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Frist, Do No Harm!

Senate Majority Leader Pushes Bills That Deny Injured Patients Their Legal Remedies, Protect Profits of HCA, the Family Business, and Others

Sen. Majority Leader Bill Frist (R-Tenn.) is waging a myth-based campaign against medical negligence victims with proposed legislation that will slash their legal remedies while safeguarding the profits of the Frist family healthcare empire and other insurers. The two bills that Frist has catapulted straight to the Senate floor, with no committee scrutiny or hearings, are the curtain-raisers for what he has dubbed “Health Week,” which debuts today.

“Frist is performing legislative quackery, prescribing a draconian cure for a non-existent disease,” said Joan Claybrook, president of Public Citizen. “He’s trying to scare the public into letting him amputate a healthy vital organ – their legal rights – without which they would be permanently disabled. If he were doing this in the medical arena, it would be malpractice.”

Both proposals set limits on the amount of damages that severely injured patients could potentially recover from the medical providers responsible, and include a complement of liability and procedural restrictions designed to frustrate the ability of patients to file malpractice claims at all. S. 22, introduced by Sen. John Ensign (R-Nev.), would apply to the provision of all healthcare services across the board. The other bill, S. 23, introduced by Sen. Rick Santorum (R-Pa.), singles out obstetrics and gynecology. It would limit the rights of only women and children while leaving male patients legally intact.

Frist and his extended family have a big stake in passage of both bills. The Frists owe their sizable personal fortune to Hospital Corporation of America (HCA), the healthcare network founded by Frist’s father and brother. HCA is the largest for-profit hospital chain in the country, counting 182 hospitals and 94 surgeries in 22 states, plus England and Switzerland. While the company is publicly traded, the family has retained a major ownership interest. Frist, his wife and children currently hold HCA stock valued at an estimated \$25 million; to avoid a potential conflict with Senate ethics rules, the stock was placed in a blind trust whose less-than-impenetrable structure might be more accurately described as “partially sighted.”

HCA has a wholly-owned insurance subsidiary, Health Care Indemnity, Inc. (HCI), that provides insurance coverage for HCA facilities, affiliated physicians and spin-off organizations. Although HCI underwrites general liability and employment practices coverage, some 95 percent of the claims it handles are for medical malpractice; it is the sixth largest medical malpractice insurer in the United States. According to its annual report, HCI paid approximately \$260 million in malpractice

claims in 2005.¹ But it reduced its reserves to cover anticipated malpractice losses in 2004 and 2005 over previous years due to the “improving frequency and moderating severity” of malpractice claims, which “can be primarily attributed to tort reforms enacted in key states.”² If those “tort reforms” were enacted at the federal level, it would make it harder for malpractice victims to file claims against any negligent HCA policyholder, not just those in states that have limited patients’ rights.

Frist claims that capping compensation for injured patients and limiting lawsuits is necessary to lower malpractice premium rates for doctors and reduce healthcare spending overall. Ironically, HCI itself has been gouging the policyholders in its own corporate family with hefty rate hikes far in excess of the claims it pays. According to an analysis prepared by insurance expert and former Missouri insurance commissioner Jay Angoff, from 2000 to 2004, HCI raised premiums 88 percent while its claims payments dropped 32 percent – that is, the company paid out just 43 cents for every premium dollar it collected.³

When it comes right down to it, however, medical malpractice liability costs account for just a tiny portion of total healthcare expenditures – less than 2 percent, according to the Congressional Budget Office (CBO).⁴ Moreover, a new study analyzing 30 years of physicians’ income and expense data collected by the American Medical Association (AMA) reveals that professional liability insurance is a relatively minor percentage of physicians’ practice costs.⁵ When inflation is taken into account, doctors paid less for medical malpractice insurance in 2000 than they did in 1986, while other practice expenses such as labor and rent increased steeply.

Here is how S. 22 and S. 23 would hurt injured patients in the name of providing an unneeded boost to the healthcare system – and shielding doctors and facilities like HCA from accountability.

