

THE MEDICAL MALPRACTICE CRISIS AND THE ISSUE OF CAPS ON DAMAGES

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Introduction

The current battle over the cost of medical malpractice insurance pits doctors and malpractice insurers against patients' rights groups and the plaintiff's bar -- groups that agree on little. This article attempts to set forth the positions of physicians and lawyers (who prosecute medical malpractice cases) on the issue of capping non-economic damages. The issue cannot be addressed in any depth in this short article. We hope only to provide a basis for thought and discussion.

While the causes and the potential remedies are disputed, all sides appear to agree that malpractice insurance rates for high risk specialties are reaching points where doctors may choose other specialties or retire early. This will create health care problems for New Jersey patients. Physicians, backed by malpractice insurers, seek to limit damages for "non-economic" damages (e.g., "pain and suffering") to \$300,000. Thus, regardless of what occurred, the most a patient could collect for pain and suffering would be capped. Plaintiffs' lawyers and patients' rights groups oppose caps. We first present what we believe to be the physicians' viewpoint, followed by what we believe to be the lawyers' viewpoints.

The Physicians' Position

1. In a nutshell

¹ The authors are members of the firm of Harwood Lloyd, LLC of Hackensack, New Jersey. Any views expressed in this article are not necessarily those of Harwood Lloyd, LLC or any client of the firm. Generally, the firm does not represent plaintiffs in medical malpractice litigation.

Materials provided by the Medical Society of New Jersey ("MSNJ") claim that "steady increases in payments for large jury awards and settlements – doubling from 1996 to 2000" has caused the medical malpractice crisis in New Jersey.² An actuarial firm confirms MSNJ's position, and defends malpractice insurers against accusations that their bad business decisions are the cause of the crisis, and instead advocates a cap. The actuarial firm states that

Insurance companies in states with non-economic damage caps are stable, although they have similar investments and business conditions.³

MSNJ also denies any "correlation between most malpractice lawsuits and the actual negligence of a physician. Most suits are just bad outcomes in high-risk cases. That is why over 70% of all obstetricians will be sued at some point." Ibid.

Doctors seek reform because the "current system is out of control and cannot be sustained without harming healthcare access for everyone." The reform they propose would provide to "[t]rue victims of preventable medical error:"

- reasonable compensation for their economic damages (medical costs, lost past and future wages, costs to care for them or their families and other unspecified similar losses; and
- reasonable limits "on the emotional component of awards, so-called non-economic damages." Ibid.

In addition, physicians seek changes to the legal system, so that

- cases are brought within a few years of the actual event⁴ and

² MSNJ, Medical Liability Reform: Q & A.

³ Ibid.

⁴ Currently, the statute of limitations for a personal injury action in New Jersey is two years. N.J.S.A. 2A:14-2. However, time does not begin to run when the injured person is unaware of the injury (such as for a latent disease). In addition, for a minor, the statute does not begin to run until the age of majority. Thus, if alleged malpractice committed at someone's birth, a suit for such malpractice could be filed 20 years later. These "long tail" claims present difficulties for physicians and their insurers.

- expert testimony is based upon sound medical knowledge and opinion. Ibid.

Physicians oppose awards of non-economic damages, because they "are impossible to quantify, play to jury sympathy and are the root cause of the current patient access crisis." Ibid.

MSNJ contends that a proposed \$300,000 cap on non-economic damages is fair, because awards

- are in addition to awards for economic loss, which "can be in the millions;" and
- it is the current system, which "is crippling the availability of health care for everyone else," that is unfair. Ibid.

2. The Tillinghast-Towers Perrin Actuarial Study

The Tillinghast-Towers Perrin Study ("TTP Study") performed for MSNJ and published in March 2003, blames increased malpractice rates upon increased claim payments. The TTP Study minimizes any impact of the stock market collapse, but notes as a secondary reason the decline in the bond market. Id. at 4. TTP estimates that the loss of investment income would result in an 11.2% premium increase -- much less than the increases practitioners have faced. Id. at 10-11.

The TTP study notes that in the early 1980s, claim payments increased greatly. Following tort-reform efforts, they then dropped significantly in the mid- and late-1980s, and stayed at a low level until the mid-1990s. A rapid (and unexplained) increase in payments commenced in 1997.⁵ The rates insurers charged for malpractice coverage generally followed the same trend. However, there is generally some lag time between when payments start to increase and when rates increase.

