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Testimony of
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Medical Malpractice Litigation Reform Hearings
Commonwealth of Pennsylvania
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Good afternoon, Chairman Gannon & Members of the Committee

I would like to take this opportunity to thank you for allowing me to speak today on HB 2122 and the topic of medical malpractice tort reform. By way of introduction, my name is Michael Okin. I am President of the Pennsylvania Orthopedic Society, which represents over 700 practicing orthopedic surgeons in the state of Pennsylvania. I am a practicing orthopedic surgeon in the city of Philadelphia, where I have been for the last 23 years serving the citizens of the Commonwealth who live in Northeast Philadelphia. Prior to that I did my training at the University of Pennsylvania.

Not long after I entered practice in this Commonwealth in the early 1970's, this state, as well as many other states were undergoing a malpractice insurance crisis. Argonaut Insurance Co. was leaving the state, this being the major insurer for medical malpractice at that time. The major problem at that time was that malpractice awards were skyrocketing causing similar increases in malpractice insurance and threatening the availability of insurance at any cost. To meet this crisis, the Pennsylvania legislature enacted Act 111, which theoretically was supposed to make professional liability insurance available at reasonable costs. In so doing, they established a system of arbitration panels to screen medical malpractice claims. They also instituted a collateral source rule as well as a cap on payments for attorneys fees for medical malpractice damage awards pursuant to a sliding scale. They made medical malpractice insurance mandatory for

health care providers. Act 111 also established a catastrophe fund to cover awards and damages higher than the basic coverage. The law mandated that the CAT fund maintain a $15 million balance at any one time. The fund would be maintained by assessing an annual surcharge to the health care providers basic malpractice premium. The original surcharge in 1976 was 10%. It should be noted the surcharge today is 164%.

In the ensuing years, all provisions of Act 111 were basically invalidated except for the preservation of the catastrophe fund and the need for physicians to maintain malpractice insurance coverage in order to maintain their license to practice in the state of Pennsylvania.

Initially, after the establishment of the fund, insurance premiums and malpractice rates leveled off and then in the 1980s malpractice awards began to skyrocket and by 1995 the CAT fund, along with the insurance carriers in the state of Pennsylvania, paid out $436 million to settle 665 claims. This amounted to an average settlement of $656,000 for each claim settled. $280 million of the monies used for the 665 claims came from health care providers in the state of Pennsylvania as a surcharge on their annual insurance premium.

According to his testimony given before the Senate Banking and Insurance Committee in September 1995, John H. Reed, the Director of the Catastrophe Fund, reported that the number of unclosed cases in the state of Pennsylvania, represent an unfunded

liability of $1.9 billion. This unfunded liability falls on the shoulders of the health care providers of the Commonwealth. It is an untenable figure and the purpose of my testimony today is to show how the need for tort reform in the state of Pennsylvania is so imperative at this time. We have to get a handle on the liability crisis that exists.

At the present time, in the state of Pennsylvania, the health care delivery system is in crisis. Physician reimbursements have been capped in this state as opposed to other states. We are capped on the revenue side by governmental Medicare reimbursements. Act 6, The No-Fault Act, capped our reimbursement rates to Medicare. Act 44, The Workers Compensation Act, also capped our reimbursements. Managed care has also capped physician/health care provider reimbursements. At the same time, our overhead costs are not capped. The largest single expense an orthopedic surgeon has in this state is his malpractice insurance premium and catastrophe fund surcharge.

This situation has a direct impact on your constituents. In the last three years I have had to lay off five personnel in my office in order to meet my expenses. This trend is happening throughout the entire Pennsylvania health care community. These are people whose health benefits and salaries I paid. If you would speak to these people, you would see the tremendous impact losing their job in this economy has had on them. If the present crisis persists, there will be more belt-tightening and more people losing their jobs, and ultimately forcing the

closure of many medical practices, which, on an economic scale, are nothing more than small businesses.

I, as well as the other orthopedic surgeons in the state of Pennsylvania, strongly feel the patient who has been injured in a medical malpractice incident should be fairly compensated. The question is, what is the most effective way to fairly compensate this individual. The present system is not working and it must be fixed.

