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e doctors in states that cap damage payouts: noneconomic awards.(Practice Trends)

(N News, August 15, 2003, by Jennifer Silverman

ysician supply is 12% higher in states that impose limits on noneconomic damages than in those without caps, a study by the Agency for Healthcare Research and Quality said.

), states with caps on average had 135 physicians per 100,000 residents; states without caps had only 120 per 100,000 residents. In contrast, there was no statistically significant ace in physician supply in 1970 between states that would eventually adopt a cap and those that would not, according to the report.

half (24) of the states have laws that limit damage payments in malpractice cases. Most of the laws limit the amounts paid for noneconomic damages, but a few limit both iic and noneconomic damages. AHRQ found that states with relatively high caps were less likely to experience an increase in physician supply than states with lower caps.

end indicates that caps may have possibly increased the availability of physicians," said report authors Fred J. Hellinger, Ph.D., and William E. Encinosa, Ph.D., both of the agency cville, Md. The study adjusted for the impact of multiple factors that may affect the physician supply, such as per capita income and physician residency programs.

dy confirms the association between reasonable limits in medical lawsuits and the supply of physicians available to treat patients, Health and Human Services Secretary Tommy G. son noted in a statement. "It is critical that we fix this broken litigation system now."

Williams, legislative counsel with the advocacy group Public Citizen, wasn't as convinced of AHRQ's results. Mr. Williams said he did a similar study several months ago and io link between state caps on noneconomic damages and the geographic distribution of physicians.

-three percent of the variation in physician population can be attributed to two factors, the income of the area and population density," he told this newspaper. "Common sense that physicians want to live in desirable, affluent areas." Those factors have nothing to do with a cap on damages, Mr. Williams added.

nments run counter to the numerous reports of physicians leaving their practices or moving to other states to flee from rising malpractice premiums. The American Medical ition recently reported that states such as California, Louisiana, and Indiana have benefited from liability legislation that places limits on noneconomic damages.

are 18 states in a full-blown medical liability crisis," said Dr. Donald J. Palmisano, president of the AMA.

s time, Senate Democrats blocked Republican efforts to consider a bill introduced by Sen. John Ensign (R-Nev.) that contained a $250,000 cap on noneconomic damages. The bill lso have ensured that patients receive 100% percent compensation for their economic losses, including medical expenses, rehabilitation costs, lost wages, and more, if harmed by a in's negligence. The House approved a similar bill known as H.R. 5, the HEALTH Act of 2003 (Help Efficient, Accessible, Low-Cost, Timely Health Care) in the spring.

nts of the legislation thought the cap on noneconomic damages was too restrictive.

studies should examine whether or not physician supply is related to the length of time since a state law has been in effect, and whether or not other types of state tort reform laws those that eliminate or weaken the principle of joint and several liability are related to physician supply, AHRQ recommended. Researchers should also study how the level at oneconomic damages is capped is related to the supply of physicians.

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The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians

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Abstract

Researchers at the Agency for Healthcare Research and Quality (AHRQ) have examined the impact of different kinds of State laws in a number of previous studies. This study examines the impact of State legislation that caps damage awards in malpractice cases on decisions of physicians about where to practice medicine.

Twenty-four States now have laws that limit damage payments in malpractice cases. Most of these laws limit the amounts paid for noneconomic damages (e.g., pain and suffering) but a few limit both economic (e.g., medical expenses and lost wages) and noneconomic damages. There is currently a national debate on the desirability of extending caps on malpractice damage awards to all States, and President Bush recently introduced a proposal to cap payments for noneconomic damages in medical malpractice cases at $250,000.

Supporters of legislation to cap damages in malpractice cases maintain that it reduces malpractice premiums and helps insure an adequate supply of physicians. They also assert that escalating, multi-million-dollar jury awards are driving malpractice premium increases and that capping damage awards for pain and suffering helps restrain the rate of increase. Without such a law, it is asserted that the loss of affordable medical malpractice insurance for physicians could eventually lead to the loss of affordable, accessible health care. Opponents of this legislation maintain that insurance companies are trying to compensate for poor business decisions and fading investment income.

Although there is some evidence in the literature demonstrating that physicians in States with tort reform laws capping malpractice awards enjoy lower malpractice premiums, there is no evidence about the impact of malpractice cap legislation on decisions by physicians regarding geographic location. This study is the first to supply such evidence.

A simple comparison of the supply of physicians per capita between States that did and did not adopt a cap revealed that States with caps experienced a more rapid increase in their supply of physicians. In 1970, before any States had a law capping damage payments in malpractice cases, States that eventually adopted a cap and States that did not eventually adopt a cap had virtually identical levels of physicians per 100,000 citizens per county (69 vs. 67). Thirty years later in 2000, States that adopted a cap averaged 135 physicians per 100,000 citizens per county while States without a cap averaged 120.

Adjusting for a variety of factors in a multivariate regression model, we found that States with caps on noneconomic damages experienced about 12 percent more physicians per capita than States without such a cap. Moreover, we found that States with relatively high caps were less likely to experience an increase in physician supply than States with lower caps.

Introduction

In recent months, physicians in New Jersey, West Virginia, and Florida have conducted work stoppages in response to the rapid increases in malpractice insurance premiums and in support of legislation limiting payments for noneconomic damages in malpractice cases.[1,2] Malpractice premium rates for internists, general surgeons, and obstretrician/gynecologists increased 25 percent, 25 percent, and 20 percent, respectively, in 2002[3]; and last year, legislation limiting noneconomic damage awards in malpractice cases was signed into law in Nevada and Mississippi.

This year bills limiting noneconomic damage awards in malpractice cases have been signed into law in Ohio and in Texas.[4,5,6] There are now 24 States that have a law that caps noneconomic damages or a law that limits total damages:Alaska, California, Colorado, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Dakota, Ohio, South Dakota, Texas, Utah, Virginia, West Virginia, and Wisconsin. We include States that limit total damages only (Indiana, Louisiana, and Virginia), as well as Colorado, which has a law that imposes separate limits on economic and noneconomic damages, and New Mexico, which has a law that limits total damages less punitive damages and medical expenses.

Proponents of tort reform maintain that the size and frequency of large jury awards and settlements in medical malpractice cases is behind the rapid increase in malpractice insurance premiums and that legislation limiting damage awards is necessary to stem these increases. They also maintain that high malpractice rates are driving physicians out of business or to States where there is legislation capping malpractice awards.[7,8,9]

The market for medical malpractice insurance is volatile, and there have been numerous "crises" in this market over the past three decades.[10] In response to a crisis in the early 1970s, California passed the Medical Injury Compensation Reform Act of 1975 (MICRA) limiting noneconomic damages in medical malpractice cases. MICRA is often cited as a model for State legislation; and research has shown that between 1975 and 2000, malpractice premiums grew more slowly in California than they did in the rest of the Nation (167 percent vs. 505 percent).[11]

A recent publication of the American Medical Association (AMA) discusses the determinants of professional liability insurance (PLI) rates:[12]

> The increase in the frequency and amount of very large awards may be one of the significant drivers of the rapid escalation in PLI costs. If this is true, then one would expect, over time, that PLI rates in states that have effective damage caps would diverge from the PLI rates in states that have effective tort reform.

There is a sizable body of economic literature demonstrating that the legal environment in a State affects the frequency of malpractice claims and the size of the awards.[13] For examples, Zuckerman, Bovbjerg, and Sloan demonstrated that physicians in States with caps on damages in malpractice cases experience lower premiums than physicians in States without such laws.[14] Danzon found that damage awards in States with caps on damages were 23 percent lower than in States without caps.[15]

In another article, Kessler and McClellan examined the impact of tort reforms on the practice of defensive medicine and found that tort reforms such as reasonable limits on noneconomic damages, which have been in effect in California for 25 years, can reduce health care costs by 5 percent to 9 percent without substantial effects on mortality or medical complications.[16] Proponents of tort reform legislation emphasize that only 28 percent of physician payments for malpractice insurance are allotted to patients and that the remaining 72 percent are consumed by administrative and related costs.[17]

Opponents of tort reform legislation that caps damage awards in malpractice cases maintain that poor quality and poor investments by insurance companies are to blame for the recent spike in malpractice rates. They argue that caps will harm those patients who suffer the most damage and who need help the most, and that payments for medical malpractice claims are not the underlying cause of rapidly increasing malpractice premiums. A recent article states:

> "According to the Consumer Federation of America, the average pay-out by medical malpractice insurance companies is about $30,000 per claim and has been virtually unchanged for the last decade."[18]

Although there is little agreement about the underlying causes of increases in malpractice premium rates, there is little dispute that rapidly increasing malpractice premium rates have mobilized physicians and engendered considerable support for legislation limiting malpractice damage awards.[19] Increasing rates for malpractice premiums and calls for tort reform coincide with increasing concerns about access to care. A recent BlueCross/BlueShield publication adds:

> "What is not in dispute is that the medical liability problem has gained prominence at a time when public concerns about access to care and the cost of that care have re-emerged with new strength."[20]

Supporters of legislation capping malpractice damage awards maintain that this legislation is necessary to assure adequate access to health care. One newspaper article points out:[21]

> "The American Medical Association says patients' access to care already is seriously threatened in a dozen states and a crisis is looming in seven others because of rising premiums for malpractice insurance."

A 2003 report by the U.S. Department of Health and Human Services has stated:

"Increasingly, Americans are at risk of not being able to find a doctor when they most need one. Doctors have given up their practices, limited their practices to patients who do not have health conditions that are more likely to lead to lawsuits, or have moved to states with a fairer legal system where insurance can be obtained at a lower price."[22]

And, last year another article reported:

"Nationally, medical liability insurance rates have skyrocketed with several states facing a meltdown of their health care system as a result. In the states with the fastest-growing rates, doctors have begun 'running bare', without insurance coverage, or have left the state altogether."[23]

Background

Two types of liability are germane to this study: contract and tort.[24,25,26] Contracts are voluntary agreements entered into for significant benefit between parties, and contract liability involves implementing the provision of contracts. Contracts specify in detail the services that will be afforded, and the liabilities created by contracts are limited to the cost of the services specified in the contract (e.g., there are no punitive damages for breach of contract or liability for unanticipated outcomes following the breach of contract). This certitude and the limited liability required under contracts have been an effective mechanism by which to assist fruitful relationships among distinct contributors in our economic system, and courts have been hesitant to void the provisions of contracts between consenting parties.

Torts are civil wrongs where the injured person asks for monetary damages from an individual in a situation where there is no contractual relationship. Tort law sets in place public procedures about how people and businesses are anticipated to act toward one another. Most people who are engaged in a "learned profession" may be sued in tort for malpractice (e.g., negligence claims by patients against their physicians for malpractice are tort claims). Compensation in malpractice cases may consist of expenses for all harm endured by the patient counting medical care costs, lost wages, pain, and suffering, as well as punitive payments in situations where there was malicious intent.

Methodology

The theoretical structure underlying the empirical analysis in this study is that one of the factors taken into consideration by physicians in selecting a site to practice is the market for medical malpractice insurance.[27] In particular, it is hypothesized that physicians are more likely to settle in a State with a law that limits their exposure to malpractice damage awards.

One recent newspaper article maintains:

> "On a much broader level, it [the litigation crisis] brought new attention to a national problem that doctors say is obliging many of them to flee certain states or give up certain specialties – or the entire profession – because of skyrocketing insurance premiums linked to soaring jury awards."[28]

And another adds:

> "Yet while the doctors will be the ones to feel the pain first, it is the patients who will do the real suffering, perhaps, in the form of higher fees, and in declining health care as more doctors hang up their surgical gowns."[29]

Our model presupposes that factors affecting the demand for physician services also affect the geographic distribution of physicians. For example, recent research has shown that economic development measured by per capita income is positively correlated with physician supply across a variety of countries.[30] In our study, we presume that States with higher personal incomes are more desirable locations in which to practice because they have a higher demand for health services, and this, in turn, will result in higher physician incomes and a greater supply of physicians. For this reason, we include personal income in our model.

Similarly, we presume that States with higher unemployment rates are likely to have a lower demand for health services and this will result in lower physician incomes. As a result, we include a State's unemployment rate in our model.

Because of the longer distances involved in seeing patients and the relative scarcity of health care resources, it is assumed that physicians will be more likely to settle in more densely populated areas. In discussing States where physicians have a problem in obtaining affordable malpractice insurance, a recent newspaper article maintains:

> Larger malpractice claims mean higher insurance premiums and more money for trial lawyers. They also mean fewer doctors, particularly in the states most affected. Within those states, the hardest hit communities are rural, where a doctor's income is not enough to offset higher premiums. Those doctors will leave the small towns for the cities, leave the state for a more friendly environment or simply quit practicing.[31]

For this reason, we include a variable that measures the number of citizens (measured in thousands) per square mile for each State. Older persons have a greater demand for health care services than younger citizens due to the increased frequency of illness. Moreover, persons over the age of 65 are almost always covered by Medicare. Thus, it is hypothesized herein that physicians will be more likely to settle in areas with relatively high proportions of elderly citizens. Consequently, this study includes a variable that measures the proportion of each State's population that is 65 years or older.

The proportion of persons working on farms is assumed to be negatively related to the demand for health services. Farm workers are more likely to lack insurance and receive low wages and thus are expected to have little disposable income to spend on health care services. Consequently, a variable measuring the percentage of the State domestic product (i.e., a measure of the value of goods and services produced within a State) attributable to farm activities is included in the model.

This study estimates the impact of State laws limiting damage awards in malpractice cases on physician availability first using statewide aggregate data and then using county data. Physician availability is measured by the number of active, non-Federal physicians practicing in each State per 100,000 population using data provided by the AMA. The primary independent variable of interest is set equal to 1 if the State has a law that limits the level of damage awards and zero otherwise. That is, this variable is set equal to 1 for the 19 States listed in Table 1A (excluding Alaska).

The aforementioned variables are utilized in the analyses based on State data. The State-level analyses are conducted on State characteristics at four points in time: 1985, 1990, 1995, and 2000. To test the robustness of these State-level analyses, we perform an additional analysis at the county level for the final 5 years (1996-2000) using two additional control variables available for these years of county data.

First, in our county-level analyses, we use a variable set equal to 1 if a county has a hospital with a physician residency training program, and we hypothesize that this variable has a positive coefficient because medical residents are more likely to settle in areas where they have trained. We do not use this variable in the State-level analyses because every State has at least one hospital with a residency program.

Second, in the county-level analysis, we are able to control for the county's health maintenance organization (HMO) enrollment. We use a variable set equal to 1 if the county has high HMO penetration (an HMO enrollment above 30 percent) at the midpoint of the 5-year period: 1998. We hypothesize that physician availability will be lower for counties with high HMO penetration since HMOs tend to restrict patient access to doctors through closed networks. We do not use this variable in the State-level analyses because of the high correlation between population per square mile and HMO penetration.

Physician availability is measured by the number of active, non-Federal physicians practicing in each county per 100,000 population. In addition, in the county analysis, we derive a measure of rural influence from a variable constructed by the U.S. Department of Agriculture that is available in the Area Resource File (ARF). We hypothesize that this variable, which we refer to as "ruralness," is negatively related to the supply of physicians.

We also use a variable measuring the number of births per capita in each county. This variable measures the youthfulness of the population, and we hypothesize that it will have a negative coefficient in our equations.

A variable measuring the unemployment rate in each county also is included. However, we do not utilize a variable that measures the proportion of income attributable to farm activities because this information is not readily available for counties.

Finally, we also include a variable that is set equal to 1 if the county has an average annual temperature of 70 degrees or higher. We hypothesize that doctors may tend to set up practice in temperate climates of the country. Moreover, the elderly tend to retire to these areas, and they require a greater level of physician services.

We estimate our model using State data and then county data because these approaches have offsetting strengths and weaknesses. The empirical analyses utilizing State data provide information about the effectiveness of State laws limiting damage awards on the supply of physicians in each State. And, because we are interested in ascertaining the impact of State laws on physician supply in a State, the use of the State as a unit of observation is reasonable. However, models using State data provide a relatively blunt instrument to assess the impact of a law that limits payments for damages in medical malpractice cases because this approach obscures the impact of variables within specific markets within a State.

Analyses based on county data include information about counties with different characteristics within each State. Thus, analyses based on county data can tell us whether a county with a hospital that has a residency program has a larger supply of physicians than a county without such a hospital.

Moreover, the use of county data may be more appropriate than State data to the extent that the impact of specific variables is felt within each county rather than within each State. For example, the unemployment rate of each county (as opposed to the unemployment rate in the State) may be a better measure of the impact of unemployment on physician supply in a given county than the unemployment rate in the State. However, in cases where the market for physician care extends beyond a county's border, the use of the county as the unit of observation may distort estimates of the impact of the law.

Adjusting for the simultaneous impact of multiple factors (i.e., independent variables including the existence of a State law limiting malpractice damage awards) on the dependent variable is accomplished using multivariate linear regression analysis. Coefficients for the independent variables in our multivariate linear regression analysis are estimated using least-squares estimators (i.e., the estimated coefficients are obtained so that they result in the lowest sums of squares of the differences between the actual and estimated value of the dependent variable). This model is estimated under the usual assumptions that the relationship between the dependent and the independent variables is linear and that the error term is normally distributed.[32]

The robust standard errors in the county analysis are heteroskedasticity-consistent and are corrected for clustering at the county level. Influential outliers were removed from the county data: about 30 counties were dropped since they were coded with either less than

10 doctors per 100,000 residents or over 1,000 doctors per 100,000 residents. This was less than 1 percent of the county sample.

Data

Information about State medical liability laws was obtained from the National Conference of State Legislatures (NCSL),[33] the American Tort Reform Association (ATRA),[34] and from publications of a large law firm.[35] The NCSL provides a listing by State of all State medical liability laws that includes the type of reform implemented (e.g., limit on economic and noneconomic damage awards) and the specific legislation that enacted this reform. In 1994, the ATRA created a publication that displayed the status of each State law on medical liability. This publication has been updated several times since that time, and it is currently available on the ATRA Web site.

McCullough, Campbell & Lane is a large general practice law firm located in Chicago with a specialty in insurance law, and this firm publishes a compendium of all legislation relating to medical malpractice for each state. This compendium is available on the McCullough, Campbell & Lane Web site (http://www.mcandl.com/states.html).

These data sources were used to ascertain the date of the legislation enacting state laws that limit damage awards in medical malpractice cases (see Table 1A). Five States enacted legislation capping awards before 1985, and the dummy variable for the cap variable in our 1985 data set was set equal to 1 for each of these five States. Each of these laws was enacted in 1975 or 1976 in response to the medical malpractice crisis in the early 1970s.

Ten States enacted laws implementing damage caps in malpractice cases in 1985 or 1986 in response to the medical malpractice crisis in the early 1980s. The 1986 Alaska law was exceptional among these laws because it excluded cases involving physical impairment or severe disfigurement, and it is uncertain how many malpractice cases were subject to this exclusion. In any event, we excluded Alaska from our analyses because of this ambiguity and because the empirical relationship between factors affecting physician decisions whether or not to locate in Alaska is likely to be quite different from this relationship for other States. The dummy variable for the cap variable in our 1990 data set was set equal to 1 for each of the nine States (excluding Alaska) that adopted caps in 1985 or 1986.

Two States implemented legislation capping damages in 1988, one in 1990, and two in 1995. Thus, we set the dummy variable indicating the existence of a law limiting damage awards to 1 for the 19 States with such a law (excluding Alaska) in our 1995 data set and we set this variable equal to 1 for the same 19 States in our 2000 data set (see Table 1A for a list of the States).

Data on State characteristics for the years 1980, 1990, 1995, and 2000 are used in our model, and these data were obtained from various issues of the *Statistical Abstract of the*

United States. The following paragraphs define each variable and indicate the underlying data source.

The variable population per square mile of land area was derived from data on each State's population and its number of square miles as provided by the U.S. Census Bureau (U.S. Department of Commerce).[36] The U.S. Census Bureau issues State population estimates that are updated annually and are based on the preceding decennial census as well as other more limited surveys. Data on proportion of the population 65 years or older for each State were obtained from the U.S. Census Bureau.

Data on State unemployment rates were obtained from the U.S. Department of Labor's Current Population Survey (CPS).[37] The CPS is a monthly, random, national survey of the noninstitutionalized population in the United States. About 50,000 households are sampled each month.

Data on mean State per capita personal income were obtained from the various issues of the *Survey of Current Business*, a publication of the Bureau of Economic Analysis, U.S. Department of Commerce.

Data on the proportion of the State domestic product attributable to farm income also were obtained from reports issued by the U.S. Department of Commerce.[38] Farm income comprises cash receipts from the marketing of crops and livestock as well as government payments made directly to farmers for farm-related activities.

Information about the number of hospital beds in each State was obtained from data published by the American Hospital Association (AHA).[39] The AHA provides information about the number of hospital beds in non-Federal, short-term community hospitals in each State that are acceptable for registration with AHA.

The data in our county analyses were obtained from the 2002 Area Resource File. The ARF is maintained by Quality Resource Systems, Inc., under contract with the Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services. The ARF is a county database that includes statistics on health facilities, health professions, economic activity, and health training programs. Just as in the *Statistical Abstract of the United States*, the ARF uses existing data sources. Indeed, in many instances, the *Statistical Abstract of the Unites States* and the ARF use the same underlying source of data.

The dependent variable in both our State-level and county-level analyses is the number of active, non-Federal physicians per 100,000 civilians residing in each State. Both the *Statistical Abstract of the Unites States* and the ARF obtain the number of active, non-Federal physicians from the AMA.[40] AMA publications contain information about the professional and individual characteristics of all practicing physicians.

Data on the population in each county are based on publications of the U.S. Bureau of the Census. Data on births in each county were obtained from the National Center for Health

Statistics, Centers for Disease Control and Prevention (CDC), and data on the unemployment rate in each county were provided by the U.S. Department of Labor.

Results

There are 196 observations for each variable in our analyses of State data (observations for 49 States at four points in time), and Table 2 presents a list of the variables and their respective means. The average number of active, non-Federal physicians practicing per 100,000 residents in each state was 208, and the average percent of the population in each State over the age of 65 is 13 percent. The average unemployment rate is 5.53 percent, and the average number of beds per 1,000 residents is 4.03.

Observations from each of the four time periods in our analyses (1985, 1990, 1995, and 2000) from each of the 49 States in our sample were combined to estimate the impact of State laws that limit payments in malpractice cases on physician availability. Table 3 presents the estimates of the coefficients of each variable derived using ordinary least squares estimation techniques. The coefficients of the independent variables in the equation were estimated using 196 observations, and the independent variables explain 52 percent of the variation between the square of the difference between the estimated and actual value of the dependent variable.

All variables entered the equation with the expected signs, and all but one were statistically significant at a 95-percent confidence level. The coefficient for States with a cap on damage awards in malpractice cases is about 24 (Table 3). This implies that States with a cap average 24 more physicians per 100,000 residents than States without such a cap. Thus, States with caps have about 12 percent more physicians per capita than States without a cap (12% = 24/208).

The coefficient for the variable measuring the proportion of the population 65 years of age or older in Table 3 indicates that States with a greater proportion of elderly citizens have more physicians. For each percentage-point increase in the age variable, the number of physicians per 100,000 residents increased by about 5. Thus, we would expect Florida, which averaged 18.5 percent of its population 65 years of age or above, to have about 42 more physicians per 100,000 residents than Georgia, which averaged 10.2 percent of its population age 65 or older over the four time periods.

Table 3 also shows that a 1-percentage-point increase in the unemployment rate was associated with a decrease in over 6 physicians per 100,000 residents, and that a 1-percentage-point increase in the proportion of a State's domestic product attributable to farm activities was associated with a decrease of about 5 physicians per 100,000 residents. Income was positively related to physician availability as hypothesized, and an increase of $1,000 per year in income was related to an increase of slightly more than 1 physician per 100,000 residents.

Population density as measured by the number of residents in thousands per square mile was also positively related to physician supply as anticipated, and an increase of 1,000

residents per square mile in a State was associated with an increase of about 17 physicians per 100,000 residents.

Table 4 presents estimates of coefficients after including dummy variables for three of the four time periods (1990 is the reference time period). This model also was estimated using the ordinary least squares regression technique, and the coefficients for each of the three nonreference time periods were statistically significant. Nevertheless, the size and sign of the coefficient for the variable for States with a law capping damage awards were still positive, statistically significant, and of similar magnitude as that in the model with time variables.

Indeed, the magnitude of the coefficient for the damage caps variable was robust across a diversity of models. In each of four equations that was estimated using data from a single time period (results not reported here), the coefficient for the damage cap variable was positive and was only slightly less than the coefficient in the combined runs. Furthermore, the coefficients were statistically significant in three of the four equations.

We also estimated our model setting the independent variable for caps equal to 1 only for States listed in a 2003 report by the U.S. Department of Health and Human Services with a cap on noneconomic damage awards of less than $350,000 (California, Hawaii, Indiana, Michigan, Montana, New Mexico, North Dakota, South Dakota, Utah, and Wisconsin)[41] and zero otherwise. We then estimated our model where the dummy variable was equal to 1 for the other nine States with a cap on malpractice damage awards above $350,000 (Colorado, Idaho, Kansas, Louisiana, Maryland, Massachusetts, New Mexico, Virginia, West Virginia) and zero otherwise. We found the coefficient for the cap variable in each of these models to be positive, but it was statistically significant only in the model where the dummy variable was equal to 1 for States with a cap on noneconomic damages of less than $350,000.

Variables with coefficients that are not statistically significant are considered to have effects that are not distinguishable from a zero-effect. Thus, a State that passes legislation capping payments for noneconomic damages in malpractice cases at relatively high levels might not realize an increase in the number of physicians practicing in the State.

Ohio, Oregon, and Texas had provisions that set limits on noneconomic damages in malpractice cases that were struck down by their State Supreme Court, and these limits were in effect for more than 4 years.[a] We estimated our State data model setting our cap variable equal to 1 during the time periods the State law capping noneconomic payments in malpractice cases was in effect for Ohio, Oregon, and Texas in addition to setting it

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[a] Alabama, Florida, Idaho, Illinois, and Washington also had statutes overturned but they were in effect less than 4 years. Idaho overturned a statute that capped noneconomic damages that applied only to medical liability cases, but another statute that capped noneconomic damages in all liability cases was passed and is still in effect.

equal to 1 for our original 19 States. The coefficient for the cap variable remained positive, significant, and of similar magnitude.

While the State data provided a picture of liability caps over the years 1985, 1990, 1995, and 2000, we next used county data to provide a finer, more detailed analysis of the final 5-year period: 1996-2000. Table 5 presents the means of each of the variables used in our analyses based on 14,640 observations from county data over the 5 years from 1996 through 2000.

The average number of physicians per 100,000 population was 117 over this time period. This figure is significantly lower than the 208 physicians per 100,000 that we found in our analyses of State data from 1985, 1990, 1995, and 2000. The reason for this is that most counties are rural with a low number of doctors; and since each county has equal weight in the county analysis, the average number of doctors per 100,000 population across all counties (117) is lower than the average number of doctors across all States (208), which is skewed upward by the highly populated metropolitan areas of the State.

Table1A lists the number of physicians per 100,000 county residents State by State for States that had caps in the year 2000. In contrast, Table 1B lists the number of physicians per 100,000 county residents State by State for States that either did not have caps or had their caps overturned in court. Table 5 shows that about 10 percent of all counties had a hospital that operated a residency training program, and the average unemployment rate was 5.3 percent. About 22 percent of counties had a high HMO enrollment rate (i.e., an HMO penetration rate greater than 30 percent).

Table 6 presents results using county data for the years 1996 through 2000. The coefficient for the variable of interest is 13.65. That is, counties in States without caps have 111.83 doctors per 100,000 population, while counties in States with caps have 13.65 more doctors per 100,000 population (i.e., 125.48 doctors) (The mean number of doctors—111.83 in noncapped States and 125.48 in capped States—is simulated from a linear prediction of the regression results in Table 6.) Thus, States with caps have 12.2 percent more doctors per county than States without caps (i.e., 12.2%=13.65/111.83). This county coefficient is about half the absolute size of the coefficient found using State data because the number of doctors per 100,000 residents is lower at the county level than at the aggregate State level. However, the percentage impact is about the same (12 percent). The coefficient of each of the other variables in the equation was of the expected sign, and all coefficients were statistically significant at a 99 percent level of confidence.

Discussion

Between 1970 and 2000, the supply of physicians per capita increased at a faster rate in those States that passed tort reform laws that capped damage payments in malpractice cases (see Tables 1A and 1B). In 1970, before any States had enacted caps, the average number of physicians per 100,000 population per county was 69 in States that eventually

enacted caps between 1970 and 2000, compared with 67 in States that never enacted caps. This difference (69 vs. 67) is statistically insignificant (P=0.22). However, by the year 2000, the States that had enacted caps had a significantly higher number of doctors per 100,000 population per county (135) compared with States that did not enact caps (120) (P=0.006).

