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NEW HAMPSHIRE'S EARLY OFFER LAW

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Thank you for the opportunity to address the committee about the recently enacted early offer medical malpractice law. I am Joanne Doroshow, President and Executive Director of the Center for Justice & Democracy at New York Law School, a national public interest organization that is dedicated to educating the public about the importance of the civil justice system. I also co-founded Americans for Insurance Reform, a coalition of nearly 100 public interest groups that works for better oversight of the insurance industry. I served on a New York State Medical Malpractice Task Force in 2007 and 2008.

I testified against the New Hampshire early offer law on April 26, 2012. I have also testified in Congress six times on medical malpractice issues, including once in 2006, sharing a panel with the late Professor Jeffrey O'Connell. At that time, Professor O'Connell was attempting to pitch the merits of a similar proposal to Congress. Congress is an institution with many members seeking to change our nation's medical liability system. I think it's fair to say that following that 2006 hearing, we never heard another word about Professor O'Connell's proposal. An idea that is so dismissive of constitutional rights and potentially calamitous for injured patients had no audience there. Nor has it in any other state in the nation. It is startling that New Hampshire has gone down this road. We urge New Hampshire lawmakers to repeal this law.

This law is unethical. It violates the legal rights of patients. It flouts basic notions of fairness. It will increase medical errors. The support for it, as articulated in the law's findings, is riddled with inaccuracies, so many that we are concerned that New Hampshire lawmakers were significantly misled by those who lobbied for it.

Before exploring the details of this law, I would first like to note the irony of the criticism made by providers and insurers who say this law was needed for the citizens of New Hampshire because the malpractice system delivers compensation too slowly. Obviously, the burdensome medical screening panel process that they support, which forces patients to bear extra time and

expense just to get to court, is a large reason for this. Moreover, despite the delays created by the screening process, malpractice cases in New Hampshire still resolve within two years as indicated in a letter sent last year to the Committee from one of the state's largest insurers, as well as in testimony from counsel.

This new statutory scheme tilts the legal playing field so dramatically in favor of insurers as to essentially eviscerate patients' rights to adequate compensation. Expediency is clearly not the goal of this law. The goal is to interfere with a process that ensures at least some semblance of fairness for patients.

THIS LAW IS BOTH UNFAIR AND UNETHICAL

Under this law, if there is an incident of malpractice, the patient may be approached to enter into an early offer program. If they do, the patient notifies the provider that they are entering into this program. Of course, the patient can do this without first being approached by the hospital, but it seems likely that if the hospital knows malpractice has occurred, it would pursue this avenue. The notice to the provider must be accompanied by the patient's legal waiver and release form, the "legalese" text of which is written into the law. And the patient is required to sign this document before they have any idea what compensation and courtroom rights they are relinquishing. Where there is a serious injury with complications that might not be known for some time, such as the case of a brain-injured newborn, no layperson will ever be capable of making a reasoned decision as to what they may need at this early stage. On this basis alone, this "consent" process is highly unethical.

But there are many other reasons. While its proponents argue that participation in this waiver is voluntary, the actual "consent" process violates even the most basic precepts of what constitutes a voluntary program. A waiver of rights, to be ethical and voluntary, cannot be written in legalese. It must loudly explain exactly what harm could come to a patient who participates in this program – for example, that every single decision-maker is heavily weighted toward the provider or insurer with conflicting financial motives to reject or reduce compensation for individual claims; that after an incident of possible malpractice, the hospital's lawyer, insurer, and doctor will decide if malpractice occurred and what the compensation should be; that the patient will have to fight to get bills paid for the rest of his or her life – in other words, that the injured patient is rendered virtually powerless in this process and is at the mercy of the hospital and their insurer and, should they get to court, they could lose everything they own under the law's onerous "loser pays" rule. (See more about these provisions below.)

In addition, to be ethical, patients who "opt into" this process must be able to "opt out" without prejudice. They must be able to discontinue participation at any point, without penalty or loss of benefits to which they are entitled. Such a scenario is obviously not contemplated here.

A Biased Process and Severely Reduced Compensation

Once a patient has signed away their rights, their ability to collect what amounts to severely-capped compensation is infected by conflicts of interest at every step, beginning with allowing

the medical provider to choose its own doctor to decide a patient's damages. While these physicians may not be "affiliated" with the provider, they are chosen by and paid for by the provider, for whom the chief motivation is to cut costs. It should be obvious to anyone that this presents a conflict of interest that is highly unfair to the patient.

The law prohibits compensation for lost earning capacity (*i.e.*, while future lost wages are theoretically covered, it appears that if a poor medical student were injured, for example, s/he would not be compensated for lost future earning capacity as a physician). Patients are also prohibited from being compensated for non-economic injuries. This should offend every New Hampshire citizen.

Non-economic injuries range from mutilation to blindness to loss of a woman's reproductive ability to permanent male sterility and beyond. In fact, when a person is seriously injured, the greatest loss is non-economic – the loss of the enjoyment of life, the pleasure, the satisfaction, or the utility that human beings derive from life, separate and apart from earnings. People are not chattel or property. What is truly valuable to us as human beings is our ability to live life on a daily basis free of debilitating physical or emotional problems that diminish our capacity to enjoy life and compromise our sense of self-worth, dignity, and integrity. The pleasure of living lies in our ability to participate fully in the give and take of family and career. It lies in our experience of the ordinary day – waking up without pain; drinking a cup of coffee without someone's help; driving or walking to a bus stop in the brisk air, rather than being wheeled to a lift van. These and thousands of everyday things are what we live for. Such injuries go to the very essence of our quality of life as human beings. Defining these kinds of injuries as worth nothing is not only heartless but goes against our nation's very definitions of individualized justice, a cornerstone of our democratic system.

What's more, eliminating compensation for these kinds of injuries is discriminatory. When President Bill Clinton vetoed a products liability bill in 1996, he explained, "The legislation would make it impossible for some people to recover fully for non-economic damages. This is especially unfair to senior citizens, women, children, who have few economic damages, and poor people, who may suffer grievously but, because their incomes are low, have few economic damages." In a 2004 law review article, University of Buffalo Law Professor Lucinda Finley wrote about empirical research she conducted of jury verdicts, which found "certain injuries that happen primarily to women are compensated predominantly or almost exclusively through noneconomic loss damages. These injuries include sexual or reproductive harm, pregnancy loss, and sexual assault injuries." Also, "juries consistently award women more in noneconomic loss damages than men.... [A]ny cap on noneconomic loss damages will deprive women of a much greater proportion and amount of a jury award than men. Noneconomic loss damage caps therefore amount to a form of discrimination against women and contribute to unequal access to justice or fair compensation for women."[1]

Of course, this law does not just cap non-economic damages; it eliminates them altogether.

