

**MEDICAL LIABILITY REFORM PROPOSALS:
An Analysis of Legislation Supporting the President's Plan**

In a speech at the Highpoint University in North Carolina, President Bush proposed major legislative reforms to address the medical liability crisis. To make health care more affordable, more available, and better and safer for patients, the President proposed national minimum standards for medical liability reforms and new protections for good-faith efforts by health professionals to improve health care quality and safety.

Recent news reports have highlighted the healthcare crisis faced by numerous states including Nevada, Mississippi, and Pennsylvania that has resulted from skyrocketing medical malpractice insurance costs. The President's speech coincides with the release of a report by the Department of Health and Human Services detailing the restriction of services, escalation of local and national costs and the detrimental effects on patient safety that have resulted from the current malpractice regime.

The President's proposed national standards for medical liability suits and protections for quality and safety improvement efforts are embodied in two sets of congressional initiatives. H.R. 4600 and S. 1370 envision numerous reforms to the medical malpractice tort system for the purposes of national cost savings. These savings would purportedly increase access to and affordability of medical care. House bill 4889 and Senate bill 2590 call for the creation of systems to gather information on health care quality and, in the context of litigation, to hold this information as privileged so as to encourage its collection. This paper will examine both initiatives, point out differences in approach by each division of Congress, and discuss positions likely to be taken by those both for and against these changes.

I. Medical Liability Tort Reforms

H.R. 4600 and S. 1370 contemplate a number of tort reforms for the purpose of reducing the cost of medical malpractice insurance. It is said that this reduced cost will keep doctors from abandoning practices, thereby maintaining or improving patient access to care. It is also contented that these savings will be passed along to consumers in the form of lower insurance and medical service cost, recovered by workers in higher wages, and will save the federal government billions of dollars in the administration of its health programs. At the same time, these reforms are designed to encourage quick, predictable and equitable settlements between parties ensuring that more individuals are fairly compensated for actual harm. It has been pointed out that California enacted similar reforms decades ago and has dramatically controlled costs without reducing the quality or safety of medical services. To achieve these goals, the following changes are proposed.

A. Statute of Limitations

For medical liability suits, the House bill would impose a statute of limitation of one year from the date of discovery of an injury, which in no case could exceed three years from the date of actual injury. The Senate bill would provide for a two-year statute of limitation running from the time the injury and cause are discovered or reasonably should have been discovered.

Between the two bills, there are exceptions for claimants who are minors, legally disabled or whose lawsuits have been stayed or enjoined.

Opponents may argue that the House version imposed too strict a statute of limitations as some injuries may not manifest themselves immediately and potential claimants may be denied recovery if their injury only becomes apparent after the three year limit. Conversely, proponents are likely to point out that the vast majority of malpractice claims will be immediately apparent

and that claimants have a full year to file suit after they discover such injury. The three year time limit could be seen as necessary to ensure that claims are legitimate, that causation can be reliably established, and that defendants can reach a state of repose for events that are distant in time and for which memories fade and evidence becomes stale and conflicted.

B. Compensatory Damage Caps

While the Senate bill does not address economic damages, the House bill explicitly states that economic damages shall not be limited. Actual, provable economic harm is exactly what the tort system is meant to address; therefore, unlimited economic damages are less likely to be contentious. Both bills contemplate that non-economic damages (pain and suffering) be limited to \$250,000 per claimant, that any award for future non-economic damages not be discounted to present value, and that the jury not be informed of the limitation on non-economic damages. Any jury award for non-economic damages in excess of the cap is to be reduced by the judge with the first reduction to be made from future awards if available.

