

February 1, 2011

The Honorable Lamar Smith, Chairman  
U.S. House Judiciary Committee  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairman Smith:

### **CONSUMER AND PATIENT SAFETY GROUP OPPOSITION TO H.R. 5**

The undersigned consumer and public interest groups strongly oppose H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, which would limit the legal rights of injured patients and families of those killed or injured by negligent health care. Moreover, the legislation goes beyond shielding negligent doctors, to restrict liability in cases involving unsafe drugs and medical devices, and nursing home abuse and neglect.

Even if these provisions applied only to doctors and hospitals, the Congressional Budget Office believes they would save no more than 0.5 percent in health care costs, which is likely a significant overestimate.<sup>1</sup> At the same time, the U.S. death rate could increase by 0.2 percent, killing another 4,000 people each year.<sup>2</sup> Additionally, the pharmaceutical industry liability limitations in H.R. 5, removing a significant incentive for drug companies to act safely, would result in untold numbers of additional death and injuries. This is unacceptable.

Medical malpractice is already at epidemic levels in this country. It has been over a decade since the Institute of Medicine's seminal study "To Err is Human"<sup>3</sup> was published, and experts agree a meaningful reduction in medical errors has not occurred in the United States. According to a November 2010 study by the Office of Inspector General of the U.S. Department of Health and Human Services, about 1 in 7 hospital patients experience a medical error, 44 percent of which are *preventable*. These errors cost Medicare alone \$4.4 billion a year.<sup>4</sup> Moreover, "(t)hese Medicare cost estimates do not include additional costs required for follow-up care after the sample hospitalizations." Congress should focus on improving patient safety and reducing deaths and injuries, not insulating negligent providers from accountability and saddling taxpayers with the cost.

Further, medical malpractice premiums for doctors, inflation-adjusted, are nearly the lowest they have been in over 30 years and they may go even lower. This drop in rates is happening everywhere in the country whether or not a state has enacted "tort reform" laws. At the same time, according to the National Center for State Courts, medical malpractice claims are in steep decline, down 15 percent from 1999 to 2008. Payouts in constant dollars have been stable or falling for a decade, down 45 percent since 2000. Even if insurance premiums were increasing,

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<sup>1</sup> [http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort\\_Reform.pdf](http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf).

<sup>2</sup> See, [http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort\\_Reform.pdf](http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf).

<sup>3</sup> *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 1999. This study found that between 44,000 and 98,000 patients are killed in hospitals each year due to medical errors.

<sup>4</sup> U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), <http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf>.

this bill would remain unacceptable because it essentially eliminates patients' fundamental right to seek compensation for the injuries caused by others' wrongdoing.

Many of us already live in states with "caps" and other laws that make it difficult or impossible to have cases heard before judges and juries, as this legislation would do. These laws have had terrible consequences for injured patients who have been shut out of courts altogether, and for patient safety, in general. They have also burdened taxpayers because victims are forced to turn to taxpayer-funded health and disability programs to provide for injured family members. Liability limits shift costs of caring for malpractice victims from perpetrators of malpractice to state Medicaid systems and taxpayers. It would be a tragic mistake to impose such "tort reform" laws on the rest of the country. (See attached document for an analysis of specific provisions in H.R. 5).

#### Real Malpractice Reform Should Include:

- A physician's registry that tracks doctor records in all 50 states. Public Citizen's examination of the National Practitioners Data Bank found that fewer than 5% of doctors commit 54% of the malpractice. Such a registry would be a transparent way to ensure that incompetent and dangerous physicians would be unable to move from state to state – as they do today – and injure more patients. Alternatively, we could simply open the National Practitioners Data Bank to the public.
- Incentivize state medical boards to improve their monitoring and discipline of doctors.
- Enact a federal law that mandates disclosure of medical errors. Given the tremendously high number of adverse events that injure or kill patients, a transparent system to monitor trends in patient safety will reduce preventable mistakes.

#### Real Federal Insurance Reform Should Include:

- Repeal of the McCarran-Ferguson Act's exemption of the health and medical malpractice insurance industry from anti-trust laws. Congress must prohibit insurers from cooperating in collusion and price fixing, behavior that costs doctors and consumers a tremendous amount.

Health care reform should not be accomplished by taking away the legal rights of patients who are injured through no fault of their own, or reducing the accountability of those who commit wrongdoing. We urge opposition to H.R. 5. Thank you for your consideration. (For any questions or comments, please contact Joanne Doroshow at Center for Justice & Democracy (212) 267-2801 or Christine Hines at Public Citizen, (202) 454-5135.)