[1] Lucinda Finley, "The Hidden Victims of Tort Reform: Women, Children, and the Elderly," 53 *Emory L.J.* 1263, 1266 (2004).

It should be noted that the "schedule of benefits" included in the law is not a replacement for non-economic damages, even if they were at adequate levels. Schedules like this eliminate any room for consideration of circumstances for these types of injuries, which judges and juries – not politicians or insurers – are uniquely suited to evaluate after hearing all the evidence in a case. As pointed out in 2006 congressional testimony by Duke Law Professor Neil Vidmar, "Even when some leeway is built into compensation schedules, they cannot take into account the number of factors and extreme variability of pain and suffering, physical impairment, mental anguish, loss of society and companionship, and other elements of damages that fall under the rubric of non-economic damages. That is why these matters have been entrusted to juries. They provide justice on an individualized basis."[2]

As far as receiving any future medical expenses, the patient or their family is forced to undergo a burdensome struggle to get bills paid from the medical provider, which has a financial incentive to deny claims and/or cut costs. It is entirely within the provider's discretion to decide what is "reasonable proof" for a claim. In other words, this law contemplates condemning patients – or their injured children – to a lifetime of fighting medical providers just to get their bills paid. Any notion that this law contemplates fairness when it comes to compensating a patient for economic damages is absurd.

And if the patient disagrees with any of this, they can argue their case before a hearing officer paid for by the provider. If the hearing officer decides that the patient's claim is "frivolous," the patient – who likely will have no legal representation since few patients could afford an attorney for a hearing like this – will be forced to pay up to a $1,000 penalty. (The provider is supposed to offer the unrepresented patient a "neutral advisor" but this individual is on the provider's payroll, as well. The provider, on the other hand, has his or her own attorneys at every step of the way fighting the patient.)

Courtroom Rights are Obliterated

Because the medical provider has so much discretion and cost-cutting motivation to reject portions of a patient's claim, the patient may have no option but to go to court at that point. But before even getting to court, they must comply with New Hampshire's onerous medical screening panel process. Assuming they survive that costly process, the injured patient can file their case in court - but only if they're willing to risk having to reimburse a hospital or insurance company for costs and inflated, hourly legal fees. This would be on top of dealing with the economic devastation they may already be facing due to an inability to work and other related costs, including having already financed a case before the screening panel.

Specifically, under this law, if the patient either loses their case, or *wins* but gets a verdict less than 125 percent of the offer, the patient must pay the defendants' fees. This "loser pays" rule is also known as "the British rule." Our founding fathers had no interest in bringing it here for a

[2] Testimony of Neil Vidmar, Russell M. Robinson II Professor of Law, Duke Law School, before the U.S. Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 18 (citations omitted).

reason. It chills victims' right to file suit. The British rule was recently rejected in Indiana.[3] For those who argue that "loser pays" opponents are exaggerating its consequences, we commend to your attention the recent story of Texas patient Connie Spears.[4] Connie's legs were unnecessarily amputated because of apparent negligence by ER doctors. Texas is one of the only states in the nation with a "loser pays" law, and in ER cases, it is triggered during the earliest stages of litigation. Because of this provision and other "tort reforms" on the books in Texas, Connie could not find an attorney. Finally, one heroic attorney took her case saying, "her life has basically been ruined by all of this, and there was just no way I could turn her down." However, "the case fell apart under the new expert-witness rules," and "if the patient "fail[s] to produce adequate expert reports within 120 days of filing their cases, they are liable for defendants' legal fees." She tried but couldn't meet this time-frame because of the law's punishingly difficult requirements. Writes the *Texas Tribune*, "With her retirement savings tapped and her husband out of work, she is afraid they will lose their home."

As the *Union Leader* put it in a June 26 editorial against the law,

> The bill tilts the playing field heavily in favor of hospitals and physicians. Patients who opt for the early offer and get lowballed by a medical provider could reject the offer and sue. But if they do, they would be required to post a bond sufficient to cover the provider's expected legal fees. Who has that kind of money lying around? If a patient goes to court and loses – or wins, but the jury awards less than 125 percent of the early offer – the patient would have to pay the provider's legal fees. There is no provision requiring providers to pay the legal fees of a patient who prevails in court.[5]

Under the New Hampshire "loser pays" provision, it is safe to say that no New Hampshire patient will ever risk having to pay such costs, which could be assessed *even if they win their case*. This law renders their right to access the courts virtually meaningless.

THE FINDINGS AND CONCLUSIONS ARE RIDDLED WITH INACCURACIES AND MYTHS

The point of departure for this law is that, "[S]ignificant resources are diverted from health care and spent on litigation costs and defensive medicine. The result is a system that has higher than necessary health care costs, higher liability insurance premiums, higher health insurance premiums, and ultimately reduced access to care." We disagree with every element of this premise.

MYTH: SIGNIFICANT RESOURCES ARE SPENT ON LITIGATION COSTS.

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[3] Mary Beth Schneider, "Gov. Mike Pence-backed tort reform bill exits quietly," *Indianapolis Star*, January 31, 2013.

[4] Becca Aaronson, "Despite Counsel, Amputee Hindered by Tort Laws," *The Texas Tribune*, January 25, 2013; http://www.texastribune.org/2013/01/25/double-amputee-challenges-texas-tort-reform/

[5] "'Early offer': Try again next year," *New Hampshire Union Leader*, June 26, 2012, http://www.unionleader.com/article/20120627/OPINION01/706279940.

Underlying this finding is the notion that because providers and their insurers spend inordinate amounts of money fighting patients with legitimate claims - beginning with the state's onerous and costly screening panel process - we should further strip patients of their legal rights. As others have written,[6] "This argument strikes us as an example of the 'chutzpah defense,' best exemplified by the individual who killed his parents, and then threw himself on the mercy of the court because he was an orphan." Nothing today prevents providers or liability carriers from settling legitimate claims with patients before they file a court case or from paying valid claims expeditiously. Yet they do not. They would prefer to fight patients often by denying, delaying, and defending legitimate claims, and causing the system's transaction costs to spiral. Patients should not be penalized because of this.

