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Medical Liability Reform and the Need for ACCESS

With widespread agreement that our nation’s medical liability system does not serve the needs of our patients, the 115th Congress must act to make necessary reforms at the federal level that will help reduce health care costs, preserve patients’ access to quality medical care, and put an end to medical lawsuit abuse.

The ACCESS Act, H.R. 1704, will help ensure that physicians and health care providers are able to provide vital — and affordable — medical services to all patients without the threat of meritless lawsuits.

Section 2: The system is broken

The ACCESS Act addresses a system that can be both costly and inefficient, directly and indirectly hitting patients with high expenses.

Patients face expensive health care bills — in the form of steep insurance premiums and because of “defensive medicine,” where patients may receive unnecessary tests and costly medical treatments in order to reduce the risk of litigation — to the tune of \$160 billion to \$289 billion per year (when applied to 2015 health care costs).¹ The government’s share of health care costs related to this flawed medical liability system continues to rise, and the non-partisan Congressional Budget Office has found that \$55 billion in federal health savings and \$62 billion in deficit reductions overall could be achieved over a 10-year period if the federal government passed reforms like those in California and Texas.²

Research has also shown that our liability system often benefits those without valid claims, as well as those who are truly the victims of medical negligence. Twenty-seven percent of recent claims involving errors were uncompensated, and conversely, the same percentage of compensated claims did not involve an error.³

¹ *Medical liability reform now!* American Medical Association, 2016

² Congressional Budget Office; Options for reducing the deficit: 2017-2026.

³ Studdert DM, Mello MM, Gawande AA. Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. *N Engl J Med* 2006;354(19):2024-2033.

The severity of the situation necessitates the implementation of reasonable, comprehensive, and effective health care liability reforms.

Section 3: A timely resolution

Deserving patients should have a timely resolution to their claim.

Under the current patchwork of laws, a recent study found that the average physician, practicing for 40 years, would spend nearly 11 percent of his or her career with an open, unresolved claim.⁴

Language in the ACCESS Act establishing a three-year statute of limitations from the date of injury, or one year following the discovery of such injury, creates an environment where physicians are not under threat of lawsuits years after the medical incident in question has occurred or discovered. In instances where states have passed their own statute of limitations with more stringent requirements, the state law prevails.

A strong statute of limitations keeps claims efficiently moving through the system, making it less likely for claims of questionable merit to languish for years on end before bringing forth a lawsuit.

Section 4: Compensating deserving patients

Non-economic damages are paid to fully compensate an individual for physical and emotional pain, suffering, inconvenience, mental anguish, loss of enjoyment of life, and other intangible, non-monetary losses.

Section 4 of the ACCESS Act allows for the full recovery of all economic damages, including medical bills and lost wages (even those that occur in the future). It also allows *additional* compensation — up to \$250,000 — for non-economic damages, such as damages awarded for pain and suffering. In states that have passed laws specifying damage limits of any amount, the state law prevails.

Amounts for non-economic damages above \$250,000 have been found to contribute to higher health care costs. Claims occurring in a state lacking tort reform resulted in an average indemnity payment that was over \$200,000 higher compared to states that enacted tort reform and placed reasonable limits of \$300,000 or less on non-economic damages.⁵

For example, an analysis of efforts in California to raise the reasonable limits on non-economic damages above the current \$250,000 estimated that liability premiums would increase up to 38 percent, based on the experience of other states that have imposed or eliminated limits. Without

4 Seabury SA, Chandra A, Lakdawalla D, et al. On average, physicians spend nearly 11 percent of their 40-year careers with an open, unresolved malpractice claim. *Health Aff.* 2013;32(1):111-119.

5 PIAA Closed Claim Comparative, 2015.

such limits, California's annual health costs alone would rise by \$9.9 billion, leaving the average family of four with an extra \$1,000 in health care costs annually.⁶

Section 5: Protecting patients – not personal injury lawyers

Patient-friendly provisions limit attorney fees so that damage awards go to the patients that need them the most.

When attorneys file a lawsuit on a contingency fee basis, Section 5 of the ACCESS Act gives the court the authority to restrict the percentage of a patient's recovery that his or her attorney may take, and to redirect the damages to the deserving patient. Under this bill, contingency fees would be limited to 40 percent of the first \$50,000; 33.3 percent of the next \$50,000; 25 percent of the next \$500,000; and 15 percent of any amount above \$600,000 – allowing personal injury lawyers to pocket more than \$220,000 on a \$1 million award. In instances where states have passed laws further limiting contingency fees, the state law prevails.

State laws have proven successful at redistributing money from personal injury lawyers to deserving patients. In California, contingency fee reform and limits on non-economic damages caused plaintiff attorney fees to be reduced 60 percent while minimizing the impact on patients and their families, reducing net recoveries by just 15 percent.⁷

Section 6: Collateral sources

By keeping the jury uninformed about what expenses have been or will be paid by other sources, personal injury lawyers hope to escalate awards further to increase their fees (which are based on a percentage of the award).

Collateral sources could include health insurance reimbursement, workers' compensation, and disability insurance payments. The result: double recovery of damages by plaintiffs since both the defendant and another party, such as an insurance company, pay the plaintiff for the same loss.

Section 6 of the ACCESS Act eliminates this rule and allows evidence of collateral source payments to be offered in court. This gives the *jury* the chance to decide the extent to which collateral source benefits should be factored into an award. The plaintiff would still be fully compensated for his or her injuries but would be less likely to receive a windfall; as would be the attorney. State law prevails if it specifies a mandatory offset of collateral source benefits against an award in a health care liability lawsuit.