This trend indicates that caps may have possibly increased the availability of physicians. To examine whether this was indeed the case, we controlled for other State and county characteristics that may have also impacted physician availability (such as medical residency programs, HMO penetration, etc.). In particular, this study utilizes information about such numerous State characteristics in the years 1985, 1990, 1995, and 2000, as well as information about numerous county characteristics in 1996, 1997, 1998, 1999, and 2000 to ascertain the relationship between State tort reform laws that cap damage payments in malpractice cases and the supply of physicians. This study finds evidence supporting the claim that States with caps on noneconomic damages awards or caps on total damage awards benefit from about 12 percent more physicians per capita than States without such laws.

This evidence was derived first in analyses where the State was the unit of observation and then in analyses where the county was the unit of observation. We found that the magnitude of the impact of laws limiting damage payments using State data and county data was similar. Furthermore, we found that the magnitude of the coefficient of the variable representing the existence of a State law limiting damage payments was similar across various specifications of each type of model. The robustness of this finding supports the argument that State laws limiting noneconomic damages in medical malpractice cases increase the number of physicians who practice in the State.

Nevertheless, this study has limitations. First, there are factors other than those included in our model that affect the supply of physicians. For example, the proportion of the population without health insurance is likely to be related to physician supply through its influence on the demand for physician services. Nonetheless, the proportion of people without health insurance is likely related to the unemployment level in a State as well as to the proportion of its production attributable to farm activities. Thus, there are variables in our analysis that are likely to account for at least some of the influence of these omitted variables. In any event, the variables in our model explain more than half of the variation around the mean in our State analyses, and this is quite large for a model that is estimated with predominantly cross-sectional data.

Second, there are other State laws that may affect physician location decisions. For example, some States have passed laws that permit awards in malpractice cases to be made over a period of time (i.e., they permit periodic payments) and laws that eliminate or weaken the "joint and several liability" principle (the common rule of joint and several liability calls for losing defendants to pay all the damage in spite of their level of fault). Although such laws may be related to the decision of a physician on whether or not to practice in a given geographic area, these types of laws are not nearly as conspicuous as laws that cap payments. Previous research has shown that laws that indirectly affect the

level of malpractice damage awards (e.g. laws permitting periodic payments) have less impact on malpractice premiums than laws that directly limit malpractice damage awards.[42]

Finally, this study employs State and county data. Consequently, there may be problems with aggregation bias (i.e., the relationships that exist at the individual level may be obscured when observations are viewed as a group).[43,44] There is, however, justification for estimating an equation using State and county data because the independent variable of interest in this study is whether or not a State has a law that limits damage awards in malpractice cases, and we are interested in the impact of this type of State law on the supply of physicians.

Although it is not possible to conduct a randomized trial to confirm the findings of this study, future studies should include more variables and utilize data from more time periods. Future studies also should focus on important questions such as: how the level at which noneconomic damages is capped is related to the supply of physicians; whether or not physician supply is related to the length of time since the law has been in effect; and whether or not other types of state tort reform laws such as those that eliminate or weaken the principle of joint and several liability are related to physician supply.

Table 1A: Supply of physicians in States with caps on malpractice awards for noneconomic damages: 1970-2000[a]

States with caps in 2000	Year cap law was passed	Doctors per 100,000 county residents in 1970	Doctors per 100,000 county residents in 2000	Percent increase in supply of doctors
Alaska	1986	66	130	97.0%
California	1975	127	187	47.2%
Colorado	1990	74	140	89.2%
Hawaii	1986	108	239	121.3%
Idaho	1990	70	95	35.7%
Indiana*	1975	61	108	77.1%
Kansas	1988	66	97	47.0%
Louisiana*	1975	55	112	103.6%
Maryland	1986	98	239	143.9%
Massachusetts	1986	163	331	103.1%
Michigan	1986	71	125	76.1%
Missouri	1986	51	82	60.8%
Montana	1995	69	131	89.9%
New Mexico*	1976	65	119	83.1%
North Dakota	1995	60	125	108.3%
South Dakota	1986	57	110	93.0%
Utah	1986	62	109	75.8%
Virginia*	1976	66	215	225.8%
West Virginia	1986	68	124	82.4%
Wisconsin	1985	67	137	104.5%
Average supply of doctors in all States with caps in 2000:		69	135	95.7%

[a]States that overturned their caps are not listed here (see Table 1B for overturned caps).

* Cap on total damages.

Sources: National Conference of State Legislatures (33, 10), American Tort Reform Association (34), McCullough, Campbell and Lane (35), U.S. Department of Health and Human Services (22), and the 2002 Area Resource File of the Health Resources and Services Administration, U.S. Department of Health and Human Services.

Table 1B: Supply of physicians in States without caps on malpractice awards for noneconomic damages: 1970-2000[a]

States without caps in 2000	Year cap law was passed	Doctors per 100,000 county residents in 1970	Doctors per 100,000 county residents in 2000	Percent increase in supply of doctors
Alabama	1987, overturned	45	98	117.8%
Arizona	no cap	68	120	76.5%
Arkansas	no cap	52	92	76.9%
Connecticut	no cap	136	273	100.7%
Delaware	no cap	100	203	100.3%
Florida	1988, overturned	75	150	100%
Georgia	no cap	51	104	103.9%
Illinois	1995, overturned	62	108	74.2%
Iowa	no cap	69	89	29.0%
Kentucky	no cap	53	99	86.8%
Maine	no cap	85	196	129.1%
Minnesota	no cap	75	126	68.0%
Mississippi †	no cap	51	94	84.3%
Nebraska	no cap	61	113	85.3%
Nevada †	no cap	77	96	24.7%
New Hampshire	no cap	141	263	86.5%
New Jersey	no cap	115	250	117.4%
New York	no cap	128	212	65.6%
North Carolina	no cap	72	153	112.5%
Ohio †	overturned twice	67	120	79.1%
Oklahoma	no cap	54	73	35.2%
Oregon	1987, overturned	79	148	87.3%
Pennsylvania	no cap	95	192	102.1%
Rhode Island	no cap	99	299	202.0%
South Carolina	no cap	56	128	128.6%
Tennessee	no cap	50	106	112.0%
Texas †	1977, overturned	60	89	48.3%
Vermont	no cap	117	231	97.4%
Washington	1986, overturned	77	142	84.4%
Wyoming	no cap	81	135	66.7%
Average supply of doctors in all States without caps in 2000:		67	120	79.1%

[a]The term 'overturned' indicates that the State's Supreme Court found the cap on noneconomic damages to be unconstitutional.

† Cap later passed in 2002 or 2003.

Sources: National Conference of State Legislatures (33, 10), American Tort Reform Association (34), McCullough, Campbell and Lane (35), U.S. Department of Health and Human Services (22), and the 2002 Area Resource File of the Health Resources and Services Administration, U.S. Department of Health and Human Services.

Table 2. State data: Variable means
(1985, 1990, 1995 and 2000 data; N = 196)

Description of variable	Mean
Number of physicians per 100,000 residents	208.37
Percent of population age 65 years or older	13.08
Hospital beds per 1,000 residents	4.03
Percent of population unemployed	5.53
Population in thousands of residents per square mile of land area	.58
Personal income in thousands of dollars	13.158
Farm income as percent of State domestic product	2.90
State law capping damage awards in malpractice cases (1=yes, 0=no)	.28

**Table 3. State data: Ordinary least squares (OLS) estimates—
Number of physicians per 100,000 residents**
(1985, 1990, 1995, and 2000 data; N = 196)

Explanatory variable	Coefficient	Standard error	t statistic
Intercept	172.56	25.81	6.65
Percent of population age 65 years or older	5.18	1.49	3.47
Hospital beds per 1,000 residents	-.04	.02	-1.58
Percent of population unemployed	-6.45	1.77	-3.65
Population in thousands of residents per square mile	17.37	2.28	7.63
Personal income in thousands of dollars	1.33	.37	3.60
Farm income as percent of State domestic product	-4.97	1.08	-4.59
State law capping damage awards in malpractice cases (1=yes, 0=no)	23.90	6.32	3.78

- Adjusted R^2 = .52.

Table 4. State data: Ordinary least squares (OLS) estimates—
Number of physicians per 100,000 residents
(1985, 1990, 1995, and 2000 data with dummy time variables; N = 196)

Explanatory variable	Coefficient	Standard error	t statistic
Intercept	104.54	30.08	3.47
Percent of population age 65 years or older	3.89	1.78	2.19
Hospital beds per 1,000 residents	-.03	.03	-1.02
Percent of population unemployed	-4.59	1.92	-2.39
Population in thousands of residents per square mile	16.67	2.20	7.58
Personal income in thousands of dollars	5.00	.96	5.21
Farm income as percent of state domestic product	-4.20	1.09	-3.81
State law capping damage awards in malpractice cases (1=yes, 0=no)	**23.99**	**6.21**	**3.86**
1985 (1=yes, 0=no)	24.08	10.98	2.19
1995 (1=yes, 0=no)	-16.08	8.80	-1.83
2000 (1=yes, 0=no)	78.96	21.50	3.67

- Adjusted $R^2 = .58$.

Table 5. County data: Variable means
(1996, 1997, 1998, 1999, and 2000 data; N =14,640)

Description of variable	Mean
Number of physicians per 100,000 residents	116.84
Residency = 0/1, =1 if county had a hospital with a residency training program in 2000	.10
Percent of population unemployed	5.33
Births = number of births per 100,000 residents	1305.80
Rural, measures degree of "ruralness" of county on scale (0 = least rural, 9 = most rural)	5.43
High HMO penetration (above 30 percent) (1=yes, 0=no)	21.7
Temperate climate (average temp>70 degrees) (1=yes, 0=no)	.04
State law capping damage awards in malpractice cases (1=yes, 0=no)	.37

Table 6. County data: Ordinary least squares (OLS) estimates— Number of physicians per 100,000 residents

(1996, 1997, 1998, 1999, and 2000 data with dummy time variables; N =14,640)

Explanatory variable	Coefficient	Standard error	t statistic
Intercept	167.49	7.80	21.47
Residency program in hospital in county (yes = 1, no = 0)	169.68	8.80	19.30
Percent of population unemployed	-285.53	44.70	-6.39
Births per 100,000 population	-0.02	0.005	-3.84
Measures of rural influence (0 = least rural, 9 = most rural)	-8.19	0.65	-12.57
High HMO penetration (above 30 percent)	18.87	4.43	4.26
Temperate climate (average temp>70 degrees)	60.50	15.89	3.81
State law capping damage awards in malpractice cases (1=yes, 0=no)	13.65	3.30	4.13
1997 (1=yes, 0=no)	2.29	.39	5.91
1998 (1=yes, 0=no)	4.66	.60	7.74
1999 (1=yes, 0=no)	6.11	.72	8.44
2000 (1=yes, 0=no)	7.20	0.96	7.53

- R^2 = .42. Robust standard errors are corrected for clustering at the county.

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THE WEISS RATINGS REPORT ON MEDICAL MALPRACTICE CAPS
Propagating the Myth That Non-Economic Damage Caps Don't Work

On June 3, 2003, Weiss Ratings, Inc. published a report regarding the performance of the medical malpractice insurance industry entitled *Medical actice Caps The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage* .[1] The recommendation of the report is that "Legislators should put proposals involving non-economic damage caps on hold until convincing evidence can be ced to demonstrate a true benefit to doctors in the form of reduced med mal costs."[2] Unfortunately, the Weiss report is ill conceived, and misleads the r by falsely demonstrating that non-economic damage caps have not worked. Both of the data sources used by Weiss have gone on record eeing with the report's methodology, as described herein.

The conclusions drawn by Weiss are opposite of those previously published by reputable entities, such as the Congressional Budget Office, US tment of Health and Human Services, Joint Economic Committee of the United States Congress, Standard & Poors, American Academy of Actuaries, hast, and Milliman, USA, to name a few (see Appendix A). Unlike Weiss, all of these highly respected organizations have considerable experience and tance by government and industry for their knowledge and analytical product.

The purpose of this document is to evaluate Weiss' use of the data and analytical process. In short, Weiss misuses published industry data in an to demonstrate that non-economic damage caps enacted by several states have not been effective in reducing medical malpractice premiums in those as compared to states without caps. Weiss underestimates the "average" claim costs for the two groups of states by employing inappropriate ical technique to represent the burden on insurers. This is an error that is readily obvious to those who work with medical malpractice claims data, and eads the reader to an inappropriate conclusion.

' DID WEISS DO WRONG?

ing the States

Weiss has grouped 19 states as having caps on non-economic damages, and 32 others (including the District of Columbia) as not having caps. unately, states with effective caps, such as California with a $250 thousand cap, are considered the same as states having various levels of caps up to cluding $1 million. In fact, only 5 of the 19 states have a $250 thousand dollar cap similar to that being proposed under current legislation[3]. Eleven of ates have caps of $500 thousand or greater. No attempt has been made to evaluate the effectiveness of caps at various levels, they have simply been d together. The American Academy of Actuaries has testified that caps are a key element of tort reform, and must be set at a level low enough, such as)00, to have an effect.[4] Any comparison chosen to demonstrate the effectiveness of non-economic damage caps should be sensitive to the level of n the various states and to their individual effectiveness.

In addition, as clearly shown on Appendix 1 of the Weiss report, more than half of the states enacting non-economic damage caps had not done so ɔ the baseline date of 1991. Weiss compares premiums and claims costs for only two years, 1991 and 2002. The caps enacted in 10 states were not :e in 1991, and thus, these states should not be included in the "cap states" category for this analysis. Two other states had only adopted their caps in and the beneficial effects of these laws may not have been recognized in the data by 1991 due to constitutional challenge and uncertainty about the te effects of the caps.[5]

ıring the Premiums

Weiss uses the annual insurance rate surveys published by *Medical Liability Monitor* (MLM) for three medical specialties[6] as the source of nce premium data. He calculates median average premiums by state and then calculates a median premium for 1991 and 2002 for the two groups of

For example, Alabama had two insurers listed in the 2002 study, each with a premium for the three specialties. Weiss simply ranks the premiums ɜast to most, and then selects the middle value (or mean average of the two middle values when there is an even number of rates) as the median ȝe value, as shown below.

MEDICAL LIABILITY MONITOR RATE SURVEY DATA
ALABAMA

Insurer	Specialty	1991 Rate	2002 Rate
FPIC[7]	Internal Med	N/A	$ 6,043
ProAssurance[8]	Internal Med	$ 5,008	6,806
FPIC	Gen Surgery	N/A	19,286
ProAssurance	Gen Surgery	25,629	27,694
FPIC	OB/GYN	N/A	36,506
ProAssurance	OB/GYN	45,368	38,873
Median		25,629	23,490*

*calculated as the mean average of $19,286 and $27,694

Alabama was selected for this discussion simply because it is alphabetically the first state. However, these data demonstrates many reasons why the use of the median is improper:

(Data for different insurers are used for the two comparison years.

(The median value is representative of only general surgery rates because general surgery rates are always higher than internal medicine and lower than OB/GYN.

(Because two carriers are represented in 2002 and only one in 1991, the median value chosen by Weiss (the average of the two general surgery rates) is actually lower than the 1991 rate. However, the actual general surgery rates for the only carrier shown for both years increased – the opposite of Weiss' result.

(The premiums shown are not adjusted for various discounts or surcharges, and do not reflect any dividends which may have been paid back to policyholders, thus reducing their total outlay. Medical malpractice insurers paid substantial dividends in the 1991 era, which had been largely reduced by 2002 due to industry losses.

Using the product of this calculation to represent insurance industry revenues is flawed for many additional reasons. First, there is no certainty that any able rates listed in MLM are actually charged. Carriers may have a premium filed in a given state (or in multiple territories in states), but may not write usiness there. Weiss' analysis gives no weight to the actual amount of insurance sold by the various companies in any state, nor does it reflect nts or surcharges which are routinely applied to standard premiums. In addition, many insurers pay policyholder dividends, which in effect reduce the premiums paid.

MLM has objected to Weiss' misuse of its data. In a July 7, 2003 email to Senate Majority Leader Frist, MLM Editor Barbara Dillard states "We believe it ading to use median annual premiums compiled with data from Medical Liability Monitor to demonstrate the effect of non-economic damage limits on rates."

The Weiss analysis only includes premium data for three medical specialties, thus ignoring the experience for all of the rest. Even more glaring is the t the MLM data does not exist for seven of the capped states and five of the non-capped states for 1991. But, this did not stop Weiss from irresponsibly g these states in the analysis (see Weiss's Appendix 1 and 2).

An analysis using actual premiums as reported to the National Association of Insurance Commissioners (not medians) is helpful in evaluating ces between states having effective damage caps throughout the period of Weiss' analysis and those without. Such premiums include surcharges counts which may have been applied to standard rates.

The four states having a $250,000 cap prior to 1991 (CA, CO, IN, KS) saw their total premiums increase by 28.0% between 1991 and 2001 (2002 data ilable yet). States not having the $250,000 non-economic damage cap experienced a collective 47.7% increase in premiums, over 70% greater. See lix B for details. This wide gap in premiums actually collected compares inversely to Weiss' faulty conclusion that annual premiums in states with creased by 48.2% as compared to 35.9% in states without caps.

ing Claim Costs

n order to evaluate the difference in claim costs between the two groups of states, Weiss analyzes median claim payments by state for 1991 and 2002 rted to the National Practitioner Data Bank (NPDB). The NPDB provides the only readily available source of medical malpractice insurance indemnity its by state. However, in order to use these data effectively, one must understand the nature of the claim payment values reported, and the mings from that which might be normally expected (see Appendix C for a discussion of the NPDB claim payment data).

The use of the median claim payment value greatly compromises the accuracy of Weiss' analysis. While the median (or middle value of the claim it distribution) might be an effective descriptor of what a plaintiff might receive as payment (before paying almost half to his/her lawyer), it cannot be measure the claim payment burden on insurers. The use of total claim payments reported by state shows a much larger differential result than reported payout increase of 83.3% for capped states as compared to 127.9% for non-capped states.

The increase in total claim payments for the four states having a $250,000 non-economic damage cap during the period of the Weiss analysis is compared to 100.1% for all other states – an 89.6% difference (See Appendix D). Thus the experience in the capped states is almost twice as good for states without effective non-economic damage caps prior to 1991. Using his faulty median calculation, Weiss would have us believe that the ce is only 53.5% (127.9/83.3).

The NPDB has gone on record opposing Mr. Weiss' methodology, saying that "Although the statistical median is usually the best measure of the ie" malpractice payment received by claimants, it does not show the 'burden on insurers.' The 'burden on insurers' is the total amount of dollars paid, 'average' or median payment." (see Appendix E for NPDB statement).

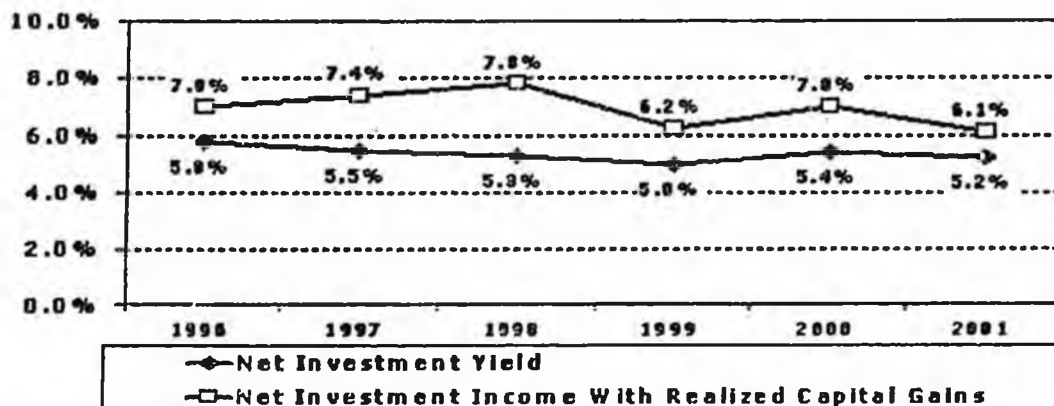
nent Performance

n addition to inappropriate analysis of premium and claims data, the Weiss report comments on the investment performance of medical malpractice s. Being a long tail line of insurance, medical malpractice insurers routinely utilize the investment income generated by the premiums they collect and the payment of claims in the future.[9] It is no secret that bond yields have declined over the past decade, and are now at historically low levels.

n spite of the fact that medical malpractice insurers are 80% invested in bonds and have less than 10% invested in the stock market[10], Weiss still ies that stock market losses are responsible for insurers' poor performance. While the fall in interest rates has reduced the interest income available t premiums, Weiss fails to mention that when rates go down, bond values go up, and insurers have been able to book capital gains to bolster their ient income.

As shown in the exhibit which follows, the total return on investments for the industry has remained fairly stable, and does not explain why rates are Rates are rising because of increasing claim costs.

Medical Malpractice Insurance Investment Income



urce: A.M.Best Aggregates & Averages, 1997 through 2002 Editions,
'edominantly Medical Malpractice Insurers).

USION

'he Weiss report recommends that "...legislators must immediately put on hold all proposals involving non-economic damage caps until convincing :e can be produced to demonstrate a true benefit to doctors in the form of reduced med mal cost." This information exists, as reported herein and by ther reputable sources, and now is the time for the enactment of effective federal health care liability reform.

\PPENDICIES Appendix A
Appendix B
Appendix C
Appendix D
Appendix E

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ed version of the report dated June 2, 2003, which contains apparently corrected estimates of median claim payouts as well as other minor adjustments.
al Malpractice Caps The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage, p.2.
S.11.
nony of James E. Hurley, ACAS, for the American Academy of Actuaries, Hearing before the Subcommittee on Health of the Committee on Energy and Commerce, U.S. House sentatives, February 27, 2003.
ornia and its MICRA law are often cited as the prime example of a successful non-economic damage cap. Enacted in 1975, MICRA's effects were not realized until 10 years then the trial bar's constitutional challenges of the law were finally silenced.
al Medicine, General Surgery, OB/GYN.
Professionals Insurance Company
ssurance – known as Mutual Assurance, Inc. in 1991
verage, medical malpractice claims are reported to insurers 22 months after the incident in question, and are closed or paid by the insurer an additional 33 months hence (PIAA aring Project, December 2002).
Investments Affect Medical Malpractice Premiums?, Brown Brothers Harriman, January 2003, p. 3.

Medical Liability Crisis And Access To Care

A Response To The General Accounting Office

In the summer of 2003, the U.S. General Accounting Office (GAO) released two reports related to America's medical liability crisis.* These reports address several separate but related issues. The first report, released in June 2003, confirms that, since 1999, medical liability premiums skyrocketed in some states and specialties—and increasing settlements and jury awards ("paid claims") are the primary drivers for these increases. The second report, released in August, confirms that America's medical liability crisis is causing access to health care problems in high-risk medical specialties and in select locations throughout America. In the five states studied by the GAO, all previously identified by the American Medical Association (AMA) as liability crisis states, the GAO found health care access problems. The GAO reports also confirm what the AMA has long held to be true—tort reform works. Medical liability premiums in states with strong caps on non-economic damages grew at a slower rate than states without caps on non-economic damages.

We appreciate the GAO's efforts and note that it, like others who have tried to quantify the medical liability crisis, found that data sources are difficult to locate, inconsistent, and often lagging. We would hope that instead of looking at this work as a one-time project, the GAO will continue to gather data over time so that the impact of the current crisis can be measured. In some fields, such as economic forecasting, the fact that an event has occurred is not determined until after it is over. For example, workers who lose their jobs know that the economy is bad, but a recession is often not declared until after it is over. We cannot afford the luxury of waiting until the liability crisis is over to declare a crisis and take action. Too many patients will be hurt.

Among its general findings, the GAO confirmed that:

- Increased losses on claims are the primary contributor to higher medical liability premium rates. (GAO 03-702, p.15)
- Premiums were higher (GAO 03-702, p. 14) and grew more quickly (GAO 03-836, p.30) in states without non-economic damage caps than in states with non-economic damage caps.
- Physician responses to medical liability pressures in the five crisis states have reduced access to services affecting emergency surgery and newborn deliveries. (GAO 03-836, p.5)
- Similar examples of access reductions attributed to medical liability pressures were not identified in the four non-crisis states. (GAO 03-836, p.5)
- Insurers are not charging and profiting from excessively high premium rates. (GAO 03-702, p.32)
- None of the insurance companies studied experienced a net loss on investments. (GAO 03-702, p.25)

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* U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates,* GAO-03-702 (June, 2003); and *Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* GAO-03-836 (August, 2003).

While verifying that the liability crisis has affected access to health care services, the GAO made several determinations in its August report relating to the extent of the liability crisis that the AMA believes do not accurately reflect the severity of the current crisis in real time. Numerous changes to the GAO methodology would strengthen the basic findings of this report. Among the data sources, measures, or analytical methods that could be improved are the following:

- *Examination of all crisis states.* The GAO only examined five of the 19 crisis states. The current medical liability crisis is far more widespread, extending to the additional 14 states as well.
- *Appropriate measurement of physician mobility.* Physician counts were based on state licensure data, which do not accurately reflect the number of physicians practicing in a given location. Actual physician practice location information must be used instead.
- *More accurate counts of physicians by specialties and local markets.* Physician/population ratios that aggregate physicians across local markets and specialties obscure the significant market-specific or specialty-specific changes in the supply of physicians and availability of critically important medical services.
- *Use of multi-payor data to accurately measure access to health care services that Medicare data alone do not capture.* Utilization statistics based exclusively on data from a single payor (Medicare) exclude data for obstetric and emergency care, and fail to capture the impairment of access among other vulnerable populations, such as Medicaid patients.
- *Use of current source of data to capture the magnitude of the access problem in real time.* The GAO accorded no weight to current sources of data which reflect the magnitude of impairment of patient access today.

In addition to our general comments on both of the GAO reports, the AMA has particular concerns relating to the August report. While the GAO verified many examples of impaired access to critical health care services, several of the GAO's conclusions do not logically follow from its analysis, including the following:

The GAO claims that access to care problems are not widespread.

> The GAO's measurement of access problems is incomplete. The report uses Medicare claims data to examine changes in the utilization of medical services. Medicare data are inadequate to identify changes in obstetric services because a vast majority of Medicare eligible beneficiaries are beyond reproductive age. Limitations in the data also preclude an assessment of changes in emergency room services. Therefore, the report significantly understates the impact of rising liability insurance premiums because it does not examine the two clinical areas of patient care in which impairment of patient access has been the most severe—obstetric and emergency room services.
>
> To date, the AMA, in conjunction with its federation of state medical associations, has identified 19 states in a liability crisis. The GAO investigated access problems in only five of those states. In each of those states it found examples of reduced access to hospital-based services. We believe that the GAO would have found similar access to care problems if it had examined the other 14 crisis states. In fact, the GAO did not

identify any access problems in the four non-crisis states it examined. Therefore, the GAO's conclusion that access to care problems are not widespread is not substantiated.

The GAO concludes that access problems were largely limited to rural areas where there are other factors present that contribute to access to care problems.

It is well documented that access to care is more problematic in rural areas than in urbanized areas. Many rural areas suffered from physician shortages prior to the recent escalation in liability premiums. It is precisely in those areas where access is already threatened that one would first notice the impact of physicians' relocation or curtailment of certain services.

Health care access problems do not have to affect every part of a state to create crisis conditions. Health care by its nature is local, where a loss of just one or a few physicians or other health care providers in a community can have a traumatic impact on the availability of health care services in that community. Mrs. Leanne Dyess, a recent witness before House and Senate committee hearings, found this out when her husband was rushed to the closest hospital after he suffered severe head injuries in a car crash. On that night, that hospital did not have the necessary specialist on duty to treat her husband's injuries because physicians in the community had been forced to close their practices due to the liability crisis. By the time her husband was airlifted to a hospital with the proper staff it was too late—he suffered permanent brain damage.

The GAO states that it was unable to substantiate all of the claims of physician relocation, practice closings, or retirement.

We are heartened to learn that some hospital departments were able to find temporary solutions to what is likely to be a long-term problem. Nevertheless, many reports of physician relocation, practice closings, and retirement were confirmed and, as the GAO reported, have had a significant impact on patient access to care.

The AMA has verified that, in at least one instance, the GAO relied on inaccurate interpretations of the information it was provided in making this assertion. In particular, the GAO reported it was unable to substantiate a report that Collier and Lee counties in Florida lost all of their neurosurgeons because the GAO found five neurosurgeons practicing in each county. In fact, the information provided to the GAO stated there were no "pediatric" neurosurgeons in those two counties, an important distinction indicative of the lack of critical access for all local children.

Some of the GAO's conclusions are not supported by its facts. For example, the GAO cites a litany of examples where patients' access to health care has been limited in Mississippi, but then relies solely on licensure data—an inappropriate indicator of physician mobility—to assert that there is not an access problem.

In several cases, the GAO implies that (a) because state-level physician to population ratios from state licensing data have remained largely unchanged, or that (b) because the number of physicians departing a state accounts for a small percentage of physicians licensed in the state, that access to care has not been affected.