Cap on non-economic damages: Unlike similar legislation introduced in previous years and passed by the House in 2005, the new proposals are modeled on a 2003 Texas statute that proponents claim was responsible for lowering medical malpractice premiums in the state. This legislation purports to limit non-economic damages to a total of \$750,000. But a closer look at the complex structure for apportioning liability and the way this has played out in Texas reveals that, in most cases, patients would not be eligible to recover more than \$250,000 in non-economic damages. The formula caps individual physician liability at \$250,000, regardless of the number of physicians involved or the number of people who sustain losses. Liability for institutions, such as hospitals and nursing homes, is capped at \$250,000 per hospital, up to a maximum total of \$500,000, if two or more hospitals are negligent. Only in the extremely rare circumstance where at least one doctor and at least two hospitals have injured or killed a patient would the potential to recover \$750,000 be reached. There has never been such a case in Texas. A recent study of closed medical malpractice claims reported to the Texas Department of Insurance over the period 1988 to 2002 found that 79.5 percent of claims named one or more physicians, 45.2 percent of claims named a hospital, and just 9.7 percent of claims involved more than one hospital.⁶ Thus, in more than half of all claims, potential compensation for non-economic damages would be capped at no more than \$250,000. In any event, the cap structure is unfair in that it bases a patient’s eligibility for non-economic damages on the number and type of defendants who have committed harm, rather than on the circumstances of the plaintiff.

Placing a cap on non-economic damages harms the most catastrophically injured patients, who have already been victimized by substandard healthcare. Non-economic damages compensate patients for very real injuries, such as loss of fertility or mobility, excruciating pain, permanent and severe disfigurement, or the loss of a spouse or child. Many of the most vulnerable members of society, such as children and the elderly, are particularly harmed by limits on non-economic damages because they

often have few, if any, out-of-pocket losses. If their non-economic damages are capped, they will be severely under-compensated for serious and debilitating injuries—that is, if they can bring a lawsuit at all.

Limits on contingency fees for plaintiffs’ attorneys: Both S. 22 and S. 23 limit what patients can pay their attorneys to 40 percent of the first \$50,000 recovered, 33 1/3 percent of the next \$50,000, 25 percent of the next \$500,000, and just 15 percent of any amount over \$600,000. This scheme presents two problems. First, attorneys representing defendant doctors or hospitals are not restricted in the amount of compensation they can receive. Thus, they have every incentive to draw out cases as long as possible in order to maximize their fees. This puts patients at a great disadvantage by exacerbating the already-significant imbalance in litigation resources between plaintiffs and defendants. Second, the “diminishing returns” structure perversely creates a disincentive for plaintiffs’ attorneys to go the extra mile to ensure the greatest recovery for their clients. As a new CBO report on the impact of medical malpractice liability changes on healthcare costs points out, “If caps on awards and on attorneys’ fees reduced contingency payments, plaintiffs’ attorneys would be less likely to take on certain cases, and in the longer run, fewer attorneys might practice that branch of law.”⁷

Collateral source rule abolished: “Collateral source benefits” are payments made by third parties to compensate the victim for economic injuries – medical costs and loss of income. These may include life, health and disability insurance, as well as government entitlements such as Social Security disability and workers’ compensation. A long-held principle of tort law known as the “collateral source rule” bars defendants from introducing evidence at trial showing that a plaintiff will recover collateral source benefits. The purpose of a collateral source rule is to ensure that defendants are held fully accountable for their wrongful acts. Both S. 22 and S. 23 require the court to reduce a plaintiff’s award based on any collateral source benefits to which the injured patient is entitled. By abolishing this rule, the bill gives a windfall to the negligent defendant’s insurance company and shifts the cost of medical care and wage loss from the defendant to the victim, the victim’s employer, health care provider and taxpayers – the negligent party ends up having to pay only for any damages remaining after all other sources of income are considered. By giving wrongdoers a write-off on the harms they have committed, the bills diminish a medical provider’s incentive to meet the professional standard of care and perform with utmost diligence.

