

Critique of HB 2122 – Med Mal “Tort Reform”

A comparison of HB2122 to the Governor’s original proposal and other states actions

This summary highlights only some of the provisions. It does not cover the amendments to the Certificate of Merit provisions and only briefly discusses the provisions concerning physician discipline, the Patients Injury Fund and the limited tax credits.

- **Caps on Damages: §55-7B-8 places an absolute \$250,000 cap on non-economic damages.** This means that damages for the death of a child, homemaker or retiree will effectively be capped at \$250,000. Likewise, serious disfigurement, loss of the ability to have children, loss of a limb (or more than one limb) are all capped at \$250,000. (The cap will increase annually in an amount equal to the consumer price index.) The current cap is 1 million dollars.
- **The Governor’s bill** proposed a sliding scale of caps with a \$500,000 per person cap for death and more serious injury and disfigurement. His proposal followed the recent Ohio medical malpractice legislation.
- **Other States: The House bill is more extreme than recent legislation in other states.** The Governor’s bill follows the recent Ohio “tort reform.” Nevada adopted a \$350,000 cap on non-economic damages, but the Nevada law includes a provision that permits non-economic damages in excess of \$350,000 where there is gross malpractice or where *“the court determines, by clear and convincing evidence admitted at trial, that an award in excess of \$350,000 for non-economic damages is justified because of exceptional circumstances.”* Mississippi also adopted a \$500,000 cap on non-economic damages last year, but the Mississippi cap does not apply to damages for disfigurement and rises to \$1,000,000 by 2017. Thus, **the House bill will give WV the distinction of adopting the most draconian limits on the value of injury and death of any state that has recently addressed this issue.**
- **Problems:** Compensation is supposed to help a victim find some solace in a life that has been scarred by unnecessary injuries. This provision limits that loss to \$250,000 (less costs and attorney fees). **Many serious injuries do not involve economic loss.** For example, if negligent medical care causes the death of a child, the proposed legislation values the life of that child at an absolute maximum of \$250,000 -- no matter how painful the death or egregious the negligence. The same is true for a grandparent who dies due to negligent medical care in a nursing home. Similarly, a girl or young woman who has an unnecessary hysterectomy loses the ability to have children, but her loss is capped at \$250,000 (less costs and fees). A young man suffers an injury that impairs his ability to have an intimate relationship with his wife or to have children. Again, the cap is \$250,000. Is this fair compensation for the loss of the ability to have children, for serious disfigurement that alters the ability to enjoy life, for the loss of a

limb (or both limbs)? Under the legislation proposed by the House, it doesn't matter how severe the pain, how clear the negligence or how traumatic the injury to the victim, \$250,000 is it.

Given the cost of bringing these cases (expert witnesses often charge \$500-\$1000 per hour and plaintiff's counsel must pay for the plaintiff's experts, for the time spent taking the depositions of the defendant experts, for depositions and for travel to the various states in which the experts live) and the \$250,000 limit, plaintiff's attorneys will rarely if ever file cases unless there is a substantial economic loss. Thus children and seniors who have little economic loss to demonstrate will be effectively shut-out of any compensation whatsoever.

There may also be constitutional issues regarding a cap this low. In fact, some fear that the purpose of this rather draconian provision is to create an election issue that will be used against any justice who votes to hold the cap unconstitutional.

Collateral Source Provisions: § 55-7B-10 requires the deduction of certain "collateral source" payments from any verdict for the plaintiff. Under § 55-7B-2, the term "collateral source" is defined to include social security benefits, disability income benefits, workers compensation benefits, health insurance benefits and other types of benefits (except life insurance).

- *The Governor's bill does have a collateral source provision, but it does not include disability insurance benefits or social security benefits in its definitions and it does not apply to future medical expenses.*

Problems:

(1) This provision means that a person who paid for disability insurance to protect himself and his family will find that the doctor who injured him gets credit for the patient's own disability benefits, *i.e.*, the verdict will be reduced in the amount of the benefits (less some of the premiums).

Similarly, **the worker who worked all his life for social security benefits will learn that the doctor who disabled him will be able to deduct his hard earned social security disability benefits from the verdict. However, health insurance companies are protected. Health insurers and others with a lien on the plaintiff's verdict will be able to recover any payments they made to or on behalf of the plaintiff.**

(2) The proposed collateral sources are not limited to collateral source benefits received at the time of trial, but **deductions for prospective (future) collateral benefits are also included.** In other words, it appears that a defendant is allowed to introduce evidence that an individual will receive collateral payments in the future from sources such as health insurance or federally assisted programs such as Medicaid or Medicare.