Relying on the total number of licensed physicians in a state to track physician mobility is inappropriate. According to James Thompson, MD, President and CEO of the Federation of State Medical Boards of the U.S. (FSMB):

> The number of licensed physicians in a state is not an accurate measure of whether patients have adequate access to health care. Physicians may reduce their practice, stop treating high-risk patients, or stop practicing altogether and still maintain their license. Also, the number of licensed physicians is not an accurate indicator of the distribution of those physicians in underserved areas. Licensed physicians may work in administrative, academic or other settings where they may not have a clinical practice. Also, many retired physicians maintain a license. Information in the Federation of State Medical Boards' database shows that approximately 60% of physicians are licensed in more than one state which indicates that they are licensed in states where they do not maintain a full-time or part-time practice.

The state licensing board data that the GAO examined runs through 2002, and therefore do not capture changes in physician location that occurred in 2003. Moreover, the decision to retire or relocate is a complicated one in which physicians must weigh their duty to their patients against the financial viability of their medical practice. It is not a decision made lightly, or made overnight. We expect to see the rate of physician retirements and relocation increase over time if premiums continue to escalate.

The GAO's method of measuring physician supply and potential access to care is not appropriate. Access problems are specialty and locality specific and are completely obscured when one looks at state-level physician to population ratios that aggregate physicians across specialties and local markets. Similarly, the number of high-risk sub-specialists that depart from any locality would likely account for only a small percentage of physicians in the state.

The GAO uses Medicare utilization data to conclude that, over the January 1997 through June 2002 period, rates of spinal surgeries, selected orthopaedic services, and orthopaedic surgeries remained as high in "crisis" states as in the nation at large.

The GAO's conclusion is misleading for a variety of reasons. For example, data from January 1997 through June 2002 are not likely to capture the impact of increases in medical liability premiums on access to care that took place between 2000 and 2001, let alone more recent increases between 2001 and 2002. We would not expect to see a

measurable reduction in services until late 2002 and more likely not until 2003. The examples of service reductions cited by the GAO are just the tip of the iceberg.

Also, AMA analysis shows that the GAO's estimate of the increase in orthopaedic procedures in Pennsylvania over the 1997 to 2002 period (approximately 40%) was largely driven by increases in "minor procedures." One code in particular (CPT 20610 - Drain/inject, joint/bursa) accounts for about half of utilization in the code range that the GAO examined. The inclusion of these minor procedures overstates the provision of and increase in orthopaedic procedures, and understates the true magnitude of the patient access problem.

The GAO concludes that the cost of defensive medicine cannot be reliably estimated.

Research published in peer-reviewed journals on economics suggests that the reduction in defensive medicine from the adoption of direct tort reforms would reduce selected hospital expenditures by 5% to 9%.[†]

The GAO criticizes reports that extend an estimate of the cost of defensive medicine from data on selected hospital services provided to Medicare patients (it says that results from Medicare data can not be generalized). Yet, the GAO bases its own conclusion that patient access has not been affected on a widespread basis on the same Medicare data.

The GAO states that it could not determine the extent to which differences in claim payments across states are caused by tort reform laws, such as caps on non-economic damages.

Research published in peer-reviewed journals on economics shows that claim payments in states with caps are lower than in states without caps. These research articles offer the best evidence that caps work because they consider, and rule out, other competing explanations for why claim payments differ across states.

A recent study by two economists at the Agency for Healthcare Research and Quality (AHRQ) shows that between 1985 and 2000 physician supply increased at a faster rate in states that passed caps than in states that did not. This study is even more powerful than the recent examples verified by the GAO because it considers and rules out other competing explanations for why physician supply differs across states. Also, it uses data on where physicians' main practices are located rather than state licensure data.

Long-term premium stability in California, a state with a cap on non-economic damages, shows that caps help keep medical liability premium growth in check. According to data from the National Association of Insurance Commissioners, while aggregate medical liability insurance premiums in California increased by 182% over the 1976 to 2001 period, premiums in the rest of the United States increased by 569%.

[†] Daniel P. Kessler & Mark B. McClellan, *Do Doctors Practice Defensive Medicine*, Quarterly Journal of Economics, 111(2): 353-390 (1996).

Further, an examination of recent premium data by various governmental agencies, including the GAO, indicates that growth in claim payments and premiums has been much lower in states with caps on non-economic damages than in states without caps.

The AMA will continue to advocate on behalf of patients and physicians for national reforms similar to those already passed by the U.S. House of Representatives. America's patients are the ones who will suffer if Congress does not act soon. This is a crisis, it is not waning, and without real reforms more patients will be unable to find a doctor to deliver a baby, perform life-saving trauma surgery, or provide other critical care to high-risk patients who need it most.

Medical Liability Crisis And Access To Care
AMA's Response To The General Accounting Office
September 2003

The U.S. General Accounting Office (GAO) recently released two reports related to America's medical liability crisis.* The first report (June 2003) confirms that, since 1999, medical liability premiums skyrocketed in some states and specialties—and increasing settlements and jury awards ("paid claims") are the primary drivers for these increases. The second report (August 2003) confirms that America's medical liability crisis is causing access to health care problems in high-risk medical specialties and in select locations throughout America.

The GAO reports also confirm what the American Medical Association (AMA) has long held to be true—tort reform works. Medical liability premiums in states with strong caps on non-economic damages grew at a slower rate than states without caps on non-economic damages.

We appreciate the GAO's efforts and recognize that it is difficult to quantify the medical liability crisis. **Among its findings, the GAO confirmed that:**

- Increased losses on claims are the primary contributor to higher medical liability premium rates. *(GAO 03-702, p.15)*
- Premiums were higher *(GAO 03-702, p. 14)* and grew more quickly *(GAO 03-836, p.30)* in states without non-economic damage caps than in states with non-economic damage caps.
- Physician responses to medical liability pressures in the five crisis states have reduced access to services affecting emergency surgery and newborn deliveries. *(GAO 03-836, p.5)*
- Similar examples of access reductions attributed to medical liability pressures were not identified in the four non-crisis states without reported problems. *(GAO 03-836, p.5)*
- Insurers are not charging/profiting from excessively high premium rates. *(GAO 03-702, p.32)*
- None of the insurance companies studied experienced a net investment loss. *(GAO 03-702, p.25)*

However, the GAO's August report fails to accurately reflect the severity of the current crisis. Numerous changes to the GAO methodology would strengthen the basic findings of this report. **Among the data sources, measures, or analytical methods that could be improved:**

- ***Examine <u>all</u> crisis states.*** To date, the AMA, in conjunction with its federation of state medical associations, has identified 19 states in a medical liability crisis. The GAO investigated access problems in only five of those states. In each of those states it found examples of reduced access to care. The GAO would have found similar access problems if it had examined the other 14 crisis states. In fact, the GAO did not identify any access problems in the four non-crisis states it examined. Therefore, the GAO's conclusion that access problems are not widespread is not substantiated.

- ***Recognize increased impact on rural areas.*** Health care access problems do not have to affect every part of a state to create crisis conditions. Health care by its nature is local, where a loss of just one or a few physicians or other health care providers in a community can have a traumatic impact on the availability of health care services in that community. Many rural areas suffered from physician shortages prior to the recent escalation in liability premiums. It is precisely in those areas where access is already threatened that one would first notice the impact of physicians' relocation or curtailment of certain services.

- ***Appropriately measure physician mobility.*** Physician counts were based on state licensure data, which do not accurately reflect the number of physicians practicing in a given location. Actual physician practice location information must be used instead.

  Relying on the total number of licensed physicians in a state to track physician mobility is inappropriate. According to James Thompson, MD, President and CEO of the Federation of State Medical Boards of the U.S. (FSMB) in September 2003:

  > *The number of licensed physicians in a state is not an accurate measure of whether patients have adequate access to health care. Physicians may reduce their practice, stop treating high-risk patients, or stop practicing altogether and still maintain their license. Also, the number of licensed physicians is not an accurate indicator of the distribution of those physicians in underserved areas. Licensed physicians may work in administrative, academic or other settings where they may not have a clinical practice. Also, many retired physicians maintain a license. Information in the Federation of State Medical Boards' database shows that approximately 60% of physicians are licensed in more than one state which indicates that they are licensed in states where they do not maintain a full-time or part-time practice.*

- ***Accurately count physicians by specialties and local markets.*** The GAO's method of measuring physician supply and potential access to care is not appropriate. Physician/population ratios that aggregate physicians across local markets and specialties obscure the significant market-specific or specialty-specific changes in the supply of physicians and availability of critically important medical services. Similarly, the number of high-risk sub-specialists that depart from any locality would likely account for only a small percentage of physicians in the state.

- ***Use multi-payor data to accurately measure access to health care services that Medicare data alone do not capture.*** Utilization statistics based exclusively on data from a single payor (Medicare) exclude data for obstetric and emergency care, and fail to capture the impairment of access among other vulnerable populations, such as Medicaid patients. Medicare data are inadequate to identify changes in obstetric services because a vast majority of Medicare eligible beneficiaries are beyond reproductive age. Limitations in the data also preclude an assessment of changes in emergency room services. Therefore, the report significantly understates the impact of rising liability insurance premiums because it does not examine two clinical areas in which impairment of patient access has been the most severe -- obstetric and emergency room services.

The AMA will continue to advocate on behalf of patients and physicians for national reforms similar to those already passed by the U.S. House of Representatives. America's patients are the ones who will suffer if Congress does not act soon. This is a crisis. It is not waning, and without real reforms more patients will be unable to find a doctor to deliver a baby, perform life-saving trauma surgery, or provide other critical care to high-risk patients who need it most.

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[*] U.S. General Accounting Office, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates, GAO-03-702 (June, 2003); and Medical Malpractice: Implications of Rising Premiums on Access to Health Care, GAO-03-836 (August, 2003).

U.S. Department of Health and Human Services

Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

March 3, 2003

This paper was prepared by the Office of Disability, Aging and Long-Term Care Policy within the U.S. Department of Health and Human Services. For additional information, you may visit the DALTCP home page at http://aspe.hhs.gov/daltcp/home.htm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. The e-mail address is: webmaster.DALTCP@hhs.gov.

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INTRODUCTION

Americans enjoy high quality health care. But we can do better. To that end, the Administration is undertaking a number of initiatives to increase access to care, while enhancing even further the quality of care and constraining cost increases. The Administration is acting to make more information available to consumers to help them identify quality care and to choose providers that offer quality care. We are encouraging and promoting the introduction of computer technology in health care to support the efforts of health professionals and to reduce the chance of error. Reform of the litigation system is a further, critical part of our efforts to improve quality. The excesses of the litigation system raise the cost of health care for everyone, threaten Americans' access to care, and impede efforts to improve the quality of care.

Americans spend far more per person on the costs of litigation than any other country in the world. The excesses of the litigation system are an important contributor to "defensive medicine"--medical treatments provided for the purpose of avoiding litigation. Doctors' insurance premiums are increasing at a rapid rate, particularly in states that have not taken steps to make their legal systems function more predictably and effectively. Some doctors cannot obtain insurance despite having never had a single malpractice judgment or even faced a claim. As multimillion-dollar jury awards have become more common in recent years, these problems have reached crisis proportions.

This is a threat to health care quality for all Americans. Increasingly, Americans are at risk of not being able to find a doctor when they most need one. Doctors have given up their practices, limited their practices to patients who do not have health conditions that are more likely to lead to lawsuits, or have moved to states with a fairer legal system where insurance can be obtained at a lower price. In addition, excessive litigation is impeding efforts to improve quality of care. Hospitals, doctors, and nurses are reluctant to report problems and participate in joint efforts to improve care because they fear being dragged into lawsuits, even if they did nothing wrong.

This broken system of litigation also is raising the cost of health care that all Americans pay, through out-of-pocket payments, insurance premiums, and taxes.

Judgments for very large amounts of non-economic damages in a small proportion of cases and the settlements they influence are driving this litigation crisis. At the same time, most injured patients receive no compensation. The current litigation system hurts everyone--injured patients and Americans seeking high-quality care. The only ones who benefit are those who operate the system--particularly the trial lawyers who bring these cases and those who defend them. Some states have already taken action to squeeze the excesses out of the litigation system. But federal action, in conjunction with further action by states, is essential to help Americans get high-quality care when they need it, at a more affordable cost.

We reported on the growing access crisis in the report we issued on July 24, 2002,[1] and updated with two supplements.[2] As we predicted, the crisis has only worsened since we issued those reports. The scope and intensity of the crisis have increased. More doctors, hospitals, and nursing homes in more states are facing increasing difficulty in obtaining insurance against lawsuits, and as a result more patients in more states are facing greater difficulty in obtaining access to doctors. Premiums charged to specialists in 18 states without reasonable limits on non-economic damages increased by 39% between 2000 and 2001.[3] Premiums in these states have now gone up an additional 51%.[4] Thus, specialty premiums have almost doubled in two years in hard-hit states. This report describes the problems we currently face, the reasons these problems have arisen, and how we can fix them.

I. THE CRISIS AFFECTS ALL AMERICANS

1. Access to Care is Threatened

There are a number of obstacles that limit access to affordable health care in this country, including the difficulty many Americans have in obtaining private insurance and an outdated Medicare program. We now face another obstacle--the litigation crisis that has made insurance premiums unaffordable or even unavailable for many doctors, through no fault of their own. This is currently making it more difficult for many Americans to find care, and threatening access for many more. This crisis affects patients, physicians, hospitals, and nursing homes all across the United States.

The crisis is affecting access to care in numerous ways in states that have not reformed their litigation systems. A few examples of the real problems we face:

- Three obstetrician-gynecologists who staffed a practice responsible for delivering half of all babies in Fayette County, Pennsylvania, stopped delivering babies effective November 1 in an effort to reduce malpractice premium expense. The policy would have been $400,000 if they had continued OB services and will be under $100,000 without it.[5]
- Dr. Lauren Plante, a maternal-fetal medicine specialist in Philadelphia, stopped practicing because her malpractice insurance premiums increased 60% in one year.[6]
- Dr. Peter Blanc, a vascular surgeon in Wilkes-Barre, shut down his practice in August because "...increasing insurance premiums have forced him out of business." Dr. Blanc, who has never been sued, would have had to pay $51,000 to renew his medical liability coverage in October, up from $27,000 in 2000.[7]
- Abington (PA) Memorial Hospital closed the only trauma center in Montgomery County at the end of 2002 because insurance carriers were not willing to offer malpractice liability insurance to doctors staffing it. Since 1999, annual hospital liability premiums have risen from $7 million to $23 million.[8]
- In Tacoma, Washington, some doctors were faced with a tripling of their premiums. The Washington State Medical Association has reported a 31% increase in the number of physician members moving out of state since 1998.[9]
- The Vermont Medical Society reported that malpractice premiums are rising so rapidly that doctors are being forced out of the profession.[10]
- According to the president of the Massachusetts Medical Society, obstetricians in the state have seen their insurance premiums double in the past year. Insurance premiums for obstetrician-gynecologists in Massachusetts are among the highest in the country and have forced several doctors practicing in the Springfield area to stop delivering babies.[11]
- The University of Nevada School of Medicine has estimated that Clark County should have between 150 and 160 obstetricians delivering babies but has only 85 in practice, due to the medical litigation crisis.[12]
- The University of Nevada Medical Center closed its trauma center in Las Vegas for ten days in July 2002. Its surgeons had quit because they could no longer afford malpractice insurance.[13] Their premiums had increased sharply, some from $40,000 to $200,000. The trauma center was able to re-open only because some of the surgeons agreed to become county government employees for a limited time, which capped their liability for non-economic damages if they were sued. This is obviously only a temporary solution.
- Dr. Cheryl Edwards, 41, closed her decade-old obstetrics and gynecology practice in Las Vegas because her insurance premium jumped from $37,000 to $150,000 a year. She moved her practice to West Los Angeles, leaving 30 pregnant women to find new doctors.[14]
- Dr. Darren Housel, who had been practicing in Las Vegas since 1996 delivering more than 200 babies a year, saw his patients for the last time September 19. He moved to Utah, where his malpractice premiums will drop from nearly $100,000 to $39,000 annually.[15]
- Dr. Frank Jordan, a vascular surgeon, in Las Vegas, closed his practice. "I did the math. If I were to stay in business for three years, it would cost me $1.2 million for insurance. I obviously can't afford that. I'd be bankrupt after the first year, and I'd just be working for the insurance company. What's the point?"[16]
- A doctor in a small town in North Carolina decided to take early retirement when his premiums skyrocketed from $7,500 to $37,000 per year. His partner, unable to afford the practice expenses by himself, may now close the practice, and work at a teaching hospital.[17]
- Many physicians in Ohio saw their malpractice premiums triple in 2001, and some are leaving their practice as a result. Dr. James Wilkerson, an Akron urologist, decided to retire. Had Dr. Wilkerson continued to practice, he would have spent seven months of his yearly income to cover the $84,000 premium. "I would have had to go back to working 90 hours a week and I didn't want to do that..."[18]

- West Virginia is also facing critical access problems for urgently needed care such as obstetrics. In rural areas, such as Putnam County and Jackson County, the sole community provider hospitals have closed their OB units because the obstetricians in those areas cannot afford malpractice insurance.[19]

- Many communities in Mississippi are losing access to needed medical care. Physicians, who specialize in family medicine and obstetrics/gynecology in Indianola, and in other rural areas of the state, have stopped delivering babies because of skyrocketing insurance costs.[20]

- Most of the cities with populations under 20,000 in Mississippi no longer have doctors who deliver babies.[21]

- Due to rising insurance costs, only one doctor with expertise in head trauma was available last July to cover all the hospitals in Gulfport, Mississippi. Tony Dyess suffered permanent brain damage as a result.[22]

- One in six participants in an August 2002 survey by the Florida Medical Directors Association reported that attending physicians have stopped following patients in nursing homes in the last 12 months because of difficulty obtaining liability coverage; 27% reported that physicians in their facilities had been informed that their medical liability coverage would not be renewed or would be more costly because they attended patients in nursing homes. In 2001, Florida had one of the highest premium costs per nursing home bed in the United States ($11,000).[23]

- In Georgia, the 80-bed Bacon County Hospital in Alma took out a loan to cover a premium that more than tripled.[24]

- Another Georgia hospital, Memorial Hospital and Manor in Bainbridge, which operates a hospital and a nursing home, was faced with a 600% premium increase from 2001 to 2002.[25]

- In New Jersey, 65% of the hospitals report that physicians are leaving because of increased premiums (over 250% over the last three years).[26]

- Arizona Family Care Association, an operator of rural health clinics on the Arizona-Mexico border, saw its malpractice insurance increase from $500,000 per year with no deductible to $897,000 per year with a $50,000 deductible, and that was only if it stopped performing OB. AFCA stopped delivering babies; the closest OB services are an hour away.[27]

- The Wyoming Medical Society has indicated that it is increasingly difficult for physicians to stay in business due to increasing medical liability costs--one of the two insurance carriers providing OB coverage increased rates 40% in 2002.[28] Dr. Willard Wood, an obstetrician serving three Wyoming counties, stopped delivering babies during the winter of 2003; his annual malpractice premium to provide only gynecological services was $116,000, or three times what he had paid a year earlier.[29]

- Doctors who would volunteer their time to provide care in free clinics and other volunteer organizations, or who would volunteer their services to the Medical Reserve Corps, are afraid to do so because they do not have malpractice insurance. This makes it more difficult for clinics to provide care to low-income patients. The clinics must spend their precious resources to obtain their own coverage, and have less money available to provide care to people who need it. The proportion of physicians in the country providing any charity care fell from 76% to 72% between 1997 and 1999 alone, increasing the need for doctors willing to volunteer their services.[30] Health Link Medical Center opened in March 2001 in Southampton, Pennsylvania, to provide free health care to the working poor. Dr. Theodore Onifer, a retired physician, volunteered his services on the board but was unable to volunteer to provide medical care because of the fear of lawsuits and the cost of insurance.

- A substantial number of nursing home chains, including Beverly Enterprises, National Healthcare Corporation, Extendicare and Health Ventures, have been forced to sell nursing homes in Florida and Arkansas because they could not obtain liability insurance coverage for these facilities.[31]

- Six of the largest nursing home companies, both privately and publicly owned, have filed for bankruptcy in the past two years. A significant factor in their financial downturn is uncontrolled costs associated with medical liability premiums and tort related expenses.[32]

American Medical Association has reported that an alarming number of physicians are unable to obtain or afford medical liability urance in 12 states.[33] The American College of Obstetricians and Gynecologists (ACOG) has identified nine states in which access to care is compromised due to availability and affordability of malpractice insurance for obstetricians.[34] A 2002 ACOG survey of obstetrician-gynecologists found that 73% of respondents in these states have been forced to retire, relocate, or modify their practice (e.g. decrease surgical procedures, stop obstetrics, and/or decrease the amount of high-risk obstetric care).[35]

Similarly, the American Association of Neurological Surgeons has identified 25 crisis states in which neurosurgeons faced either a 50 percent increase in premiums from 2000 to 2002, or average premiums near or over $100,000 in 2002.[36]

A new study conducted by the American Hospital Association and the American Society of Hospital Risk Management demonstrates that the scope of the crisis extends beyond physicians: one-third of hospitals saw an increase of 100% or more in liability insurance premiums in 2002. Over one-fourth reported either a curtailment or complete discontinuation of one service or another as a result of growing liability premium expenses.[37]

The effect this crisis is having on patients' access to care is indicated by a recent survey conducted by the Blue Cross Blue Shield Association (BCBS).[38] A substantial number of BCBS plans predict that surgical fees and emergency room costs will increase as a result of higher medical malpractice premiums.

2. Quality of Care is Jeopardized

Physicians Too Often Order Procedures for Litigation Purposes, not Medical Need

The litigation crisis affects the quality of care available to Americans in a number of ways. Physicians are reacting to the threat of litigation by avoiding the specialties that present the greatest risk of suit. A recent survey of physicians reveals that one-third shied away from going into a particular specialty because they feared it would subject them to greater liability exposure.[39] When in practice, physicians increasingly are forced to engage in defensive medicine to protect themselves against suit. They perform tests and provide treatments that they would not otherwise perform merely to protect themselves against the risk of possible litigation. The recent survey revealed that over 76% of physicians are concerned that malpractice litigation has hurt their ability to provide quality care to patients.[40] Because of their fear of the excesses of the litigation system:

- 79% said that they had ordered more tests than they would, based only on professional judgment of what is medically needed, and 91% have noticed other physicians ordering more tests;
- 74% have referred patients to specialists more often than they believed was medically necessary;
- 51% have recommended invasive procedures such as biopsies to confirm diagnoses more often than they believed was medically necessary; and
- 41% said that they had prescribed more medications, such as antibiotics, than they would based only on their professional judgment, and 73% have noticed other doctors similarly prescribing excessive medications.

A large majority of nurses (66%) and hospital administrators (84%) who participated in the survey reported that unnecessary or excessive care is provided because of fear of litigation.[41] Every test and every treatment that is not taken for medical reasons poses an unnecessary risk to the patient, and takes away funds that could better be used to provide health care to those who need it.

A recent survey of 1,573 physicians in three South Florida counties[42] revealed how litigation fears have influenced the way physicians practice:

- 44% recently stopped performing high-risk procedures, including some spinal surgeries and treatment of chest wounds;
- 66% are performing more tests to protect themselves from lawsuits;
- One in nine respondents no longer has malpractice coverage;
- Seven of 29 radiologists have stopped reading mammograms; and
- Almost 31% limit their practice in hospital emergency rooms

The Litigation System Does Not Promote Quality of Care

The liability system is not an effective way of improving quality. In many cases it does not provide a useful guide to what care should be, and does not provide a guide to providers or to patients. A comprehensive study of the prevalence of medical errors found that most events for which claims were filed in fact did not constitute negligence.[43] Other studies demonstrate the same pattern of randomness.[44] Several medico-legal scholars have noted that "Evidence is growing that there is a poor correlation between injuries caused by negligent medical treatment and malpractice litigation.... [I]n a sample of 31,000 patients treated in 51 New York State hospitals, there was a poor correlation between a malpractice suit and the presence of actual malpractice."[45]

Not surprisingly, most professionals involved in health care delivery believe that the system does not accurately reflect the realities of health care or correctly identify malpractice. A 2002 survey indicated that 83% of physicians and 72% of hospital administrators do not believe the system achieves a reasonable result.[46]

Because its results are largely random and unpredictable, the litigation system often does not accurately identify negligence, deter bad conduct, or provide justice. "The evidence is growing that there is a poor correlation between injuries caused by negligent medical treatment and

malpractice litigation."[47]

For example, obstetricians face more suits than any other specialty, more than two per career on average, and claims for neurologically impaired infants make up 30 percent of them, according to the American College of Obstetricians and Gynecologists. The average award by juries in such cases is about $1 million. However, a study released in January 2003 finds that doctors are often sued for brain damage that can result from oxygen deprivation during delivery, even though the vast majority of such cases actually stem from infections and causes that are beyond the control of physicians and other delivery room staff.[48] The study, which is "one of the most highly peer-reviewed reports ever,"[49] suggests that suits are being brought against doctors for brain damage and cerebral palsy that were not caused by negligent care.[50]

With this randomness, the litigation system cannot be relied upon to deter error or set meaningful standards of care. That this is in fact the case is evidenced by the Institute of Medicine's estimate that as many as 98,000 people die each year from medical error.[51] Results like these indicate that the current system is failing to ensure quality care.

The Litigation System in Fact Impedes Efforts to Improve the Safety and Quality of Care

Health professionals' understandable fear of unwarranted litigation threatens patient safety in another way. It impedes efforts of physicians and researchers to improve the quality of care. Specifically, fear of liability discourages open discussion of medical errors and ways to reduce them. As medical care becomes increasingly complex, there are many opportunities for improving the quality and safety of medical care, and reducing its costs. However, because of the litigation environment, only one-fourth of physicians, nurses and hospital administrators think that their colleagues are very comfortable discussing adverse events or uncertainty about proper treatment with them. Even fewer, roughly 5%, think that their colleagues are very comfortable discussing medical errors with them.[52]

The best way to achieve these needed improvements in quality of care is to provide better opportunities for health professionals to work together to identify errors, or practices that may lead to errors, and to correct them. Experts believe these quality improvement opportunities hold the promise not only of significant improvements in patient health outcomes, but also of reductions in medical costs by as much as 30%.[53] Many problems in the health care system result not from one individual's failings, but from complex system failings. These can best be addressed by collecting information from a broad range of doctors and hospitals, and encouraging them to collaborate to identify and fix problems. Already many health care systems are beginning to make these improvements:

- Intermountain Health Care and LDS Hospital in Utah improved quality and efficiency of the intensive care unit by applying quality improvement techniques and improving collaborative efforts.
- The Pittsburgh Regional Healthcare Initiative has brought together hospitals, health plans, physicians, and purchasers of health care in a collaborative effort to identify better ways to provide care. It has reduced blood infections in intensive care units by 20% in just two years, and it is encouraging reporting to reduce medication errors.
- The Baylor Medical Center in Dallas, Texas, has recently initiated an error reporting system and integrated it into care delivery to reduce medication and other errors.[54]
- Through the Northern New England Cardiovascular Disease Study Group, eight hospitals reduced mortality for cardiac bypass surgery by developing a collaborative patient registry, tracking how care is delivered and what the outcomes are, and sharing what they learn.
- A proprietary drug-dispensing system developed by the Veterans' Administration that uses bar-code technology has reduced problems associated with medication errors by 74% in the five years since its introduction.[55]

However, these efforts and other efforts are impeded and discouraged by the lack of clear and comprehensive protection for collaborative quality efforts. Doctors are reluctant to collect quality-related information and work together to act on it for fear that it will be used against them or their colleagues in a lawsuit. Perhaps as many as 95% of adverse events are believed to go unreported.[56] To make quality improvements, doctors must be able to exchange information about patient care and how it can be improved--what is the effect of care not just in one particular institution or of the care provided by one doctor, but how the patient fares across all providers. These quality efforts require enhancements to information and reporting systems.

In its report, "To Err is Human," the Institute of Medicine (IOM) observed that, "[R]eporting systems are an important part of improving patient safety and should be encouraged. These voluntary reporting systems [should] periodically assess whether additional efforts are needed to address gaps in information to improve patient safety and to encourage health care organizations to participate in…reporting, and track the development of new reporting systems as they form."[57]

However, as the IOM emphasized, fear that information from these reporting systems will be used to prepare a lawsuit against them, even if they are not negligent, deters doctors and hospitals from making reports. This fear, which is understandable in the current litigation climate,

impedes quality improvement efforts. According to many experts, the "#1 barrier" to more effective quality improvement systems in health care organizations is fear of creating new avenues of liability by conducting earnest analyses of how health care can be improved. Without protection, quality discussions to improve health care can be used as fodder for more litigation. Doctors are busy, and they face many pressures. They will be reluctant to engage in health care improvement efforts if they think that reports they make and recommendations they offer will be thrown back at them or others in litigation. Quality improvement efforts must be protected if we are to obtain the full benefit of doctors' experience in improving the quality of health care.