Opponents of these restrictions might argue that a static cap is not appropriate for all situations and that such determinations should be left up to the fact finder. An argument may also be made that non-economic damage awards help to pay legal fees and therefore allow for a recovery that is large enough, at a minimum, to cover the economic damages of the plaintiff. Proponents of this change will likely argue that it is impossible to place a dollar figure on pain and suffering which leads to disparate and unpredictable jury awards. As to the payment of attorney fees, it could be argued that a contingency fee applied to a \$250,000 non-economic award (not to mention economic damages) should be enough to adequately compensate legal counsel. Proponents will also assert that these mega-verdicts are not only responsible for taxing the resources of the malpractice insurance system directly, but also indirectly by driving up

settlement offers which also increase costs. On this view, it is the strain on the insurance infrastructure that is responsible for restricting or denying care to a significant portion of the population and increasing cost for all.

C. Punitive Damage Restrictions

Both bills would change the standard of proof for punitive damages in health care liability cases to that of clear and convincing evidence. Plaintiffs would also be prohibited from initially pleading punitive damages and would only be able to amend their complaint upon a showing that there is a likelihood of success in proving willful or malicious conduct on the part of the defendant. There are also restrictions on what evidence is admissible when addressing the issue of punitive damages, and a provision for a separate punitive damage hearing if requested by either party. Punitive damages could not be awarded unless the plaintiff was also awarded compensatory damages. Punitive awards would thereafter be limited to three times compensatory damages under the Senate bill or two-times compensatory damages under the House bill. Under both bills, in no instance will the limit be less than \$250,000.

Opponents of such limitations will argue that punitive damages are necessary to punish and deter wrongdoers who seek to profit from negligent practices. Restrictions on the magnitude of these awards might isolate defendants with deep pockets from the intended detrimental effects of these awards. They will also likely point out that these awards are not often given out. Proponents could be expected to counter that the heightened standards proposed will help assure that punitive awards are used correctly and not as a vehicle to increase awards for a sympathetic plaintiff or for a jury to punish a defendant for simple negligent behavior. The primary goal of the tort system is not and should not be punitive; that is the province of criminal law. Furthermore, proponents will suggest that closely tying punitive awards to a proportion of

compensatory damages will assure that a minimally injured plaintiff does not reap a windfall award to the detriment of future claimants or the health care system in general.

The House bill also contains provisions excluding punitive damages from product liability suits for medical devices and pharmaceuticals that have complied with all FDA regulations concerning approval and post-approval regulation. These provisions would also prohibit naming the doctors who prescribe FDA approved devices and medicines as defendants in any product liability suit.

Opponents of such a change would argue that it would limit the theories under which and parties from whom recovery could be sought for an injured plaintiff; proponents will maintain that compliance with FDA procedures and the prescription of FDA approved items should be strong evidence against willful and wonton misbehavior.

D. Limiting Contingency Fees

Both bills contemplate caps on contingent attorney fees. The Senate version would impose a blanket cap of 25 percent for all health care liability actions. The House version would impose a graduated reduction in percentage as the plaintiff's award increases. The House bill would limit contingency fees to 40 percent for the first \$50,000 followed by 33 1/3 percent for the next \$50,000, then 25 percent for the subsequent \$500,000 and 15 percent for any additional amount recovered.

Those opposed to these restrictions might point out that a limit on recovery may lead plaintiffs' attorneys to turn down less profitable cases. It is the money from the high profile, high recovery cases that allow trial lawyers to subsidize less lucrative or certain ventures. Those in favor might argue that large contingency fees feed a system of excessive litigation that primarily favors lawyers over clients. Attorneys do not have an incentive to settle cases they

think may reach sympathetic juries and even if a recovery is made for a plaintiff the balance may not be enough to cover the basic economic damages of the victim once up to 50 percent of the award is claimed by the attorney. Proponents of the caps could also point to the tremendous sums consumed by contingency fees as an example of the economic waste exhibited by current system of compensation. The money consumed by excessive contingency fees could better be used to compensate the injured.

E. Consideration of Collateral Source Benefits

The House bill would allow for evidence of collateral source benefits and the amount paid to secure those benefits to be used in court. The House version would also bar the provider of any collateral benefits from seeking indemnity from the claimant or subrogating the plaintiffs claim. The Senate version, however, contemplates a mandatory offset of collateral benefits from any award. The cost of procuring these benefits would be credited to the claimant.