Yet, an individual who has health insurance at the time of trial may lose his health insurance in the future due to an inability to pay the policy premiums, because of changes in coverage under the policy, or because the individual changes employment. Moreover, there is no guaranty that governmental programs that exist today will continue to exist unchanged in the future. *Thus, this future use of collateral sources is speculative, unworkable and provides a windfall to medical providers who may have negligently injured an individual.*

Elimination of Joint and Several Liability: § 55-7B-9 eliminates joint liability and expressly provides that “[t]he court may not enter joint liability against any defendant.” The jury is required to “consider the fault of all parties in the litigation including any settling party.” **Thus, if two parties are equally at fault and one has no insurance and goes bankrupt, the plaintiff will only be able to collect 50% of his damages – no matter how egregious the negligence may have been.**

- The Governor’s bill also eliminates joint liability. However, in the Governor’s bill, the jury does not include the settling party in determining the relative fault of the parties.
- **Problems:** Joint and several liability makes sense in most cases. Consider a non-medical example: a bar owner continues to serve an alcoholic, knowing he is drunk and that he is going to drive; he even helps him to his car. The drunk driver hits another car head-on while driving on the wrong side of the road. A teenager in the other car is paralyzed and faces millions of dollars in future costs for medical care, therapy, etc. The jury, under our comparative fault system, finds each of them 50% at fault. The drunk driver has an umbrella policy and is wealthy. He can afford to fully compensate the injured teenager. The bar owner forgot to pay his insurance premium, has few assets and files for bankruptcy. When the teenager asks the wealthy drunk driver to pay all of his damages, the drunk driver has an absolute defense to paying more than 50% of the damages under the proposed legislation. Without “joint liability,” the drunk driver only has to pay 50% of the loss since the jury split the “fault” between him and the bar owner. **The victim only gets half his damages.**

This problem occurs because “comparative fault” is not really an assessment of “fault” in the traditional sense. Rather, when the jury divides up “fault,” it is really deciding what percentage of the damage award each defendant should pay assuming that they all can afford to chip in their share. However, the system was never intended to allow one negligent party who was substantially responsible for the injury to avoid paying the full amount of the damage by saying, “*Sorry, I don’t have to pay the person I maimed because of someone else who helped me cause the injuries.*”

The House bill attempts to address this problem by making the State of West Virginia pay the difference through a **“Patients Injury Compensation Fund.”** **No one knows how much this will cost or how it will be funded.**

Currently, there is no joint liability in medical cases unless the health care provider was at least 25% at fault. There seems no good reason to change this. If political considerations demand a change, it makes more sense to raise the minimum fault level than to eliminate joint and several liability entirely.

Periodic Payment of Damages: The jury is required, by § 55-7B-11, to determine the medical and other expenses that will be incurred by the injured victim of medical negligence *for each year in the future*. § 55-7B-11(d) states that “[f]uture damages for medical and other related expenses shall be paid in the years that the trier of fact determines that they will accrue.” **Under this provision, the verdict form will require that the jury separately determine medical and other expenses for each year in the future. For a child, the resulting verdict form apparently will be over 70 lines long, one line for the medical expenses for each year in the future. The payments can only be made in the years that the jury determined they would accrue.** If the victim dies, the liability terminates. The defendant must fund these payments by an annuity or other funding plan approved by the court. If future payments are \$100,000 or less, this provision does not apply.

- **The Governor’s Bill did not include this provision.**
- **Problems: This provision appears unworkable.** Imagine a juror trying to figure out how much the malpractice victim will have to spend year by year for every year of life. In some cases, the expert can annualize some expenses, but in many cases the year in which the expense will accrue is uncertain. For example, consider the injured child who will have to have expensive surgery at some point in the future. The expert can only say that the surgery will be necessary between five and ten years in the future because it depends on how the child’s condition progresses. The jury is required to pick a year. **If the jury picks year eight, but the surgery turns out to be necessary in year four, there will be no money available for the surgery** because the statute expressly states that the future expenses will “shall be paid in the years that the trier of fact finds they will accrue.” § 55-7B-11 (d).
- **The main winners with this provision are the insurance companies.** The provision requires the issuance of an annuity or similar payment plan that allows the insurance company or a sister company to hold and invest the funds until they are due. Worse, **the Bill gives a windfall to medical liability insurance companies. If a plaintiff dies before the life**

expectancy found by the jury, the liability for future payments terminates. This is true even if the victim's death is a result of the original injury. On the other hand, **if a plaintiff outlives the life expectancy found by the jury, the plaintiff is precluded from receiving any future payments for the years beyond that calculated by the jury to be his normal life expectancy.** As such, the insurance carrier gets the benefit of an untimely death of a plaintiff, but is not required to make payments if a plaintiff lives beyond his life expectancy.