TTP projects that losses and expenses for all New Jersey medical malpractice insurers for 2003 will be approximately \$600 million. More than 89% of that amount (\$536 million) consists

⁵ TTP Study at 7.

of claim payments and legal expenses (defense costs). For those insurers to earn a profit of 5%, they need to collect approximately \$532 million in premiums. (The difference would be covered by investment income earned by the insurers.) Projected 2003 premiums will only generate \$308 million in revenue. Depending upon other uncertainties, insurers would have to raise premiums between 47% and 99% to reach \$532 million. Id. at 12.

The TTP Study finds that caps would cause "premiums to increase more slowly than otherwise." Id. at 15. In the 1980s malpractice crisis, reforms (including caps in some states) resulted in a reduction of claim payments. Finally, when premiums began to increase in 2001, increases in states with caps were less than those in states without caps. Id. at 16

3. "Equity points" favoring the doctors.

There is no question that doctors are giving up specialties, because of lawsuits and malpractice rates. Others are retiring completely. Hospitals are losing good doctors. The loss of experienced practitioners can jeopardize health care.

Physicians appear to be getting squeezed by higher liability rates while being paid less for procedures now than they were in the past. Medicare might pay an Ob/Gyn \$800-\$1,600 for a hysterectomy. An HMO might pay \$1,500 for the delivery of a baby (including months of pre-natal care). In order to pay the malpractice premium alone, that Ob/Gyn has to perform a lot of those procedures. (Of course the more procedures the doctor performs the greater chance of being sued.) On the other hand, a successful plaintiff's attorney can have a much more lucrative payout: a third of the first \$500,000 collected.⁶

⁶ New Jersey Court Rule 1:21-7 limits contingent fees to 1/3 of the first \$500,000, 30% of the next \$500,000, 25% of the next \$500,000 and 20% of the next \$500,000. A judge determines the fee on cases in which more than \$2 million is recovered. The fee is awarded on the total

The Lawyers' Viewpoint

1. In a nutshell.

Plaintiffs' lawyers deny the allegation that too many lawsuits and aggressive lawyers are the culprits. Statistics lend some credence to their position. The number of malpractice suits in New Jersey has declined from 2,200 in 1994 to 1,613 in 2001, a decrease of over 25%.

Year	Malpractice Filings	Total Filings
1998	1,776	123, 904
1999	1,787	117.639
2000	1,772	111,610
2001	1,613	105,510 ⁷

During the 10 years ending December 2000, there were only 5,556 medical malpractice payments made by physicians in New Jersey and the median payment was \$115,000.00. This ranked New Jersey 30th of the 50 states.⁸

In addition, lawyers question the effect of caps because caps vary from state-to-state and this variance minimizes their statistical viability as predictors of premium decreases. Even the TTP Study was "not able to make a precise estimate of the expected effect of a cap..."⁹

2. Caps for pain and suffering offer false hope for the targeted specialties.

The specialties whose rates have soared the most are those that present the greatest risk: obstetrics and gynecology, perinatology, orthopedics and neurosurgery. However, conscious

amount, regardless of whether the loss is considered "economic" or "non-economic." As with all contingent fees, if the claimant is unsuccessful, the lawyer receives nothing.

⁷ Records from the New Jersey Administrative Office of the Courts.

⁸ National Practitioner Data Bank.

⁹ TTP Study at 16.

pain and suffering can be only a minor component of any award, if such damages are awarded at all. Rather, the "big numbers" in such cases are the "economic" damages. Examples are:

- The cost of lifetime care, in the case of an infant who will survive for 50 years but will never emerge from a vegetative state;
- The loss of income for a 28 year-old working mother, who dies during childbirth;
- The loss of income for a 40 year-old executive, earning \$300,000 per year, who dies during surgery.

Awards for such damages are generally based upon testimony by actuaries and economists.

They often dwarf pain and suffering awards, particularly where the malpractice causes the patient's death.

3. A cap primarily benefits malpractice insurers, not their policyholders.

Plaintiffs' lawyers view the current cap controversy as being spearheaded by malpractice insurers seeking to restrict patients' rights with no concomitant reduction in insurance costs. A March 13, 2002 press release from the American Insurance Association (AIA) warned that tort reform measures would not necessarily result in rate decreases. It begins, "[T]he insurance industry never promised that 'tort reform' would achieve specific premium savings."¹⁰

Lawyers also cite the Princeton Insurance Company's Annual Report of 2000, which states:

- that Princeton had enjoyed three "stellar" years in a row;
- a profit of nearly \$30 million;
- that at the end of 2000, total assets had increased to \$715 million from \$695 million the year before; and
- that its statutory surplus had increased by \$12 million to \$165 million.