The IOM Report emphasized the importance of shifting the inquiry from individuals to the systems in which they work: "The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system."[58] But the litigation system impedes this progress--not only because fear of litigation deters reporting but also because the scope of the litigation system's view is restricted The litigation system looks at the past, not the future, and focuses on the individual in an effort to assess blame rather than considering how improvements can be made in the system. "Tort law's overly emotional and individualized approach...has been a tragic failure."[59]

3. Health Care Costs are Increased

The medical litigation system attacks the wallet of every American. Money spent on malpractice premiums (and the litigation costs that largely determine those premiums) raises health care costs. A GAO study in 1994 estimated that malpractice premiums comprise 1% of total health care expenditures; given current spending, this amounts to $14 billion dollars.[60]

The litigation system also imposes large indirect costs on the health care system. Defensive medicine that is caused by unlimited and unpredictable liability awards not only increases patients' risk but it also adds costs. A leading study estimates that reasonable limits on non-economic damages, such as California has had in effect for 25 years, can reduce health care costs by 5-9% without "substantial effects on mortality or medical complications."[61] With national health care expenditures currently estimated to be $1.4 trillion, if this reform were adopted nationally, it would save $70-126 billion in health care costs per year.

The costs of the runaway litigation system are paid by all Americans, through higher premiums for health insurance (which reduces workers' take home pay if the insurance is provided by an employer), higher out-of-pocket payments when they obtain care, and higher taxes.

The Federal Government--and thus every taxpayer who pays federal income and payroll taxes--pays for health care in a number of ways. It provides direct care, for instance, to members of the armed forces, veterans, and patients served by the Indian Health Service. It provides funding for the Medicare and Medicaid programs. It funds Community Health Centers. It also provides assistance, through the tax system, for workers who obtain insurance through their employment. The Federal Government spends $33.7-$56.2 billion per year for malpractice coverage and the costs of defensive medicine.[62] Reasonable limits on non-economic damages would reduce the amount of taxpayers' money the Federal Government spends by $28.1-$50.6 billion per year.[63]

II. THE LITIGATION SYSTEM IS RESPONSIBLE FOR THE CRISIS

The crisis that we face--as consumers, taxpayers, or health care professionals--is caused by our expensive litigation system, which often finds liability on a random basis and increasingly imposes very large judgments for non-economic damages.

The insurance premiums that health professionals and hospitals must pay are largely determined by the costs that the litigation system imposes on the insurers. The malpractice insurance system and the litigation system are inexorably linked.

Although most cases do not actually go to trial, it costs a significant amount of money to defend each claim--expenses on claims settled in 2001 averaged $39,819.[64] Data from states that maintain this information demonstrate the rapid rate of increase in recent years. Between 1999 and 2001, the average expense, per defendant, in a medical litigation case in Illinois increased 30.3% (from $14,855 to $19,363).[65] In the period 1980 to 1984, the average defense cost in Missouri was $4,700; in the period 1995 and 1999, it increased to almost $19,000--an increase of more than 300% percent.[66]

And payments made on claims are increasing. In Illinois, the average payment per paid claim increased from just under $129,000 in the period 1980-1984 to almost $500,000 in the period 1995-1999.[67] Missouri reported similar increases--the average payment per defendant rose 38% between 1999 and 2001.[68]

Between 1991 and 2001, the number of payments made for malpractice claims against physicians reported to the National Practitioner Data Bank (NPDB) increased 21.6% from 13,711 to 16,676.[69] During this same period, the median payment more than doubled--from $63,750 to $135,941--while the maximum reported payment escalated from $5,300,000 to $20,700,000.[70]

Of particular concern is the rise in mega-awards and settlements. The number of payments of $1 million or more reported to the NPDB exploded in the past 7 years, not only in AMA crisis states such as New Jersey, Pennsylvania and Ohio, but nationwide. Between 1991 and 2002, the number of payments of $1 million or more that were reported to the NPDB increased from 298 to 806; payments of $1 million or more increased from 2.2% to 5.4% of total payments reported. While the NPDB represents the most comprehensive data source for medical malpractice claims payments, it may understate the extent of the crisis since it includes all doctors, and the problem is concentrated in high risk specialties.

Mega-awards for non-economic damages have occurred in states that do not have limitations on the amounts of non-economic damages that can be recovered. A number of states have experienced mega-judgments. See Table 1.

TABLE 1. Mega Awards In States Without Caps

State	Jury Award	Year
Arizona	$3,000,000	1998
Kentucky	$13,000,000	1998
Mississippi	$100,000,000	2002
Nevada	$6,000,000 $5,400,000 $4,600,000	2001 2001 2001
New York	$94,500,000 $80,000,000 $91,000,000	2002 2002 2002
North Carolina	$23,500,000 $4,500,000 $8,100,000	1997 2001 2001
Ohio	$3,500,000	2002
Pennsylvania	$100,000,000 $7,000,000	1999 2003
Texas	$4,400,000	2002
Washington	$3,790,000	1998

Source: ASPE Review of Media Reports from The Advocate, Las Vegas Review, North Carolina Lawyers Weekly, and other select sources.

A large proportion of these awards are not to compensate injured patients for their economic loss--such as wage loss, health care costs, and replacing services the injured patient can longer perform (such as child care). Much of the judgment (in some cases, particularly the largest judgments, perhaps 50% or more) is for non-economic damages. Awarded on top of compensation for the injured patient's actual economic loss, non-economic damages are meant to be compensation for intangible, non-monetary losses, such as pain and suffering, loss of consortium, hedonic (loss of the enjoyment of life) damages, and various other theories that are developed.

Recent data from the Florida Department of Insurance Closed Claims Database show that non-economic damages comprised 77% of awards.[21] In Texas, the average judgment today is $2.1 million; of that, 70% is for non-economic damages. Texas has experienced a 500% increase in the size of judgments awarded in the last 10 years.[22]

Non-economic damages are an effort to compensate a plaintiff with money for what are in reality non-monetary considerations. The theories on which these awards are made however, are entirely subjective. As one scholar has observed: "The perceived problem of pain and suffering awards is not simply the amount of money expended, but also the erratic nature of the process by which the size of the awards is determined. Juries are simply told to apply their 'enlightened conscience' in selecting a monetary figure they consider to be fair."[23] Unless a state has adopted limitations on non-economic damages, the system essentially gives juries a blank check to award huge damages.

Even though few cases end with mega jury awards, they encourage lawyers in the hope that they can win this litigation lottery, and they influence every settlement that is entered into. Mirroring the increase in jury awards, settlement payments have steadily risen over the last two decades. The average settlement payment per paid claim increased from approximately $110,000 in 1987 to $250,000 in 1999.[24]

III. THE LITIGATION SYSTEM DOES NOT BENEFIT THE INJURED PATIENT

The litigation system is expensive, and, at the same time, it is slow and provides little benefit to patients who are injured by medical error.

Most victims of medical error do not file a claim--one comprehensive study found that only 1.53% of those who were injured by medical negligence even filed a claim.[75] When a patient does decide to go into the litigation system, only a very small number recover anything. Most claims--57-70%--result in no payment to the patient.[76, 77] One study found that only 8-13% of cases filed went to trial; and only 1.2-1.9% resulted in a decision for the plaintiff.[78]

The results are as arbitrary for patients as they are for providers. When there are recoveries, they often are based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status (educated, attractive patients recover more than others).[79]

One prominent personal injury trial lawyer explained the secret of his success: "The appearance of the plaintiff [is] number one in attempting to evaluate a lawsuit because I think that a good healthy-appearing type, one who would be likeable and one that the jury is going to want to do something for, can make your case worth double at least for what it would be otherwise and a bad-appearing plaintiff could make the case worth perhaps half..."[80]

Only a small number of claimants achieve the large judgment for non-economic losses. A winning lottery ticket in litigation, moreover, is not as attractive as it may seem at first blush. A plaintiff who wins a judgment must pay the lawyer 30-40% of it, and sometimes even more. Lawyers, therefore, have an interest in finding the most attractive case. They develop a portfolio of cases and have an incentive to gamble on a big "win." If only one case results in a huge verdict, they have had a good payday. Thus, they have incentives to pursue selected cases to the end in the hope of winning the lottery, even when their client would be satisfied by a settlement that would make them whole economically. The result of the contingency fee arrangement is that lawyers have few incentives to take on the more difficult cases or those of less attractive patients.

For most injured patients, therefore, the litigation process, while offering the remote chance of a jackpot judgment, provides little real benefit, even for those who file claims and pursue them. Even successful claimants do not recover anything on average until five years after the injury, longer if the case goes to trial.[81]

The friction generated by operating the system consumes most of the money. When doctors and hospitals buy insurance (sometimes they are required to buy coverage that provides more "protection" than the total amount of their assets), it is intended to compensate victims of malpractice for their loss. However, only 28% of what they pay for insurance coverage actually goes to patients; 72% is spent on legal, administrative, and related costs.[82]

Our current system forces injured patients to sue their doctors in order to obtain compensation and forces both patients and doctors to go through what is a traumatic process for all. Patients must wait years for recovery (if they ever win any). Doctors are subject to minute scrutiny of actions they took, often years before, and their actions are judged on the basis of hindsight and perhaps even on the basis of changed medical standards. The process consumes the time and energy of the doctor that could better be spent in patient care. It is essentially punitive in nature, yet random. Rather than helping doctors do better, it causes them to engage in defensive medicine. It is a process that benefits no one except those who must operate it--trial lawyers, both those who represent plaintiffs and those who represent defendants.

The cost of these awards for non-economic damages is paid by all other Americans through higher health care costs, higher health insurance premiums, higher taxes, reduced access to quality care, and threats to quality of care. The system permits a few plaintiffs and their lawyers to impose what is in effect a tax on the rest of the country to reward a very small number of patients--and their lawyers--who happen to win the litigation lottery. It is not a democratic process.

IV. AS A RESULT, INSURANCE PREMIUMS ARE RISING RAPIDLY

The costs imposed by the litigation system show up in the cost of insurance coverage. Premiums have increased rapidly over the past several years, particularly for doctors who practice internal medicine, general surgery, and obstetrics/gynecology (see Table 2 below). The average increases ranged from 12% to 18% in 2000, were about 10% in 2001, but accelerated rapidly in 2002. The most recent report revealed that rate increases are now averaging 20% and above.[83]

TABLE 2. Medical Malpractice Liability Average Premium Increases by Specialty (Date is When Survey Was Taken, Compared to Previous Period)

Specialty	July 2000	July 2001	July 2002
Internists	18%	10%	25%
General Surgeons	15%	10%	25%
Obstetrician/Gynecologists	12%	9%	20%

Source: Medical Liability Monitor. The data reflect an average for the listed specialties in all states. Averaging disguises the different experiences in states that have reformed their litigation systems and those that have not.

As seen in Table 3, which shows the highest rate increase reported for any of the three specialties, specialty physicians in states without reasonable limits on non-economic damages have experienced very significant premium increases from 2001 to 2002.

TABLE 3. Highest Premium Increases for Specialists in States without Meaningful Caps*	
State	**Premium Increase from 2001-2002**
Arkansas	112%
Connecticut	40%
Florida+	75%
Georgia	40%
Maryland	37%
Mississippi	99%
Nebraska	36%
Nevada	50%
New Hampshire	50%
North Carolina	50%
Ohio+	60%
Oregon	80%
Pennsylvania	40%
South Carolina	42%
Tennessee	65%
Texas+	40%
Virginia	113%
Wyoming	38%

Source: Medical Liability Monitor, 2002.
*Highest increase in rates for internal medicine, general surgery or obstetrics-gynecology as reported in MLM Survey, October 2002.
+ Florida imposes a cap of $250,000-$350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate. Florida is not considered to have a meaningful cap on non-economic damages because of the confusion associated with the arbitration provision. An Ohio statute limiting non-economic damages was declared unconstitutional in 1999. The Texas statute limits damages ($1.4 million in 2002) in wrongful death cases only; application of it to all negligence actions was ruled unconstitutional in 1990.

Analyzing the data differently, the same pattern is evident in Table 4, which shows that the highest premium increases averaged among all three specialists increased substantially in 2002.

TABLE 4. Average Combined Highest Premium Increases for Specialty Providers in States Experiencing a Litigation Crisis	
State	**Premium Increase from 2001-2002**
Florida	61%
Iowa	29%
Mississippi	66%
Nebraska	31%
New Hampshire	42%
North Carolina	50%
South Carolina	38%
Tennessee	30%
Virginia	22%

Source: Medical Liability Monitor, October 2002. Data represent the average of the highest premiums reported for internal medicine, general surgery and obstetrics-gynecology specialists.

The states with the highest average premiums are states that have not reformed their litigation systems.[84] Table 5 compares the premiums in non-reform states with those charged in California, which reformed its system in 1975.

TABLE 5. States with High Premiums in 2002 by Specialty, Compared to California			
State	OB/GYNs	Surgeons	Internists
Florida	$211-$78K	$164-$55K	$56-$15K
Nevada	$142-$59K	$85-$38K	$23-$11K
Michigan	$141-$51K	$107-$43K	$46-$14K
New York	$115-$33K	$66-$19K	$17-$6K
Illinois	$110-$47K	$76-$29K	$32-$9K
Texas	$117-$43K	$88-$33K	$34-$11K
Maryland	$96-$29K	$38-$24K	$11-$6K
West Virginia	$95-$69K	$64-$40K	$18-$9K
Connecticut	$95-$69K	$43-$37K	$14-$7K
District of Columbia	$90-$84K	$43-$38K	$13-$11K
California	$75-$28K	$49-$18K	$21-$5K
Source: Medical Liability Monitor October 2002 Report. Highest and lowest premiums reported for internal medicine, general surgery and ob-gyn physicians.			

The effect of these premiums on what patients must pay for care can be seen from an example involving obstetrical care. If an obstetrician delivers 100 babies per year (which is roughly the national average) and the malpractice premium is $200,000 annually (as it is in Florida), each mother (or the government or her employer who provides her health insurance) must pay approximately $2,000 merely to pay her share of her obstetrician's liability insurance. If a physician delivers 50 babies per year, the cost for insurance premiums per baby is twice as high, about $4,000. It is not surprising that expectant mothers are finding their doctors have left states with litigation systems imposing these costs.

Nursing homes are a new target of the litigation system. From 1990 to 2001, the average size of claims tripled, and the number of claims increased from 3.6 to 11 per 1,000 beds.[85] Premium increases paid by nursing homes are rising rapidly because of dramatic increases in both the number of lawsuits and the size of awards. Between 1995 and 2001, the average premium increased from $240 per occupied skilled nursing bed per year to $2,360. These costs vary widely across states, again in relation to whether a state has implemented reforms that improve the predictability of the legal system. Florida ($11,000) had one of the highest per bed costs in 2001.[86] Nursing homes in Mississippi have been faced with increases in total premiums as great as 900% in the past two years.[87] Since Medicare and Medicaid pay most of the costs of nursing home care, these increased costs are borne by taxpayers, and consume resources that could otherwise be used to expand health (or other) programs.

V. INSURERS ARE LEAVING THE MARKET

The litigation crisis is affecting patients' ability to get care not only because many doctors find the increased premiums unaffordable but also because liability insurance is increasingly difficult to obtain at any price, particularly in non-reform states. Demonstrating and exacerbating the problem, several major carriers have stopped selling malpractice insurance.

- St. Paul Companies, which was the largest malpractice carrier in the United States, covering 9% of all doctors, announced in December 2001 that it would no longer offer coverage to any doctor in the country.[88]
- MIXX pulled out of every state; it has reorganized and sells only in New Jersey.
- PHICO and Frontier Insurance Group have also left the medical malpractice market.[89, 90]
- Doctors Insurance Reciprocal stopped writing group specialty coverage at the beginning 2002.[91]

Fifteen insurers have left the Mississippi market in the past five years.[92] The number of medical liability insurance companies active in Florida dropped from 66 in the late 1990s to only 12 in 2002.[93] These remaining companies have limited capacity to write new policies for providers

whose carriers have departed the market.[24]

According to the Missouri Insurance Commissioner's office, of the 32 companies writing medical malpractice coverage in the state in 2001, only 8 are still writing policies for doctors.[25] The companies that are still in business are charging more and offering fewer discounts. Five specialties in Missouri are facing particular problems in getting coverage: obstetrics-gynecology, orthopedics, neurosurgery, radiology and trauma. Similarly, the two major carriers of professional liability coverage for doctors in Iowa, MMIC and PIC Wisconsin, have reached near capacity (which limits their ability to write new or additional coverage).[26]

The National Association of Insurance Commissioners (NAIC) has examined the increasing unwillingness of insurers to sell malpractice insurance and explains the reasons for this crisis:

> "The reason insurers are not writing, or are pulling back from medial malpractice insurance, is because there are many other lines of insurance that offer more opportunities for profit at a lower risk. The uncertainties and historical return in this line of business lead many commercial insurers to commit capital in other lines of commercial insurance. It is our experience this market will remain volatile in some states until such time as claims costs stabilize."[27]

VI. STATES WITH REALISTIC LIMITS ON NON-ECONOMIC DAMAGES ARE FARING BETTER

The insurance crisis is acute in states that have not reformed their litigation systems. Over the last two years, states with limits of $250,000 or $350,000 on non-economic damages have seen average combined highest premium increases of 18%, but states without reasonable limits on non-economic damages (in states representing almost half of the entire United States population) have seen average increases of 45%, as shown in Table 6.

TABLE 6. Comparison of States with Caps to States without Meaningful Non-Economic Caps (Average Highest Premium Increase)							
States with Caps < $250,000				States without Caps			
	2001	2002	Avg,		2001	2002	Avg,
California	20%	20%		Arkansas	18%	104%	
Indiana	16%	55%		Connecticut	50%	28%	
Montana	21%	35%		Florida+	47%	59%	
Utah	5%	35%		Georgia	32%	37%	
AVERAGE	16%	36%		Illinois	52%	72%	
AVERAGE over 2 years			26%	Mississippi	0%	66%	
States with Caps < $350,000				Nevada	35%	50%	
	2001	2002		New Jersey	24%	13%	
California	20%	20%		North Carolina	0%	50%	
Hawaii	0%	5%		Ohio+	60%	60%	
Indiana	16%	55%		Oregon	56%	80%	
Michigan	39%	13%		Pennsylvania	77%	62%	
Montana	21%	35%		Rhode Island	60%	9%	
New Mexico	12%	42%		Tennessee	17%	49%	
North Dakota	0%	15%		Texas+	32%	45%	
South Dakota	0%	20%		Virginia	37%	74%	
Utah	5%	35%		Washington	55%	6%	
Wisconsin	5%	5%		West Virginia	44%	46%	
AVERAGE	13%	24%		AVERAGE	39%	51%	
AVERAGE over 2 years			18%	AVERAGE over 2 years			45%

SOURCE: Medical Liability Monitor, October 2001 and October 2002. Percentages represent the combined average of the highest premium increases for OB/GYNs, Internists, and General Surgeons among select states, 2002. Average highest premium increase is derived from the

highest potential premium increase among internal medicine, general surgery or obstetrics/gynecology specialists in that state during 2002. These combined averages are not weighted.
+ Florida imposes a cap of $250,000-$350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate. Florida is not considered to have a meaningful cap on non-economic damages because of the confusion associated with the arbitration provision. An Ohio statute limiting non-economic damages was declared unconstitutional in 1999. The Texas statute limits damages ($1.4 million in 2002) in wrongful death cases only; the statute had applied to all negligence actions but was ruled unconstitutional in 1990.

As Table 7 below shows, there is a substantial difference in the level of medical malpractice premiums in states with meaningful caps and states without meaningful caps. For example, internists in Los Angeles are charged less than one-half of the premium charged internists in Ft. Lauderdale and Miami. General surgeons and obstetrician-gynecologists in Florida are charged three to four times as much as their peers in California.

In each instance, the premiums in California are less than those charged to specialists in non-reform states. The success of California, and othe states that have taken similar actions to rein in the excesses of the litigation system, is not accidental. It is a result of a willingness to confront the problem and enact reforms. In the early 1970s California faced an access crisis like that facing many states now. With bi-partisan support, including leadership from Jerry Brown, then Governor, and from Henry Waxman, then chairman of the Assembly's Select Committee on Medical Malpractice, California enacted comprehensive changes to make its medical liability system more predictable and rational. The Medical Injury Compensation Reform Act of 1975 (MICRA) made a number of reforms, in particular:

- Placing a $250,000 limit on non-economic damages while continuing unlimited compensation for economic damages.
- Shortening the time in which lawsuits could be brought to three years (thus ensuring that memories would still be fresh and providing some assurance to doctors that they would not be sued years after an event that they may well have forgotten).
- Providing for periodic payment of damages to ensure the money is available to the patient in the future.

California has more than 25 years of experience with this reform. It has been a success. Doctors are not leaving California. Insurance premium have risen much more slowly than in the rest of the country without any effect on the quality of care received by residents of California. Insurance premiums in California have risen by 167% over this period while those in the rest of the country have increased 505%.[28]

States that do not have the benefit of reforms like California's will continue to experience larger payments for non-economic losses, larger settlements, higher premiums, and reduced access to care. The National Association of Insurance Commissioners--the organization of the state insurance regulators--is concerned about the premiums charged by medical malpractice insurers--concerned that they are too low. Referring to the amounts paid out on claims and defense costs, the NAIC recently warned, "Because of extremely high loss ratios in many states, regulators concerns have been with rate inadequacy, and not excessiveness or unfair discrimination."[29]

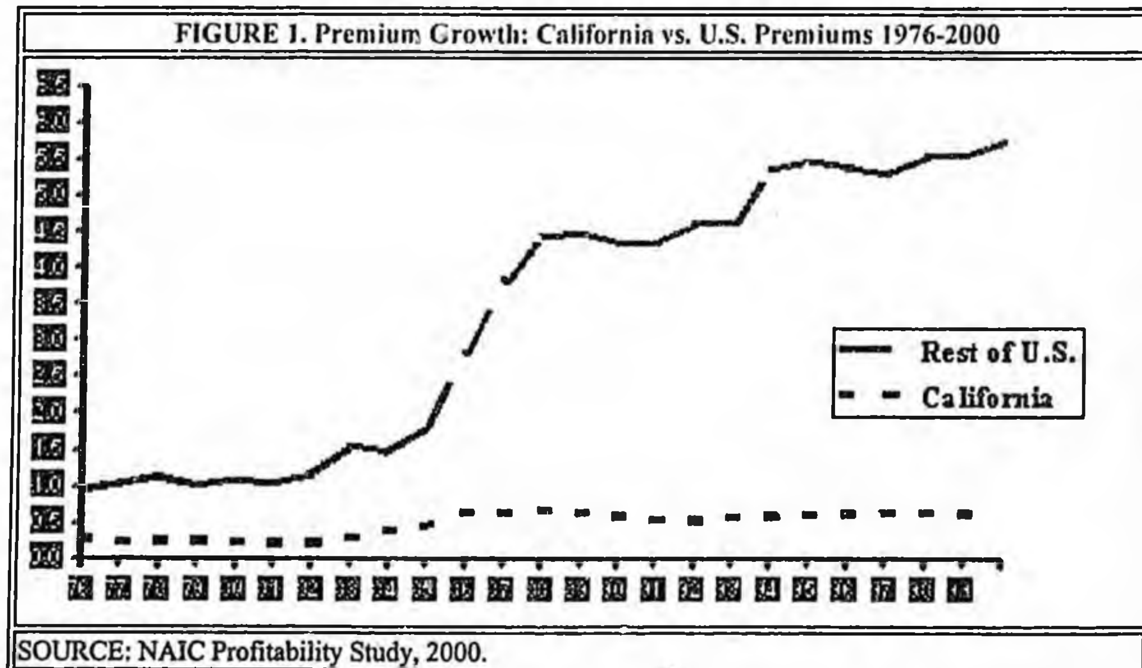
TABLE 7: Malpractice Liability Rate Ranges by Specialty by Geography as of October 2002			
	Cap on Non-Economic Damages	Low	High
INTERNISTS			
State Wide Data			
Wisconsin	$350,000	$4,500	$6,000
Montana	$250,000	7,000	7,900
Utah	$250,000	7,900	10,600
Hawaii	$350,000	7,100	7,100
Connecticut	No cap	7,400	13,800
Washington	No cap	6,700	9,800
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$8,800	$21,200
Pennsylvania (Urban Philadelphia area)	No cap	11,000	12,000
Nevada (Las Vegas area)	No cap	17,400	23,600
Illinois (Chicago area)	No cap	19,900	31,700
Florida (Miami and Ft. Lauderdale areas)*	No cap	26,800	56,100
GENERAL SURGEONS			
State Wide Data			

Wisconsin (state wide)	$350,000	$16,000	$19,300
Montana (state wide	$250,000	21,900	31,400
Utah (state wide)	$250,000	35,500	39,100
Hawaii (state wide)	$350,000	25,800	25,800
Connecticut (state wide)	No cap	36,900	43,400
Washington (state wide)	No cap	20,100	35,200
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$30,700	$49,400
Pennsylvania (Urban Philadelphia area)	No cap	50,100	104,400
Nevada (Las Vegas area)	No cap	59,800	85,100
Illinois (Chicago area)	No cap	63,600	75,600
Florida (Miami and Ft. Lauderdale areas)*	No cap	95,500	174,300
OBSTETRICIANS/GYNECOLOGISTS			
State Wide Data			
Wisconsin (state wide)	$350,000	$21,500	$27,800
Montana (state wide	$250,000	33,900	52,200
Hawaii (state wide)	$350,000	42,900	42,900
Utah (state wide)	$250,000	46,900	60,000
Connecticut (state wide)	No cap	69,500	95,000
Washington (state wide)	No cap	30,900	51,900
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$54,600	$65,400
Pennsylvania (Urban Philadelphia area)	No cap	64,300	116,400
Nevada (Las Vegas area)	No cap	93,200	141,800
Illinois (Chicago area)	No cap	102,400	110,100
Florida (Miami and Ft. Lauderdale areas)*	No cap	136,200	210,600

Source: Medical Liability Monitor, October 2002: Shook, Hardy, Bacon, L.L.P., October 9, 2001.
* Florida imposes caps of $250,000-350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate. Florida is not considered to have a meaningful cap on non-economic damages because of the confusion associated with the arbitration provision.

The litigation system must be reformed to protect Americans' access to high quality health care.

FIGURE 1. Premium Growth: California vs. U.S. Premiums 1976-2000



SOURCE: NAIC Profitability Study, 2000.

VII. THE PRESIDENT'S FRAMEWORK FOR IMPROVING THE MEDICAL LITIGATION SYSTEM

Federal and state action is needed to address the impact of the medical litigation crisis on health care costs and the quality of care.

1. Establish a Fair, Predictable, and Timely Process

As years of experience in many states have proven, reasonable limits on the amount of non-economic damages that are awarded significantly restrain increases in the cost of insurance premiums. These reforms improve the predictability of the medical litigation system, reducing incentives for filing frivolous suits and for prolonged litigation. Greater predictability and more timely resolution of cases means patients who are injured can get fair compensation more quickly. They also reduce health care costs, enabling Americans to get more from their health care spending and enabling federal health programs to provide more relief. They improve access to care, by making insurance more affordable and available. They also improve the quality of health care, by reducing defensive medicine and enabling doctors to spend significantly more time focusing on patient care. President Bush has, on several occasions, urged Congress to give all Americans the benefit of these reforms, eliminate the excesses of the litigation system, and protect patients' ability to get quality care.

The President supports federal reforms in medical liability law that would implement these proven steps for improving our health care system:

- Improve the ability of all patients who are injured by negligence to get quicker, unlimited compensation for their "economic losses," including the loss of the ability to provide valuable unpaid services like care for children or a parent.

- Ensure that recoveries for non-economic damages could not exceed a reasonable amount ($250,000).

- Reserve punitive damages for cases that justify them--where there is clear and convincing proof that the defendant acted with malicious intent or deliberately failed to avoid unnecessary injury to the patient--and avoid unreasonable awards (anything in excess of the greater of two times economic damages or $250,000).

- Provide for payment of a judgment over time rather than in one lump sum--and thus ensure that the money is there for the injured patient when needed.

- Ensure that old cases cannot be brought years after an event when medical standards may have changed or witnesses' memories have faded, by providing that a case may not be brought more than three years following the date or injury or one year after the claimant discovers or, with reasonable diligence, should have discovered the injury.

- Informing the jury if a plaintiff also has another source of payment for the injury, such as health insurance.

- Provide that defendants pay any judgment in proportion to their fault, not on the basis of how deep their pockets are.

The success of the states that have adopted reforms like these shows that malpractice premiums could be reduced by 34%.[100] The savings to the Federal Government resulting from reduced malpractice premiums could be $4.8 billion.[101]

In October 2002, the House of Representatives passed H.R. 4600--a bill introduced by Congressman Jim Greenwood with almost 100 bipartisan cosponsors. The Senate did not act. The bill was reintroduced in the House in February 2003, as H.R. 5. Enactment of similar legislation, with improvements to ensure that its meaningful standards will apply nationally, will be a significant step toward the goals of affordable, high-quality health care for all Americans, and a fair and predictable liability system for compensating injured patients.