— **Trauma Care:** Under § 55-7B-13, all damages for care for “emergency condition” in designated trauma centers as well as for directly related follow-up care are limited to \$500,000. This includes economic and non-economic damages. The provision does not apply once the patient is stabilized and capable of receiving treatment as a non-emergency patient or to conditions unrelated to the original emergency condition. The definition of emergency condition in the House bill applies to “emergency care” in designated trauma centers:

“‘Emergency condition’ means any acute traumatic injury or acute medical condition which, according to standardized criteria for triage, involves a significant risk of death or the precipitation of significant complications or disabilities, impairment of bodily functions, or with respect to a pregnant woman, a significant risk to the health of the unborn child.”

· The Governor’s bill has a similar trauma limit although the definition of the medical care that falls within the scope of the \$500,000 limit is different. The definition follows:

“‘Traumatic injury’ means any acute wound or condition for which the patient is being treated in the trauma care unit of any health care facility designated as a trauma center by the Bureau for Public Health, Office of Emergency Medical Services. For the purposes of the limitations set forth in section thirteen, article seven-b of this chapter, such an acute wound or condition must be one which, according to standardized criteria for triage, involves both (A) a significant risk of death or the precipitation of significant complications or disabilities, impairment of bodily functions, or with respect to a pregnant woman, the health of the fetus, and (B) a trauma alert has been issued by the trauma care unit.”

Problems: Aside from the breadth of the definition of covered care and the question of how the State will pay for damages above the cap (under the House Bill), **will every emergency room qualify as a trauma center? Depending on the regulations defining "trauma center," this may be a limited provision or one that applies broadly to emergency rooms throughout the State.**

– **Expert Witness Requirements:** § 55-7B-7 requires an expert witness to devote $\frac{3}{4}$ of his or her professional time in the active practice of or teaching in his or her medical field of specialty. It also requires the expert to maintain a license in the same or a substantially similar medical field as the defendant.

• **The Governor’s bill does not require licensure in a specialty, require $\frac{1}{2}$ of the expert’s time in practice or teaching in the specialty, requires that the expert provide an affidavit to meet the requirement, and expressly excludes extrinsic evidence on the issue.**

• **Problems:** Many doctors have multiple specialties or varied practices. Setting an arbitrary percentage for professional time devoted to the specialty does not necessarily correlate with the expert's actual ability or knowledge, especially if the arbitrary standard is as high as $\frac{3}{4}$ of the expert's professional time. **Normally courts decide whether an expert is qualified on a case by case basis, not by the imposition of an inflexible standard applicable to all cases.** Moreover, there is no showing that the $\frac{3}{4}$ time requirement is related to any real measure of the minimum level of skill or ability required to provide expert testimony in a given specialty, let alone in each and every specialty. On the other hand, insurance companies know that, in the present environment, doctors are hesitant to testify as experts for victims in medical malpractice cases. *Thus, the $\frac{3}{4}$ time requirement can best be understood as an arbitrary rule designed to reduce the number of individuals eligible to testify as experts. (Note, the West Virginia Supreme Court has held that the courts, not the legislature, determines the standards for expert witnesses.)*

– **Loss of a Chance:** § 55-7B –3(c) provides that, where the case is based on the loss of a chance of recovery, the plaintiff must prove that the treatment which should have been rendered would have resulted in a “greater than fifty percent chance” of recovery.

• The proposed changes to 55-7B-3 also make significant alterations to the firmly developed West Virginia law regarding recovery for the loss of chance. *Thornton v. CAMC*, 305 S.E.2d 316 (W.Va. 1983); *Shia v. Chavasta*, 377 S.E.2d 664 (W.Va. 1989); and *Caplett v. MacQueen*, 375 S.E.2d 184 (W.Va. 1988). Under the current status of a claim brought under loss of chance, if an injured party in a medical malpractice action can prove by a preponderance of the evidence that the medical care provider’s acts or omissions have increased the risk of harm to the injured party, and such increased risk of harm was a **substantial factor** in bringing about the ultimate injury, then the defendant medical provider is liable for the ultimate injury. The amendment effectively abolishes this theory by requiring proof a “greater than 50% chance that the patient would have an improved recovery or would have survived.” § 55-7B-3(c).