I propose to you today that the problem is not with the health care delivery system, but with the legal system which allows and even encourages lawsuits to spiral out of control.
If one goes to the literature, we can easily see there are only a few studies that have been performed on the subject of medical malpractice. The statistics below are derived from a study reported in the Annals of Internal Medicine, 1992, volume 117. From 1977 thru 1992 there were 8,231 closed malpractice cases reviewed in the state of New Jersey. Of these cases, 4,730 or 57% were closed without payment and 43% were closed with payment. Of these cases closed with payment, only 12% required trial. The cases perceived to be indefensable by the insurance carrier were settled 91% of the time, without the need for a jury trial. Only 1/4 of the cases requiring a jury verdict resulted in payments to the plaintiff.

What this study showed was that the majority of the cases in medical malpractice tort can be successfully settled by arbitration panels. Very few cases are required

to be litigated in the courts. This study points out the feasibility for an arbitration panel to be set up to settle many of the malpractice claims that are brought in the Commonwealth. This would expedite just compensation to the injured party.

One of the questions we have to ask ourselves is what is the present liability crisis costing us? In terms of manpower, the best physicians coming out to practice medicine today will be discouraged from choosing the state of Pennsylvania as their place of practice. For example, a friend of mine, an ear/nose/throat specialist, was looking to bring a new associate into his practice. However, the salary package he could offer could not be competitive with the states of New Jersey, Maryland or Delaware. He could not afford to hire a third person in his practice because the expense in Pennsylvania is so prohibitive, that his practice could not be competitive with other states in the surrounding area.

As a second example, my daughter, Cynthia, is graduating this year from the Medical College of Ohio in the top 5% of her class. She was considering going to Jefferson University Medical Center for her residency in obstetrics and gynecology. Her husband is a young general surgeon who has been in practice in Ohio for four years. She had to eliminate Jefferson University Hospital from her selection of residency because her husband could not afford to practice in the state of Pennsylvania. In that same vein, the expense is too high for an orthopedic surgeon entering practice today in the city of Philadelphia. He is faced with a malpractice premium of approximately $60,000 before he can

open his door. He is then faced with the unknown business expense of further surcharges for the CAT fund during that year, which he cannot budget for. He will not choose the state of Pennsylvania but will most likely pick the state of New Jersey, where malpractice rates are known to be approximately $30,000 a year for an orthopedic surgeon. Additionally, regular malpractice premiums and the CAT fund surcharge are typically due on the same date. At the beginning of this year, I borrowed $128,000 to cover these charges plus the emergency surcharge.

Secondly, physicians in high risk specialties are performing less and less risky procedures because of the fear of liability. Many orthopedic surgeons are no longer performing back surgeries or treating trauma; obstetricians have stopped delivering babies; physicians in the height of their career are either retiring early or leaving the state because they cannot afford the malpractice premiums in this state.

On a national basis, over $20 billion is spent on unneeded tests designed to guard doctors and hospitals against malpractice suits. $3,000 of an $18,000 pacemaker is used to pay for the liability tax on that piece of instrumentation. A two-day maternity stay averages $3,367.00 - $500 of which is a lawsuit tax.

In 1992 the American College of Obstetricians did a survey and 12% of the obstetricians surveyed had stopped delivering babies, 10% decreased the number of deliveries because of high risk malpractice suits.

The CEO of Biogen Industries testified at the U.S. Senate Commerce Committee in September 1993 that he could not undertake the development of an AIDS vaccine because of the inherent liability of billions of dollars involved in that pursuit. 96% of the diphtheria vaccine cost goes to product liability. Chemical companies and manufacturers of materials used to make heart valves, artificial blood vessels and other implants have been quietly warning medical equipment companies that they intend to cut off deliveries because of the fear of lawsuit. On that note, I would like to know how many of you have had or know someone who is in need of an artificial joint replacement. At the most recent meeting of the American Academy of Orthopedic Surgeons, it was noted there is only one company left in this country producing polyethylene, which is the major component of artificial joint replacements. It is easy to see that this problem transgresses more than just the medical liability tort system. It goes throughout many other industries.

Since 1976, 60% of the medical malpractice lawsuits in the state of Pennsylvania were closed without payment. It must be noted that almost half of all medical liability insurers defense costs are spent defending cases that ultimately are closed without compensation made to the claimant. A more efficient mechanism for early identification of non-meritorious claims would reduce these excessive litigation costs. Only 43% of every dollar spent on medical liability litigation reaches the injured patient as compensation according to estimates of

the Rand Corp. The rest is spent on attorneys fees on both sides, litigation expenses and insurance administration costs. It should be noted that tort reforms are not anti-patient. It allows the injured party to receive a larger portion of the award payment. 78% of America's physicians report the threat of medical liability suits causes them to order tests they might otherwise consider unnecessary. The AMA estimated that $15.1 billion in non-premium defensive medicine costs were incurred in 1989. Nationwide the cost of physician liability insurance premiums tripled in the 1980s, rising from $1.7 billion to $5.6 billion in 1989.