Just as disturbing is the law's finding II(b) supporting this law, namely that "medical injury cases are highly complex, requiring specialized medical evidence and testimony. This complex medical evidence and testimony requires additional discovery and case preparation that results in a particularly lengthy process for resolving cases." Again, whose fault is that? The provider possesses all the medical records. The patient needs to find out what happened. As Michelle Mello and her colleagues at the Harvard School of Public Health reported, "[O]ur findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information *that litigation triggers*."[7] Access to legal representation and experts *helps the patient*. Every patient who pursues a claim deserves a level legal playing field, their own lawyer and experts, and the opportunity to litigate their case as they see fit. They should not be punished because insurers drive up the system's costs.

MYTH: SIGNIFICANT RESOURCES ARE SPENT ON DEFENSIVE MEDICINE.

Dr. Fred Hyde, Clinical Professor in the Department of Health Policy and Management at Columbia University's Mailman School of Public Health,[8] defined "defensive medicine" this way:

> That, in contravention of good medical judgment, the basic rules of Medicare (payment only for services that are medically necessary), threats of the potential for False Claim Act (prescribing, referring, where medically unnecessary), physicians will, as a group, act in ways which are possibly contrary to the interests of their patients, certainly contrary to reimbursement and related rules, under a theory that excessive or unnecessary prescribing and referring will insulate them from medical liability.[9]

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[6] David A. Hyman and Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 *Vand. L. Rev.* 1085, 1122 (2006).

[7] David M. Studdert, Michelle Mello et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine,* May 11, 2006.

[8] Dr. Hyde holds both medical and law degrees from Yale and an MBA from Columbia, consults for hospitals, physicians, medical schools and others "interested in the health of hospitals," has served twice as chief executive of a non-profit hospital and as vice president of a major university teaching hospital.

[9] Fred Hyde, M.D., Clinical Professor, Department of Health Policy and Management, Columbia University Mailman School of Public Health, "Defensive Medicine: A Continuing Issue in Professional Liability and Patient

Clearly, most physicians in New Hampshire are not engaged in this practice. Most physicians are good doctors who order tests and procedures for the very reasons that they certify to Medicare and Medicaid – because they are medically indicated.[10] They are practicing good medicine. As one physician participating on a listserve recently about this topic explained: "As a physician, the first problem I face is what does it mean to say a test is 'unnecessary.' The term suggests that tests live in two categories, those that are helpful and those that are not, but in reality what we're really dealing with is a continuum of probability." Perhaps some doctors do commit Medicare fraud, and clearly "fee-for-service" medicine creates a perverse incentive for providers to do too many tests. But it certainly is the lesson of history that even if you remove litigation as a factor, the extent of tests and procedures that will be ordered will not change.

But let's assume for the moment that "defensive medicine" exists in some form. In 2009, the Congressional Budget Office issued an analysis of cost savings from "tort reform."[11] Of the 0.5% in overall health care savings CBO found, 0.3% was attributed to "slightly less utilization of health care services" or "defensive medicine." Many believe that these numbers, low as they are, are still exaggerated.[12] Yet CBO believed to achieve even this defensive medicine "savings," the nation would have to enact a complete menu of draconian tort restrictions. This includes not just a $250,000 cap on non-economic damages, but also a punitive damages cap of $500,000 or two times the amount of economic damages, repeal of the collateral source rule, one-year date of discovery statute of limitations (3 years for children) and repeal of joint and several liability. And it would still amount to less than 0.5% of overall health care costs. As Dr. Hyde succinctly put it, "[t]he cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care."[13]

In addition, there are no reliable data showing that liability considerations are ever the exclusive reason why most tests and procedures are performed, which is the definition of "defensive medicine." In June 2012, the *Journal of Empirical Legal Studies* published a groundbreaking study which examined Medicare spending after Texas enacted severe "tort reform" in medical

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Safety Discussions; Is There a Role for ACOs, CER, PCORI and 'Health Reform' in 'Tort Reform.'" (2010). The article was funded by a grant from the Center for Justice & Democracy and has been submitted for publication.

[10] See., e.g., Office of Technology Assessment (OTA), U.S. Congress, Office of Technology Assessment, Defensive Medicine and Medical Malpractice, OTA-H--6O2 (1994) ("OTA found that most physicians who 'order aggressive diagnostic procedures . . . do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability.' The effects of 'tort reform' on defensive medicine 'are likely to be small.'")

[11] Congressional Budget Office, "CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ('Tort Reform')," October 9, 2009, http://www.cbo.gov/publication/41334.

[12] See, e.g., Letter from Sen. John D. Rockefeller IV (D-WV) to Douglas W. Elmendorf, Director, Congressional Budget Office (Oct. 21, 2009), available at http://rockefeller.senate.gov/press/102109%20Ltr%20to%20CBO%20on%20Med%20Mal.pdf. *See also*, Statement of CJ&D Executive Director Joanne Doroshow before the U.S. House Committee on Energy and Commerce Subcommittee on Health, "Hearing on The Cost Of the Medical Liability System Proposals for Reform, including H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011," April 6, 2011 at 2, https://www.centerjd.org/system/files/CJDECHealth2011testimonyF.pdf.

[13] Fred Hyde, M.D., Clinical Professor, Department of Health Policy and Management, Columbia University Mailman School of Public Health, "Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and 'Health Reform' in 'Tort Reform.'" (2010).

malpractice cases.[14] The authors[15] found no evidence of a decline in health-care utilization or any impact on so-called "defensive medicine." Among the report's relevant findings:

- "One possibility [as to why "tort reform" doesn't lower health-care spending] is that there may not be much 'pure' defensive medicine – medical treatments driven solely by liability risk. If liability is only one of a number of factors that influence clinical decisions, even a large reduction in med mal risk might have little impact on health-care spending."[16] In fact, "[l]ower med mal risk could lead some doctors to practice less defensive medicine, yet make other doctors more willing to offer aggressive medical treatment that is profitable to the doctor but of doubtful value to the patient."[17]

- Moreover, "[p]olitically convenient myths are hard to kill. The myth that defensive medicine is an important driver of health-care costs is convenient to politicians who claim to want to control costs, but are unwilling to take the unpopular … steps needed to do so. It is convenient for health-care providers, who prefer lower liability risk. It is also convenient for members of the public, who find it easy to blame lawyers and the legal system for problems that have more complex and difficult roots, and call for stronger responses."[18]

Others have expressed similar skepticism. Dr. Hyde wrote, "'Defensive medicine' by all accounts has become such a myth, a combination of surveys of interested parties and the 'imagination' that those parties are avoiding – or believe they are avoiding – liability through alteration of their medical practices."[19] In fact, anonymous physician "surveys" is the only method ever used to establish its widespread existence:

> Defensive medicine has mainly been invoked as an argument for tort reform in the years between malpractice crises when other pressures for legal change have ebbed. The methods used to study the existence, prevalence and impact of defensive medicine have been, primarily, survey of those (practicing physicians) who may be perceived as having a position or stance in the political discussion….[20]

In these surveys, doctors never actually identify specific tests or procedures they have conducted for the primary purpose of avoiding a lawsuit, let alone a service they would no longer perform if

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[14] Myungho Paik et al., "Will Tort Reform Bend the Cost Curve? Evidence from Texas," *Journal of Empirical Legal Studies* (June 2012), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1635882.
[15] Professor Bernard S. Black, Northwestern University – School of Law, Northwestern University – Kellogg School of Management and the European Corporate Governance Institute (ECGI); David A. Hyman, University of Illinois College of Law; Myungho Paik, Northwestern University School of Law; and Charles Silver, University of Texas School of Law.
[16] *Id*. at 210.
[17] *Ibid*.
[18] *Id*. at 210-11.
[19] Fred Hyde, M.D., Clinical Professor, Department of Health Policy and Management, Columbia University Mailman School of Public Health, "Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and 'Health Reform' in 'Tort Reform.'" (2010).
[20] Fred Hyde, M.D., Clinical Professor, Department of Health Policy and Management, Columbia University Mailman School of Public Health, "Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and 'Health Reform' in 'Tort Reform.'" (2010).

"tort reform" were enacted. Indeed, such surveys are usually conceived by organized medicine, whose purpose is to give the impression of a scientifically conducted poll, yet they are not. In fact, in 2003, the General Accountability Office (GAO) condemned the use of "defensive medicine" physician surveys, noting everything from low response rates (10 and 15 percent) to the general failure of surveys to indicate whether physicians engaged in "defensive behaviors on a daily basis or only rarely, or whether they practice them with every patient or only with certain types of patients."[21] GAO also noted that those who produced and cited such surveys "could not provide additional data demonstrating the extent and costs associated with defensive medicine."[22]

Often tests are done to satisfy insurance requirements. And there are other reasons, as well. As the GAO noted, "[s]ome officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can mitigate defensive practices." Moreover, "[a]ccording to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit." [23]

Many have pointed out that one of the biggest cost drivers under Medicare is that physicians are paid by the services they provide and not by outcome. A recent *60 Minutes* investigation on end-of-life care found, for example, that "there are other incentives that affect the cost and the care patients receive. Among them: the fact that most doctors get paid based on the number of patients that they see, and most hospitals get paid for the patients they admit.… 'So, the more M.R.I. machines you have, the more people are gonna get M.R.I. tests?' [Steve] Kroft asked. 'Absolutely,' [Dr. Elliott Fisher, a researcher at the Dartmouth Institute for Health Policy] said."[24]

Interestingly, CBO found little evidence of "defensive medicine" except in studies of Medicare, not in studies of private managed care systems. According to CBO, the problem is Medicare's emphasis on "fee-for-service" spending, whereas private managed care "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 admits that to the extent defensive medicine exists at all, it can be controlled through simply managing care correctly as opposed to trying to manipulate legal rules.

Finally, the entire rationale behind the "defensive medicine" argument is that by eliminating lawsuits, doctors will not have to think about liability anymore. Unless absolute immunity were conferred on the entire health care system for all negligence and recklessness that doctors commit, doctors will never stop presenting "defensive medicine" as the reason for tests and

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[21] General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* GAO-03-836 (August 2003) at 27, http://www.gao.gov/new.items/d03836.pdf.
[22] *Ibid*.
[23] General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* GAO-03-836 (August 2003) at 27, http://www.gao.gov/new.items/d03836.pdf.
[24] "The Cost of Dying: End-of-Life Care," *60 Minutes*, August 6, 2010, http://www.cbsnews.com/2102-18560_162-6747002.html?tag=contentMain;contentBody.

procedures. This was well illustrated in Dr. Atul Gawande's June 2009 article in the *New Yorker* magazine called "The Cost Conundrum; What a Texas town can teach us about health care," which explored why the town of McAllen, Texas "was the country's most expensive place for health care."[25] The following exchange took place with a group of doctors and Dr. Gawande:

> "It's malpractice," a family physician who had practiced here for thirty-three years said.
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> "McAllen is legal hell," the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.
>
> That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn't lawsuits go down?
>
> "Practically to zero," the cardiologist admitted.
>
> "Come on," the general surgeon finally said. "We all know these arguments are bullshit. There is overutilization here, pure and simple." Doctors, he said, were racking up charges with extra tests, services, and procedures.

In sum, as Dr. Darshak Sanghavi, the chief of pediatric cardiology at the University of Massachusetts Medical School, put it in a recent Sunday *Boston Globe Magazine* article, "[s]tudies show that doctors order a lot of questionable testing and treatment even when malpractice risks are very low."[26] While doctors may tell pollsters that tests are done to avoid lawsuits, digging further usually reveals that there are other factors at work. In fact, if doctors were routinely billing for tests they believed were unnecessary, they would be committing Medicare fraud.[27] We do not believe this is happening. The bottom line is that trying to address overutilization by imposing this law on New Hampshire patients will solve nothing but will continue to make it more difficult for patients who are harmed.

MYTH: THESE COSTS RESULT IN HIGHER THAN NECESSARY HEALTH CARE COSTS.

As noted above, in June 2012, the *Journal of Empirical Legal Studies* published a groundbreaking study, which concluded that limiting injured patients' legal rights will not reduce overall health-care spending.[28] The authors examined Medicare spending after Texas enacted

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[25] Atul Gawande, "The Cost Conundrum," *New Yorker*, June 1, 2009, http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande.

[26] Dr. Darshak Sanghavi, "Medical malpractice: Why is it so hard for doctors to apologize?" *Boston Globe Magazine,* January 27, 2013.

[27] 42 U.S.C. § 1320c-5(a)(1); 42 U.S.C. § 1395y(a)(1)(A). *See also, Mikes v. Strauss*, 274 F. 3d 687, 700-1 (2d Cir. 2001) and cases cited therein (holding that compliance with § 1320c-5(a)(1) is a condition of participation in the Medicare program but not a condition of payment; other courts do not make that distinction, *e.g.*, *United States ex rel. Kneepkins v. Gambro Healthcare, Inc.*, 115 F. Supp. 2d 35, 41 (D. Mass. 2000) (holding that compliance with § 1320c-5(a)(1) is a condition of payment). *See*, http://www.cms.gov/cmsforms/downloads/CMS1500805.pdf.

