



***Oppose H.R. 1215: Congress Should Protect Patients. Period.***

***As many as 440,000 Americans die from preventable medical errors every year, making it the third leading cause of death in the U.S. behind heart disease and cancer.***

It's back with a different name, but you have seen this bill before. H.R. 1215, the so-called "Protecting Access to Care Act of 2017" does nothing to ensure that patients have access to health care. Instead, this bill would severely limit the ability of injured patients and their families to hold health care and medical providers accountable. The bill is so broadly drafted that it would also limit remedies against for-profit nursing homes, insurance providers, and even against doctors who commit intentional torts such as sexual abuse. It also contains a new provision making it more difficult to hold the pharmaceutical industry responsible for patient harm.

Proponents of H.R. 1215 claim the bill would help control costs associated with defensive medicine. Really? Patients do not believe that they are getting too much care. In fact, in 2015 only a fifth of a penny was spent on compensating patients of medical negligence and defending claims for every \$1 spent on health care.<sup>1</sup> Furthermore, there is no evidence that defensive medicine actually exists or contributes to health care costs.<sup>2</sup> These same providers also fail to acknowledge that charging insurance companies, Medicare and Medicaid for care they deem "unnecessary medical care" is insurance fraud. And even if the providers' behavior falls short of fraud, the fee-for-service system permits certain doctor self-referrals, which in turn contributes to sky-rocketing health care costs.<sup>3</sup>

Researchers have concluded that the tort reform measures contained in H.R. 1215 would not only increase costs, but would also reduce the quality of health care provided. A 2016 study by researchers at Northwestern University and the University of Illinois looked at the effect of caps on damages on healthcare spending and found that changes to the tort system had no impact on hospital-based spending, and actually caused a 4-5% increase in physician-service spending.<sup>4</sup> In 2014, those same researchers had already determined that caps actually resulted in an increase in health care costs because physicians were increasing the amount of care they provided:

*"physicians appear to respond to lower med mal risk by increasing the quantity of healthcare they deliver to elderly patients... There is no evidence that limiting med mal lawsuits will bend the healthcare cost curve, except perhaps in the wrong direction. Policymakers seeking a way to address rising healthcare spending should look elsewhere."*<sup>5</sup>

Aside from higher costs, tort reform was also directly correlated with lower quality healthcare: *“evidence on the relationship between med mal reform and healthcare quality suggests that med mal reform could have an unfortunate double effect—higher spending and lower quality. The two effects could be related—lower care quality could cause spending to rise.”*<sup>6</sup>

### **General Problems with H.R. 1215:**

- **Sweeping preemption of state law.** The bill broadly preempts state law and is designed to override only the state laws that protect consumers and patients while keeping in place state laws that favor doctors, hospitals, nursing homes, HMOs, pharmaceutical and medical device manufacturers, and other health care defendants at the expense of patient safety.
- **Sponsors fail to address concerns raised by champions of states’ rights.** The sponsors of the bill want to trick you into believing that they have addressed concerns raised by champions of the 10<sup>th</sup> amendment and states’ rights. This is not true.
  - Specifically, the bill preempts all areas of state law covered by the bill, including state rules regarding joint and several liability, the availability of damages, collateral sources, attorneys’ fees, and periodic payments of future damages.
  - The bill does not preempt any state defenses designed to protect health care providers.
  - The bill would leave in place existing state caps on economic and non-economic damages, but also adds new damage caps for states that do not have limitations on damages, including states whose limitations were struck down as unconstitutional by state supreme courts.
  - Some states would keep their damage caps, but be forced to also except federal cap mandates, undermining the work of state legislatures who have carefully considered these issues and struck the appropriate balance for their state.
    - For example, the California MICRA cap only applies to non-economic damage claims against medical providers. California would keep that cap, but also cap non-economic damages against the pharmaceutical, nursing home, and insurance industries.
  - States with an overall medical malpractice cap, such as Indiana’s \$1.25<sup>7</sup> million cap would also have to except a \$250,000 non-economic damage cap for medical malpractice, medical products, insurance companies, and nursing homes.
- **Breathtaking scope.** The bill applies to medical malpractice, pharmaceutical products, nursing homes and health insurance claims. If the proponents were truly concerned about doctors, why does this bill cover product liability claims against pharmaceutical and medical device manufacturers, and civil actions against nursing homes, HMOs, and insurers?
  - Proponents may argue that H.R. 1215 has a narrower application than previous versions of the bill. Careful reading of the definitions proves otherwise.
  - The definition of “health care provider” means any person or entity required by State or Federal laws or regulations to be licensed, registered or certified to provide health services. On its face, this includes all doctors, dentists, nurses, and other licensed medical professionals, hospitals, surgery centers, nursing homes, assisted living facilities, mental health and other rehabilitation facilities, and insurance companies.

