

**Alliance for Justice
Center for Justice & Democracy
Center for Medical Consumers
ConsumerWatchdog
CT Center for Patient Safety
National Consumers League
Public Citizen
Texas Watch
USAction**

November 12, 2010

Co-Chair Sen. Alan Simpson
Co-Chair Erskine Bowles
Sen. Max Baucus
Rep. Xavier Becerra
Rep. Dave Camp
Sen. Tom Coburn
Sen. Kent Conrad
David Cote, Chairman and CEO, Honeywell International
Sen. Mike Crapo
Sen. Richard Durbin
Ann Fudge, Former CEO, Young & Rubicam Brands
Sen. Judd Gregg
Rep. Jeb Hensarling
Alice Rivlin, Senior Fellow, Brookings Institute
Rep. Paul Ryan
Rep. Jan Schakowsky
Rep. John Spratt
Andrew Stern, former President, Service Employees International Union
National Commission on Fiscal Responsibility and Reform
1650 Pennsylvania Ave NW
Washington, DC 20504
via email: commission@fc.eop.gov

Dear Chairmen Simpson and Bowles and Members of the National Commission on Fiscal Responsibility and Reform:

The undersigned consumer and patient safety organizations are writing to express great concern about one section of the National Commission on Fiscal Responsibility and Reform November 2010 Co-Chair's Proposal ("Co-Chair's Proposal"). While the Co-Chair's Proposal may be considered alarming for a number of reasons, this letter addresses one section in particular:

Pay lawyers less and reduce the cost of defensive medicine
- Enact comprehensive medical malpractice liability reform to cap non-economic and punitive damages and make other changes in tort law.

While we are somewhat hampered in our response due to the vagueness of this paragraph, we assume it is based at least in part on the Congressional Budget Office analysis presented in a 7-page

October 9, 2009 letter to Senator Hatch discussing health care savings from restricting patients' rights. In this letter, CBO identified a health care cost savings of about 0.5% (with 0.3% attributed to "defensive medicine") if Congress enacted restrictions on the legal rights of patients that are so extreme that no single state in the nation has imposed all of them collectively on patients. Two of the items – a \$250,000 cap on non-economic damages¹ and one-year statute of limitations - have been rejected by the vast majority of states. The \$250,000 cap was also considered and rejected by the U.S. Senate on Motions to Proceed five times between 2003 and 2006. Many states have also declared unconstitutional many of these so-called tort "reforms."

To find this small 0.5% in health care cost savings, CBO looked at a handful of studies, several of which are noted to contradict each other. Some of these same studies indicate that the cost of achieving such minor savings would be a significant increase in medical errors resulting in injury or death. One of them suggests that 50,000 more people could die in the next ten years (beyond the 98,000 that already die annually from medical errors²) should Congress further limit the legal rights of patients. Based on these same numbers, another 400,000 or more could be injured (given that one in 10 injured patients die³). The costs of these errors, which the Institute of Medicine already puts between "\$17 billion and \$29 billion, of which health care costs represent over one-half," would clearly increase given that the average length of stay per hospitalization is around 4.4 days⁴ and the average cost per day in the hospital is around \$2,000 per day per injury. Consider those expenses on top of physician utilization inherent in caring for these new patients, and the cost increase due to more injuries is significant.

Also completely ignored by both CBO and the Co-Chair's Proposal are direct financial burdens on the government should liability limits be enacted. Limiting liability ends up shifting the costs away from those who should pay -- insurance companies for health care providers who have committed malpractice – onto the government and taxpayer. Among these additional costs are:

New Burdens on Medicaid. If someone is brain damaged, blinded, mutilated or rendered paraplegic as a result of medical negligence but cannot obtain compensation from the culpable party through the tort system, he or she may be forced to turn elsewhere for compensation, particularly Medicaid. We are aware of families with children severely injured by medical malpractice who had to seek government assistance to survive because tort "reform" reduced their compensation, burdening their own state Medicaid system. None of these increased costs are considered by the CBO or in the assumption of the Co-Chair's Proposal that this would save funds.

Liens and Subrogation. Whenever there is a successful medical malpractice lawsuit, Medicare and Medicaid can both claim either liens or subrogation interests in whatever the patient recovers, reimbursing the government for some of the patients' health care expenditures. Without the lawsuit, Medicare and Medicaid will lose funds that the government would otherwise be able to recoup. Again, none of these lost funds are factored in by the CBO or the Co-Chair's Proposal.

Other Countervailing Tort System Benefits Are Overlooked. Any legitimate analysis of tort system costs must consider the countervailing cost benefits of the legal system due to its deterrence function - future injuries and deaths prevented, health care costs not expended, wages not lost. For

¹ A Rand study "found that the most significant impact of California's 29 year old medical malpractice caps law falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes."

<http://www.consumerwatchdog.org/patients/articles/?storyId=16557>

² *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 1999.

³ Study of California hospitals cited in Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press, 2005.

⁴ http://www.cdc.gov/nchs/data/injury/InjuryChartbook79-01_UtilPayment.pdf

example, in one August 2009 study, researchers found that in 86 percent of obstetrical cases they examined, “improved health outcomes associated with medical malpractice pressure” led to cost-savings in the health sector and these cost-saving *exceeded* any marginal costs of defensive medicine, leading also to “an improvement in net social benefits rather than a decline, as should be the case for defensive medicine.”⁵

It should also be noted that despite much heated rhetoric about so-called “defensive medicine,” CBO found little evidence of this in private managed care systems, which, unlike Medicare’s emphasis on “fee-for-service” spending, “limit[s] the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as ‘defensive medicine’).” In other words, CBO virtually admitted that to the extent defensive medicine exists at all, it can be controlled through simply managing care correctly as opposed to taking away patients’ rights and possibly killing and injuring more people.

Finally, there is already a wealth of evidence and experience at the state level proving with certainty that enacting even the most draconian “tort reform” measures results in no reduction in health care costs. In Texas, for example, “Medicare spending has risen 16% faster than the national average *since* Texas restricted the legal rights of patients” and “4 of the nation’s 15 most expensive health markets as measured by Medicare spending per enrollee are in Texas.”⁶ At the same time, many patients in Texas have been left without any remedy regardless of the severity of their injuries or the degree of negligence that may have occurred.⁷

In sum, not only would the tort “reform” provision in the Co-Chair’s Proposal fail to reduce the government’s debt, it would increase it. And it would do so by taking away the legal rights of patients who are injured through no fault of their own, and reducing the accountability of those who commit wrongdoing. The recommendations of the Co-Chairs are only that, recommendations. We urge you to reject this measure, and when coming out with a substantive final plan instead focus on reforms that would reduce cost by reducing the incidents of medical malpractice.

Thank you for your consideration. (For any questions or comments, please contact Joanne Doroshow at Center for Justice & Democracy, joanned@centerjd.org, 212/267-2801.)

Sincerely,

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⁵ Praveen Dhankhar, Mahmud Khan, “Threat of Malpractice Lawsuit, Physician Behavior and Health Outcomes: A re-evaluation of practice of ‘Defensive Medicine’ in Obstetric Care,” Tulane University - Health System Management Area, August, 03 2009. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1443555

⁶ See., Texas Watch, citing Dartmouth Atlas of Health Care; <http://www.dartmouthatlas.org/index.shtm>

⁷ See, for example, the June 1, 2009, *New Yorker* magazine article by Dr. Atul Gawande, “The Cost Conundrum; What a Texas town can teach us about health care.”