Sincerely,

#### **NATIONAL GROUPS**

Alliance for Justice

Center for Justice and Democracy

Consumer Federation of America

Consumer Watchdog

National Consumers League

The National Consumer Voice for Quality Long-Term Care (formerly NCCNHR)

National Women's Health Network

Public Citizen

**STATE GROUPS**

Alliance for Safety Awareness for Patients  
Sherman Oaks, CA

PULSE of NY  
Long Island, NY

The Empowered Patient Coalition  
San Francisco, CA

North Carolina Coalition for Patient Safety  
Raleigh, NC

Citizens for Patient Safety  
Denver, CO

James's Project  
Wayne, PA

PULSE of Colorado  
Pueblo, CO

Mothers Against Medical Error  
Columbia, SC

Connecticut Center for Patient Safety  
Hartford, CT

South Carolina Voices for Patient Safety  
Chesterfield, SC

MRSA Survivors Network  
Hinsdale, IL

Patient Safety America  
Houston, TX

Voice4Patients  
Warren, ME

Texas Watch

New Hampshire Patient Voices  
Bow, NH

New York Public Interest Research Group (NYPIRG)

## ANALYSIS OF SPECIFIC PROVISIONS OF H.R. 5

### **\$250,000 Cap on Non-Economic Damages**

Caps on non-economic damages do nothing but stop the most severely injured patients from getting adequate compensation.<sup>5</sup> They apply to all patients no matter how egregious the misconduct or devastating the injury. In many cases, a patient may have few out-of-pocket losses, but suffer great non-economic harm. For example, an 18-year-old woman who loses her ability to have a child for the rest of her life may suffer no monetary loss but has enormous non-economic injuries.

Caps also have a devastating impact on Medicare patients, leading to an increase in government health care spending that will add to the deficit, not decrease it. Noneconomic damages caps disproportionately hurt senior citizens, forcing Medicare to pay for their care instead of the culpable medical provider's insurance company. Caps on non-economic damages make their cases economically impossible for attorneys to bring. The same reasoning applies for any injured person with low wages, including women who do not work outside the home, and children, who are more likely to receive a greater percentage of their compensation in the form of non-economic damages. In fact, this has occurred in states with non-economic damages caps, such as California. Insurance defense attorney Robert Baker, who defended malpractice suits for more than 20 years, told Congress several years ago: "As a result of the caps on damages, most of the exceedingly competent plaintiff's lawyers in California simply will not handle a malpractice case ... There are entire categories of cases that have been eliminated since malpractice reform was implemented in California."<sup>6</sup>

### **Restrictive statute of limitations**

Under this bill, a lawsuit would have to be filed no later than one year from the date the injury was discovered or should have been discovered, but in no case later than three years after the "manifestation" of injury. This unfair rule is much more restrictive than many state rules, and would arbitrarily cut off meritorious claims involving diseases or injuries with long incubation periods that may be difficult to identify. In addition, the bill limits the rights of injured children by requiring claims to be filed within three years of the manifestation of the injury, with some exceptions if the child is under 6 years. In contrast, many state laws preserve the rights of minors to bring suit on their own behalf until they reach the age of majority.

This idea lacks logic from a deficit reduction angle since its only impact would be to cut off meritorious claims, especially those involving diseases with longer incubation periods. If a patient is harmed by medical negligence but unable to sue due to an unreasonably unfair statute of limitations period, he or she (or a child's family) would be forced to turn elsewhere for compensation, such as Medicaid. In other words, unreasonably reducing a state statute of limitations would cause deficit increases, not decreases.

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<sup>5</sup> A survey by the RAND Corporation found that the "most significant impact" of California's three decades-old \$250,000 cap "falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes." Source: "RAND Study: California Patients Killed or Maimed by Malpractice Lose Most Under Damage Caps," Consumer Watchdog, July 13, 2004.

<sup>6</sup> See, <http://www.multinationalmonitor.org/mm2003/032003/court.html>

## **Eliminating Joint and Several Liability**

According to CBO, this proposal could *increase* costs, not lower costs. Specifically, CBO said that modifying joint and several liability “may increase the volume and intensity of physician services.” In other words, this change could cause a deficit increase, not decrease.

We also note that this proposal is unfair to injured patients. The doctrine of joint and several liability has been a part of the common law for centuries. It is a rule that applies to allocating damages when more than one defendant is found *fully responsible* for causing an entire injury. If one of them is insolvent or cannot pay compensation, the other defendants must pick up the tab so the innocent victim is fully compensated. Courts have *always* held that it applies only to injuries for which the defendant is fully responsible. That means that their negligent or reckless behavior must be an “actual and proximate” cause of the entire injury, a high standard.<sup>7</sup> Having said that, joint and several liability limits have already been enacted in over 40 states, so the proposal is also superfluous.<sup>8</sup>

## **Attorneys’ Fee Limits**

This bill gives the court power to restrict plaintiff’s attorney fees regardless of whether recovery is by judgment, settlement, or any form of alternative dispute resolution. The bill specifies that contingent fees, regardless of the number of plaintiffs, may not exceed: (1) 40 percent of the first \$50,000 recovered; (2) 33 1/3 percent of the next \$50,000 recovered; (3) 25 percent of the next \$500,000 recovered; and (4) 15 percent of any recovery in excess of \$600,000. Under a contingency fee arrangement, a lawyer agrees to take a case on behalf of an injured patient without obtaining any money up front from the client. This is a risk, because if the case is lost, the lawyer is paid nothing. But it is a critical system because it provides injured consumers who could not otherwise afford legal representation with access to the courts. The principal impact of contingency fee limits is to make it less likely that attorneys will be able to afford to risk bringing many cases, particularly the more costly and complex ones. This provision practically provides immunity for many wrongdoers. Yet insurance companies will still be permitted to pay their teams of lawyers at high hourly rates, which also encourages them to drag out litigation for as long as possible.