If one can prove a “greater than 50% chance” of survival, one doesn’t usually need the loss of a chance theory at all.

For example, an individual appears at a hospital with classic signs of impending myocardial infarction. The hospital allows the individual to sit in the waiting room untreated; turns him or her away because they don’t have insurance or other means for payment of medical services; or even injects the individual with the wrong medication, any of which results in the death of the patient. If appropriately treated and timely care had been rendered, the patient would have a 49 percent chance of making a complete recovery. Under the amendments in subsection (c), that individual would be precluded from asserting a claim against the medical providers. **Practically, this proposed change provides complete immunity to any medical provider, no matter how gross, willful, or intentional their malpractice, if a patient when seen has a 50 percent or less chance of having an improved recovery or death. This change would virtually eliminate all failure to diagnose cases, including cancer, heart attack, and infectious disease claims.**

· § 55-7B-12 prohibits claims by individuals who are not patients of the health care provider in the absence of “reckless disregard.” This was not even in the Care Coalition bill. It may have been designed to prevent cases where the physician is sued for prescribing drugs to an addict who then causes injury to a third party.

Miscellaneous Other Provisions: The bill also provides various amendments to last year’s certificates of merit, and adds assisted living and related facilities to the definition of “health care provider.

There are a number of other differences in the bills. Both contain some form of relief for malpractice premiums. The House bill provides a tax credit against income taxes for 20% of the adjusted annual premium. This primarily helps those specialties with the higher premiums. The Governor’s bill allows a tax credit against the provider for a percentage of any tail policies and, in addition, a credit for those insured by BRIM based on either their annual premium or their tail.

Both provide doctors with a \$250,000 exemption if they file bankruptcy due, in part, to a medical malpractice verdict. (How likely is a bankruptcy given the provisions of either bill?)

The House Bill also proposes to study and implement a patient compensation plan to reimburse patients who don’t recover all of their damages due to the limit on damages for trauma care and the elimination of joint and several liability. However, no provision for funding is included. Finally, the House Bill provides some new disciplinary and reporting provisions.

Miscellaneous Points of Interest

- **There was substantial decrease in the filing of medical malpractice claims in 2002.** This appears related to the law requiring a “certificate of merit” that was passed in 2001 and went into effect in March 2002. As noted in an article in the *Daily Mail* on 1/17/03, a survey of the counties by Bill Druckman demonstrated that “... **224 medical malpractice suits were filed in the state last year. That's down more than 25 percent from 2001, when 309 were filed,** according to the survey.” The drop is even more dramatic if one compares the last nine months of 2002 (following the effective date of the Certificate of Merit law) with the last nine months of 2001. According to the survey, 225 suits were filed during the last nine months of 2001, but only 124 were during the same period in 2003.
- **The proposed legislation does not address the so-called frivolous lawsuit.** Instead, it sets harsh limits on the recovery in meritorious lawsuits such that, in most cases, no competent plaintiff’s attorney will make the financial investment necessary to pursue the claim.
- ***New England Journal of Medicine, December 17, 2002: According to a survey published in The New England Journal of Medicine, four of every 10 Americans and one of every three doctors say that they or their family members have been the victims of a preventable medical error, and nearly 10 percent say a family member has died as the result of a medical error.*** Contrast the doctors statements in this survey with the tendency of doctors to minimize the problem in the public discussion of “tort reform.”
- In explaining why the Patients Injury Compensation Fund won’t be expensive to the state, **Speaker Kiss told a public radio interviewer that there aren’t many large verdicts in West Virginia. If so, why do we need such draconian legislation?** The Speaker’s comments are available from public radio on tape.
- ***Nothing is done to reduce premiums now.*** The House bill is so extreme that it should lead to an immediate reduction in lawsuits even beyond the reduction that occurred in 2002. Yet, there is no mandate that the Insurance Commissioner reexamine rates. ***The House bill, combined with current premiums, is likely to give Medical Assurance windfall profits.***

Prepared for WV Consumers & Victims Coalition for Insurance Reform

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