Joint and several liability abolished: The common law doctrine of joint and several liability says that when two defendants, such as a doctor and a hospital, are both found liable for negligence, a plaintiff may recover the entire award from either of them if necessary. Joint and several liability is good public policy because it ensures that the burden of wrongful acts will fall on those who commit them, rather than on those who are hurt by them. S. 22 and S. 23 would change this rule, leaving patients with no recovery for the share of damages assigned to an uninsured or bankrupt defendant.

Periodic payments of damages: By instituting a “periodic payment rule” for future damages over \$50,000, S. 22 and S. 23 would allow defendants and insurance companies to string out payments for future damages over the life expectancy of the victim, rather than have to pay up front. This is money that rightfully belongs to the plaintiff, yet defendants and insurers would be able to invest and earn interest on the vast majority of a plaintiff’s compensation. Injured patients would be left to cope with changing needs and medical costs, as well as increased transportation and housing costs. The bills provide no protection to the victim if his or her needs change, or if the insurance company becomes insolvent.

Statute of limitations restricted: The bills require injured adults to bring a lawsuit within three years of the date of manifestation of injury or one year of the date the injury is discovered. This severe limitation will extinguish many meritorious claims. Although in most cases an injury is immediately apparent, a victim may not know until much later whether the injury was caused by malpractice. Under the bills, injured children have three years from the date the injury is manifest, unless the child is under 6 years of age, in which case the statute may be extended until the child's eighth birthday. This means that a permanently injured child whose parents may not have the wherewithal to bring a claim, or who is in a precarious living situation lacking an assertive advocate on his or her behalf, is forever foreclosed as an adult from seeking compensation.

S. 23 discriminates against women and children: By singling out obstetric and gynecological services, S. 23 piles insult upon injury by limiting judicial access and compensation only for women and infants. This means that similarly situated injured patients would be treated quite differently in the determination of their damage awards based solely on gender. For example, a woman whose doctor fails to diagnose her cervical cancer in a timely fashion would have her non-economic damages capped, although a man whose prostate cancer treatment was delayed by a wrong diagnosis would be unlimited in the amount of damages he could potentially recover.

Pre-emption of State Laws

Tort law has traditionally been the purview of the state courts. S. 22 and S. 23 would infringe on judicial prerogatives that have existed since the founding of this country by imposing federally-mandated rules and remedies on state courts. And because the bills have complicated preemption conditions that will apply to the myriad variety of state tort laws in different ways, the scheme is sure to be a source of confusion and inequity. While the bills do not affect non-economic damage caps enacted by the states, they do create a default cap in the 17 jurisdictions that have decided not to restrict non-economic compensation for patients. Moreover, they preempt all other state medical malpractice rules (e.g., statute of limitations, joint and several, collateral source, etc.) that are less protective of healthcare providers than the bills in terms of limiting their liability, loss or damages. If states want to pass laws that are still more restrictive for patients, they are free to do so, but their hands are tied if they want to hold providers accountable for their acts—or if the consequences of the federal legislation are demonstrated to be prejudicial to injured patients.

The Discredited Claims Perpetrated by Frist and the Medical Lobby

Medical Malpractice and Doctor Supply – the Crisis that Isn't

Imposing a non-economic damage cap will not improve access to healthcare by reversing the trend of doctors abandoning practice due to high cost of medical malpractice insurance quite simply because there has been no exodus of doctors from practice. The number of practicing doctors in the United States has continually increased over the years, exceeding population growth, even in rural areas and states designated by the American Medical Association (AMA) as “crisis states.” This includes high-risk specialists such as obstetricians. AMA data show that the number of practicing physicians in the United States increased 203 percent from 1965 to 2004, while population grew just 49 percent over the same period.⁸ In each of the 21 states that the AMA claims are experiencing a “full-blown medical liability crisis,” physician growth has outpaced population growth—even from