- The definition of “non-economic damages” specifically includes damages from health care services or medical products. The bill further defines “medical product” as a drug, device, or biological product. Why cap damages at \$250,000 for medical products if the cap does not apply to the pharmaceutical industry?
  - The definition of “health care liability claim” includes all claims against a health care provider, which “are based upon the provision or use of (or failure to provide or use) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.” Why include medical products in this definition if provisions such as the non-economic damages cap, the elimination of joint liability, and the statute of limitations don’t apply to cases brought against drug and device companies for harm caused to patients?
  - If proponents wanted to limit the scope of the bill to medical malpractice claims, they could have done so. The bill text has no such limitations.
- **Definition of “Health Care Lawsuit” is Extremely Broad:** Proponents of H.R. 1215 may say that the bill is limited to patients receiving health care in which coverage was provided in whole or in part under a federal program, subsidy, or tax benefit as limiting the scope of the bill to traditional government-subsidized health insurance programs, such as Medicare and Medicaid. If that was really what they meant, then the bill would limit remedies to the elderly and poor. Is that what they really think?
    - Government touches health care in so many ways that another reading of the bill would include anyone who receives health care under Medicare, Medicaid, the Affordable Care Act, Veterans or military health plan, such as Tricare, COBRA, flexible spending benefits, an ERISA plan (pre-tax dollars); a multi-employer health care plan (pre-tax dollars); or a health savings plan (again, pre-tax dollars).
    - Because H.R. 1215 was rushed to committee consideration without so much as a single hearing, it is unclear what this definition actually means.

### **Specific Problems with H.R. 1215:**

**Section 2: Shorter Statutes of Limitations.** The legislation reduces the amount of time an injured patient has to file a lawsuit to three years after the date of injury or one year after the claimant discovered, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. Claims filed by minors must be brought within three years from the date of injury, except that a claim brought by a minor under the age of six years may be commenced within three years from the date of discovery of the injury or before the minor’s 8<sup>th</sup> birthday, whichever provides a longer period.

- This statute of limitations, which is much more restrictive than the majority of state laws, would cut off meritorious claims involving diseases with long incubation periods.
- Thus, a person who contracted HIV through a negligent transfusion but learned of the disease more than five years after the transfusion would be barred from ever filing a claim.
- The state flexibility language is not flexible. It would preempt any state law that provide for a period of time that is greater than three years after the date of injury or one year after the injury is discovered.

**Section 3(b): Arbitrary and discriminatory \$250,000 cap on non-economic damages.** The bill limits non-economic damages to \$250,000 in the aggregate, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury. *This cap is more restrictive than any state cap.*

- It is ridiculous to mandate that a damage cap apply to separate actions. If a patient is severely injured when his doctor leaves a foreign object in his abdomen during surgery, and the patient brings a claim against the doctor and hospital, but also brings a separate claim against his insurance company for subsequently failing to cover the operation under the terms of coverage of a valid insurance contract, why should these claims be limited by the same damage cap?
- Non-economic damages compensate patients for very real injuries such as the loss of a limb or sight, the loss of mobility, the loss of fertility, excruciating pain and permanent and severe disfigurement. They also compensate for the loss of a child or a spouse. These are very real damages, and juries are to calculate them fairly on a case by case basis.
- Caps on non-economic damages disproportionately affect women, children, the elderly, the disabled, and others who may not have substantial economic loss (i.e., lost wages or salary).

**Section 3(d): Elimination of joint liability for economic and non-economic damages.** The bill completely eliminates joint liability, preempting the law in many states. Under joint liability, injured patients are compensated fully for their loss.