Opponents of such a change would likely assert that it is unfair to allow a negligent defendant to benefit from the fact that the injured person happened to be medically insured. Proponents will likely counter that adoption of such a rule would be more economically efficient by preventing double recovery and by driving compensation towards an insurance system, which would be more efficient than litigation.

F. Handling of Awards for Future Damages

Both House and Senate bills contemplate that any award for future compensatory damages be paid out according to the Uniform Periodic Payments of Judgements Act if the future award is in excess of \$50,000 or \$100,000 respectively and either party requests it.

G. Alternative Dispute Resolution

The Senate bill explicitly contemplates that states should be encouraged to establish

extra-judicial mechanisms for claimant compensation. The bill directs the Attorney General to develop guidelines to help the states along in this process. The Senate bill also provides that if either party to a settlement facilitated by one of these programs subsequently seeks redress in the court system, that party can be subject to sanction. If the subsequent trial judgment favors the party not bring suit by 25 percent of the previous award, the party bringing suit will be liable for all costs incurred by the litigation, including legal fees.

Opponents will argue that these alternative dispute regimes could be used to pressure injured individuals to accept settlements that are not representative of the true value of their claim. This argument has been made in response to the establishment of the September 11 Victims' Fund. Proponents would likely point out that victims would receive speedy compensation thereby allowing them to pay necessary bills and that the amount any award may be diminished by the process would more than be offset by not having the wait, uncertainty, and, most importantly, having to share a large percentage with legal counsel.

H. State Law Preemption

Each bill deals with the preemption of state law in a slightly different fashion. The House bill contains a blanket preemption of state law that is less restrictive than the provisions it contains although states would be free to maintain or enact more restrictive laws relating to health care liability. The one exception contained in the House bill is the right of states to maintain or enact different (higher or lower) damage caps than those contained within the bill. This provision does not apply to the House bill's section stating that economic damages will not be limited. The Senate version shares essentially the same preemption language but also contains a provision that would effectively allow states to opt-out. In suits between residents of

the state filed in that state's court, the provisions of the Senate bill would not apply if that state's legislature enacted law exempting the state from participation.

The President's framework calls for national adoption of his proposals. It has been reported that the President supports federal preemption of state tort law as a function of the failure of some states to enact reasonable limits for medical malpractice cases. Moreover, the inability of some states to control health care liability is impacting on and raising the cost of medical services provided by federal government.

II. Patient Safety Improvement

The Patient Safety and Quality Improvement Act (H.R. 4889 and S. 2590) is designed to encourage the collection of quality control information relevant to the health care industry. The findings contained in the bills assert that the current litigation climate discourages the collection of this data for fear that it will subsequently be used against the industry in a court proceeding. The failure to collect this data and engage in active quality management and improvement lowers the quality of care for all patients and puts them in substantial danger. To help improve the quality and safety of the national health care system, Congress is contemplating the following initiatives.

A. Patient Safety Data Privilege

To encourage the health care industry to actively engage in quality control, both the House and Senate bill provide that data collected for such purposes shall not be subject to subpoena, discovery or the Freedom of Information Act in any civil, criminal or administrative proceeding. Nor will it be allowed to be entered into evidence in any such proceeding. The bills also extend the privilege to individuals subject to adverse employment, certification, credentialing or licensing actions. This "patient safety data" is protected during collection,

storage by an organization or subdivision of an organization engaged in quality control activities or during dissemination of that data from one of these quality control or “patient safety” organizations.

This privilege does not totally restrict the sharing of patient safety information. This information may be used in a criminal proceeding if it is relevant and there is no other source for the information. Also, the basic patient files that exist apart from any quality control effort are also beyond the privilege. The privilege only applies to separate, comprehensive databases that could be used to analyze for local, state or regional trends. Patient safety data may also be used to assess products subject to review by the FDA for public safety.

Proponents and opponents basically will argue over whether the fear that quality control data could be used in a civil suit prevents sufficiently widespread compilation of valuable safety information, which in turn might affect patient safety and quality improvements in medicine.