1995 to 2004, when medical malpractice insurance premiums reached unprecedented heights.⁹ The number of physicians practicing in non-metropolitan areas skyrocketed nearly 100 percent over this same period, going from 64, 519 in 1995 to 122,922 in 2004.¹⁰ The number of physicians practicing high-risk specialties, such as obstetrics, has followed a similar growth pattern. In fact, the physician-population ratio for ob/gyns has continued to increase despite a significant decline in the birth rate since 1990, even in AMA “crisis states,” indicating that rather than there being a shortage of doctors to deliver babies, we have an excess of obstetricians.¹¹ The trend in physician growth shows no sign of changing, at least not in the near term: the 2005-2006 class entering U.S. medical schools is the largest on record.¹²

An August 2003 report issued by the Government Accountability Office found that AMA claims that doctors are leaving states, retiring early or limiting services could not be substantiated or did not affect access to healthcare on a widespread basis.¹³ A study conducted by the National Bureau of Economic Research found that malpractice costs “do not seem to affect the overall size of the physician workforce.”¹⁴

The Medical Malpractice Insurance Scam

Not only is the size of the Texas cap misleading, but so are the effects attributed to it. Enactment of the non-economic damages cap in Texas did not bring down malpractice insurance premium rates in that state. Indeed, insurers in Texas fought hard to keep lawmakers from including a proposed rate rollback provision in the bill. Once the cap passed, instead of reducing premiums, major insurers petitioned the Texas Department of Insurance for rate hikes of up to 35 percent for doctors and 65 percent for hospitals.¹⁵ Only after an outraged Texas legislature threatened to mandate rate cuts did insurers lower medical malpractice premiums. Still, the premium relief that doctors have seen in Texas falls far short of compensating for prior meteoric rate increases. For example, the Texas Medical Liability Insurance Association, which accounts for 41 percent of the market, raised rates 147 percent from 1999-2003; even with reductions in subsequent years, their policy holders are still paying 130 percent more for the same coverage than before the cap passed.¹⁶

Moreover, focusing on Texas obscures the larger picture of what has been happening in the insurance industry over the past two years. The insurance cycle has gradually turned in line with an improved economy and medical malpractice premium rates have stabilized or dropped everywhere in the country, even in states with no cap on non-economic damages.¹⁷ For instance, in Pennsylvania, designated a “crisis state” by the AMA due to its lack of a cap, the largest malpractice insurer announced it would not raise rates in 2006. In Washington state, also without a cap, doctor-owned Physicians Insurance proposed lowering rates 7.7 percent. Judging by experiences throughout the rest of the country, medical malpractice premium rate increases in Texas would likely have ground to a halt, if not crept downward, by 2005, even if the non-economic damage cap had not passed.

The Myth of Defensive Medicine

On May 5, Frist told the Senate in a floor statement that “it is estimated that so-called defensive medicine costs anywhere from \$100 billion to \$125 billion a year.” “Defensive medicine” is a term coined to refer to tests and procedures that are unnecessary, but performed by physicians to “cover all their bases” in the event of a lawsuit. Just what are these unnecessary tests and procedures? The truth is, no one can tell you.

An Economic and Budget Issue brief released by the CBO in 2004 explains that “some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients. On the basis of a review of existing studies and its own research, the CBO estimated that savings from reducing “defensive medicine” would be very small.¹⁸ The fact is that defensive medicine is not responsible for high healthcare costs.

Tort Limits Do Not Reduce Healthcare Costs

Claims that caps on damages will lower healthcare costs for the average American are simply not supported by the evidence. In fact, some changes in the law may *increase* the costs of healthcare. A recently released CBO report concluded that “the estimated effect of implementing a package of previously proposed tort limits is near zero.”¹⁹ The report found that it was impossible to prove an impact on healthcare spending per capita resulting from caps on non-economic damages, allowing collateral-source benefits to be introduced at trial, a cap or ban on punitive damages, or any direct tort limit.²⁰ In fact, the only measure that did have provable impact was the elimination of joint and several liability, but this actually *increased* healthcare spending per capita.²¹ The report also noted that even “a reduction of 25 to 30 percent in medical malpractice premiums would not, by itself, have a significant impact on total health care costs.”²²

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¹ HCA Annual Report 2005, p. 28.

