reward Convicted Wrong-Doers At The Expense Of Malpractice Victims They Injure: Like HR 4600, MICRA permits defendants found liable for malpractice to pay jury awards on a periodic, rather than a lump sum, basis, if the award equals or

exceeds \$50,000 and the defendant requests it. Jury-designated malpractice awards can be restricted by the judge as to the dollar amount paid each period and the schedule of payments. The periodic payment arrangement, once approved by a judge, cannot typically be modified -- unless the victim dies earlier than expected, in which case the defendants, rather than the family of the deceased, retain the balance of what they owe.

This provision of MICRA, like HR 4600's provisions, allows the negligent provider or its insurance carrier to control, invest and earn interest upon the victim's compensation year after year. No adjustment is made in the payments to reflect unexpected trends in the inflation rate or changes in the cost of medical care.

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. Another problem is that an inflexible payment schedule leaves the victim without sufficient resources in the event that unanticipated medical or other expenses arise. This is most likely to occur in the years immediately following the injury, when the periodic payments are unlikely to cover the aggregate costs.

Periodic payments allow wrong-doers to invest and earn interest on the money owed injured victims. Periodic payment schedules permit convicted perpetrators to control the money owed victims and profit from its use year after year. If the physician happens to fall into bankruptcy due to bad investments, the victim is denied the agreed upon compensation.

If a patient dies, all payments stop and the victim's family receives nothing. Wrong-doers are rewarded for causing the most severe, life threatening injuries. If a patient dies, periodic payments cease and the guilty physician is allowed to keep the remainder of their money. Awards do not revert to the next of kin.

Periodic payments reduce the already limited compensation received by victims, as the value of the verdict diminishes over time due to inflation. No adjustment is ever made in the payments to reflect the inflation rate or changes in the costs for medical care -- which have risen sharply and well above the inflation rate for many years.

Periodic payments put the burden on the victim to meet their basic needs. The periodic payment arrangement, once approved, is extraordinarily difficult to modify. If costs of the victim's medical care

increases beyond their means, or a special expensive medical technology is made available which the victims requires, the injured patient must retain a lawyer to have the schedule modified --- and may very well not succeed.

Capping Plaintiff Attorney Contingency Fees, But Not Defense Attorney Fees, Denies Victims Representation: Like HR 4600, MICRA sets a sliding contingency fee schedule for plaintiffs' attorneys representing victims of medical malpractice. The MICRA fees are limited to 40% of the first \$50,000 recovered; 33 1/3% of the next \$50,000; 25% of the following \$100,000, and 15% of any amount exceeding \$200,000. MICRA does not limit the fees of the defendant's lawyers.

Only the most seriously injured victims with clear-cut cases to prove can ever find legal representation. In states with caps on attorney contingency fees for medical malpractice cases (and particularly in states such as California where a victim's pain and suffering compensation is also capped), victims of medical malpractice simply can not find legal representation. It is not cost effective for attorneys to take the vast majority of cases. Says the President of Safe Medicine For Consumers, a California- based medical malpractice survivors group, "The vast majority of individuals who contact us are women, parents of children or senior citizens. 90% of these individuals are unable to pursue meritorious medical malpractice cases because they can not find legal representation on a contingency basis and their savings have been wiped out."

Limiting plaintiff attorney contingency fees, but not defense attorney fees creates an uneven playing field for victims. Defendants can typically afford very high priced attorneys who fly special expert witnesses in from out of state. A contingency fee practice demands that a plaintiff's attorney must front the cost of expert witnesses to refute the testimony of experts flown in by the defendant. With caps on fees, such costs become prohibitive for the victim's legal counsel.

Undermining the contingency fee mechanism contributes to a deteriorating quality of health care and passes costs onto taxpayers. Left without legal representation in California, victims go uncompensated, and dangerous doctors go undeterred. Taxpayers pay the cost of low income victims' medical care and basic needs through public assistance programs if the physicians responsible for the injuries are not held accountable.

Undermining the viability of contingency fee mechanism discriminates

against low income patients who are most at risk of medical malpractice. A contingency fee system is a poor patient's only hope of affording an attorney to challenge a negligent physician. Undermining such a system through caps on fees, that reduce incentives for attorneys to take malpractice cases, fails to punish negligence in poor neighborhoods.

Imposing A Collateral Source Offset Forces Taxpayers And Policy Holders To Pay For Wrongdoers' Errors: 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 social security and disability. 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 by requiring the defendant to pay all the victim's expenses -- even if a collateral source has already paid them.

Application of another legal doctrine, known as subrogation, ensures that the collateral source rule does not result in "double recoveries" for injured victims. 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. HR 4600's provisions are not necessary because there are already controls on "double recoveries."