In addition, there are other promising approaches for compensating patients injured by negligence fairly and without requiring them to go through full-scale, time-consuming, and expensive litigation. States should also adopt and evaluate alternatives to litigation.

Early Offers is one innovative approach.[102] This would provide a new set of balanced incentives to encourage doctors to make offers, quickly after an injury, to compensate the patient for economic loss, and for patients to accept. It would make it possible for injured patients to receive fair compensation quickly, and over time if any further losses are incurred, without having to enter into the litigation fray. Because doctors and hospitals would have an incentive to discover adverse events quickly in order to make a qualifying offer, it would lead to prompt identification of quality problems. The money that otherwise would be spent in conducting litigation would be recycled so that more patients get additional recovery, more quickly, with savings left over to the benefit of all Americans. It may also be possible to implement an administrative form of Early Offers as an option for patients who are injured in the course of receiving care under certain federal health programs.

A second innovative approach involves strengthening medical review boards to reduce claims of malpractice. Boards with special expertise in the technical intricacies of health care can streamline the fact gathering and hearing process, make decisions more accurately, and provide compensation more quickly and predictably than the current litigation process. Physicians must have confidence that the "legal system will get the facts right in the first place."[103] As with Early Offers, incentives are necessary for patients and health care providers to submit cases to the boards and to accept their decisions.

The Administration intends to work with states on developing and implementing these alternatives to litigation, so that injured patients can be fairly compensated quickly and without the trauma and expense that litigation entails.

2. Improve Health Care Quality Through Litigation Reform

Medical professionals, not lawyers, are the key to quality care. High quality care that achieves the best possible patient outcomes makes litigation unnecessary. The Administration is already taking many steps to improve quality of care.

The ability of Americans to work with their doctors to choose and control their own health care is an important ingredient of quality. The people who are most affected by the quality of care--patients and their families--should be the ones deciding how and from whom they obtain their health care. To do so, they need helpful information.

The Administration is undertaking a number of activities to promote quality by increasing and improving the information available to patients, and taking other steps to make the system safer and more effective. Some specific activities include:

- Providing quality information about nursing homes on the Internet to enable families to make comparisons and informed judgments.
- Promoting the use of information technology to provide better real-time information for doctors, to include all the relevant information in the patient's record and to make it accessible no matter where the patient is.
- Promoting the introduction and use of bar coding for dispensing prescription drugs to reduce errors. This action alone stands to dramatically reduce the number of medication errors in hospitals, and reduce the costs to society of preventable drug adverse events--recently estimated total direct and indirect costs to society to be a staggering $177 billion yearly.
- Adopting comprehensive standards necessary to make the creation of an electronic health care record possible. This would make a patient's medical records available across different care sites, and to the patient.
- Encouraging disease management programs that can improve the quality of care for people with asthma and diabetes.
- Promoting computer software that hospitals can use to identify quality problems, assisting in quality improvement activities.

The Administration will work to expand these efforts, to give patients and their doctors the information they need to make informed and appropriate medical decisions, while protecting the confidentiality of sensitive information from inappropriate uses.

One of the key ingredients to reducing errors is optimizing doctors' to improve patients' health care. We must encourage them and other experts to identify problems before they result in injury and to develop better ways of providing care.

Researchers have found that most errors are system failures, rather than individual faults. Doctors could do their job correctly, and most errors would still occur. In addition, since human error inevitably occurs, built-in systems should automatically prevent, detect and/or correct errors before they occur. Continuous quality improvement processes, which have been effective in many other "high-risk" sectors, focus on finding ways to design work processes so that better results and fewer errors can be achieved. This requires measurement and analysis of the ways health care is provided, and the results of care for patients. By encouraging the experts to work both inside their own organization and with outside groups to share information on how medical errors or "near misses" occur and ways to prevent them, health care organizations have begun to develop tools to prevent injury and increase knowledge of how errors occur.

Success in improving health care practices to prevent errors and deliver high-quality care, however, requires a legal environment that encourages health care professionals and organizations to work together to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients.

A principal obstacle to taking these steps is the fear by doctors, hospitals, and nurses that reports on adverse events and efforts to improve care will be subject to discovery in lawsuits. As several distinguished physicians recently wrote, "for reasons that include liability issues and a medical culture that has discouraged open discussion of mistakes, the power of individual case presentation, so important in the physician's clinical medicine education, has not been harnessed to educate providers about medical errors."[104]

A number of states have enacted peer review statutes that protect the confidentiality of information within hospitals and other health care entities.

Confidentiality protections provided by law for specific activities also have proven successful in identifying problems and reducing medical errors:

- The National Nosocomial Infections Surveillance System, operated by the Centers for Disease Control, receives voluntary reports from hospitals on hospital-acquired infections. It has reduced these infections by 34%. The system works because federal law assures participating hospitals that information supplied by them will be kept confidential.
- MedWatch is a voluntary Medical Products Reporting System operated by the Food and Drug Administration. Adverse events concerning medical devices and drugs may be reported to it to identify problem areas. Names of the reporting doctors and hospitals, and the name of patients involved, are not releasable under the Federal Freedom of Information Act.
- The Department of Veterans Affairs maintains a Patient Safety Reporting System to learn about issues related to patient safety. To encourage reporting, federal law provides that reports relating to new safety ideas, close calls, or unexpected serious injury are confidential and privileged. This is based on the successful system operated by the National Aeronautics and Space Administration for aviation safety reporting.
- New York State operates the New York Patient Occurrence Reporting and Tracking System. Adverse events are reported to it. New York State law prevents disclosure of reports under the state's freedom of information law.

The IOM report "To Err is Human" noted that while many of the legal protections developed by states have promise, many current state peer review statutes do not go far enough. For example, these laws typically provide legal protection for communications within individual institutions, and usually only for certain committees. These laws do not reflect the systemic nature of health care as it is now provided. They do not provide a way to obtain data from various providers at one time and to compare results. Many states, moreover, do not have any peer review statutes at all. The IOM, therefore, recommended legislation to ensure that peer review proceedings and reports remain confidential.[105]

The President believes that new, good faith efforts to improve the quality and safety of health care should be protected and encouraged, not penalized by new lawsuits. President Bush has on several occasions urged Congress to address this problem by enacting legislation that will give health professionals the confidence necessary to expand their reporting of problems in the health care system.

Following the President's request, and with assistance from the Administration, legislation was introduced in both Houses of Congress last year that would provide confidentiality and other protections for information reported to Patient Safety Organizations and for their collaborative efforts to improve care. A tri-partisan Bill that reflects the President's goals, sponsored by Senators Jeffords, Breaux, Frist, and Gregg, was introduced in the Senate last year (S. 2590). The House Energy and Commerce Committee and the Ways and Means Committee recently reported similar bills (H.R. 663 and H.R. 877 respectively). Passage of this kind of legislation will ensure that patient safety and quality reports are given the protection they deserve.

The assurance of confidentiality is a proven approach to increase reporting by doctors, nurses, and other health care providers. With more information, quality experts will be better able to identify problems and recommend improvements in a proactive way. Rather than reacting to an avoidable injury or quality problem after it occurs, without benefit of careful and systematic review, medical professionals will be able to find system weaknesses and fix them before a patient is injured. Passage of the legislation will improve the quality of health care.

VIII. IT IS SPECIOUS TO BLAME INSURERS FOR THE CRISIS

Trial lawyers, and interest groups associated with them, do not dispute the fact that there is an insurance crisis. They argue, however, that the fault lies with the insurance companies themselves--not the litigation system--and that the cure is not to impose a reasonable limit on the amount of non-economic damages, but instead for doctors to form their own insurance companies.

The trial lawyers' advice to doctors to organize their own insurance companies overlooked the fact that doctors have already done this. Physician-owned companies currently insure more than 60% of doctors.[106] A number of doctor-owned companies were created in the 1970s, when many doctors were unable to obtain coverage. Not surprisingly, however, these companies have suffered the same increases in claim costs as the commercial companies.[107] The reason is that the overriding cost element--the litigation the excesses of the litigation system--affects all insurers regardless of their form of ownership.

The trial lawyers assert, however, that the problem is not the increase in the amounts insurers pay out but the insurers' management practices. They argue that insurers are making up for bad investments in the stock market; they point out that interest rates have declined; and they complain that the premiums the insurers charged in the 1990s were too low. From these statements they somehow seek to persuade us that the

litigation system is not causing the crisis.

If the factors alleged by the trial lawyers explained the problem, insurers in every state would be forced to increase their premiums to the same extent. But the fact is that the insurers are being forced to increase their premiums more rapidly and more steeply in the non-reform states than in states that have placed reasonable limits on non-economic damages.

The difference in premiums among the different states cannot be explained by management practices. When St. Paul Companies pulled out of the malpractice insurance market in 2002, they continued to offer other lines of insurance. The difference is the litigation climate in which the different lines of insurance are required to operate.

The argument that the problem is caused by bad investments is similarly specious. In fact, investments by medical malpractice companies have been conservative. Most states have laws that specifically limit the percentage of assets an insurance company can put in stocks. Over the last five years, the industry wide allocation of assets into equities has been relatively constant. Medical malpractice insurers' investments in equities as a percentage of total assets, as shown below, has been 11% or less.

TABLE 8. Five Year Historical Asset Allocation Table for Medical Malpractice Carriers

	Asset Class						
	Cash	Corp	Equity	Govt	Muni	Other	Pref
	%	%	%	%	%	%	%
1997	4.98	27.61	8.87	21.12	34.19	1.27	1.96
1998	5.83	26.51	8.93	18.77	36.44	1.89	1.64
1999	5.39	28.52	10.78	15.54	36.89	1.37	1.51
2000	6.48	30.89	9.72	14.90	35.03	1.40	1.57
2001	7.74	34.84	9.03	13.73	31.41	1.53	1.73
SOURCE: Brown Brothers Harriman & Co., 2002.							

Insurers' returns on bonds have decreased. Interest rates have declined in the country and the world. The amounts earned on investments help pay claims. But the investment climate is a fact, beyond the control of the insurance companies. Their need to raise premiums can best be reduced by controlling increases in the amounts they must pay out--particularly for unreasonable amounts of non-economic damages. Neither asset allocation nor investment income correlates to, much less causes, the current medical malpractice crisis. Specifically, Brown Brothers Harriman & Company analyzed the relationship between premiums and the change in investment yields among malpractice insurers. The results showed that the performance of the economy and interest rates do not determine medical malpractice premiums.[108]

While the trial lawyers' argue that insurers' premiums were too low in prior years, premiums are affected by the competitive climate, in the context of costs that all participants must bear. If premiums were "too low" in previous years, this just means that physicians were charged less then than the trial lawyers believe they should have been. It does not change the costs the insurers are forced to pay or the total amount of premiums that would have to be collected; even under the trial lawyers' theory of how the insurers should price their product, some undetermined amount of the premiums being charged currently should have been collected in previous years. It would not change the total revenue needs of the insurers (which are determined by the amount they must pay out).

The trial lawyers' argument that the root of the crisis lies in the organizational form or management practices of the insurers thus has no validity.

Trial lawyers also attempt to shift the blame to insurers by asserting that they have engaged in anti-competitive practices. The NAIC has reviewed this assertion and reported that "insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation."[109] Rather, the NAIC also says, "the preliminary evidences points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice [insurance] prices."[110]

Consistent with their failure to focus on the costs the insurers must bear, the trial lawyers argue, finally, that California's MICRA legislation, placing reasonable limits on non-economic compensation, is not the cause of California's success in avoiding the increase in premiums that non-reform states have experienced. They point, instead, to a change in the law of California in 1988 that imposed rate review on the premiums of insurance companies. Regulation, however, cannot avoid the need for insurers to receive a premium sufficient to pay their expenses and make a fair profit. Nor does California's regulation of premiums differentiate it from the rest of the country. As the NAIC explains, "Almost all states have rating laws for property and casualty insurers, including medical malpractice. These rating laws require that insurance rates not be excessive, inadequate or unfairly discriminatory."[111] California's adoption of increased regulation in 1988 therefore does not explain its ability to avoid the rapid increase in premiums and access problems that states without reasonable caps have experienced.

In fact, premiums in the rest of the country already were increasing more rapidly than in California before 1988, as shown in Figure 1. What makes the difference is the litigation system, not insurance reforms.

CONCLUSION

Americans' access to high quality care is threatened by the excesses of the litigation system. Higher costs for defending claims, larger judgments, particularly for subjective non-economic damages in states that have not introduced reasonable limits on non-economic damages, and settlements that reflect the trend of jury awards are raising insurers' costs. Insurers must raise premiums to pay claims. Patients are paying the price in reduced access to care as doctors increasingly leave the states with the highest costs, retire, or restrict their practice. Patients are being injured. The crisis is going to get worse if we do not act; the insurance regulators believe premiums in many states are currently too low States like California that have placed reasonable limits on the amount of non-economic damages are not suffering the same high premiums and reductions of access to care as the states that do not have such limits. The Administration supports legislation that will ensure that all state have the benefit of reasonable limits, which will stabilize their insurance markets and encourage doctors to continue to practice there.

In addition, legislation is necessary to protect efforts by hospitals, doctors, and other experts to improve quality by encouraging reporting of needed information and collaborative use of it. Reports about safety problems and "close calls" in the course of health care are essential to improving quality, but the litigation system now discourages reporting and impedes the exchange of information and collaboration necessary t improve quality. The efforts of health professionals to improve quality will be enhanced if the information developed for these purposes is protected from use in the litigation system. Quality of care can best be protected, and improved, by health care experts, not by lawyers.

Enactment of these two reforms will improve the litigation system, increase access to health care, reduce the cost of health care, and improve quality. It will do so while ensuring that injured patients have the same access to information about their care as they do now, and that they can recover all their actual losses and a reasonable amount of non-economic damages as well.

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Medicaid, Veterans' Affairs, and other federal programs; $263 million in liability insurance paid through health benefits for its employees and retired employees; and $1 billion in lost tax revenue from self-employed and employer-sponsored health insurance premiums that are excluded from income.

63. Total Federal health care expenditures in 2002 were estimated to be $562 billion. Estimates show that medical liability reforms would lead to a decline in medical expenses from defensive medicine amounting to 5% to 9% of total medical costs (See Kessler, D. and McClellan, M, 1996). Our estimate of the savings to the Federal Government from reduced defensive medicine would range from $28.1 billion (5% of $561.837 billion) to $50.5 billion (9% of $561.837 billion).

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107. The current President of PIAA, Lawrence Smarr, reported in a presentation at the Health Policy Summit in Jacksonville, FL on

December 17, 2002, that he himself once thought that physician-owned malpractice insurance companies would be able to restrain costs more effectively than commercial companies. He left employment with a commercial company to work for a physician-owned one. He described, however, that experience taught him otherwise. Physician owned and commercial carriers face the same challenges--the escalating losses that are generated by the litigation system.

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110. Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.

111. Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.

Caps on Damages

Over 25 states have enacted laws that place a cap on damages in medical liability actions. Of these laws, states vary widely in the amount of the cap and type of damages that are covered by the cap. For example, California has a $250,000 cap on noneconomic damages. By comparison, Nebraska has a $1.75 million cap on total damages. (of which qualified health care providers shall only be liable for $200,000). In addition, state laws vary in the type of circumstances in which the cap applies. For example, Michigan has a secondary cap on noneconomic damages of $500,000 that applies in cases where the plaintiff is hemiplegic, paraplegic, or quadriplegic due to an injury to the brain or spinal cord, or where the plaintiff has permanently impaired cognitive capacity. Likewise in many states the cap on damages does not apply in cases of gross malpractice. Finally, caps in many states are adjusted annually for inflation.

At least eleven states have enacted caps that have been challenged and overturned by state courts as unconstitutional. Many of the states, such as Ohio, Oregon, and Washington, are now facing a medical liability crisis. In addition, existing caps in at least three states are either currently facing a legal challenge or will likely face a legal challenge in the near future. The Constitution in several states also explicitly prohibit caps on damages, such as Arizona, Kentucky, Pennsylvania, and Wyoming

Below please find a summary of state laws that cap damages in medical liability actions (regular type) and state laws that have been legally challenged and overturned by state courts (bold).

Caps on Damages - Summary of State Laws and Legal Challenges

(Note: with the exception of Georgia and Pennsylvania, the following information does not address state caps on punitive damages.)

key: Hard fixed cap with no exceptions for certain injuries
Cap adjusted annually or scheduled to increase on specific da[illegible]

Alabama- None
$400,000 cap on noneconomic damages; $1 million cap on wrongful death damages, overturned, *Smith v. Shulte,* 671 So.2d 1331 (1991), *cert. denied,* 517 U.S. 1220 (1996).

Alaska-$400,000 cap on noneconomic damages, or $8000 multiplied by the injured party's life expectancy, whichever is greater. For severe medical impairment/ disfigurement, limits are the greater of $1 million or life expectancy multiplied by $25,000. (1997). Upheld, *Evans v. State,* 56 P.3d 1046 (Alas. 2002).

Arizona-None - Constitution prohibits limiting recoverable damages

Arkansas-None

California-$250,000 cap on noneconomic damages. (1975) Upheld, *Fein v. Permanente Medical Group,* 38 Cal. 3d 137, 695 P.2d 665 (1985).

Colorado-$1 million cap on total damages, including any derivative claim by any other claimant, of which non-economic losses shall not exceed $250,000 (including any derivative claim by any other claimant). Upon good cause shown and if the court determines such limit would be unfair, the court may award damages in excess of the limit. In this case, the court may award the present value of additional future damages only for loss of such excess future earnings or such excess future medical and other health care costs, or both. (1988) Upheld, *Scholz v. Metropolitan Pathologists P.C.*, 851 P.2d 901 (1993).

Connecticut-None

Delaware-None

D.C.-None

Florida- For providers, $500,000 cap on non-economic damages for causes of action for injury or wrongful death due to medical negligence of physicians and other health care providers. Cap applies per claimant regardless of the number of defendants. Cap increases to $1 million for certain exceptions. For non-providers, $750,000 cap on non-economic damages per claimant for causes of action for injury or wrongful death due to the medical negligence of nonpractitioners, regardless of the number of nonpractitioner defendants. Cap increases to $1.5 million for certain exceptions. (2003)

Previous law upheld but subject to rules on voluntary arbitration, *Univ. of Miami v.Echarte*, 618 So.2d 189 (1993).

Georgia-$250,000 cap on punitive damages. (1992)

Hawaii-$375,000 cap on noneconomic damages, with exceptions for certain types of damages, ie. mental anguish. (1986)

Idaho- $250,000 cap on non-economic damages per claimant in personal injury and wrongful death actions. The cap will be adjusted annually beginning July 1, 2004 based on the average annual wage. The limit does not apply to causes of action arising out of willful or reckless misconduct, or felonious action. (2003) Upheld, *Kirkland v. Blaine County Medical Center*, 134 Idaho 464, 4 P.3d 1115 (2000).

Illinois- None
$500,000 cap on noneconomic damages, overturned *Best v. Taylor Machine Works*, 689 N.E.2d 1057 (Ill. 1997).

$500,000 cap on economic and noneconomic damages, overturned *Wright v. Central DuPage Hospital Assn.*, 63 Ill.2d 313, 347 N.E.2d 736 (1976).

Indiana-$750,000 cap on total damages for any act of malpractice that occurs after 12/31/89 and before 7/1/99. $1.25 million total cap for any act of malpractice that occurs after 6/30/99. Health care providers are not liable for more than $250,000 for an occurrence of malpractice any

amount awarded in excess of $250,000 will be paid through the Patient Compensation Fund. (1975) Upheld, *Johnson v. St. Vincent Hospital*, 404 N.E. 2d 585 (1980).

Iowa-None

Kansas-$250,000 cap on noneconomic damages. This is the total amount of non-economic damages recoverable by each party from all of the defendants. (1988) Upheld, *Samsel v. Wheeler Transport Services, Inc.*, 246 Kan. 336 (1990)

Previous law struck down as unconstitutional, *Kansas Malpractice Victims Coalition v. Bell*, 243 Kan. 333, 757 P.2d 251 (1988).

Kentucky- None. Constitution prohibits cap on damages.

Louisiana-$500,000 cap on total damages, excluding damages recoverable for medical care. A health care provider covered by the Patient's Compensation Fund shall not be liable for more than $100,000. The Patient's Compensation Fund will cover the excess amount awarded up to the cap. (1975) Upheld caps on total damages, but future medical expenses are excluded from cap, *Butler v. Flint Goodrich Hospital of Dillard University*, 607 So. 2d 517 (1992).

Maine-$400,000 cap on noneconomic damages in wrongful death actions. (1999)

Maryland-$500,000 cap on noneconomic damages in any action for personal injury or wrongful death arising on or after October 1, 1994. The cap will be increased by $15,000 on October 1 each year beginning in 1995. As of 10/1/2002 the cap is $620,000. In wrongful death actions with two or more claimants or beneficiaries, the judge may award up to 150% of the cap. (1986, 1989, 1994, 1997, 2000) Upheld, *Murphy v. Edmunds*, 325 MD 342, 601 A.2d 102 (1992).

Massachusetts-$500,000 cap on noneconomic damages, with exceptions for proof of substantial disfigurement or permanent loss or impairment, or other special circumstances which warrant a finding that imposition of such limitation would deprive the plaintiff of just compensation for the injuries sustained. (1986)

Michigan - $280,000 cap on noneconomic damages, adjusted annually for inflation, except cases where the plaintiff is hemiplegic, paraplegic, or quadriplegic due to an injury to the brain or spinal cord, or where the plaintiff has permanently impaired cognitive capacity rendering him incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of normal daily living, or the plaintiff has permanent loss or damage to a reproductive organ resulting in the inability to procreate, [illegible] noneconomic damages shall not exceed $500,000. As of 2002 the $280,000 cap is $349,700 and the $500,000 cap is $624,500. (1993) Upheld, *Zdrojewski v. Murphy*, 202 Mich. App. Lexis 1566 (2002).

Minnesota-None

Mississippi-$500,000 cap on noneconomic damages for any action for injury based on malpractice or breach of standard of care. Cap does not apply if the judge determines that a jury may impose punitive damages or to damages for disfigurement. Cap will be adjusted to $750,000 for claims for causes of action filed on or after July 1, 2011 but before July 1, 2017. Cap will be adjusted again on July 1, 2017 to $1,000,000. (2002)

Missouri-$350,000 cap on noneconomic damages, adjusted annually for [illegible] 1/1/2003 the cap is $557,000. (1986) Upheld, *Adams v. Children's Mercy Hospital*, 848 S.W. 2d 535 (1993).

Montana-$250,000 cap on noneconomic damages per occurrence. If a single incident of malpractice injures multiple, unrelated patients, the $250,000 cap applies to each patient and all claims deriving from injuries to that patient. (1995, 1997)

Nebraska-$1.75 million in total damages. Health care providers who qualify under the Hospital-Medical Liability Act (i.e. carry minimum levels of liability insurance and pay surcharge into excess coverage fund) shall not be liable for more than $200,000 in total damages. Any excess damages shall be paid from the excess coverage fund. (1976, 1984, 1986, 1992, 2003) Upheld, *Prendergast v. Nelson*, 256 N.W.2d 657 (1977); *Gourley ex. rel Gourley v. Nebraska Methodist Health System Inc.*, 265 Neb. 918, 633 N.W.2d 43 (Neb. 2003).

Nevada-$350,000 cap on noneconomic damages awarded to each plaintiff from each defendant except when:
(1) the defendant's conduct constitutes gross malpractice, or
(2) the court determines by clear and convincing evidence that a higher award is justified because of exceptional circumstances. (2002)

New Hampshire-None
$875,000 cap on noneconomic damages, overturned, *Brannigan v. Usitalso,* 587 A.2d 1232 (N.H. 1991).

$250,000 cap on noneconomic damages in medical malpractice, overturned, *Carson v. Maurer,* 424 A.2d 825 (N.H. 1980).

New Jersey-None

New Mexico-$600,000 cap on total damages, excluding punitive damages and past and future medical care. Health care providers personal liability shall not exceed $200,000, any award in excess of this amount shall be paid by the patient compensation fund. (1992) Upheld, *Fed. Express Corp. v. United States*, 228 F. Supp. 2d 1267 (NM 2002).

New York-None

North Carolina-None

North Dakota-$500,000 cap on noneconomic damages. (1995) Economic damage awards in excess of $250,000 are subject to judicial review for reasonableness. (1987)

Previous law struck down as unconstitutional. *Arneson v. Olson*, 270 N.W.2d (N.D. 1978).

Ohio- Establishes a sliding cap on non-economic damages. The cap shall not exceed the greater of $250,000 or three times the plaintiff's economic loss up to a maximum of $350,000 for each plaintiff or $500,000 per occurrence.
The maximum cap will increase to $500,000 per plaintiff or $1,000,000 per occurrence for a claim based on either (A) a permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or (B) a permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and person life sustaining activities. (2002)

Note: The Ohio Legislature's previous attempts to enact a law with a cap on non-economic damages were overturned by the Ohio Supreme Court. For example, $250,000-500,000 sliding scale cap on noneconomic damages, overturned, State ex rel. Ohio Academy of Trial Lawyers v. Sheward, *86 Ohio 3d 451, 715 N.E. 2d (1999).*

Oklahoma- cap on non-economic damages of $300,000 in cases involving pregnancy, labor and delivery, or care provided immediately post-partum. The cap also applies in cases involving emergency-room care or medical services provided as a follow up to such care. The judge may lift the cap if the judge makes a finding, out of the presence of the jury, that there is clear and convincing evidence of negligence. The cap applies regardless of the number of parties against whom the medical negligence action is brought. The $300,000 damage limit does not, however, apply in wrongful death cases because the Oklahoma Constitution specifically limits damage limitations in those types of cases. The cap provision will sunset in 5 years. (2003)

Oregon-None
$500,000 cap on noneconomic damages, overturned, *Lakin v. Senco Products*, 987 P.2d 463 (Or. 1999).

Pennsylvania-Constitution prohibits caps on non-economic damages. Punitive damages are capped at 2 times actual damages.

Rhode Island-None

South Carolina-None

South Dakota-$500,000 cap on total general (non-economic) damages. (1985, revived by 1996 court decision)

Struck down cap on total damages, revived cap on non-economic damages, *Knowles ex. rel. Knowles v. United States*, 544 N.W. 2d 183 (SD 1996).

Tennessee-None

Texas-$250,000 cap on non-economic damages for claims against physicians and other health care providers. The cap applies per claimant regardless of the number of defendants. Also provides a $250,000 cap on noneconomic damages in judgment against single health care institution and a $500,000 cap on noneconomic damages if judgment is rendered against two or more health care institutions, with the total amount of noneconomic damages for each individual institution, not exceeding $250,000 per claimant, irrespective of the number defendants, causes of action, or vicarious liability theories involved. The *total* amount of noneconomic damages for health care institutions cannot exceed $500,000. Combining the liability limits for physicians, health care providers, and institutions, the maximum noneconomic damages that a claimant could recover in a health care liability claim is capped at $750,000. (2003)
Proposition 12, a ballot initiative to amend the Texas Constitution to specifically allow the legislature to enact laws that place limits on non-economic damages in health care and medical liability cases, was approved by the voters on September 13, 2003.

$500,000 cap on total civil damages for wrongful death, indexed for inflation since 1977. The cap does not apply to medical, hospital, and custodial care received before judgment or required in the future. In 2002 the cap reached approximately $1.6 million. (1977, limited by 1990 court decision)

$500,000 cap on noneconomic damages (adjusted annually), overturned as applied to cases other than wrongful death, *Rose v. Doctors Hospital,* 801 S.W. 2d 841 (Tex. 1990).

Utah-$250,000 cap on noneconomic damages for causes of action arising before July 1, 20[illegible] $400,000 cap on noneconomic damages for causes of action arising on or after July 1, 2001, and before July 1, 2002. Indexed annually for inflation thereafter. (1986, 2001)

Vermont-None

Virginia-$1.5 million cap on total damages for acts occurring on or after Aug. 1, 1999. This is increased by $50,000 annually beginning on or after July 1, 2000 until July 1, 2006. On July 1, 2007 and July 1, 2008 the cap is increased by $75,000. The last increase shall be July 1, 20[illegible] (1976, 1977, 1983, 1999, 2001) Upheld, *Etheridge, et.al. v. Medical Center Hospitals*, 237 Va. 87, 376 S.E.2d 525 (Va. 1989).

Washington-None
Sliding cap on noneconomic damages, overturned, *Sophie v. Fiberboard Corp.,* 771 P.2d 711 (Wash. 1989).

West Virginia- $250,000 cap on non-economic damages per occurrence, regardless of the number of plaintiffs and number of defendants. The cap increases to $500,000 per occurrence, for the following types of injuries; permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system; or permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities. The limits only apply to defendants who have at

least $1,000,000 per occurrence in medical liability insurance. The limits will be adjusted annually for inflation up to $375,000 per occurrence or $750,000 for injuries that fall within the exception. (2003)

Upheld previous cap on non-economic damages, *Robinson v. Charleston Area Med. Center,* 186 W.Va. 720 (1991); *Verba v. Ghaphery* 552 S.E. 2d 406(W.Va. 2001).