## **Repealing the collateral source rule**

The collateral source rule prevents a wrongdoer, such as a negligent hospital, from reducing its financial responsibility for the injuries it causes by the amount an injured party receives (or could later receive) from outside sources. Payments from outside sources are those unrelated to the wrongdoer, such as health or disability insurance, for which the injured party has already paid premiums or taxes. The collateral source rule is one of fairness and reason. The rule’s premise is that the wrongdoer’s liability and obligation to compensate should be measured by the harm done and the extent of the injuries inflicted. In this way, the rule helps promote deterrence.

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<sup>7</sup> See, e.g., Richard Wright, “The Logic and Fairness of Joint and Several Liability,” 23 *Memphis State Law Review* 45 (1992).

<sup>8</sup> See, e.g., Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, Appendix C, July 2009. <http://insurance-reform.org/pr/090722.html>.

In fact, representatives from the conservative American Enterprise Institute found that modifying the collateral source rule could endanger infant safety. They wrote:

[C]ollateral source reform leads to a statistically significant increase in infant mortality.... For whites, the increase is estimated to be between 10.3 and 14.6 additional deaths per 100,000 births. This represents an increase of about 3 percent. For blacks, the collateral source reversal leads to between 47.6 and 72.6 additional deaths per 100,000 births, a percentage increase between 5 and 8 percent. These results suggest that the level of care provided decreases with the passage of collateral source reform.... The relationships we estimate between reform measures and infant mortality rates appear to be causal.... In summary, these results show that collateral source reform leads to increased infant mortality.”<sup>9</sup>

### **Restrictions on Punitive Damages**

This bill provides that punitive damages may only be awarded if the plaintiff proves by an impossibly heightened standard of clear and convincing evidence that: (1) the defendant acted with malicious intent to injure the plaintiff; or (2) the defendant understood the plaintiff was substantially certain to suffer unnecessary injury, yet deliberately failed to avoid such injury. The bill further limits punitive damages to two times the amount of economic damages or \$250,000, whichever is greater. Moreover, the bill completely immunizes manufacturers of drugs and devices that are approved by the FDA from punitive damages and extends immunity to the manufacturers of drugs and medical devices that are not FDA-approved, yet are “generally recognized as safe and effective.” Finally, the bill immunizes the manufacturer or seller of drugs from punitive damages for packaging or labeling defects. Punitive damages are assessed against defendants by judges or juries to punish particularly outrageous, deliberate or harmful misconduct, and to deter the defendant and others from engaging in similar misconduct in the future. According to the Bureau of Justice Statistics, only 6 percent of medical malpractice plaintiffs who prevailed at trial were awarded punitive damages. Although rare, the prospect of having to pay punitive damages in a lawsuit by an injured patient causes companies and other wrongdoers, particularly pharmaceutical companies, to operate more safely.

### **Structured Settlements.**

Allowing all future damages over \$50,000 to be paid periodically, as does H.R. 5, leaves those injured by malpractice and unsafe products vulnerable and undercompensated while large insurance companies reap the benefit of earning interest off of a plaintiff’s jury award. Moreover, this provision increases the hardships of the most seriously injured patients who are hit soon after an injury with large medical costs and must make adjustments in transportation and housing.

### **One-Way Preemption.**

Like most recent federal tort reform bills, H.R. 5 would present a major interference with the traditional authority of state court judges and juries in medical malpractice and products liability

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<sup>9</sup> Jonathan Klick & Thomas Stratmann, “Does Medical Malpractice Reform Help States Retain Physicians and Does It Matter?” (March 8, 2004), presented at American Enterprise Institute forum, “Is Medical Malpractice Reform Good for Your Health?,” Sept. 24, 2003, available at [http://www.aei.org/events/eventID.614/event\\_detail.asp](http://www.aei.org/events/eventID.614/event_detail.asp).

cases. It would be a massive federal preemption of state law, pandering to this country's insurance and pharmaceutical companies. Its *one-way* preemption of state law provisions that protect patients makes clear that the intent of this legislation is not to make medical malpractice and products liability laws uniform in the 50 states. Rather, it is a carefully crafted bill to provide relief and protections for the insurance and drug companies. Every provision places a ceiling on patient recovery in tort litigation, but allows state laws to survive where those laws place more restrictions on patients' rights. There is nothing in this bill to protect patients.