¹⁰ New Jersey's Center for Justice and Democracy, March 19, 2002.

President Patricia Costante of New Jersey malpractice insurer Medical Inter Insurance Exchange ("MIIX") testified before the New Jersey General Assembly that MIIX had consistently made money in New Jersey. Its current problems stemmed from massive losses in other states.¹¹

Lawyers claim that today's high premiums are the result of bad investments and inadequate underwriting by the insurance companies, compounded by increases in reinsurance premiums. At least one medical group appears to agree.¹² To a large extent, so does Study GAO-03-702 (June 2003) by the Government Accounting Office, which attributes much of the current rate activity to the "hard" insurance market.

4. How the lawyers view the problem and the solution

Plaintiffs' lawyers feel that

- the malpractice insurance companies and their business decisions should be investigated and better regulated.
- health insurers (including Medicare and Medicaid) should be required to fairly pay doctors for their services, so that doctors can either absorb or pass on the increased cost of malpractice insurance.¹³
- doctors should better police the ranks of medical practitioners.¹⁴

The plaintiffs' lawyers also question why

- the doctors are joining forces with the insurers, rather than doing battle with them

¹¹ Testimony of Patricia Costante, June 3, 2002

¹² The "American College of Obstetrics and Gynecology, for the first time, conceded that malpractice insurance carriers' business practices have contributed to the current problem", says Alice Krakman, spokeswoman for the Professional Group, "we are admitting it is a much more complex problem than we had previously talked about." Wall Street Journal, June 24, 2002, [Assigning Liability](#) Insurers' Missteps Help Provoke Malpractice Crisis.

¹³ Lawyers recognize that many HMOs or other providers of "managed care" pay doctors less now for many procedures than they did 20 years ago.

¹⁴ Lawyers feel that "bad doctors" are inadequately disciplined – a position that articles in two major New Jersey newspapers support. (See Asbury Park Press January 28 and 30, 2002 and Bergen Record August 6 and 7, 2003.)

- injured plaintiffs should be limited in what they can collect for their injuries because their doctors' insurance companies have made bad underwriting and investment decisions
- injured plaintiffs should be limited in what they can collect, because their doctors cannot pass on increased premiums due to the fact that HMOs inadequately compensate doctors¹⁵
- insurance companies charge exorbitant premiums to doctors who have been sued for but exonerated of malpractice
- more effort is not invested in investigating the insurance industry and the need for the high premiums, instead of reducing the rights of injured people
- we have yet another malpractice crisis, despite the reforms that have taken place during the last thirty years

Finally, the lawyers are skeptical that caps are going to prevent a recurrence of a malpractice crisis if there is another downturn in the economy in a few years.

5. Equity points for the plaintiffs' lawyers

The institution of caps makes the injured party pay for the insurer's bad business decisions. Caps on non-economic loss necessarily discriminate against patients who would not sustain great economic losses as a result of malpractice, namely, the young, the old, women and minorities. Taking an extreme example, were a doctor to amputate the healthy leg of a young child, that child would likely be hard-pressed to show economic loss. By the same token, a doctor should be hard-pressed to say that \$300,000 is enough compensation for having to go through life with no legs.

Conclusion

¹⁵ Put another way, why should injured patients be the ones to increase the profitability of HMOs and malpractice insurers?

There are no easy answers to the problem. All sides cite statistics to buttress their arguments. With the exception of the GAO study, the statistics each side cites seem carefully culled from larger sets (that might not support that party's position).

In our legal system, culpable parties are supposed to compensate victims for their errors or omissions. Compensatory damages are meant to place victims in the same place they would have been had no injury occurred. They are not meant to serve as a lottery or to punish physicians. (Punitive damages are rarely awarded and not covered by insurance.) A cap on non-economic damages removes the lottery payoff from consideration and may reduce claim costs. It may also persuade doctors not to abandon certain specialties or the state altogether. However, a cap could also leave the victim of malpractice in a worse position than before, through no fault of the victim, solely because the victim was injured by a doctor, rather than a truck driver.

If in fact a cap is the only way to stem the rising price of malpractice insurance, New Jersey must determine if rate stabilization should be paramount. New Jersey's lawmakers should determine: (1) what caps have been in place in other jurisdictions and how they compare to those being advocated by MSNJ; (2) whether sufficient data exist to determine if the caps in other states have indeed effected rate reductions or rate stability; and (3) whether our public policy favors rate stability over patients' rights.