Wisconsin-$350,000 cap on noneconomic damages for bodily injury or death. The cap applies to each occurrence on or after May 1, 1995 and is adjusted at least annually for inflation. In wrongful death actions, noneconomic damages shall not exceed $350,000 per occurrence in the case of a deceased adult, and $500,000 per occurrence for a deceased minor. As of 4/1/03 the cap on non-economic damages is [illegible]. (1979, 1985, 1995) Upheld, *Guzman v. St. Francis Hospital,* 240 Wis. 2d 559, 623 N.W. 2d 776 (2000).

Wyoming-None - Constitution prohibits caps

For more information please contact the AMA Advocacy Resource Center at (312) 464-4765.

Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

STATE	CAPS	CASELAW	RATIONALE
Alabama	Struck down (Upheld caps only in wrongful death actions).	Moore v. Mobile Infirmary Association, 592 So.2d 156 (1991).	Cap represents impermissible burden on the right to trial.
Alaska	*Upheld*	*Evans v. State, 56 P.3d 1046 (Alas. 2002).*	*Upheld cap as constitutional. Court held the cap does not infringe on the right to a trial by jury or access to courts and does not deny substantive due process. The cap does not violate the equal protection clause, separation of powers, or the prohibition against "special legislation."*
California	Upheld Upheld	Hoffman v. United, 767 F.2d 1431 (1985). *Fein v. Permanente Medical Group, 38 Cal 3d 137, 695 P.2d 665 (1985).*	Upheld on constitutional grounds - statute does not involve a suspect classification or fundamental right and legislature had a legitimate purpose (reducing insurance premiums.) *Upheld on constitutional grounds – cap does not violate due process or equal protection clause because it is rationally related to a legitimate state interest.*
Colorado	Upheld	Scholz v. Metropolitan Pathologists P.C., 851 P.2d 901 (1993).	State statute does not infringe on a fundamental right, nor create a classification based on race, religion, national origin or gender. It also bears a reasonable relationship to a legitimate state objective.
Florida	Upheld but subject to rules on voluntary arbitration. (Punitive damages in excess of 3 times economic damages or $500,000 are presumed excessive). ***Note: New law enacted in 2003***	University of Miami v. Echarte, 618 So.2d 189 (1993).	*Upheld on constitutional grounds – statute does not violate the right of access to courts because the cap is only used within the arbitration process which provides claimants with a commensurate benefit in exchange for the loss of full non-economic damages.* *Without discussion the court also held the cap does not violate the right to a trial by jury, equal protection clause, substantive due process clause, single subject rule, takings clause, or the non-delegation doctrine.*
Idaho	*Upheld*	*Kirkland v. Blaine County Medical Center, 134 Idaho 464, 4 P.3d 115 (Idaho, 2000).*	*Cap does not violate state constitution prohibition against special legislation because it was not an arbitrary, capricious, or unreasonable method for addressing the state's legitimate interest in protecting availability of liability insurance.*
Illinois	Struck down	Best v. Taylor Machine Works 179 Ill.2d 367, 689 N.E. 2d.1057 (1997).	Cap on non-economic damages struck down as unconstitutional. *Court held that the cap violated the prohibition against special legislation and separation of powers clause.*

Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

STATE	CAPS	CASELAW	RATIONALE
Indiana	Upheld	Johnson v. St. Vincent Hospital, 404 N.E.2d 585 (1980).	*Upheld the Indiana Medical Malpractice Act as constitutional. In particular, found that the cap on total damages does not violate the state or federal due process clauses, equal protection clause, or right to a jury trial.*
Kansas	Upheld	Samsel v. Wheeler Transport Services, Inc., 246 Kan. 336 (1990).	Cap on non-economic damages provided in the 1988 law does not violate due process or right to trial. Disapproved on other grounds. Differentiated Kansas Malpractice Victims which overturned 1987 law capping non-economic damages.
Louisiana	Upheld caps on total damages, but future medical expenses are excluded from cap	Butler v. Flint Goodrich Hospital of Dillard University, 607 So. 2d 517(1992).	Cap on damages does not violate due process or equal protection clauses because it is not arbitrary, capricious, or unreasonable.
Maryland	Upheld	Murphy v. Edmunds, 325 MD 342, 601 A.2d 102 (1992).	Cap is constitutional because it is rationally related to a legitimate governmental interest and does not restrict access to the courts.
Michigan	Upheld	Zdrojewski v. Murphy, 202 Mich. App. Lexis 1566 (2002).	Cap is constitutional because the legislature has the right to modify common law and statutory rights and remedies. Also, the jury still determines the facts and amount of damages so the right to trial by jury is not violated.
Minnesota	*Upheld* ***Note: Statute repealed.***	*Schweich, et. al. v. Ziegler, 463 N.W.2d 722 (Minn. 1990).*	*Cap does not violate state constitution because it achieves a legitimate legislative purpose of lowering insurance rates and providing predictable damage awards.*
Missouri	Upheld	Adams v. Children's Mercy Hospital, 848 S.W. 2d 535 (1993).	Statute does not violate equal protection, open courts doctrine, or right to jury trial. Statute is related to a legitimate state interest - medical malpractice insurance crisis.
Nebraska	Upheld	Prendergast v. Nelson, 256 N.W.2d 657 (1977).	Upheld the constitutionally of a state medical liability statute, holding that defendant failed to rebut the presumption of the statue's constitutionality.
	Upheld	*Gourley ex. rel Gourley v. Nebraska Methodist Health System Inc., 265 Neb. 918, 633 N.W.2d 43 (Neb. 2003).*	*Cap on total damages does not violate the state constitution's equal protection clause, right to jury trial, open courts doctrine, separation of powers, or principles prohibiting special legislation.*

American Medical Association
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Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

STATE	CAPS	CASELAW	RATIONALE
New Hampshire	Struck down $875,000 cap *Struck down $250,000 cap*	Brannigan v. Usitalo, 587 A.2d 1232 (N.H. 1991). *Carson v. Maurer, 425 A.2d 825 (NH 1980).*	Cap violated equal protection. The purpose of the legislation did not outweigh the rights of individuals. *Cap violated state equal protection clause.*
New Mexico	*Upheld*	*Fed. Express Corp. v. United States, 228 F. Supp. 2d 1267 (NM 2002).*	*Cap is not arbitrary and capricious and does not violate equal protection clause in state constitution because it is rationally related to a legitimate legislative goal of ensuring a source of recovery for victims of medical malpractice and curbing runaway costs of healthcare.*
North Dakota	Struck down **Note: N.D. Cent. Code §32.42-02 enacted in 1995 established $500,000 cap on total non-economic damages**	Arneson v. Olson, 270 N.W. 2d (N.D. 1978).	The cap constituted an unconstitutional deprivation of the right to a jury trial under N.D. Const. § 7. Found entire statute unconstitutional.
Ohio	Struck down (see below) ***Note: New law enacted in 2002***	State v. Ohio Academy of Trial Lawyers v. Sheward, 86 Ohio 3d 451, 715 N.E. 2d (1999).	*Court overturned caps as a violation of the due process clause. Court also found the entire bill unconstitutional as a violation of the one subject rule and separation of powers clause.*
Oregon	Struck down	Lakin v. Senco Products, Inc. 329 OR 62, 987 P.2d 463, (1999).	Court overturned cap as a violation of the right to a jury trial which is customary under common law.
South Dakota	*Struck down cap on total damages, revived cap on non-economic damages*	*Knowles ex. rel. Knowles v. United States, 544 N.W. 2d 183 (SD 1996).*	*Cap on total damages held unconstitutional as a violation of the right to a trial by jury because the amount of damages is a factual issues to be decided by a jury. The cap also violated the open courts doctrine by limiting a provider's liability and the due process clause because it created an arbitrary classification of claimants in a malpractice action.*

American Medical Association
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Text in italics updated by Advocacy Resource Center, October 2003

Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

STATE	CAPS	CASELAW	RATIONALE
Texas	Struck down	Lucas v. United States, 757 S.W. 2d 687 (1988).	*Court found cap unconstitutional as applied to common law medical malpractice cases. The court held the cap violated the open courts doctrine because such limits are an unreasonable and arbitrary way to assure a rational relationship between actual damages and amounts awarded.*
	Upheld cap in wrongful death ***Note: New law enacted in 2003***	Rose V. Doctors Hospital, 801 S.W. 2d 841 (1990). (Wrongful death case)	*Upheld cap as applied to wrongful death cases. Court held cap does not violate open courts doctrine or state or federal equal protection clauses.*
Virginia	*Upheld*	*Etheridge, et. al. v. Medical Center Hospitals, 237 Va. 87, 376 S.E. 2d 525 (Va. 1989).*	*The cap is constitutional. It does not infringe on a right to a trial by jury because once the jury determines the facts, the court merely applies the law to the facts. Cap also does not violate the procedural due process, substantive due process clauses, separation of powers clause, or the prohibition against special legislation. The court also held the statute does not violate the equal protection clause of the U.S. constitution.*
Washington	Struck down	Sofie v. Fibreboard Corp. 112 N.W. 2d 636,771 P.2d. 711 (1989).	Court held that cap is an unconstitutional infringement of the right to trial by jury.
West Virginia	Upheld previous cap on non-economic damages	Robinson v. Charleston Area Med. Center, 186 W.Va. 720 (1991).	Upheld constitutionality of cap against challenge of equal protection, special legislation, due process and right to a jury trial. The legislation provides an alternative legal remedy. The purpose of the law is to curtail/eliminate a social/economic problem – exorbitant medical malpractice insurance premiums. The cap on non-economic damages applies to the aggregate claims of all plaintiffs.
	Upheld previous cap on non-economic damages ***Note: new law enacted in 2003***	*Verba v. Ghaphery 552 S.E. 2d 406 (W.Va. 2001).*	*Affirmed Robinson and rejected appellant's claim that cap is invalid because of inflationary erosion and that attorney fees and costs should be awarded in cases where non-economic damages exceed the statutory cap.*
Wisconsin	Upheld	Guzman v. St. Francis Hospital, 240 Wis. 2d 559, 623 N.W. 2d 776 (2000).	The cap does not infringe on the right to a jury trial because the right to trial is not affected and the legislature can set amount of recovery. *Cap also does not violate the access to courts doctrine or the separation of powers, equal protection, or substantive due process clauses.*

American Medical Association
Original content provided by Division of Health Law
Text in Italics updated by Advocacy Resource Center, October 2003

Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

Deleted reference to Montana case, Linder v. Smith, 629 P.2d 1187 (Mont. 1981) because the case concerned only Montana's Medical Legal Panel Act, not the cap on non-economic damages.

Deleted reference to Georgia case, Denton v. Con-Way Southern Express, Inc. 402 S.E.2d 269 (1991) because the case concerned the constitutionality of collateral source reform.

NOV 14 2003

Medical Insurance Exchange of California
Claremont Liability Insurance Company
Medical Underwriters of California
management company

Memo

Date: November 11, 2003

To: MIEC Board of Governors & Committee members
MUC Board of Directors
Dave Willett; Tim Shannon; Don Steffen; Ron Kozlowski; Tom Hermes;
Lauren Kielian; Jim King; Vicki Nicely; Diane Major; Judy Huerta

From: Ron Neupauer *Ron*

Re: Medical Liability Monitor 2003 Rate survey

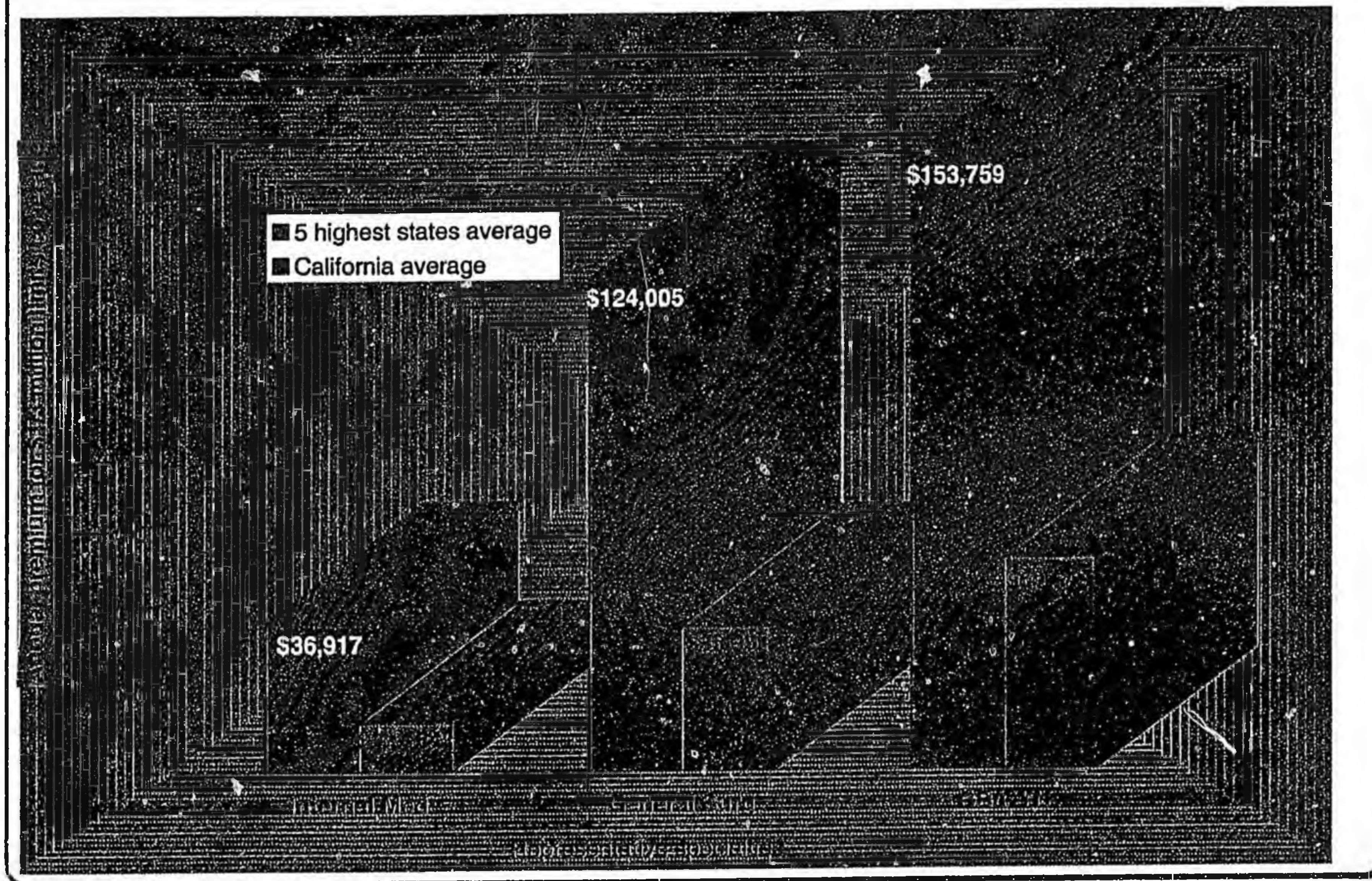
Each year, Medical Liability Monitor asks leading medical liability insurers in each state to supply current malpractice insurance rate information for three representative medical specialties: Internal medicine, general surgery, and ob/gyn. They are asked to give rates for $1/3 million limits, mature claims made coverage, or the nearest equivalent. Some states use mandated Patient Compensation Funds to provide excess coverage. The comparisons factor in the cost of these funds.

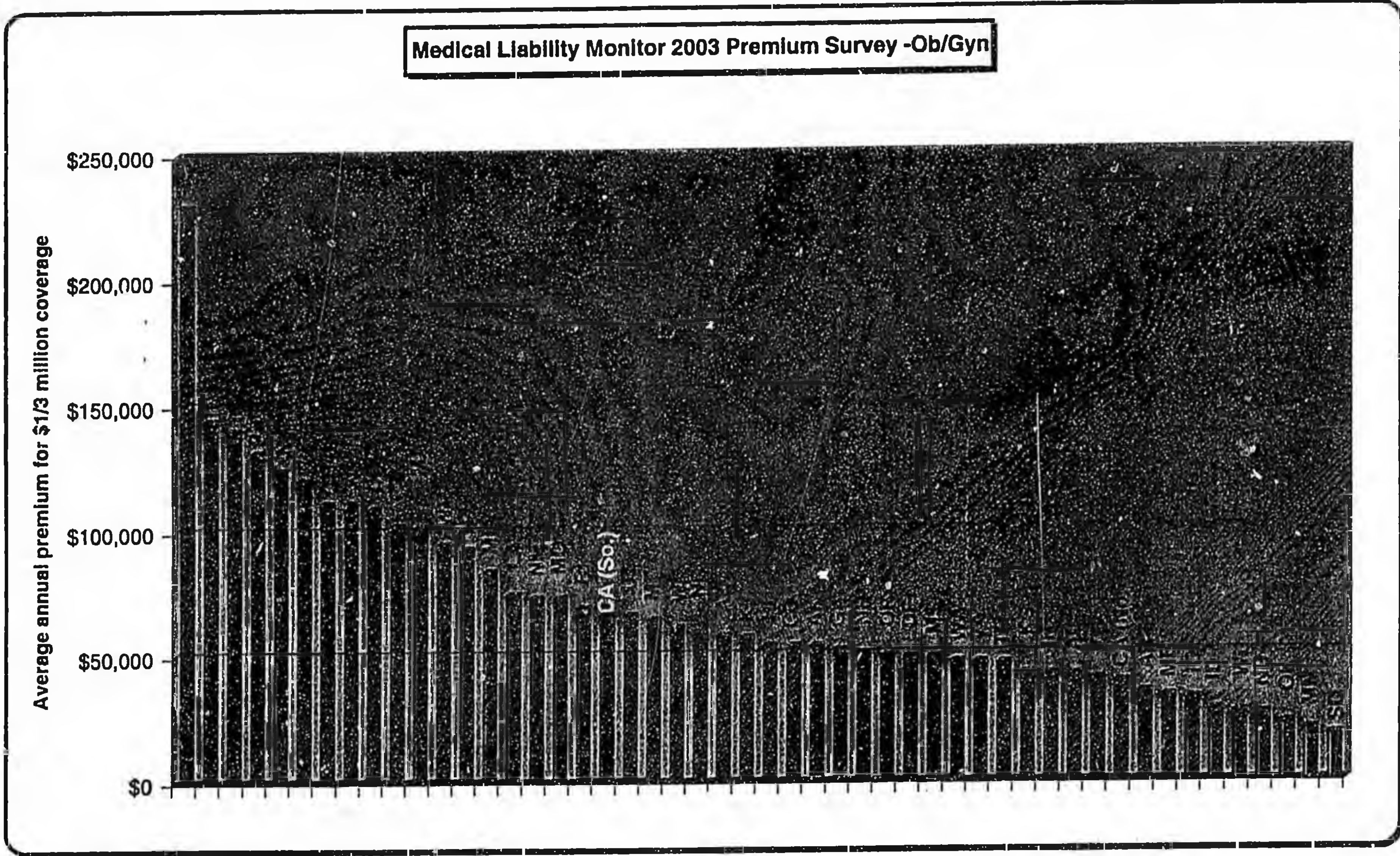
Medical Liability Monitor includes comments on trends. Here are some quotes from this year's issue:

- Of the 641 rate changes reported, 196 were increases of between 25 to 69 percent, and 15 were increases of 70% or more.
- Doctor-owned companies in Illinois, Washington, Mississippi, Pennsylvania and Missouri have stopped accepting new business due to capital constraints.
- Doctors are restricting their practice, buying lower limits of coverage and looking to start up alternative means of funding malpractice risk to escape the higher premiums.
- 83% of the survey respondents predict additional large rate increases will be needed in the future.
- California rates are significantly lower than other states with similar population demographics. To illustrate this, we converted the data for each specialty to a series of bar graphs depicting average premium by state, from the most expensive to least. We divided California into Northern and Southern due to the considerable disparity in rates between the territories. Attached is the result for ob/gyn. On the reverse side is a second bar graph showing the difference between average California (entire state) rates and those of the five highest states. The differential in the three representative specialties has grown to 3:1. The only reasonable conclusion that can be drawn by this is that MICRA has kept California rates at levels dramatically lower than they would be absent these tort reforms. No other populous state has anything like MICRA, and we can offer no plausible explanation other than MICRA for this huge rate disparity.

Please let me know if you have questions or comments about this survey.

Physician owned insurers malpractice premium comparison - 2003





Medical Liability Monitor 2003 Premium Survey -Ob/Gyn
$250,000
$200,000
$150,000
$100,000
$50,000
$0
Average annual premium for $1/3 million coverage
CA (So.)

Date: September 23, 2003

Media Contact:

Chuck Moran
Pennsylvania Medical Society
(717) 558-7820

For Immediate Release

New Study Validates Caps on Non-Economic Damages as Critical Lawsuit Abuse Reform

Milliman USA study proves caps work

(Harrisburg, Pa.) - A cap of $250,000 on non-economic damages would reduce combined losses and defense costs for liability insurance policies by about 18 percent says a new report released today.

That's the conclusion by Milliman USA, Inc., after investigating the impact of limits on non-economic damage awards in Pennsylvania.

According to the study, with caps the level of losses to the state's Mcare fund would be projected to decrease by 42 percent.

In calculating its findings, Milliman USA used data from the National Practitioner Data Bank, as well as state insurance departments. The report notes that in Florida more than 75 percent of paid losses are for non-economic damages, while in Texas, 60 percent of paid losses are for non-economic damages.

"Caps on non-economic damages are widely viewed as the most effective reform measures to help control escalating medical malpractice costs," the study's report reads.

The study further concluded that while tort reforms directly affect verdicts, settlements would also be impacted.

"Lawsuit abuse is causing patients to lose access to care," said Edward H. Dench Jr., MD, president of the Pennsylvania Medical Society. "Key reforms are needed if Pennsylvanians are to maintain access to quality health care services."

The Pennsylvania Medical Society has been working to enhance the patient-doctor relationship since 1848. With member physicians throughout the commonwealth, as well as a statewide Patient Advisory Board, the Medical Society addresses concerns of both patients and doctors to improve the delivery of health care services.

A MILLIMAN GLOBAL FIRM

Milliman USA

Consultants and Actuaries

Contact :
Laura Rzasa, Donley Communications
(212) 751-6126, lrzasa@donleycomm.com

MILLIMAN USA ANALYSIS SEES SAVINGS FOR PROFESSIONAL MEDICAL MALPRACTICE COSTS

Examines Large States Using Caps on Non-Economic Damages

NEW YORK, April 8, 2003: A Milliman USA analysis of medical malpractice claims in the 15 largest states from late 1990 to early 2001 shows wide differences in medical malpractice loss costs by state for physicians, and these differences correlate to whether or not the state has enacted caps on non-economic damages. The study demonstrates that the large states with caps on non-economic damages have below-average medical malpractice loss costs for physicians. Conversely, the large states without caps have the highest medical malpractice costs.

"The data indicate that caps on non-economic damages reduce the cost of insuring medical malpractice for physicians in the states in our study that have instituted this element of tort reform," said Richard S. Biondi, Principal and Consulting Actuary at Milliman USA and the author of the Milliman study. "The study implies that caps on non-economic damages would significantly reduce total losses for both physicians and hospitals."

The data is consistent with results others have observed in California, which is well-known for capping non-economic damages at $250,000 since 1975. In that state, the medical malpractice losses per physician are about half (52%) of the countrywide average. Other large states in the study that have instituted caps and subsequently have lower medical malpractice losses per physician are: Colorado (69% of the countrywide average), Indiana (86%) and Maryland (64%).

Conversely, large states without caps have higher than average medical malpractice losses per physician. They include: Florida (136% of countrywide average), Illinois (144%), New Jersey (131%), New York (156%), Pennsylvania (171%), and Washington, D.C. (144%).

In a separate 1997 analysis performed by Mr. Biondi using data for New York, which does not have caps, savings were estimated on physicians' medical malpractice losses if caps were instituted. It was projected that caps of $250,000, $500,000, $750,000, and $1,000,000 would result in a reduction in losses of 29%, 20%, 14% and 11% respectively on policies providing $1 million to $3 million coverage for physicians.

"There are other differences between these states besides the fact that they either have or don't have caps, and there are also differences in the size and application of the caps in the states that have them," said Mr. Biondi. "However, the pattern in this particular study is still very clear in showing that caps on non-economic damages are highly correlated to medical malpractice costs."

The data in the Milliman USA study included physicians' statistics by state from the National Practitioners Data Base Public Use Data File (NPDB), which contains selected variables from medical malpractice payment reports on physicians, dentists and other licensed healthcare professionals. A spreadsheet summarizing the results is attached.

Milliman USA, whose corporate offices are in Seattle, serves the full spectrum of business, financial, government and union organizations. Founded in 1947 as Milliman & Robertson, the company has 29 offices in the United States as well as offices in Bermuda, Hong Kong, Japan, Korea, Brazil, and the UK. Milliman USA employs approximately 1,750 people, including a professional staff of over 750 qualified consultants and actuaries. The firm has consulting practices in property and casualty, employee benefits, healthcare and life insurance. It is a founding member of Milliman Global, an international organization of consulting firms serving insurance, employee benefits and healthcare clients worldwide. For further information, visit www.milliman.com.

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Consultants and Actuaries

NPDB* Loss Data for 15 Largest States and Nationwide

NPDB* Public Use Data File

*NPDB refers to the National Practioners Data Base

9/1/90-4/30/01

National Claim and Loss Rate per Doctor Reported to the NPDB
(annual losses not trended)

	Doctors (approximate number in 1990)	Annual Loss Per Doctor	Relativity	Status Re Caps (Reference: Aug./Sept. 2002 Medical Liability Monitor)
CA	66,996	2,884	0.52	$250K cap on non-economic damages.
CO	6,724	3,817	0.69	$250K cap on non-economic damages. $1M cap total.
DC	3,068	7,901	1.44	No cap.
FL	26,394	7,508	1.36	No cap for most claims. Caps apply when parties arbitrate.
IL	25,565	7,929	1.44	No cap. Declared unconstitutional.
IN	9,607	4,734	0.86	$1.25M cap on total damages.
KS	4,673	5,846	1.06	No cap. Declared unconstitutional.
MA	20,089	3,802	0.69	$500K cap on non-economic damages with exceptions.
MD	15,061	3,503	0.64	$500K cap on non-economic damages.
MI	18,463	4,347	0.79	$345K cap on non-economic damages.
NJ	18,765	7,232	1.31	No cap.
NY	56,264	8,610	1.56	No cap.
OH	22,401	6,443	1.17	No cap. Declared unconstitutional.
PA	29,784	9,386	1.71	No cap.
TX	29,004	6,083	1.11	No cap.
All Others	181,034	4,363	0.79	
Total	537,389	5,502		

Milliman USA Study includes physicians' statistics from the NPDB Public Use Data File, which contains selected variables from medical malpractice payment reports on physicians, dentist and other licensed healthcare professionals.

Author of Milliman USA Study: Richard S. Biondi, Principal and Consulting Actuary, New York office
Contact: Laura Rzasa, Donley Communications, (212) 751-6126, lrzasa@donleycomm.com

Lou

From: "Daniel Blaney-Koen" <Daniel_Blaney-Koen@ama-assn.org>
To: <asma@alaska.net>; <Jclark@csms.org>; "Sara Thran" <Sara_Thran@ama-assn.org>; <koos@isms.org>; <nelson@isms.org>; <white@kyma.org>; <WTA@kyma.org>; <cmcmullen@mag.org>; <JScott@medone.org>; <lmariner@medone.org>; <Shanbacker@msdc.org>; <Sgreenhoe@msms.org>; <PDWeber@msnj.org>; <RSeligson@ncmedsoc.org>; <DOwens@osma.org>; <tjc@wsma.org>; <swacker@wyomed.org>
Cc: "Jim Rodgers" <Jim_Rodgers@ama-assn.org>; "Kathy Kuntzman" <Kathy_Kuntzman@ama-assn.org>; "Mindy Schneiderman" <Mindy_Schneiderman@ama-assn.org>; "Teresa Marchiori" <Teresa_Marchiori@ama-assn.org>
Sent: Wednesday, April 02, 2003 2:46 PM
Attach: Patients losing access survey March 2003dft.doc
Subject: Revised national survey release -- DRAFT attached

I apologize for the late notice, but due to further consideration of releasing financial averages for liability premiums and the concern of ACOG that the financial information previously included might confuse media and others, those sections have been removed from the national release.

If your society is issuing a release tomorrow, we would strongly advise to not include or make any mention of those national averages at this time. If your society is releasing state-specific financial data, that remains up to you, and the AMA will continue to refer reporters to your society when asked about a specific state's experience. We will not be discussing national averages at this time.

The AMA will only make select charts and graphs available to reporters and those will be forwarded to you as soon as they are ready.

A revised DRAFT release is attached. A final release will be sent tomorrow.

Please let me know if you have any questions.