Without this reform, a jury may be forbidden from knowing that a patient has already received payments from outside sources.

⁶ "California's Malpractice Ruse," *The Wall Street Journal*, 16 April 2015.

⁷ Pace NM, Golinelli D, Zakaras L. *Capping Noneconomic Awards in Medical Malpractice Trials xxiv*. RAND Corp: 2004.

Section 7: Periodic payments

Future damages are the plaintiff's losses that are projected to occur after the claim is resolved. They include, among other things, future medical and rehabilitative expenses, domestic services, and lost earnings.

The ACCESS ACT allows the defendant to make periodic payments of future damages over \$50,000, if the court deems appropriate, instead of a single lump sum payment. The plaintiff would continue to receive full and immediate compensation for all out-of-pocket expenses, non-economic damages, and future damages of \$50,000 or less. In instances where state law specifies a threshold of any other amount for periodic damages, or that mandate periodic payments absent a request from either party, state law prevails.

This provision would allow the defendant to pay for future losses with funds that have a lower present value but are expected to grow over time. It also would ensure that funds continue to be available to the plaintiff to cover these future damages as they occur by avoiding the possibility of mismanagement of a lump sum payment. In short, periodic payment vehicles are generally better for patients and keep health care costs affordable.

Section 8: Absolved from product liability

Physicians rely on the integrity of Food and Drug Administration (FDA) medicines and products.

Section 8 of the ACCESS Act ensures that health care providers shall not be named liable in a product liability lawsuit involving the FDA-approved products they prescribe and dispense, nor can they be named in a class action lawsuit against the manufacturer for such products. Health care providers should not be held liable for doing what the government said they should do.

Section 9: Apologies accepted

Many physicians wish to express sympathy or condolences following an adverse medical outcome without being threatened by a lawsuit.

Presently, several state laws allow doctors to say they are sorry without the apology being used against them in court as evidence of wrongdoing.

The ACCESS Act gives physicians clear guidance on expressions of sympathy, condolence, and compassion upon learning of an adverse outcome from a medical procedure. In instances where states have deemed additional communications inadmissible, the state law prevails.

Programs based on this concept have found success in many health care organizations, including Stanford Hospital's version, named Process for Early Assessment, Resolution and Learning (Pearl). At Stanford, from 2009 to 2014, following the introduction of Pearl, the frequency of

lawsuits was 50 percent lower, and indemnity costs in paid cases were 40 percent lower compared with the 2003 to 2008 period.⁸

Section 10: Notification of litigation

Physicians deserve to know if someone is pursuing medical liability litigation against them.

Under Section 10 of the ACCESS Act, plaintiffs are required to provide written notice 182 days before filing litigation to ensure that a physician and patient have time to address an adverse outcome before resorting to litigation. Any claimants facing an expiration of the statute of limitations are exempt from this notification window. In instances where state laws specify a different time period for conveying written notice, the state law prevails.

Section 11: Statement of merit

High-risk specialties are often the target of medical lawsuit abuse — and in too many cases, the claims have no merit.

Section 11 directs attorneys to file, simultaneously with any lawsuit, an affidavit of merit, signed by a health professional who meets the requirements for an expert witness, stating that the claim is legitimate. In instances where states have passed legislation establishing additional requirements for the filing of an affidavit of merit, the state law prevails.

Without such a statement of merit, the system is ripe for lawsuit abuse. Over the past five years, the majority of closed claims, 66 percent, were shown to lack merit, but still consumed valuable time and resources. These claims were dropped, withdrawn, or dismissed with no indemnity payment to the claimant, but nevertheless incurred an average defense expense of \$29,336.⁹

In 2015, the total expenses for research and defense of claims that were dropped, withdrawn, or dismissed amounted to more than \$159 million.¹⁰

Section 12: Expert witness

Expert witnesses must be qualified to provide the testimony that they are offering in a medical liability case.

To ensure that juries get accurate information from both sides of a claim, Section 12 permits only licensed health care professionals who meet stringent criteria to testify as expert witnesses. This section requires expert witnesses to be of the same specialty as the plaintiff, and match their

⁸ “Hospitals find a way to say, ‘I’m sorry,’” *Wall Street Journal*, 1 February 2016.

⁹ PIAA Closed Claim Comparative, 2015.

¹⁰ PIAA Closed Claim Comparative, 2015.

board certifications, if applicable. These health care professionals must have spent the year prior to the occurrence of the injury within that specialty, or if not applicable, as a general practitioner. If the expert witness does not meet these requirements, they can be disqualified by the court, and they can in no way serve if their fee is contingent upon the outcome of the case.

In instances where state laws place additional requirements upon expert witnesses, the state law prevails.

Section 14: Other federal laws/Vaccine injury

Other Federal laws not affected.

This section does not alter any aspects of the National Vaccine Plan, nor any federal laws related to the defense available to a defendant in a medical liability case.

Section 15: States' rights

In many states, patient-friendly legislatures and Governors have been able to stand up to the personal injury lobby, protecting patients in the wake of a deteriorating liability climate that fails those who need help the most. Unfortunately, not every state has been so lucky — leaving patients to foot the personal injury lawyers' bill.

The ACCESS Act preserves state medical liability laws that are not addressed directly by this legislation. In addition, the language in sections 3, 4, 5, 6, 7, 9, 10, 11 and 12 defers to state laws that directly address that same issues covered in the bill.

While these reforms serve as a national framework, they in no way inhibit a state's ability to enact laws that take additional steps to end medical lawsuit abuse.