- Joint liability enables an individual to bring one lawsuit against the entities responsible for practicing unsafe medicine or manufacturing a dangerous, defective product and have the defendants apportion fault among them, if the jury finds for the plaintiff. Our civil justice system has determined that it is the *injured patient*, not multiple negligent medical providers, who deserves the greatest measure of protection under the law.
- H.R. 1215, the “Protecting Access to Care Act” would eliminate joint and several liability for both economic and non-economic loss. This is very extreme. Not even California’s MICRA law eliminates joint liability for economic loss.
- Under joint liability, if a patient is injured during surgery at a hospital and the doctor is uninsured or underinsured, the remaining damages are paid by the hospital. This is a fairer approach and ensures that negligent providers—not taxpayers—are responsible for the patient’s injuries.
- States have rejected the elimination of joint liability for economic loss because it would shift the cost from negligent health care providers onto the taxpayers. When an injured patients’ economic loss remains uncompensated, the patient is forced to rely on taxpayer funded programs like Social Security Disability and Medicare, which provides health insurance to patients who have exceeded the insurance coverage of their own insurance policies.

**Section 4: Severe restrictions on contingent fees.** The bill gives the court power to restrict a patient’s attorney fees regardless of whether recovery is by judgment, settlement, or any form of alternative dispute resolution. The bill specifies that contingent fees, regardless of the number of plaintiffs, may not exceed: (1) 40% of the first \$50,000 recovered; (2) 33 1/3 % of the next \$50,000 recovered; (3) 25% of the next \$500,000 recovered; and (4) 15% of any recovery exceeding \$600,000.

- This is an unfair restriction on the right to contract. Congress should not be dictating the terms of the rights of patients to contract with attorneys for legal representation, especially

since no such restrictions are placed on corporate institutions, such as hospitals and nursing homes.

- It is unjust to restrict plaintiff's attorney fees when defendants have no such restrictions. Under the contingent fee system, lawyers are paid only if they are successful, and thus, plaintiffs' attorneys have a built-in incentive to accept and bear the costs of only the most meritorious cases.
- This provision is especially unfair in the context of claims against pharmaceutical and insurance giants, whose huge resources make it difficult to take them on, especially when their fees are unlimited.

**Section 5: Periodic payments of all future damages.** Allowing all future damages over \$50,000 to be paid periodically punishes meritorious patients who were injured by malpractice and unsafe products and leaves them vulnerable and under-compensated. Meanwhile, large insurance companies reap the interest accruing benefits of a patient's jury award.

**Section 6: Provides Immunity to the Pharmaceutical Industry.** This new provision grants immunity to any health care provider, which could include a doctor, dentist or other licensed medical service provider; a hospital, nursing home, or assisted living facility; a mental health treatment center, drug and alcohol rehabilitation facility, out-patient surgery center, or any other person or facility licensed to provide medical services for prescribing or dispensing a prescription drug by prohibiting such a provider from being named in a product liability lawsuit and specifying that these providers should not be liable in class action lawsuits involving medical products. What if the pharmacist, the dispenser of the product, is also the manufacturer, which is often the case in compounding pharmacies? What if the medical product manufacturer blames the doctor or hospital that cannot be named in the case for the patient's injuries, and the patient loses the lawsuit, instead barely surviving on Social Security Disability and Medicare? This provision simply shifts costs away from injured patients to taxpayers.

- The injured patient often doesn't know who is responsible for her injuries, just that she has been injured by a defective drug or medical device prescribed by her physician and wants answers. Frequently, it takes civil discovery to get these answers and properly ascertain who the responsible party truly is, and there are oftentimes multiple wrongdoers. However, H.R. 1215 would prevent certain parties from even being added to the lawsuit, much less held accountable, as long as a drug or medical device company is involved. This is just wrong.
- Health care providers are often named in product liability actions so that the pharmaceutical industry cannot place the blame on the empty chair—the doctor for prescribing the wrong product or the pharmacist for dispensing the wrong drug—for the patient's injury.
- When patients with life-altering injuries cannot hold wrongdoers accountable, they often rely on taxpayer funded programs, such as Social Security Disability and Medicaid, to survive.
- Here are some examples:
  - In 2012, a fungal meningitis outbreak killed 64 people and sickened more than 750 in 20 states across the country. This preventable tragedy was the result of contaminated steroid injections used to treat pain produced at the New England Compounding Center (NECC) in Massachusetts. The center used expired ingredients and failed to follow multiple sterilization procedures as required by law. The pharmacists and NECC employees made the medical product at the pharmacy and dispensed it to patients. Under the provision, the pharmacists cannot be named in a party to the

lawsuit with the pharmacy's owners, and the bill's prohibition on class actions makes the administration of justice impossible.