Daniel

Daniel Blaney-Koen

American Medical Association
Field Communications Manager
Phone: (312) 464-4415
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daniel_blaney-koen@ama-assn.org

American Medical Association

Physicians dedicated to the health of America

FOR IMMEDIATE RELEASE **April 3, 2003**

AMA SURVEY SHOWS PATIENTS LOSING ACCESS TO CARE

America's medical liability crisis causing physicians to limit their practices

CHICAGO—America's out-of-control legal system and skyrocketing medical liability insurance premiums have caused nearly two-thirds of high-risk specialists to make changes to their practice, including stopping providing certain services and referring complex cases, according to a new American Medical Association survey. The survey analysis looked at the differences between high and low-risk specialties as well as crisis versus non-crisis states.

More than 30 state and national medical specialty societies took part in conducting the survey, which included responses from more than 4,800 physicians nationwide. The high-risk specialties include emergency medicine, general surgery, neurosurgery, obstetrics/gynecology, orthopedic surgery and thoracic surgery.

The crisis states identified in an AMA analysis released last month are Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia.

"What will it take for our elected leaders to realize that patients—and the communities in which they live—are losing access to the physicians who save lives?" asked AMA President Yank D. Coble Jr., MD. "These new data deliver hard numbers to a shocking reality—America's broken medical liability system is having disastrous effects on patients and their physicians."

Top line survey findings include:

- 64.8 percent of America's high-risk specialists have made changes to their practice, including no longer providing emergency and trauma care, performing high-risk surgical procedures, delivering babies, and more.

- 92.4 percent of high-risk specialists said that liability pressures were important in their decision to stop providing certain services.

- 41.5 percent of high-risk specialists began referring complex cases; 34 percent of physicians surveyed in AMA crisis states began referring complex cases compared to 24 percent in non-crisis states.

The U.S. House of Representatives passed legislation last month—the HEALTH Act of 2003—that Dr. Coble said would go a long way toward helping America's patients and physicians.

"Before you can heal the patient, first you have to stop the hemorrhaging," said Dr. Coble. "We strongly urge the Senate to pass common-sense medical liability reform legislation that will preserve patients'

access to care. The AMA will continue to work with patients, physicians and lawmakers at the grassroots and national levels to pass medical liability reforms until this crisis ceases to exist."

For more information, please contact:

Daniel Blaney-Koen
Field Communications Manager
(312) 464-4415

Note: The AMA encourages reporters and others interested in state and specialty-specific information to contact those societies directly.

Lou

From: "Sara Thran" <Sara_Thran@ama-assn.org>
To: <asma@alaska.net>; <Jclark@csms.org>; <koos@isms.org>; <nelson@isms.org>; <white@kyma.org>; <WTA@kyma.org>; <cmcmullen@mag.org>; <JScott@medone.org>; <lmariner@medone.org>; <Shanbacker@msdc.org>; <Sgreenhoe@msms.org>; <PDWeber@msnj.org>; <RSeligson@ncmedsoc.org>; <DOwens@osma.org>; <tjc@wsma.org>; <swacker@wyomed.org>
Cc: "Daniel Blaney-Koen" <Daniel_Blaney-Koen@ama-assn.org>; "Kathy Kuntzman" <Kathy_Kuntzman@ama-assn.org>; "Mindy Schneiderman" <Mindy_Schneiderman@ama-assn.org>; "Teresa Marchiori" <Teresa_Marchiori@ama-assn.org>
Sent: Thursday, April 03, 2003 10:47 AM
Attach: PLI newsletter final.pdf
Subject: Re: National PLI survey results

Attached are the overall survey results, which Daniel will share with any media people who request them.

National Physician Survey on Professional Medical Liability

April 2003

Prepared by: AMA's Division of Market Research and Analysis

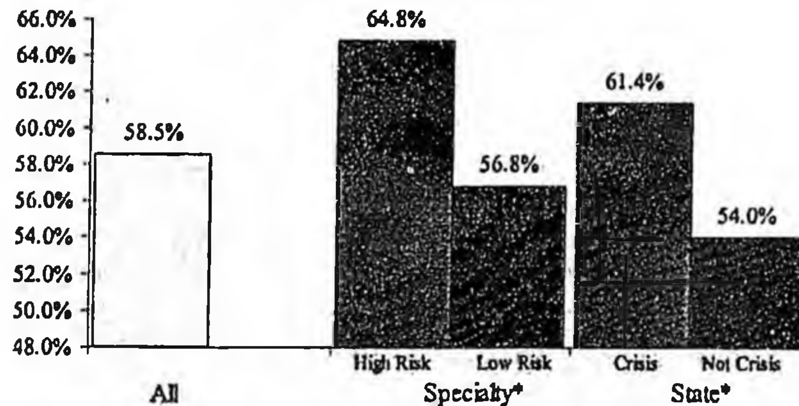
Key Survey Findings

Respondents were asked if they had made each of a number of practice changes in the last two years. Overall, 58% of physicians indicated that they had made at least one of the changes listed. The practice changes that were most often reported were: began referring complex cases (30%) and stopped providing certain services (19%). Practice changes were generally made more often among the physicians in high risk specialties and those in crisis states.

For each practice change made, respondents were asked how important professional liability pressures were in their decision to make the change. The tables below each bar chart present the percentage of respondents making a practice change who indicated that professional liability pressures were important in their decision.

Methodology

[illegible]



*Significant at p = 0.05

American Medical Association

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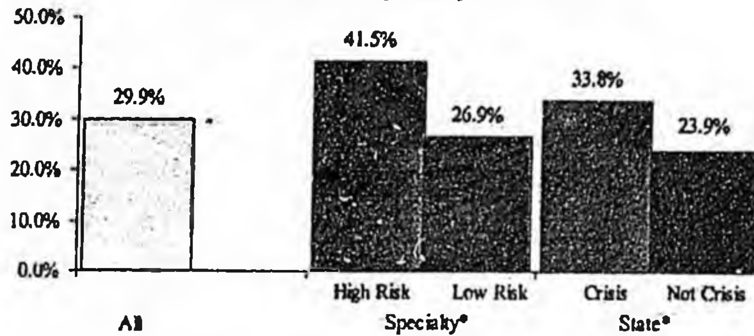
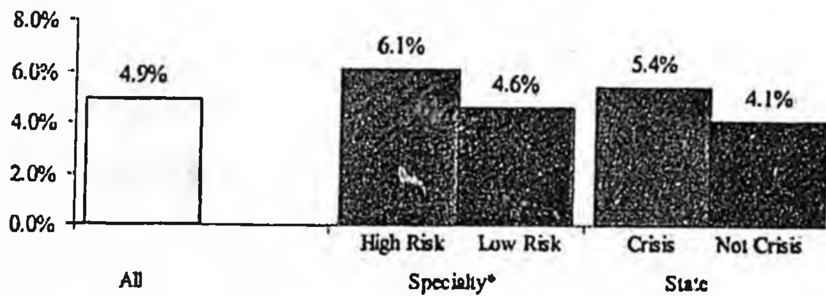


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
91.4%	94.3%	90.3%	92.9%	88.3%

*Significant at p = 0.05

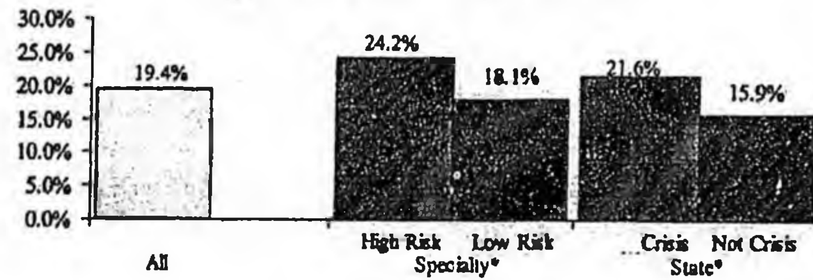


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
62.5%	83.0%	55.2%	69.7%	46.5%

*Significant at p = 0.05

Stopped Providing Certain Services

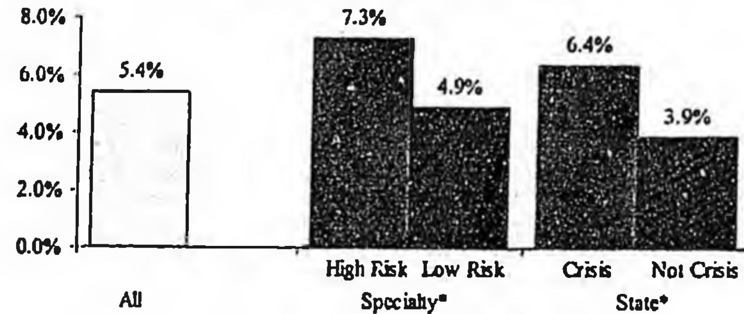


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
81.6%	92.4%	77.7%	83.9%	76.9%

*Significant at p = 0.05

Stopped Providing Patient Care

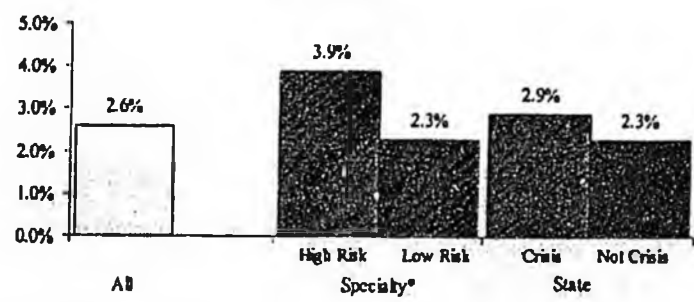


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
74.1%	83.8%	70.2%	78.7%	62.5%

*Significant at p = 0.05

Retired



Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty		State*	
	High Risk	Low Risk	Crisis	Not Crisis
73.6%	74.6%	73.2%	80.4%	60.6%

*Significant at p = 0.05

Lou

From: "Sara Thran" <Sara_Thran@ama-assn.org>
To: <asma@alaska.net>; <Jclark@csms.org>; <koos@isms.org>; <nelson@isms.org>; <white@kyma.org>; <WTA@kyma.org>; <cmcmullen@mag.org>; <JScott@medone.org>; <lmariner@medone.org>; <Shanbacker@msdc.org>; <Sgreenhoe@msms.org>; <PDWeber@msnj.org>; <RSeligson@ncmedsoc.org>; <DOwens@osma.org>; <tjc@wsma.org>; <swacker@wyomed.org>
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Sent: Wednesday, March 26, 2003 1:21 PM
Attach: PLI newsletter.doc
Subject: National PLI survey results

Attached is a preliminary summary of the national survey results. Some of the specialty society staff asked for this during our conference call. We still plan to get you the draft AMA press release in a few days.

National Physician Survey on Professional Medical Liability

March 2003

The findings from the survey confirm what many suspect, that professional medical liability premiums have increased rapidly. This has resulted in many physicians making changes in their practices that may affect patient access to care.

Key Survey Findings

Respondents were asked their annual premium for basic professional medical liability coverage for 2001, 2002, and 2003. The dollar and percent change from year to year were calculated for each respondent who answered the premium questions for both years.

Respondents were asked to report additional expenses for supplemental insurance, catastrophic insurance, surcharges for state patient compensation funds or other professional medical liability insurance coverage for 2001 and 2002. Professional liability insurance premiums have increased substantially between 2001 and 2003. Additional expenses increased between 2001 and 2002.

Premiums, changes in premiums, and additional expenses were significantly higher for physicians in high risk specialities and crisis states.

Respondents were asked if they had made each of a number of practice changes in the last two years. Overall, 58% of physicians indicated that they had made at least one of the changes listed. The practice changes that were most often reported were: began referring complex cases (30%) and stopped providing certain services (19%). Practice changes were generally made more often among the physicians in high risk specialties and those in crisis states.

For each practice change made, respondents were asked how important professional liability pressures were in their decision to make the change. The tables below each bar chart present the percentage of respondents making a practice change who indicated that professional liability pressures were important in their decision.

Table 1. Statistics on Premium Variables

	Mean	Median	25th Percentile	75th Percentile
2001 PLI Premium	16,300	10,000	6,000	20,000
2002 PLI Premium	20,900	12,000	7,000	25,000
2003 PLI Premium	26,900	15,000	8,000	33,000
$ Increase in PLI Premium 2001 to 2002	5,300	2,000	400	6,000
$ Increase in PLI Premium 2002 to 2003	6,800	2,100	0	7,400
% Increase in PLI Premium 2001 to 2002	42.0	22.2	4.2	50
% Increase in PLI Premium 2002 to 2003	38.5	24.0	0	50
2001 Additional Expense	5,200	2,000	1,000	4,400
2002 Additional Expense	6,700	3,000	1,000	6,000

Methodology

[illegible]

American Medical Association

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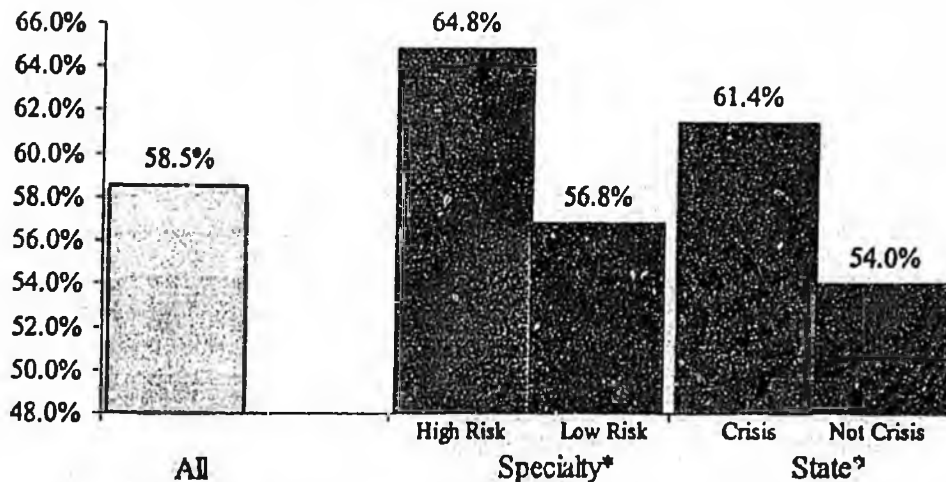
Table 2. Means of Premium Variables

	Specialty		State	
	High Risk	Low Risk	Crisis	Not Crisis
2001 PLI Premium	35,000*	10,700	17,400*	14,400
2002 PLI Premium	45,400*	13,700	23,400*	16,500
2003 PLI Premium	57,100*	17,100	30,500*	20,600
$ Increase in PLI Premium 2001 to 2002	11,900*	3,200	6,700*	2,800
$ Increase in PLI Premium 2002 to 2003	14,900*	4,200	8,400*	4,400
% Increase in PLI Premium 2001 to 2002	41.3	42.2	49.6*	28.5
% Increase in PLI Premium 2002 to 2003	41.6	37.5	44.1*	29.3
2001 Additional Expense	12,500*	3,000	5,600	4,500
2002 Additional Expense	13,600*	4,900	7,900*	4,800

*Significant at $p = 0.05$

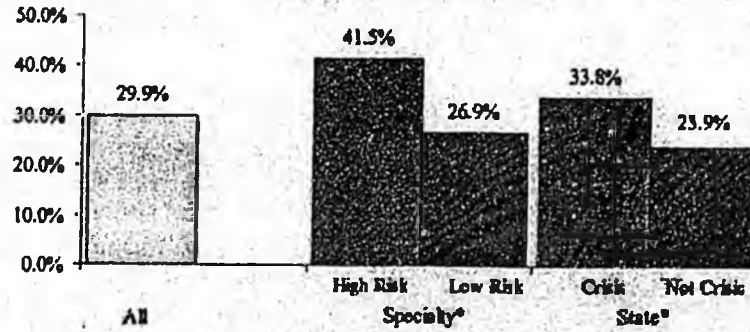
High risk specialties
- Emergency medicine
- General surgery
- Neurosurgery
- Obstetrics/gynecology
- Orthopedic surgery
- Thoracic surgery

Crisis states
- Arkansas
- Connecticut
- Florida
- Georgia
- Illinois
- Kentucky
- Mississippi
- Missouri
- Nevada
- New Jersey
- New York
- North Carolina
- Ohio
- Oregon
- Pennsylvania
- Texas
- Washington
- West Virginia



*Significant at p = 0.05

Began Referring Complex Cases

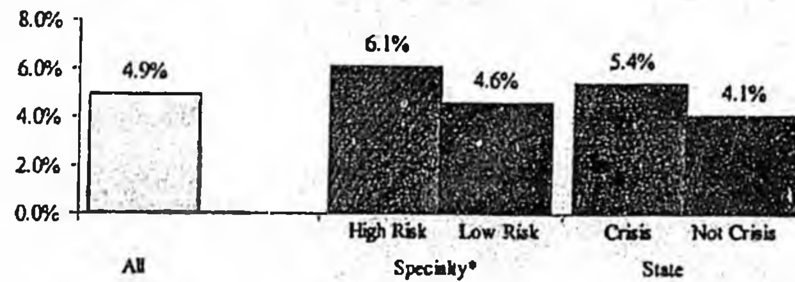


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
91.4%	94.3%	90.3%	92.9%	88.3%

*Significant at p = 0.05

Closed Practice

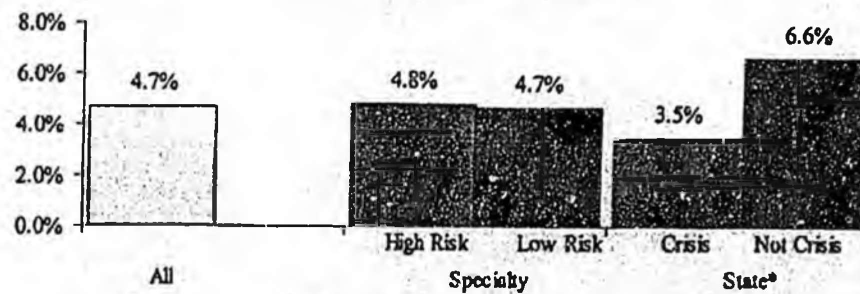


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
62.5%	83.0%	55.2%	69.7%	46.5%

*Significant at p = 0.05

Moved to Different State

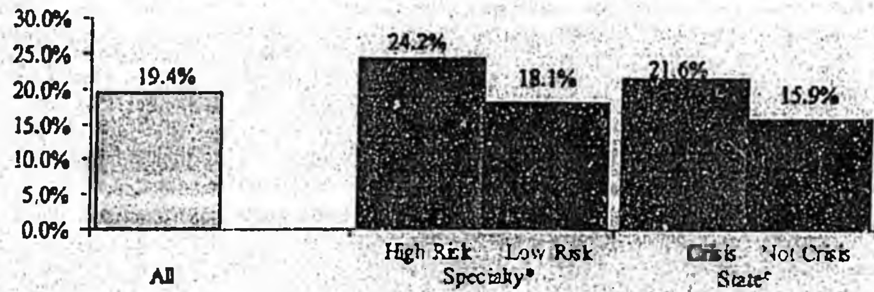


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State	
	High Risk	Low Risk	Crisis	Not Crisis
39.8%	56.4%	35.4%	36.6%	42.5%

*Significant at p = 0.05

Stopped Providing Certain Services

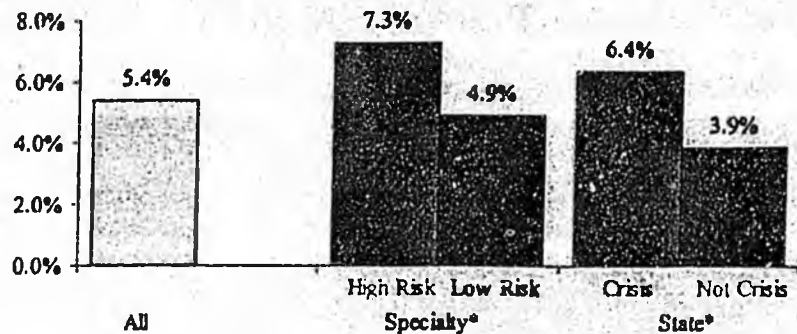


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
81.6%	92.4%	77.7%	83.9%	76.9%

*Significant at p = 0.05

Stopped Providing Patient Care

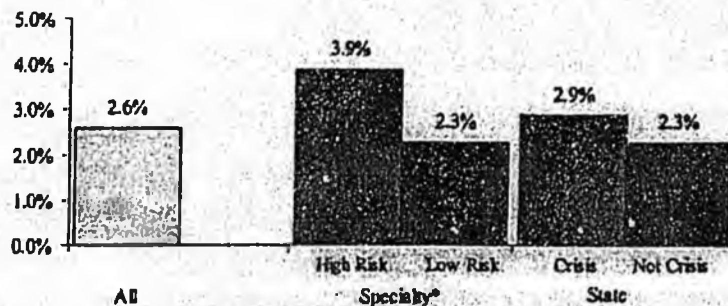


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
74.1%	83.8%	70.2%	78.7%	62.5%

*Significant at p = 0.05

Retired



Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty		State*	
	High Risk	Low Risk	Crisis	Not Crisis
73.6%	74.6%	73.2%	80.4%	60.6%

*Significant at p = 0.05

A New Crisis for the Med Mal Market?

Medical malpractice insurance loss costs are surging, insurers are quitting the business and doctors are threatening to leave their practices. Is med mal on the verge of a major new crisis?

By James D. Hurley

James D. Hurley is a principal of Tillinghast – Towers Perrin in Atlanta. He specializes in [illegible]sional liability. Mr. [illegible] has a B.S. from [illegible]ollege of Insurance in New York. He is an associate of the Casualty Actuarial Society and a member of the American Academy of Actuaries.

Following two major crises in the medical malpractice market in the 1970s and 1980s (see *Box*, page 5), U.S. insurers writing med mal policies in the 1990s enjoyed profitable financial results, thanks largely to improved underwriting and relatively high levels of investment income. Health care providers purchasing this coverage shared in this profitability as insurers lowered premiums.

Unfortunately, the malpractice market has again taken a turn for the worse. Underwriting experience has deteriorated significantly over the last three years. The industry combined ratio jumped more than 20 points to 153% in 2001. If investment income is included, the operating ratio rose more than 30 points to 138% in 2001. This means that for every dollar of premium earned in 2001, insurers lost 38 cents — the worst result since separate tracking began in 1976.

In addition, the much publicized St. Paul decision to cease writing medical malpractice policies and the forced retirements of PHICO, MIIX and Frontier, among others, removed approximately 15% of premium-writing capacity from the marketplace.

To avoid jeopardizing their surplus base and financial health, the remaining insurers are raising premium rates in response to higher loss and reinsurance costs and lower prospective investment returns. Displaced insureds have limited options in purchasing coverage, and all insureds face higher prices.

Given all these circumstances, many in the industry believe insurers *and* health care providers are headed for (or are already in) another major crisis.

Why Was Med Mal So Profitable? Why was med mal so profitable in the 1990s? And what led to the recent downturn? Following are the factors that produced favorable results for insurers in the early and mid-1990s:

- **Loss Trend Was Relatively Low.** The annual change in the cost of claims (frequency and severity) in the 1990s was lower than expected, varying from state to state and by provider type. This echoed historically low medical inflation and may have benefited from the impact of tort reforms.

- **Rates Were Flat.** Rate increases were uncommon, with declines in several states. This was justified in part because the rates established at the beginning of the last decade proved too high, inasmuch as carriers had assumed higher loss trends.

Insurers responded to the emerging favorable loss trend in different ways. Some held rates stable and paid policyholder dividends or gave premium discounts. Some reduced filed rates. Others increased rates modestly and tried to refine pricing models to improve overall program equity. In general, however, premium adequacy declined in this period. Collected rates came into line with insurers' costs, but competitive actions pushed rates even lower, particularly in some jurisdictions.

- **Favorable Reserve Development Helped.** Lower than expected loss cost trend allowed reductions in loss reserves that had originally anticipated historically higher trend levels. As experience emerged, loss reserves for prior years were reduced, contributing to very profitable calendar year results. This evidence appeared gradually over years as claims settled. Thus, the loss reserve reductions for prior coverage years helped to lower published calendar year loss ratios during the mid-to-late 1990s. But favorable development in these prior loss reserves has now ceased. (See *Exhibit 1*.)

■ **Investment Yields Were Healthy.** During the 1990s, investment returns produced a real spread between fixed income rates of return and economic inflation. Although med mal insurers had only a modest holding of equities, capital gains on stocks also helped improve overall financial results.

■ **Reinsurers Helped.** Similar to what had happened in the primary market, reinsurers reduced rates and covered more exposure, making the net results even better.

Why Results Have Turned. Although these factors contributed to the profitability of med mal in the 1990s, they also paved the way for the reversals that began at the end of the decade.

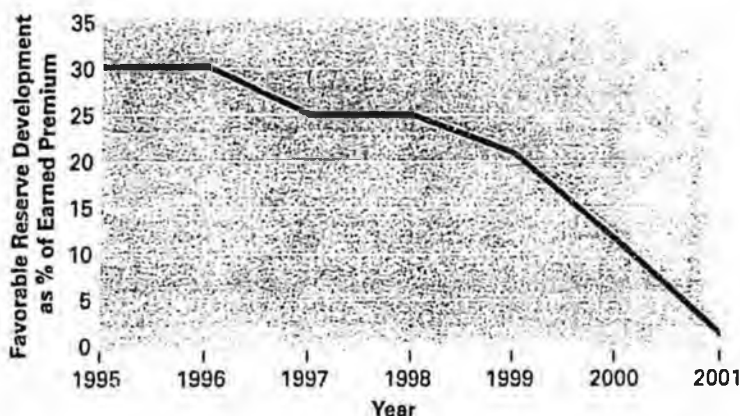
■ **Insurers Expanded Into New Markets.** Given the financial results of the early-to-mid-1990s, some insurers expanded into new markets (with limited information to develop rates). They also became more competitive in existing markets, offering more aggressive premium discounts.

■ **Loss Trend Began to Worsen.** Loss cost trends, particularly claim severity, started to pick up toward the latter part of the 1990s. The number of large claims (sometimes very large) increased, but even basic limits costs (eliminating the distortions of very large claims) began to deteriorate. This is contributing to significant upward rate indications in many states.

■ **Loss Reserves Became Suspect.** Aggregate loss reserve levels were reconciled to the lower loss cost trends. While insurers did not reduce reserves in 2001, there appears to be little or no strengthening in the aggregate, although results vary on a company-by-company basis. This means that future results will be worse on a calendar year basis than on a coverage year basis, as loss reserves ultimately have to catch up with the higher levels of loss trend.

■ **Investment Results Have Worsened.** Bond yields have declined, and equity values are down from 1990s highs. In addition to lowering interest earnings on existing assets, the lower yields also affect the expectation for investment earnings used to offset needed prospective premium levels. Rates established using an interest rate assumption of 6% rather than 7% are 2% to 4% higher (assuming no changes in other rate components) due to the multiplier effect of investment income. Moving to even lower yields compounds the impact.

Exhibit 1
Favorable Loss Reserve Development Has Ceased



Note: Based on 30 Specialty Companies, Primarily Physician Owned or Operated.

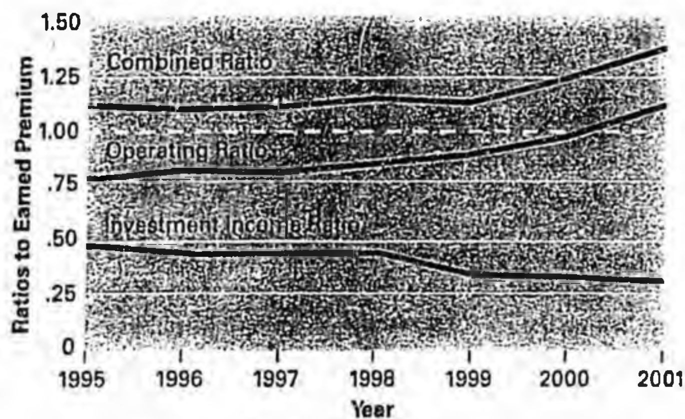
■ **The Reinsurance Market Has Hardened.** Reinsurers' experience deteriorated as their results were affected by increased claim severity and pricing changes earlier in the decade. Because reinsurers generally cover the higher layers of exposure, their results are disproportionately influenced by increases in claim severity. This, coupled with the broadly tightened reinsurance market after 9/11, caused reinsurers to raise rates substantially and tighten reinsurance terms for medical malpractice.

Are Insurers at Fault? Some allege that insurers caused the current downturn through too rapid and reckless expansion. Given the positive results of the early 1990s, some carriers expanded into new markets and offered more aggressive discounts. But before assigning blame, consider the nature of the business then.

To obtain a clearer financial picture of medical malpractice insurance, we shall focus on the results of 30 specialty companies that are primarily physician owned or operated and that write only a minor amount of non–medical malpractice business. Their results reflect the dynamics of the medical malpractice line. This sample represents about one-third of the insured exposures in the U.S.

These companies, which achieved more favorable financial results than that of the total industry, showed a slight operating profit (4% of premiums) in 2000. This deteriorated to a 10% operating loss in 2001. (See *Exhibit 2*, page 4.)