[28] Myungho Paik et al., "Will Tort Reform Bend the Cost Curve? Evidence from Texas," *Journal of Empirical Legal Studies* (June 2012), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1635882.

severe "tort reform" in medical malpractice cases and found no evidence of a decline in health-care utilization. Among the report's key findings:

- "A major exogenous shock to med mal risk from the reforms had no material impact on Medicare spending (in effect, health-care quantity), no matter how we slice the data."

- "We find no evidence that overall health-care spending, physician spending, or imaging and lab spending declined more in counties with higher med mal risk."

- "We also find no overall decline in Texas Medicare spending relative to control states, nor an overall association between spending (or spending trends) and med mal risk."

- "If anything, we find some evidence, well short of definitive, that physician spending rose after reform in larger, high-risk counties."

- "Our data are limited to Medicare, but med mal reform seems even less likely to influence treatment intensity for the privately insured, since most private insurers exercise greater oversight over treatment decisions than does Medicare."

- "The further one gets from the time of reform, the less reliable will be any effort to have confidence in a causal link between tort reform and health-care spending."

Other Texas research reaches similar conclusions. According to the consumer group Texas Watch, in Texas where patients' legal rights have been decimated, Medicare spending has risen 16% faster than the national average since Texas restricted the legal rights of patients. Four of the nation's 15 most expensive health markets as measured by Medicare spending per enrollee are in Texas.[29] Texas Watch shows that growth in Medicare spending per enrollee in the three years before patients lost their rights was 3.80% in Texas compared to 3.36% for the national average. In the three years following so-called "tort reform," average Medicare spending increased 7.43% in Texas compared to 6.03% for the national average. What's more, according to Families USA and Texas Watch, family health insurance premiums for Texas families are up 92% – more than 4.5 times faster than income.[30] Texas has the nation's highest rate of uninsured, with 24.5% of Texans lacking health insurance.[31]

Finally, in his April 2012 article, Cornell Law School Professor Theodore Eisenberg, a leading authority on the use of empirical analysis in legal scholarship, published a new article entitled, "The Empirical Effects of Tort Reform."[32] He found that "tort reform" provides little in the way of health care savings, noting, "One recent summary concludes that the 'accumulation of recent

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[29] *See*, Texas Watch, "Restricting Patient Rights Does Not Lower Health Costs," http://www.texaswatch.org/wordpress/wp-content/uploads/2010/10/MedicareSpeding-HealthCosts.pdf.
[30] Texas Watch, "Texas-Style 'Reform' Fails Patients; Costs Up, Access Down" (2010), found at www.texaswatch.org/wordpress/wp-content/uploads/2011/07/MedMal-Fact-Sheet-2010.pdf.
[31] *See*, http://pubdb3.census.gov/macro/032007/health/h06_000.htm.
[32] Theodore Eisenberg, "The Empirical Effects of Tort Reform," April 1, 2012. *Research Handbook on the Economics of Torts*, forthcoming, found at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740.

evidence finding zero or small effects suggests that it is time for policymakers to abandon the hope that tort reform can be a major element in healthcare cost control' (Paik 2012, 175)."

MYTH: THESE COSTS RESULT IN HIGHER INSURANCE PREMIUMS.

For more than 30 years, the state medical and insurance lobbies have argued that establishing legal roadblocks in the way of injured patients was the only way to reduce periodically high malpractice insurance rates and keep doctors practicing. As a result of this lobbying, many state lawmakers succumbed to political pressure and enacted hundreds of state laws that weaken the rights of patients injured by medical negligence, making it more difficult for them to obtain fair compensation, or making it harder to hold accountable those responsible – so-called "tort reform." As a result, nationally the number of injured patients bringing medical malpractice claims (*i.e.*, claims frequency) has reached "historic lows."[33] New Hampshire is no different. The medical profession here has many legal protections for negligence, and both the frequency and severity of claims are down.

In 2009, our project, Americans for Insurance Reform, took a look at medical malpractice insurance claims, premiums, and profits in the country at that time and for 30 years prior. In this report, *True Risk: Medical Liability, Malpractice Insurance and Health Care,*[34] we found that according to the insurance industry's own data, medical malpractice claims, inflation-adjusted, are dropping like a rock, down 45 percent since 2000. Inflation-adjusted per doctor claims have dropped since 2002 from $8,676.21 that year to $5,217.49 in 2007 to $4,896.05 in 2008. In fact, at no time during this decade did claims spike or "explode." As A.M. Best put it, "Overall, the most significant trend in [medical professional liability insurance] results over the five years through 2008 is the ongoing downward slope in the frequency of claims.…"[35]

Despite this drop in claims, the medical industries argue that limiting compensation for injured patients will lead to reduced medical malpractice rates, or simply slower growth for doctors. However, this argument is based entirely upon a false predicate – that the civil justice system is to blame for insurance price-gouging. History repeatedly shows that limiting damages for patients will not lead to lower rates, because what drives rate hikes has nothing to do with a state's tort law. It is driven by the insurance underwriting cycle. Indeed, the new law entirely ignores the insurance industry's major role in the pricing of medical malpractice insurance premiums.

Medical liability insurance is part of the property/casualty sector of the insurance industry. This industry's profit levels are cyclical, with insurance premium growth fluctuating during hard and soft market conditions. This is because insurance companies make most of their profits, or return on net worth, from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return, particularly in "long-tail" lines – where the insurers hold premiums for years before paying claims – like medical malpractice. Due to this intense

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[33] A.M. Best, "Solid Underwriting Undercut by MPLI's Investment Losses," *Best's Special Report*, April 27, 2009.
[34] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), found at http://insurance-reform.org/pr/090722.html.
[35] A.M. Best, "Solid Underwriting Undercut by MPLI's Investment Losses," *Best's Special Report*, April 27, 2009.

competition, insurers may actually underprice their policies (with premiums growing below inflation) in order to get premium dollars to invest. This period of intense competition and stable or dropping insurance rates is known as the "soft" insurance market.

When interest rates drop or the economy turns, causing investment decreases, or the cumulative price cuts during the soft market years make profits unbearably low, the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market. This usually degenerates into a "liability insurance crisis" often with sudden high rate hikes that may last for a few years. Hard markets are followed by soft markets, when rates stabilize once again.