² HCA Annual Report 2005, pp.20-21.

³ Jay Angoff, *Falling Claims and Rising Premiums in the Medical Malpractice Market*, Center for Justice & Democracy, July 2005.

⁴ Congressional Budget Office. *Limiting Tort Liability for Medical Malpractice*. January 8, 2004. p. 6.

⁵ Marc A. Rodwin, Hak J. Chang, and Jeffrey Clausen, “Malpractice Premiums And Physicians’ Income: Perceptions Of A Crisis Conflict With Empirical Evidence,” *Health Affairs* – Vol. 25, Number 3, p. 750 (May/June 2006).

⁶ Black, Bernard S., Silver, Charles M., Hyman, David A. and Sage, William M., “Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002.” U of Texas Law & Economics Research Paper No. 30; Columbia Law & Econ Research Paper No. 270; U Illinois Law & Economics Research Paper No. LE05-002, pp. 16-17.

⁷ Congressional Budget Office. *Medical Malpractice Tort Limits and Health Care Spending*. April 2006. p. 8

⁸ American Medical Association, *Physician Characteristics and Distribution in the U.S.*, 2006 Edition.

⁹ Table 5.17, Physicians, Population, and Physician/Populations Ratios, AMA’s *Physician Characteristics and Distribution in the U.S.*, 2006 Edition, p. 329. The crisis states are: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Washington, West Virginia, Wyoming.

¹⁰ American Medical Association, *Physician Characteristics and Distribution in the U.S.*, 2006 Edition.

¹¹ U.S. Birth Rate Reaches Record Low, CDC news release June 25, 2003; and Births: Preliminary Data for 2004, CDC National Vital Statistics Reports, Vol. 54, Number 8, December 29, 2005.

¹² AAMC press release, AAMC Reports Major Increase in U.S. Medical School Enrollment, Washington, D.C., Oct. 25, 2005. <http://www.aamc.org/newsroom/prerel/2005/051025.htm>.

¹³ United States General Accounting Office, *Medical Malpractice: Implication of Rising Premiums on Access to Health Care*. GAO030836, August 2003.

¹⁴ Baicker, Katherine; Chandra, Amitabh; *The Effect of Malpractice Liability on the Delivery of Health Care*. National Bureau of Economic Research, Working Paper 10709, 2004.

¹⁵ E.g., Darrin Schlegel, “Some Malpractice Rates to Rise Despite Prop. 12,” *Houston Chronicle*, Nov. 19, 2003; Darrin Schlegel, “Malpractice Insurer Fails in Bid for Rate Hike,” *Houston Chronicle*, Nov. 21, 2003; (October 2003 rate filing from Texas Medical Liability Insurance Association (JUA) to Texas Department of Insurance).

¹⁶ “Medical Malpractice Insurance: Overview and Discussion,” Texas Department of Insurance, Feb. 12, 2003.

¹⁷ Council of Insurance Agents and Brokers, Commercial Property-Casualty Market Survey, cited in Americans for Insurance Reform, Insurance “Crisis” Officially Over; Medical Malpractice Rates Have Been Stable For A Year, February 7, 2006, <http://www.insurance-reform.org/pr/MMSOFTMARKET.pdf>.

¹⁸ Congressional Budget Office. *Limiting Tort Liability for Medical Malpractice*. January 8, 2004. p. 6

¹⁹ Congressional Budget Office. *Medical Malpractice Tort Limits and Health Care Spending*. April 2006. p. 20

²⁰ *Ibid.* p. 3.

²¹ *Ibid.* p. 25.

²² *Ibid.* p. 11.