Between 1982 and 1989 liability premiums outpaced all office practice expenses, growing annually at a rate of 15.1%. This was 4 times the general inflation rate. In 1989, 17.6% of the total expenditures of physician services was due to liability payments in defensive medicine.

One of the major studies concerning malpractice which is always alluded to is the Harvard study. This study, which appeared in the New England Journal of Medicine in February 1991, investigated the incidence of hospital medical malpractice in the state of New York in 1984. The investigators of this study originally created their methodology from a pilot study which appeared in the Journal of Medical Care in December 1989, volume 27. As a result of the pilot study, the investigators were unable to establish a relationship between negligent adverse events and

malpractice litigation. With this methodology, the authors were unable to show any reliability of judgement when it came to medical negligence.

This, in my opinion, is one of the major flaws in the Harvard study; any conclusions drawn from it will be unreliable. The study itself stated there are many sources of potential errors within the study. The reliablity of physician's judgement and negligence had a low degree of reliability. In fact, in that study, physician trained reviewers were only able to agree on findings of malpractice in 8 of 47 actual claims that were identified in the study population. This represented only 17%.

In 1975, the state of California introduced the Medical Insurance Compensation Reform Act, known as MICRA. This was their answer to their malpractice crisis of the 1970s when the state of Pennsylvania instituted Act 111. MICRA basically has 7 components. With these 7 components the state of California created a system of medical liability insurance that allows an individual injured as a result of medical malpractice to be justly compensated. In doing so, it has created a system that has brought stability to their insurance market and allowed them the ability to perform this service for their citizens for the last 21 years. In spite of the Trial Bar trying to invalidate MICRA, the citizens of California have time and time again voted them down. The state of California has shown that MICRA does work.

The 7 components are as follows: 1) **evidence of collateral source payments are allowed in medical malpractice trials.** Under this law, health care providers defending malpractice actions

are permitted to inform the jury of collateral source payments. These are insurance benefits or other plans that pay for the plaintiff's care and can be deducted from the award given to the plaintiff as damages. This, in effect, shifts some of the cost of the health care providers away from the limited number of medical malpractice carriers in California to the more numerous health care and disability insurance providers who have already paid to provide this coverage. This, in essence, helps spread the risk.

Component #2, a $250,000 limit on non-economic damages.

This cap applies only to non-economic damages, (i.e. pain, suffering and loss of consortium). It allows injured parties to receive compensation for all economic damages such as medical expenses, loss of earnings, etc. It is inherently difficult to place a monetary value on such intangible injuries as non-economic damages. This is the one component of malpractice insurance costs that has tremendous variation from jury to jury and awards for similar types of injuries vary tremendously.

The study by the Rand Corp. issued for civil justice showed that jurors are more sympathetic to plaintiff's injured by medical malpractice than any other type of cases. Among plaintiffs with the same type of injury, the study found malpractice claims received awards almost twice as large as the awards going to work injury or product liability plaintiffs and five times the size of the awards going to a jury on property plaintiffs.

The MICRA cap on non-economic damages, the most variable component determined by juries, has moderated the size of awards, made the degree of risk involved in underwriting malpractice insurance more predictable, provided greater overall stability in the medical malpractice marketplace.

Component #3, periodic payment for future damages over $50,000. This allows a structuring of the judgement paid over a specified period of time and insures that the plaintiff will have money for health care as needed for the rest of his/her expected life. The payment schedule is flexible to accommodate the plaintiff's needs at different times of his life in the course of the rehabilitative process.

Component #4 establishes a statute of limitations.

Component #5, there are contracts requiring arbitration of medical malpractice claims. This MICRA statute allowed for a written contract for medical services to include a clause which requires both parties to resolve any dispute regarding medical malpractice through binding arbitration governed by California law. Arbitration allows most of the disputes to be resolved quickly and often with less expense than traditional court cases. This part of the law is substantiated by the study alluded to earlier in New Jersey.