- The patient was injured by a defective hip implant, which was also positioned incorrectly during surgery, causing excruciating pain, and the device shed metal debris, destroying the hip muscle and tissue. Mr. Proper sued the doctor and his surgical practice along with Depuy Orthopaedics, the manufacturer of the hip, and Johnson & Johnson, the owner of the Depuy. If the doctor was not named as a party to Mr. Proper's injuries, Depuy would have blamed the doctor for the injuries, even though both the botched surgery and the defective implant contributed to the patient's injuries.<sup>8</sup>
- The patient was seriously injured by transvaginal mesh, a product used to treat urinary incontinence and organ prolapse that caused erosion and organ perforation. She brought claims against Boston Scientific, the manufacturers of the device, along with the hospital and doctor where the surgery was performed in Connecticut. While mesh has caused problems in countless numbers of women, the court also found valid state claims against the hospital and doctor for failing to warn and violation of the doctrine of informed consent. If the doctor and hospital were missing parties, the manufacturer could blame them for failing to warn of known dangers.<sup>9</sup>

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<sup>1</sup> Personal Health Care Expenditures taken from the Centers of Medicare and Medicaid Services and is \$3.2 Trillion (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>). Total spent on paying and defending medical malpractice claim from National Association of Insurance Commissioners (*Countrywide Summary of Medical Professional Liability*, National Association of Insurance Commissioners (NAIC), 2015), and is \$6 Billion. Percentages may not round up due to both rounding and the fact that CMS does not regard medical negligence costs as health care costs.

<sup>2</sup> Carrier, Reschovsky, Mello, Mayrell, and Katz, *Physicians' Fear of Malpractice Lawsuits Are Not Assuaged By Tort Reforms*, Health Affairs, 29 No. 9 (2010).

<sup>3</sup> A *Washington Post* investigation of Wellmark and Blue Cross and Blue Shield showed that in 2005, doctors at a medical clinic on the Iowa-Illinois border were ordering eight or nine CT scans a month. But after those doctors bought their own CT scanner, the numbers ballooned to 700 CT scans. A similar analysis of Wellmark data for doctors in the region found that after CT scans were purchased, the number of scans ordered was triple that of other area doctors. Vedantam, "Doctor Self-Referrals Part of Health-Care Cost Trend," *Washington Post*, July 31, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/07/30/AR2009073004285.html>; Hughes, Bhargavan, and Sunshine, *Imaging Self-Referral Associated With Higher Costs and Limited Impact on Duration of Illness*, Health Affairs, 29, No. 12 (2010); Baker, *Acquisition of MRI Equipment by Doctors Drives Up Imaging Use and Spending*, Health Affairs, 29, No. 12 (2010).

<sup>4</sup> Paik et al., *Damage Caps and Defensive Medicine, Revisited*, Journal of Health Economics (2017, Forthcoming) November 2016, [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2110656](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2110656).

<sup>5</sup> Paik et al., *Do Doctors Practice Defensive Medicine, Revisited*, Northwestern Law & Econ Research Paper No. 13-20; Illinois Program in Law, Behavior and Social Science Paper No. LBSS14-21, October 21, 2014.

<sup>6</sup> Paik et al., *Do Doctors Practice Defensive Medicine, Revisited*, Northwestern Law & Econ Research Paper No. 13-20; Illinois Program in Law, Behavior and Social Science Paper No. LBSS14-21, October 21, 2014.

<sup>7</sup> Fearful that a cap challenge to the constitutionality of the statute would be successful, the Indiana Legislature voted to raise the cap to 1.65 million in 2017 and 1.8 million in 2017. Governor Pence is expected to sign the bill into law. This is first increase to Indiana's damage cap in twenty years.

<sup>8</sup> *Proper v. Depuy Orthopaedics at el*, No: 11-0217-CV-W-SOW (May 13, 2011 W.D. MO) and No. 13-0977-CV-W-SOW (Dec. 3, 2013 W.D. MO).

<sup>9</sup> *Fajardo v. Boston Scientific Corp., at el*, No: 3:14-cv-1922-(SRU) (Jan, 5, 2015 D.C. CT).