The country experienced a hard insurance market in the mid-1970s, particularly in the medical malpractice and product liability lines of insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. From the late 1980s through about 2001, doctors and hospitals nationwide experienced a relatively stable medical malpractice insurance market. Insurance was available and affordable. Rate increases were modest, often far below medical inflation. Meanwhile, profits for medical malpractice insurers soared, generated by high investment income. During this period, doctors benefited from an extended "soft market" period. That changed *again* after 2001.

After dropping interest rates and an economic downturn, compounded by years of cumulative price cuts during the prolonged soft market, insurers suddenly began raising premiums and canceling some coverage for doctors, or at least threatening to do so, in virtually every state in the country. This was an industry-wide insurance phenomenon, not just a medical malpractice phenomenon. It was not a state-specific phenomenon either. It was not even a country-specific phenomenon. It was happening in countries like Australia and Canada that do not have jury trials in civil cases. And this was despite the fact that claims and payouts were stable. This was a classic "hard market."

Like all hard markets, it did not last. In fact, the entire country has been in a "soft" insurance market for several years now, stabilizing rates everywhere in the country.[36] Premiums have dropped or stabilized irrespective of whether "tort reforms" were enacted in any particular state.[37] States with little or no restrictions on patients' legal rights have experienced the same level of liability insurance rate changes as those states that enacted severe restrictions on patients' rights.[38] Among states that had pure premium increases of more than 5% in the last five years analyzed were states with significant medical malpractice limits like Florida, Nevada and Utah, and states with fewer restrictions like Vermont, Wyoming – and New Hampshire. Enactment of limits on medical malpractice patients' rights has made no difference at all.

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[36] *See*, data from the Council of Insurance Agents & Brokers cited in Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), found at http://insurance-reform.org/pr/090722.html. *See also*, Joanne Doroshow, "Here's Really Why Your Insurance Rates Go Up – and Then Don't," *Huffington Post*, October 27, 2010, found at http://www.huffingtonpost.com/joanne-doroshow/heres-really-why-your-ins_b_775077.html.

[37] *Ibid.*

[38] *Ibid.*

Meanwhile, as far as profits, in 2007 (the last year analyzed), the medical malpractice insurance industry had an overall return on net worth of 15.6%, which was *well over* the 12.5% overall profit for the entire property/casualty industry.[39] But in New Hampshire, the return on net worth was 36.8% – more than double the national average!

Some of this must be due to decreasing payouts to New Hampshire patients, which I understand is confirmed by Department of Insurance data that show a substantial drop over the last few years. Clearly, this industry does not need more help.

MYTH: THESE COSTS RESULT IN REDUCED ACCESS TO CARE.

There are years of studies showing no correlation between where physicians decide to practice, their choice of specialty, and liability laws. As Professor Ted Eisenberg found in his April 2012 article:[40]

> If increasing premiums drive exit decisions, then programs alleviating premiums should have effects. But Smits et al. (2009) surveyed all obstetrical care providers in Oregon in 2002 and 2006. Cost of malpractice premiums was the most frequently cited reason for stopping maternity care. An Oregon subsidy program for rural physicians pays 80 percent of the professional liability premium for an ob/gyn and 60 percent of the premium for a family or general practitioner. Receiving a malpractice subsidy was not associated with continuing maternity services by rural physicians. Subsidized physicians were as likely as nonsubsidized physicians to report plans to stop providing maternity care services. And physician concerns in Oregon should be interpreted in light of the NCSC finding, described above, that this was a period of substantial decline of Oregon medical malpractice lawsuit filings.

Again, Texas is another good example. In 2003, injured Texans relinquished their legal rights because the insurance and medical lobbies told them this was the only way to prevent a doctor shortage in Texas. Yet doctor shortages still loom in Texas today. This is apparently due to "caps and cuts in Medicare and Medicaid funding, which help pay for residencies. Those have forced many healthcare agencies to freeze or scale back residency programs."[41]

Indeed, in late 2012, a new study was released proving that "tort reform" in Texas had no effect whatsoever on physician supply.[42] The methodology of this study, which controls for every conceivable factor, is so accurate that a national "tort reform" proponent admitted changing his

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[39] National Association of Insurance Commissioners, *Report on Profitability by Line by State in 2007* (2008) at 38.
[40] Theodore Eisenberg, "The Empirical Effects of Tort Reform," April 1, 2012. *Research Handbook on the Economics of Torts*, forthcoming, found at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740.
[41] Alex Branch, "JPS official warns Texas legislators of doctor shortage," *Fort Worth Star-Telegram*, October 19, 2010.
[42] David A. Hyman et al., "Does Tort Reform Affect Physician Supply? Evidence from Texas," Northwestern University Law School, Law and Economics Research Paper No. 12-11; University of Illinois, Program in Law, Behavior and Social Science Research Paper No. LE12-12; University of Texas Law School, Law and Economics Research Paper No. 225 (June 2012) at 8, http://ssrn.com/abstract=2047433.

mind about the issue after examining this work.[43] The authors noted, "Physician supply appears to be primarily driven by factors other than liability risk, including population trends, location of the physician's residency, job opportunities within the physician's specialty, lifestyle choices, and demand for medical services, including the extent to which the population is insured."[44]

Similarly, on August 29, 2003, the U.S. General Accountability Office released a study[45] ostensibly to find support for the AMA's assertions that a widespread health care access "crisis" existed in this country caused by doctors' medical malpractice insurance problems. The GAO found that the AMA and doctor groups had based their claims on information GAO determined to be "inaccurate" and "not substantiated," and that to the extent there are a few access problems, many other explanations can be established "unrelated to malpractice," that problems "did not widely affect access to health care," and/or "involved relatively few physicians." The health care access problems that GAO could confirm were isolated and the result of numerous factors having nothing at all to do with the legal system. Specifically, GAO found that these pockets of problems "were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services."

Other studies have also rejected the notion that there has been any legitimate access problem due to doctors' malpractice insurance problems. In August 2004, the National Bureau of Economic Research researchers found: "The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt. The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings."[46]

Other state-specific studies draw the same conclusion. In April 2007, Michelle Mello of the Harvard School of Public Health published a study of physician supply in Pennsylvania in the peer-reviewed journal, *Health Affairs*. The authors "looked at the behavior of physicians in 'high-risk' specialties – practice areas such as obstetrics/gynecology and cardiology for which malpractice premiums tend to be relatively high – over the years from 1993 through 2002. They found that contrary to predictions based on the findings of earlier physician surveys, only a small percentage of these high-risk specialists reduced their scope of practice (for example, by eliminating high-risk procedures) in the crisis period, 1999-2002, when malpractice insurance premiums rose sharply.… What's more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion who did so during 1993-1998, before premiums spiked. 'It doesn't appear that the restrictions we did

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[43] *See*, Manhattan Institute's Ted Frank, "Post-tort-reform Texas doctor supply," *PointofLaw.com*, May 4, 2012, http://www.pointoflaw.com/archives/2012/05/post-tort-reform-texas-doctor-supply.php ("I, for one, am going to stop claiming that Texas tort reform increased doctor supply without better data demonstrating that.")