For example, an injured individual's health care coverage usually pays the victim's medical bills. Under the traditional collateral source rule, if the victim sues the wrongdoer for compensation, including payment of medical bills, the defendant cannot tell the jury that the bills have already been paid by another source. However, once the jury makes an award to the victim, including damages for medical care, the health insurer can exercise its subrogation rights, and recover from the defendant (or the victim, if the award has been paid) the amount of money already paid for the victim's medical bills.

As HR 4600 proposes for the nation, MICRA repealed these rules in California. Consequently, in a trial, defendants may introduce evidence of insurance or other compensation obtained by the plaintiff. The jury is further permitted to reduce its award against the defendant by the

amount of alternative compensation the victim received or is entitled to. As with the cap on non-economic damages, abolition of the collateral source rule reduces the amount of money the wrongdoer must pay. In effect, responsibility for the harm is transferred to the victim, who purchased the insurance coverage, to the victim's insurer, and/or to taxpayers. Moreover, once the defendant tells the jury about payments made by collateral sources, MICRA prohibits the collateral source from using the subrogation process to obtain reimbursement from the wrongdoer.

Collateral source offsets will shift billions of dollars per year in malpractice injury costs caused by the negligent onto taxpayers and the health insurance system. The cost of injuries resulting from medical malpractice total \$60 billion each year according to the Harvard School of Public Health. Instead of wrong-doers bearing the full cost of these injuries, tax-payer funded programs, such as social security, and policy-holder funded health plans, will be forced to pick up the tab.

A collateral offset forces poor patients onto welfare, while wrong-doers' fortunes will be protected. Low income victims "entitled" to public assistance payments from taxpayer-funded supplemental social security, social security disability and aid to families with dependent children become government assistance recipients while the wrong-doers earn interest on profits made at the victim's expense.

MICRA'S Promises Have Never Materialized, Data Shows HR 4600 Will Enrich Only Insurers: Like HR 4600, MICRA promised drastic reductions in physician malpractice premiums. MICRA was enacted by the California legislature in 1975 in response to rapidly-increasing medical malpractice insurance premiums. The powerful insurance and physicians' lobbies told state legislators that medical malpractice lawsuits and jury awards were responsible for the higher premiums.

Insurance companies threatened that the costs associated with malpractice insurance were rising at such a rate that their only option was to raise health care professionals' liability premiums or to withdraw from the market altogether. Physicians and hospitals emerged as high visibility advocates for the legislation: many opted to "go bare" (practice without malpractice insurance), some discontinued providing certain high-risk procedures, while others threatened to quit.

The crisis, we now know, was created by the "insurance cycle." This is

a well-established phenomenon in which insurers, during bad economic times, raise premiums to cover investment losses after years in which they have lowered premiums (the good economic times) to attract capital for investment. This cycle and its inherent periods of investment losses, then as now, increased malpractice premiums, not lawsuits and claims. Reform then should focus on preventing such insurer investment practices, not restricting victims' rights.

For this reason, data from the National Association of Insurance Commissioners (NAIC) shows MICRA has not significantly lowered physician malpractice premiums compared to the national average and has resulted instead in excessive overhead costs and profit margins for insurers.

Nationally recognized actuary J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator under presidents Ford and Carter, compared national malpractice premium trends to those in California. Hunter found that from 1991 to 2000, malpractice premiums in California have stayed close to national premium trends. The 2000 average premium per doctor in California was only 8.2 percent below that of the nation (\$7,200.61 vs. \$7,843.75). The average malpractice premium in California between 1991 and 2000 actually grew more quickly (3.5 percent), than it did in the nation overall (1.9 percent.) According to Hunter, "there is not much difference in the rates or the rate of change between California and the nation based on the latest decade of experience."

If there are savings to limiting the rights and recovery of innocent victims of dangerous and culpable doctors, then insurers have not passed them onto physicians. NAIC data also shows that California insurers have, in fact, profited greatly from California patients' pain. In most years since the courts ruled that MICRA's cap was constitutional, 1986, California malpractice insurers have paid out in claims less than fifty cents of every dollar they have taken in through premiums (every year since 1989). By contrast, malpractice insurers nationally have typically paid out in claims more than two-thirds of every premium dollar. California malpractice insurers' "operating profits" have been higher than the rest of nation since MICRA was implemented, even though many insurers claim to be "not for profit." For non profits, the money taken in from doctors but not paid to victims can also be tied up in excessive overhead, assets and reserves that yield investment profits or in higher legal costs of defending against claims.

Conclusion: For what? That is the question asked by Californians who understand both the human devastation MICRA has wrought and its financial failures. Enacting similar draconian restrictions federally would fly in the face of the experience of too many California casualties who have suffered needlessly under MICRA for a result that has only benefited malpractice insurers. The real answer to skyrocketing insurance premiums, which are striking across all lines of insurance, is to regulate the insurers' pricing and accounting practices so that investment losses cannot be passed onto policyholders. Congress should not blame the victim for a crisis created by insurance companies.