Component #6, limitation on plaintiff attorney contingency fees

This MICRA provision prohibits lawyers for medical malpractice plaintiffs from collecting contingency fees in excess of 40% for the first $50,000, 33 1/3% on the next $50,000, 25% on the next $500,000 and 15% of any amount over $600,000. In effect, in a $1,000,000 verdict, the plaintiff would receive $278,000 more than he would under the typical contingency fee arrangement in personal injury cases. However, the attorney would receive $231,600.00 on a $1,000,000.00 award. Again, one sees that the injured party receives $278,000 more under the system. He is the one who rightfully deserves it.

Component 7 of this law requires 90 days notice prior to commencement of the lawsuit.

What MICRA has done is assure payment for legitimate losses; reduced the cost of health care in the state of California; maintained the access to health care for risky procedures that otherwise doctors would not perform for fear of being sued; removed the trial lawyers financial incentive to pursue the non-meritorious cases. The MICRA cap discourages dollar driven lawyers from preying upon the sympathy of jurors to win run-away pain and suffering awards, a large percentage of which goes to the lawyer, without taking into consideration the increased health care costs for all consumers as a result of excessive malpractice awards. The United States is the home of the only justice system in the world that allows juries to award unlimited recoveries for subjective

losses which need not be quantified in terms of actual monetary loss.

Before MICRA came into effect, California had the highest malpractice premiums in the country. MICRA's cap on pain and suffering created predictability where there cannot be insurability. According to Patricia M. Danza, Ph.D., a well-known academic expert on medical malpractice liability issues, I quote: "Awards for damages should be re-structured to resemble more closely the insurance people buy voluntarily. After all, in its compensation function the tort system is simply a form of compulsory insurance which people are required to buy when they buy health care. When faced with a choice, most people do not buy insurance against pain and suffering. The tort system would provide compensation for a loss of earning capacity after taxes and for reasonable medical expenses, rehabilitation and other monetary costs with a special provision for persons with no reported wage loss, such as housewives. Pain, suffering and other non-monetary losses are real losses but money cannot replace them. That is precisely why people do not choose to ensure themselves against them and the tort system should not force them to."

One factor we can't lose sight of is that MICRA maintained the predictability of both jury awards and out of court settlements. It should be noted that 80% of all medical liability cases filed in California were proved to be without merit. 97% of the remaining cases involved indemnity and are

settled short of trial which leaves only 3% of the cases determined in a trial. About 70% of the cases tried are won by the health care provider. The question is why worry about the few cases that result in jury awards. Because the amount paid for the many cases that are settled out of court is driven by the amount of the few cases that go to trial. In other words, a few jury awards drive all the costs of the medical malpractice compensation system. MICRA's cap on non-economic damages holds down the excessive awards for cases decided in court which in turn affect all the dynamics and amounts paid in cases settled out of court. Without a cap on non-economic damages, all the indemnity for medical liability becomes unpredictable and the system careens out of control.

What did MICRA do for California? The number of million dollar plus malpractice awards are substantially lower in the state of California than all states that don't have MICRA reform. It has decreased the number of frivolous lawsuits, slowed the rate of health care expenditures in the state of California by stabilization of the health care liability exposure. Health care expenditures in the state of California have not increased as rapidly as expenditures in the rest of the country. MICRA has cut medical liability insurance premiums by 50% in 1994 dollars as compared to 1976. It has assured that the injured party received just compensation.

Finally, in a state wide Pennsylvania survey the constituents speak. More than 80% of the voters in Pennsylvania say that the legal system needs to be changed. Support for change cuts across partisan and demographic lines. Voters say the present liability lawsuit system has problems that should be improved. My home district is in Montgomery County and my local representative, Ellen Bard, did a survey. The result of that survey showed that 85% of the people supported limiting lawsuits and awards.

Finally, House bill 2122 deserves your support. It doesn't include all the reforms that are needed in the Commonwealth for medical liability tort reform, but it is a good beginning. It redefines the doctrine of informed consent; introduces collateral sources; limits punitive damages not to exceed 200% of compensatory awards; redefines the statute of limitations in a more reasonable manner; requires that the expert for the plaintiff be a Board certified expert practicing in the same field as the person who is the defendant if that person is Board certified; it limits discovery time so the claim can be expedited to the benefit of the plaintiff; it requires that the plaintiff's attorney distribute the trial expert reports within three months of commencement of the action; requires the mandatory conciliation conference; provides for periodic installment payments for future damages in excess of $200,000; provides for written valid arbitration agreement which, from what I have said previously, can be a very viable way of resolving a malpractice case as only approximately 13% of the cases

that are brought ever go to court.

This bill does bring some stabilization to the market. It is not the total answer, but is a beginning and I think we all should support it.

Thank you.