[44] *Id*. at 25.

[45] General Accounting Office, *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* GAO-03-836, released August 29, 2003, found at http://www.gao.gov/new.items/d03836.pdf.

[46] Katherine Baicker and Amitabh Chandra, "The Effect of Malpractice Liabiility on the Delivery of Health Care," *NBER Working Paper Series* (August 2004), found at http://www.dartmouth.edu/~kbaicker/BaickerChandraMedMal.pdf.

observe after 1999 were a reaction to the change in the malpractice environment,' said Mello, the C. Boyden Gray Professor of Health Policy and Law at the Harvard School of Public Health."[47]

Similarly, the *Cincinnati Enquirer* reviewed public records in Ohio in the midst of that state's medical malpractice insurance crisis. The investigation found "more doctors in the state today than there were three years ago … '[T]he data just doesn't translate into doctors leaving the state,' says Larry Savage, president and chief executive of Humana Health Plan of Ohio."[48]

Past studies have also shown there to be no correlation between where physicians decide to practice and state liability laws. One study found that, "despite anecdotal reports that favorable state tort environments with strict … tort and insurance reforms attract and retain physicians, no evidence suggests that states with strong … reforms have done so."[49] A 1995 study of the impact of Indiana's medical malpractice "tort reforms," which were enacted with the promise that the number of physicians would increase, found that "data indicate that Indiana's population continues to have considerably lower per capita access to physicians than the national average."[50]

THE LAW WILL HARM PATIENT SAFETY

Here are some of the recent horrifying statistics about the worsening state of patient safety since the Institute of Medicine's seminal study "To Err is Human,"[51] published well over a decade ago, found that between 44,000 and 98,000 patients are killed in hospitals each year due to medical errors:

- A new study led by Johns Hopkins University School of Medicine, published online in the journal *Surgery*, found that surgeons make mistakes called "never events" like leaving behind foreign objects, operating on the wrong site or even the wrong patient, more than 4,000 times a year in the United States. Six percent of these patients die. Another 32.9% have permanent injuries.[52]
- According to another 2012 study from the Johns Hopkins, "as many as 40,500 critically ill patients in the United States may die annually when clinicians fail to diagnose hidden life-threatening conditions such as heart attack and stroke. The unexpectedly high

[47] "Malpractice Premium Spike In Pennsylvania Did Not Decrease Physician Supply," *Health Affairs,* April 24, 2007, found at http://www.healthaffairs.org/press/marapr0707.htm.
[48] Tim Bonfield, "Region Gains Doctors Despite Malpractice Bills," *Cincinnati Enquirer*, October 11, 2004.
[49] Eleanor D. Kinney, "Malpractice Reform in the 1990s, Past Disappointment, Future Success?" 20 *J. Health Pol. Pol'y & L.* 99, 120 (1996), cited in Marc Galanter, "Real World Torts," 55 *Maryland L. Rev.* 1093, 1152 (1996).
[50] Eleanor D. Kinney & William P. Gronfein, "Indiana's Malpractice System: No-Fault by Accident," 54 *Law & Contemp. Probs.* 169, 188 (1991), cited in Marc Galanter, "Real World Torts," 55 *Maryland L. Rev.* 1093, 1152-1153 (1996).
[51] *To Err Is Human, Building a Safer Health System,* Institute of Medicine, 1999.
[52] *See*, http://www.hopkinsmedicine.org/news/media/releases/johns_hopkins_malpractice_study_surgical_never_events_occur_ at_least_4000_times_per_year

frequency of deadly misdiagnosis in hospital intensive care units or ICUs was 'surprising and alarming,' said Dr. Bradford Winters, the lead author of the study."[53]

- Medical errors occur in one-third of hospital admissions, as much as ten times more frequently than previously estimated.[54] This is because adverse event detection methods commonly used to track patient safety in the United States today — voluntary reporting and the Agency for Healthcare Research and Quality's Patient Safety Indicators — are woefully inadequate, missing as many as 90 percent of hospital errors.
- Chief medical mistakes uncovered in the AHRQ report: "medication errors, including getting the wrong drug or being given the wrong dose of the right drug; surgical errors, such as having an operation done on the wrong site or surgical gaffes that result in bleeding or infection; and hospital-acquired infections, which often result from poor sanitation."[55] As lead researcher Dr. David C. Classen, an associate professor of medicine at the University of Utah, put it, "The more you look for errors, the more you find."[56]
- Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, about 1 in 7 experienced a serious adverse event (13.5 percent).[57] "An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their deaths, which projects to 15,000 patients in a single month."[58] "Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable. … Preventable events were linked most commonly to medical errors, substandard care, and lack of patient monitoring and assessment.… Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events."[59]

One of the precepts of conservative economic theory is that the tort system's economic function is deterrence of non cost-justified accidents, and that the tort system creates economic incentives for "allocation of resources to safety."[60] Indeed, as Professor Eisenberg noted in his recent article, "One possible factor contributing to the continued high rate of errors is that doctors do

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[53] Cristine Russell, Senior Fellow, Harvard Kennedy School of Government, "The Alarming Rate of Errors in the ICU," *Atlantic*, August 28, 2012, http://www.theatlantic.com/health/archive/2012/08/the-alarming-rate-of-errors-in-the-icu/261650/, citing Bradford Winters et al., "Diagnostic errors in the intensive care unit: a systematic review of autopsy studies," *BMJ Quality & Safety*, July 21, 2012, http://qualitysafety.bmj.com/content/early/2012/07/23/bmjqs-2012-000803.abstract.

[54] David C. Classen et al., "Events In Hospitals May Be Ten Times Greater Than Previously Measured," *Health Affairs* (April 2011), http://content.healthaffairs.org/content/30/4/581.abstract. *See also*, Chris Fleming, "New Health Affairs: Hospital Errors Ten Times More Common Than Thought?" *Health Affairs Blog*, April 7, 2011, http://healthaffairs.org/blog/2011/04/07/new-health-affairs-hospital-errors-ten-times-more-common-than-thought/.

[55] David W. Freeman, "Hospital errors rampant, study says: What can patients do?" *CBS News*, April 7, 2011, http://www.cbsnews.com/8301-504763_162-20051864-10391704.html.

[56] Steven Reinberg, "Hospital errors more common than suspected," *HealthDay*, April 8, 2011, http://yourlife.usatoday.com/health/healthcare/hospitals/story/2011/04/Report-Hospital-errors-more-common-than-suspected/45929932/1.

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

[58] *Id*. at ii.

[59] *Id*. at iii.

[60] See, e.g., William M. Landes, Richard A. Posner, *The Economic Structure of Tort Law* (1987).

not expect to bear the full cost of harms caused by their negligence. …and [h]ospitals do not bear the full costs of the harms caused in them even though hospitals directly and indirectly influence patients' risk of medical error (Mello et al. (2007)).”[61] In other words, further weakening the system's deterrent potential will only lead to more errors.

In its October 9, 2009 letter to Senator Orin Hatch on medical malpractice issues, the Congressional Budget Office noted, “The [medical malpractice] system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses….” CBO wrote that “imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes.” Of the three studies that address the issue of mortality that it examined, CBO noted that one study found tort system restrictions would lead to a .2 percent increase in the nation's overall death rate.[62] If true, that would be an additional 4,853 Americans killed every year by medical malpractice, or 48,250 Americans over the 10-year period CBO examines.[63] Moreover, based on these same numbers, another 400,000 or more patients could be injured during the 10 years that CBO examined (given that one in 10 injured patients die[64]). The costs of errors, which the Institute of Medicine put between “$17 billion and $29 billion, of which health care costs represent over one-half,” would clearly increase[65] as would the costs of caring for these new patients.

Law Professors David A. Hyman and Charles Silver, who have researched and written extensively about medical malpractice,[66] also confirm, “The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. …[T]wo major factors forced their hand: malpractice claims and negative publicity.… Anesthesiology [malpractice] premiums were...among the very highest – in many areas, two to three times the average cost for all physicians. By the early 1980s, anesthesiologists recognized that something drastic had to be done if they were going to be able to continue to be insured.… Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it.”[67] In other words, “[a]s Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious. As the title of their most recent article says, ‘it's the incentives, stupid': Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients.… In short, the notion that errors would decline if tort liability [and payouts, as contemplated by this law] are diminished is ridiculous.”[68]

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[61] Theodore Eisenberg, “The Empirical Effects of Tort Reform,” April 1, 2012. *Research Handbook on the Economics of Torts*, forthcoming, found at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740.
[62] CBO says “[t]here is less evidence about the effects of tort reform on people's health, however, than about the effects on health care spending – because many studies of malpractice costs do not examine health outcomes.”
[63] Based on 2,426,264 deaths according to the Center for Disease Control and Prevention, found at http://www.cdc.gov/nchs/FASTATS/deaths.htm.
[64] Study of California hospitals cited in Tom Baker, *The Medical Malpractice Myth*. University of Chicago Press (2005).
[65] Institute of Medicine, *To Err Is Human, Building a Safer Health System* (1999).
[66] David A Hyman and Charles Silver, “The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?,” 90 *Cornell L. Rev*. 893, 917 (2005).
[67] *Id*. at 920, 921.
[68] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 *Vand. L. Rev*. 1085, 1131 (2006).

Numerous medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. In addition to anesthesia procedures, these include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.[69] The *New England Journal of Medicine* published a 2006 article confirming this point: that litigation against hospitals improves the quality of care for patients, and that "more liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously."[70]

In sum, this law calls into serious question the continuation of hospital accountability mechanisms that are currently in place to deter errors, with the possibility of significant deleterious effects on patient safety.

DISRESPECT FOR THE CONSTITUTION

Finally, this law infringes directly on the third branch of government. This is of tremendous concern because of the fundamental nature of the right to trial by jury that would be severely limited by this law. Even assuming such a law is constitutional, which we doubt,[71] these rights are priceless and should not be casually eliminated. There are fundamental democratic principles at stake with legislation like this. As Justice Rehnquist has stated:

> The guarantees of the Seventh Amendment [right to trial by jury in civil cases] will prove burdensome in some instances; the civil jury surely was a burden to the English governors who, in its stead, substituted the vice-admiralty court. But, as with other provisions of the Bill of Rights, the onerous nature of the protection is no license for contracting the rights secured by the Amendment.[72]

Over the years, mostly under pressure from insurers, states and Congress have occasionally considered proposals that require or pressure wrongly injured persons to have their disputes resolved outside the court system and/or force them to obtain compensation from an administrative system. It would be one thing if any of these systems succeeded and could be considered appropriate models. But none has. This is due not to poor legislative construction or elements that can be fixed. Rather, it is because of one inherent flaw that infects all such systems; namely, once an area of law is removed from the civil justice system and is codified by statute, it is immediately and forever vulnerable to manipulation by political forces and turns into a nightmare for those it was originally meant to help.

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[69] Meghan Mulligan & Emily Gottlieb, "Hospital and Medical Procedures," *Lifesavers: CJ&D's Guide to Lawsuits that Protect Us All*. Center for Justice & Democracy (2002) at A-36 *et seq.*, B-12 *et seq*.

[70] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

[71] This law is in some ways similar to a proposal known as "health courts," which are unconstitutional for similar reasons. See, Amy Widman, "Why Health Courts are Unconstitutional," 27 Pace L. Rev. 55 (Fall 2006).

[72] *Parklane Hosiery Co. Inc. v. Shore,* 439 U.S. 322 (1979) (Rehnquist dissenting).

Moreover, as Penn law professor Tom Baker wrote while he was a law professor and Director of the Insurance Law Center at the University of Connecticut School of Law:

> Lawsuits make people work *through* the system, not against it. Lawsuits take place in the open. Lawsuits provide procedural protections for everyone involved. To win a lawsuit you have to be right. It is not enough just to be angry.
>
> …
>
> Responsibility lies at the heart of tort law. A tort lawsuit is a public statement that a defendant has not accepted responsibility, coupled with the demand to do so. Malpractice lawsuits ask doctors and hospitals to take responsibility for their mistakes, not just prevent future mistakes or to compensate the patient, but also because taking responsibility is the morally proper thing to do.[73]

We urge New Hampshire lawmakers to repeal this law as soon as possible. Thank you for your time and attention.

[73] Tom Baker, *The Medical Malpractice Myth* (2005) at 112, 113.