Exhibit 2
...ts Deteriorated Over the Last Three Years



Combined Ratio = Calendar Year Losses + Expenses ÷ Premium
Operating Ratio = Net Income After Taxes ÷ Premium
Investment Income Ratio = Pre-Tax Investment Income ÷ Premium

Note: Based on 30 Specialty Companies, Primarily Physician Owned or Operated.

There are two key drivers of these financial results:

- **Insurance Underwriting.** One calculates the combined ratio by dividing calendar year loss and loss adjustment and underwriting expenses by premium. The combined ratios were 124% and 138% in 2000 and 2001, respectively. The preceding five years were fairly stable, from 110% to 115%. Deterioration of the loss and loss adjustment expense ratio drove these results; the underwriting expense ratio remained relatively flat.

- **Investment Income.** Pre-tax investment income derives from policyholder-supplied funds invested until losses are paid as well as from the company surplus. The ability to offset some of the losses is measured by a percentage of earned premiums. This statistic declined over the measurement period from the mid-40% to the mid-30% level and, in 2001, to 31%.

This "offset" will continue to decline because (i) most invested assets are bonds and are affected by the lower yields of late, a change not fully felt in current investment income; and (ii) the premium base is growing due to increased rates, growth in exposure, or both. Invested assets are not increasing as rapidly as premium and, therefore, investment income as a percentage of premium will decline.

Exhibit 3 shows surplus declines as a percentage change from one year to the next. Surplus increased through 1999 and began its decline in 2000 with a more substantial loss in 2001. This decline reduces the capacity to write business prospectively and to absorb adverse loss development on business written in prior years.

Another Crisis? During the med mal crises of the 1970s and 1980s, loss trend deterioration and the unprofitability of medical malpractice insurance led to reduced capacity, large rate increases and efforts at tort reform. Are conditions today similar enough to the previous crises to produce similar problems for insurers and providers? Despite 2001 being the most unprofitable year for medical malpractice since separate tracking began, the answer, at least for insurers, is probably "no."

Although loss cost trends are increasing, these trends, at least so far, are not as dramatic as they were in the two earlier crises. Nevertheless, insurers are experiencing an increased incidence of unpredictable multimillion-dollar claims. According to one large database, the percentage of $1 million paid claims has doubled to slightly more than 7% of paid claims over the last six years, although the degree and magnitude vary by state.

Other factors militate against a similar crisis for insurers:

- **Tort Reform Is on the Agenda.** States enacted tort reform legislation after the previous crises as a compromise between an individual's right to seek recompense and affordable health care. The best known is MICRA, California's tort reform package. With MICRA, California has achieved a more stable marketplace and lower premium increases over the years than have other states. According to a compilation of NAIC data, California's premiums grew 167% over the past 25 years, compared to 505% for the other states.

Tort reform has been proposed as a solution to higher loss costs and surging rates. Many are suggesting reforms modeled after California's MICRA, although some have cautioned against modifying the MICRA package. Poorly crafted reforms may actually increase losses.

- **The Economy Is Stronger.** Current economic conditions differ from those that prevailed during the previous crises. Today's low inflation and low interest rates contrast sharply

History of Med Mal Crises

The medical malpractice line went through two crises, one in the 1970s and the other in the 1980s. The earlier crisis was mainly a crisis of availability as insurers left the marketplace and provider-owned companies were formed, offering coverage at much higher rates. In the 1980s, the crisis was one of affordability. Insurers found it necessary to increase rates dramatically in response to surging claim frequency and severity.

A question raised then — and now — is whether a decline in the quality of medical practice invited the increase in claim levels. Given advances in technology and medicine and improved access to health care, this seems unlikely.

However, these advances were accompanied by major changes in the health care delivery process (e.g., managed care, increased specialization and associated greater dependence on multiple providers in securing medical care). In fact, with expectations set so high by modern medicine, more and more patients may have become claimants when the best possible outcome was not realized. ◼

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with the high inflation–high interest rate climates during earlier difficult markets.

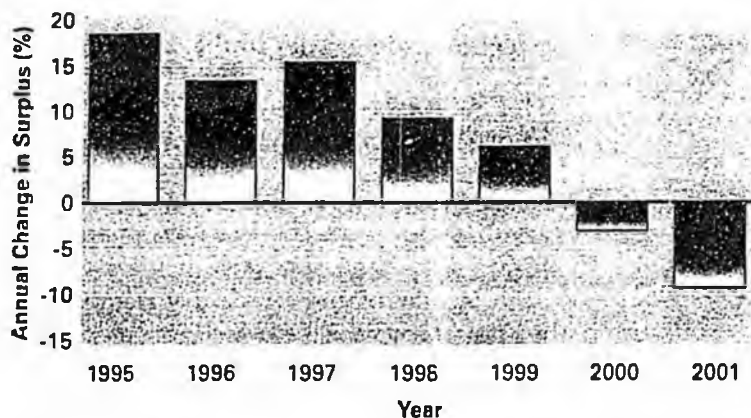
However, the decline in interest rates requires a rate increase, even if loss costs aren't a problem. Prior rates were built anticipating higher prospective investment income as an offset and this is now unlikely to be achieved. Although not affecting rates, equity market declines are similar to prior troubled periods and put added pressure on capacity as companies evaluate how best to deploy more limited available capital.

■ **The Presence of Specialty Companies.** Although the reduction in capacity to write med mal coverage is dramatic (after voluntary and forced withdrawals), a significant portion of the business is now written by specialty companies committed to provide coverage. New commercial and specialty company capacity as well as captive/self-insured programs are coming online. Nevertheless, some displaced insureds will have difficulty finding coverage and those that do will pay higher rates.

■ **Insurers Are in Better Shape.** Despite declining surplus, the active insurers, particularly the specialty companies, are better able (than were companies in the 1970s or 1980s) to handle the pressures of increasing rates and units of exposure. For most, their current financial circumstances will allow them time to realize the benefits of passing through needed rate increases.

A Crisis for Health Care Providers. Unfortunately, health care providers are in a more difficult position. Their financial proposition has become less tenable. With insurers seeking substantial rate increases, health care providers are caught in a financial squeeze because much more of their revenue is derived from private health or government medical plans (than in the 1970s and 1980s).

Exhibit 3
Surplus Declined in 2000 and 2001



Note: Based on 30 Specialty Companies, Primarily Physician Owned or Operated.

These programs limit or prevent health care providers from passing on costs to patients by increasing their fees. Without revenue and rate relief, providers may find the economics don't work, which could lead many to abandon their practices, threatening the public's access to quality health care. ◼

Lou

From: "Mike Maves EVP/CEO" <Mike_Maves_EVP#s#CEO@ama-assn.org>
To: <asma@alaska.net>
Sent: Tuesday, January 21, 2003 6:38 AM
Attach: Medliabilityq&a01-20-03fin.doc
Subject: CEO to CEO: Correction

The Q & A document sent yesterday was inadvertently marked "draft." However, it is a final version; attached is a document without the "draft" notation. The body text in both documents is exactly the same.

America's Medical Liability Crisis
Sample Q&A

Q: What are the AMA's current concerns regarding medical liability (malpractice)?

A: The American Medical Association wants to ensure that patients have access to health care when they need it. Excessive jury awards in recent years have caused liability insurance premiums to skyrocket. As a result, a growing number of physicians can no longer find or afford liability insurance. Without insurance, physicians in some parts of the country are being forced to restrict their practices – avoiding high-risk, but necessary, medical procedures such as delivering babies. Others are simply retiring early or relocating to states where reforms are in place and premiums are more affordable. The bottom line: patients in crisis states around the country are seeing their physicians disappear and are finding it more difficult to get the care they need. This has got to stop.

Q: How are patients being affected?

A: Patients living in crisis states are watching helplessly as their doctors retire early, leave the state or stop offering certain procedures, such as delivering babies or complex surgical procedures. Patients are watching helplessly as maternity wards, trauma centers and rural health clinics are forced to close. Access to patient care in the crisis states is heading for a grave meltdown, and there are increasing problem signs of the same happening in states not yet in crisis.

Q: What does the AMA think should be done to address the current crisis?

A: The AMA strongly supports a national law that is based on the reforms California has had in place since 1975. California's law (also known as MICRA) puts a reasonable limit – $250,000 – on non-economic damages. Non-economic damages – also referred to as "pain and suffering" – have been a magnet for trial lawyers and a big factor driving the current crisis. The California model caps non-economic damages at $250,000, while still allowing patients full and complete access to the courts. Under California law, patients still have the ability to recover 100 percent of their economic damages, including complete compensation for medical expenses, rehabilitation costs, childcare costs, all current and future wage earnings that are lost, and other economic loss. We need a law that is fair for all, and California's law provides that balance.

Q: Does the AMA support President Bush's recent medical malpractice reform proposal?

A: The AMA strongly supports the President's call to bring common sense back to the legal system. The current medical liability system is broken and in need of repair. Medical liability premiums have reached $200,000 a year or more in some high-risk specialties and 12 states are in crisis. Thirty more states are on the brink of crisis. If responsible action is not taken, more physicians are going to be forced from their practices and patients living in crisis areas will find it increasingly difficult to get the full-range of services they need. In addition to protecting patient access to care, instituting a $250,000 cap on non-economic damages could save our country as much as $100 billion each year in health care costs, according to a recent study by HHS.

Q: Why do doctors want to limit the amount of money a patient receives if that patient is harmed by a doctor's negligence?

A: That is not our view at all. The American Medical Association proposes no limits on what patients can recover for their medical expenses, rehabilitation costs, childcare expenses, all current and future wage earnings that are lost, including employer-based benefits, and any other economic-type losses. We do support, however, a reasonable cap on non-economic damages – which are unpredictable, subjective damages that have spurred the "lottery" mentality over-running our judicial system.

Q: By limiting non-economic damages, isn't the AMA saying that patients' pain and suffering isn't worth anything?

A: Absolutely not. When a patient is harmed by a physician's negligence – he or she should be fully compensated. But we need a system that works for everyone and not just the select few who receive "jackpot-sized" awards. The current system encourages trial lawyers to search for "lottery" cases to line their pockets. The states that are currently in crisis are those states that either have no cap on non-economic damages, or a cap that is so high it is ineffective. We need to decide: Do we want trial lawyers having access to every dollar they can squeeze from an out-of-control tort system or do we want patients having access to their physicians when they need them?

Q: Does the AMA want to limit patients' access to the courts?

A: Quite the contrary. The AMA believes patients should have full access to the courts, but let's make sure that the cases filed by trial lawyers have merit. Currently, 70-80 percent of all cases filed against doctors are dismissed without action. That's a ridiculous amount of cases that should have never been brought in the first place. We need to work to eliminate these types of frivolous lawsuits because they are driving insurance rates sky high and driving many physicians out of practice. As a physician, if I focused my energies on an intervention that failed 70-80 percent of the time, I would start looking for a new approach. I think the trial bar needs to do the same. Because the current tort system is not working and it's adversely affecting patient care in this country.

Q: What about those who say the current crisis is the fault of insurers, who are trying to make up for years of losses in the stock market by price-gouging physicians with high insurance premiums?

A: This is just one more smokescreen the trial bar is using to deflect attention from the facts. Insurance companies typically place about 80 percent of their investments in the bond market – not the stock market. And that bond market has provided them a stable return of about 5 percent per year since 1997. Clearly, we need common sense liability reforms. These reforms have stabilized the market in California and can do so for the rest of the country.

Q: Doctors make a lot of money – why are they complaining about an increase in their insurance premiums?

A: Physicians earn good incomes, but that doesn't make them immune from economic realities. And the reality is – a growing number of physicians cannot keep their practices open if liability rates continue to skyrocket. Keep in mind, we are not talking about the modest increases that most of us pay for goods and services from year to year. We are talking about increases of 100 percent or more in certain areas of the country. The median jury award has risen to $1 million, and doctors who practice in "crisis" states pay double or triple what doctors in non-crisis states pay in professional liability insurance.

Q: What about those who suggest the California insurance market is stable because of Proposition 103, not its 1975 law?

A: The truth is, Proposition 103 has had very little to do with medical liability insurance. Since 1975, California's medical liability reforms have been responsible for protecting California's patients and keeping the insurance market stable. Prop. 103 was passed in 1988 to address mainly auto insurance issues. Prop. 103 does not prohibit insurers from raising rates. It says that if an insurer wants to raise rates by more than 15 percent, there must be public hearings. That's only happened once, and the request was recalled by the insurer after the public objected. Anyone who tells you Prop. 103 is the reason for California's successful medical liability reforms is not dealing with the facts.

Q: The Institute of Medicine says that doctor mistakes kill 98,000 people a year. Shouldn't we get rid of those bad doctors?

A: The American Medical Association believes one error that harms a patient is one error too many. Unfortunately, medicine is not an exact science and we know that – despite our best efforts – mistakes do occur. The AMA agrees that bad or incompetent physicians should be removed. That's why we support strong licensing boards. But let's be clear about one very important fact – the current liability system does nothing to identify negligence. In fact, a recent Harvard study shows no correlation between medical liability award payments and physician negligence. So while we need to work to make medicine safer, let's not pretend that the current liability system is the way to go about it.

Q: Why aren't doctors doing more to improve patient safety?

A: Doctors work everyday to improve patient safety. The AMA founded the National Patient Safety Foundation to do just that. Safety starts with understanding why these errors occur in the first place. To do that, however, we need to create an environment where errors can be identified and studied openly so we can implement safeguards to prevent them. The Aviation Safety Reporting System model is one the medical community should emulate. It's a system that focuses on finding out as quickly as possible why an error has occurred and what can be done to prevent that error from occurring in the future. So while we need to work to make medicine safer, let's not pretend that the current liability system is the way to go about it. In fact, a recent Harvard study shows no correlation between medical liability award payments and physician negligence

Q: ***How do you respond to the charge that 5 percent of the nation's doctors are responsible for more than 50 percent of the nation's malpractice?***

A: That is a provocative charge based on flawed assumptions by the trial bar. If only 5 percent of the doctors are responsible for most of the malpractice in this country – then why do the vast majority of physicians get sued – many of them, two or three times. The current medical liability system doesn't identify negligence and it doesn't weed out bad doctors – it just increases the cost of medical care and decreases patient access to care. In short, there is no correlation between getting sued and malpractice, but there is clear evidence that the legal system in the crisis states is causing grave reductions in patient access to health care.

Q: Are doctors violating the Hippocratic Oath when they go on strike?

A: Physicians are NOT going on strike. Some physicians have made the difficult decision not to perform elective surgery, but even then, they are taking steps to ensure that their patients have access to emergency care and services. Physicians who have chosen to take a leave of absence are doing so only as a last resort. Many are using to this time to weigh their options, looking for ways to keep their practices open so they can continue caring for their patients and not be forced to limit services, retire early or relocate. Whether physicians leave their practices amid the media glare like they did in West Virginia and Nevada – or are leaving quietly in other communities in crisis – the end result is the same: Patients are seeing their physicians disappear and having their access to health care restricted.

Q: How much lobbying money is the AMA spending on this?

A: The AMA has made medical liability reform its top legislative priority, and we will direct all necessary resources to winning this battle for America's physicians and patients. We believe the current crisis is one lawmakers cannot afford to ignore. Like physicians, lawmakers have a responsibility to protect patient access to health care. If they choose to ignore this responsibility, the crisis will only continue to worsen.

Q: What is the AMA asking patients to do?

A: The AMA is encouraging every physician and every patient to contact their state and federal representatives and tell them, "Enough is enough—pass medical liability reforms that protect patient access to health care. And pass it now!"

A Surgical Fix for Medical Malpractice

Reforms Work Best as a Package, Study Shows

By Jeffrey Speicher

Almost everyone agrees: The medical malpractice system in the United States serves no one well. Although a few multimillion dollar settlements draw public attention, most individuals who suffer real injury at the hands of their physician or hospital accept less than the full value of their claim—and endure long delays before receiving compensation. Those most harmed—people left with lifelong medical needs or permanent loss of income—are most likely to be underpaid.

Physicians, who in the 1950s faced a 1-in-7 chance of being sued over the course of a career, now see the odds reduced to 1-in-7 *per year.* As a result malpractice insurance premiums have skyrocketed, causing many practitioners to abandon their specialties or adopt costly defensive-medicine procedures. Many insurers, buffeted since the early '70s by recurrent cycles of higher claims frequency and larger jury awards, have withdrawn from the market, which has reduced availability of coverage and further driven up costs. And as for attorneys . . . . well, even some thoughtful legal scholars believe the system is out of whack.

According to Randall Bovbjerg of Washington's Urban Institute, author of numerous studies on medical malpractice, many of the system's problems arise from a basic difference between doctors and lawyers: Physicians think about healing injuries, attorneys about resolving disputes. Says Bovbjerg, "Doctors see medical malpractice as a way to make injured patients whole—financially as well as physically. Lawyers come into the process after a conflict arises, and their focus is on justice for their client."

Jeffrey Speicher is manager of member communications for the Academy and an editor for Contingencies.

This difference in worldview intertwines medical malpractice with the legal system. Malpractice must balance the need to compensate deserving claimants, deter future violations by making doctors more careful, and obtain justice for both patients and medical providers. All this from what Bovbjerg defines as "mainly an insurance system run by experts."

A group of those insurance experts, members of the American Academy of Actuaries, recently suggested an approach to make the system less costly. According to the Academy report, "Medical Malpractice Tort Reform: Lessons from the States," the mixed results of reform attempts by the states point the way to effective federal action.

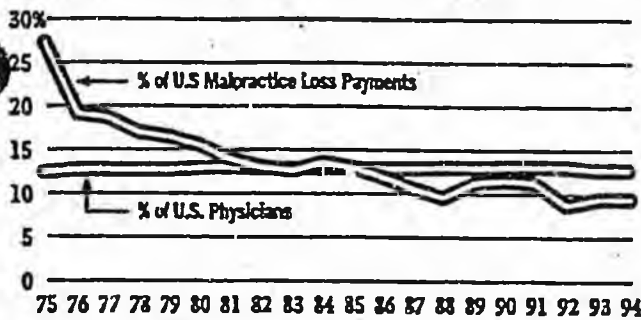
"Congress should adopt a comprehensive approach to tort reform by adopting a package of measures," says Jim Hurley, an actuary with Tillinghast/Towers Perrin and leader of the Academy group. "Our report provides a synthesis of measures that have been effective at the state level."

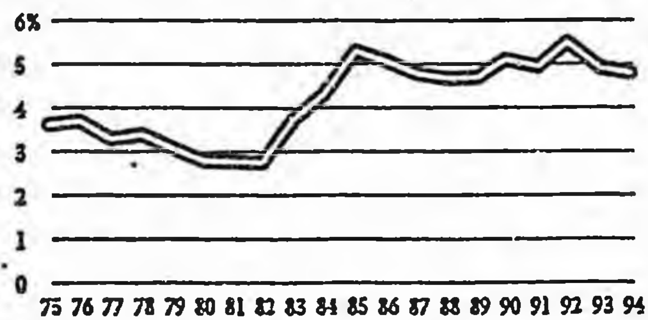
A Package Deal

The California Medical Injury Compensation Reform Act (MICRA) of 1975 shows the success of the package approach. Before MICRA's adoption, the state's percentage of total U.S. loss payments was significantly higher that its proportion of the nation's physicians. By 1981, California's loss payments had dropped and were about even with its percentage of physicians. Costs continue to fall, even as California's share of physicians remains stable. Writes the Academy group: "The relationship of decreased relative costs to the timing of reform provides strong evidence for the effectiveness of the MICRA package." [See Figure 1.]

At the head of the Academy's list for lawmakers is a nationwide cap on jury awards for noneconomic damages such as pain and suffering. As evidence, Hurley points to Ohio where malpractice costs fell after a 1975 cap on damages, only to rise dramatically after court challenges led to a 1985

American Academy of Actuaries Bi-Monthly





ruling that overturned the cap. [See Figure 2.]

Such a cap should be established on a per-medical-injury basis at a level low enough to have an impact—at $250,000, for example. In addition, a mandatory collateral-source offset rule is needed to ensure that double and triple indemnification cannot be collected through multiple suits. Under this rule, a jury or judge would have to consider compensation paid from other sources.

Above all, the Academy report warns against piecemeal or faulty changes. Loss experience in New York shows that the individual tort reform measures adopted in that state over the past two decades did not improve costs relative to the U.S. total. "Poorly crafted malpractice reform—either

> Above all, the Academy report warns against piecemeal or faulty changes. "Poorly crafted malpractice reform—either individual measures that are too limited or broad transformations that are too far-reaching—can have unintended consequences that drive up costs."

individual measures that are too limited or broad transformations that are too far-reaching—can have unintended consequences that drive up costs," says Hurley.

The Academy's suggested approach involves what medical malpractice experts call "takeaway" reforms—preserving the current reliance on the tort system, but eliminating some of the costliest and most abused features.

Other voices in the debate, including representatives of the medical community, call for a back-to-the-drawing-board approach. Unfortunately, the design that comes back often relies on a no-fault model. While no-fault medical malpractice insurance would largely untangle the process from the legal system, no-fault often rewards individuals whose claims would otherwise be denied. Says Hurley, "No-fault would drive frequency of claims through the roof—some argue by a factor of at least two and perhaps by a factor of eight or more. It's scary how many things can be compensated under the typical no-fault system."

Frequency of claims, according to Hurley, is the key driver of costs. "Over the past two decades, the plateaus and surges of claims frequency have been difficult to anticipate and measure, but the long-term trend has been up," says Hurley. Size of claims also is an important cost factor, but dollar amounts in settlements have been increasing in a more predictable fashion over time.

No-fault also would take most cases out of court and make malpractice a transaction between insurer and claimant. Advocates claim that this would cut legal costs—which are enormous. For example, according to the Insurance Services Office, legal defense costs for insurers alone accounted for 14 percent of total tort costs in 1992.

However, experience in Florida and Virginia, where no-fault for obstetric cases is already in place, does not show substantially reduced costs or less need for legal counsel. Says Bovberg, "*Everyone* who uses the no-fault system in Florida and Virginia consults a lawyer."

Other options exist. A proposal by Jeffrey O'Connell, professor at the University of Virginia School of Law, seeks a middle way between no-fault and status quo. He would shorten the process and lower costs through an early offer of payment of noneconomic damages.

O'Connell is blunt about his disgust with the current state of affairs. "Medical malpractice is a nightmare of useless circularity," he says. However, according to O'Connell, the system is not consistently biased against defendants. Most proposed changes, on the other hand, invariably favor the defendant. Justice—as well as political reality—requires benefits for the plaintiff as well.

"Reform requires a quid pro quo," says O'Connell. "While the Academy has described quite lucidly the options for takeaway reform, such measures could not get through Congress without being so watered down as to be meaningless," says O'Connell. "True reform should involve a fair trade: making it easier for claimants to be paid, but paying them less, as under workers compensation laws."

An Offer You Can't Refuse

O'Connell's ideas have found sponsorship on Capitol Hill. A bill introduced in the 104th Congress by Sen. Mitch Mc-

Connell (R-Ky.) would create an early-offer plan for all tort claims, including medical malpractice. Under the proposal, a defendant in a personal injury claim is given the option of offering payment to the injured party within 180 days of the claim. The defendant purchases for the claimant a comprehensive major medical insurance policy that covers medical expenses, rehabilitation, and lost wages beyond monies received from collateral sources. In addition, reasonable hourly fees for the claimant's attorney would be paid.

Claimants who are offered such a settlement within 180 days of the claim would be obliged to accept. This won't get egregious medical offenders off the hook, however. A normal tort claim could be pursued for noneconomic damages, but with a higher-than-current standard of evidence.

Medical malpractice is a nightmare of useless circularity.

The plaintiff must prove that the medical provider's misconduct was wanton or intentional.

Because the defendant would not be forced to offer a settlement, physicians and their insurers could take their chances in court in the case of bogus claims. However, the risk might be too great. O'Connell cites a prominent medical malpractice defense lawyer who estimates that he'd make an early offer in 200 of the his firm's 250 current cases. So the balance is tipped toward the defendant, but not without providing a substantial benefit to the plaintiff: Timely resolution and quick settlement.

The limit on legal fees would discourage what O'Connell calls "the unconscionable abuse of the system by some members of my profession." Among other criticisms, the Virginia professor points out that contingent fees are often not truly contingent on risk. Attorneys take the same settlement percentage from open-and-shut cases as from complex cases, a practice that subsidizes work on failed litigation and which O'Connell denounces as an illegal tax on deserving claimants.

Hurley gives O'Connell's proposal a mixed review. "To its credit, the early-offer plan is not mandatory for defendants, which leaves the tort system in place to challenge claims perceived as nonmeritorious," says Hurley. He also notes that periodic insurance payment to claimants allows compensation to be made as costs are incurred, eliminating the burden of large lump-sum payouts. Also, O'Connell's plan emphasizes two fundamentals that the Academy report identified: mandatory recognition of collateral benefits and controlling noneconomic damage costs. In fact, the O'Connell plan eliminates consideration of noneconomic damages altogether unless the case goes to court.

However, Hurley notes, the periodic payment plan theoretically would have to remain in force for decades. Will claimants be out in the cold after the disability policy limits are reached, or will the insurer face unlimited exposure? Another concern: Like no-fault, the early-offer plan could give incentives for unmerited claims. Insurers may pay a doubtful claim rather than incur expensive litigation costs and risk a large judgment award. In addition to increased costs, Hurley worries about a basic question: "Is it the right message to send to individuals who think doctors and insurers have deep pockets? The system may have practical advantages, but in terms of equity, it is hardly fair."

No matter which remedy is tried, no action will slash premium costs immediately, Hurley cautions. "Tying tort reform to premium reductions, as has been done in some states, is unrealistic," he says. "There is little evidence that the cost savings can be translated directly into lower costs for health care providers. More likely, reform will slow the rate of premium cost increases."

The course of reform will be determined by elected officials at the state and federal levels. The debate will be long, no matter which option—if any—is approved. In the meantime, the cost of inaction continues to be passed on to the public in the form of increased medical fees and reduced services.

By working together in recent years, insurers and healthcare providers have begun to bring medical spending under control. Effective medical malpractice reform is one way to keep the momentum going. □

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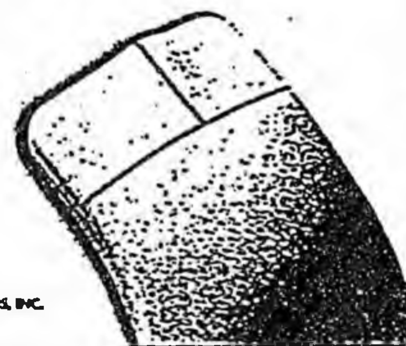

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Answer to Brain Drain, page 13: The house number is 76.

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ISSUE BRIEF
AMERICAN ACADEMY *of* ACTUARIES

Medical Malpractice Tort Reform: Lessons from the States

The cost of insuring physicians against medical malpractice claims has increased dramatically in recent years. Skyrocketing premium costs and a string of highly publicized lawsuits have led many physicians to curtail certain high-risk procedures. By reducing the availability of important medical services, this practice of defensive medicine could have serious public-health consequences. In addition, increased malpractice insurance expenses are passed on to patients and health plans, thus fueling medical inflation.

To combat these ill effects, several states have adopted reforms designed to reduce the cost of medical malpractice insurance. More recently, Congress has attempted to follow the initiative of the states but has been unable to enact comprehensive medical malpractice tort reforms into law.

To date, state efforts have enjoyed varying degrees of success in reducing medical malpractice insurance rates. What can be learned from the experience of the states? How can these conclusions be applied at the federal level? The American Academy of Actuaries Work Group on Medical Malpractice Reform has studied the impact of state reforms and offers its comments to state and federal officials who are considering national tort reform.

Findings

Any federal medical malpractice tort reform effort should be based on a *package* of measures that have exhibited some success in stabilizing medical malpractice costs. The most effective elements of such a package are a cap on noneconomic damages and an offset for collateral payments from other sources. These reforms would limit the financial exposure of health-care providers to lawsuits and would ensure that damages could not be collected through multiple suits. While there are significant limitations on data used to study specific tort reforms, persuasive results can be observed by looking at medical malpractice costs in certain states over time and relating that experience to the timing of particular tort reform measures.

In the following comparison of cost levels in three states that have enacted tort reform measures, paid losses of the individual states as a percentage of the U.S. total are used as the measure of costs. The percentage of physicians in each state as a total of U.S. physicians is used as a reasonable benchmark. The degree to which the percentage of paid losses differs from the percentage of physicians measures the effectiveness of the reforms. All else being equal, the relative cost percentages of paid medical malpractice claims should remain constant over time. Any observed changes in a state's relative cost levels provide an indication of the effectiveness of tort reform. The three states studied are California, New York, and Ohio.

The American Academy of Actuaries is the public policy organization for the actuarial profession, providing unbiased actuarial information to elected officials and regulators.

Members of the Work Group on Medical Malpractice Reform: James D. Hurley, ACAS, MAAA; William E. Burns, ACAS, MAAA; Linda A. Dembiec, FCAS, MAAA; Aileen C. Lyle, FCAS, MAAA; and Edward M. Wrobel Jr., FCAS, MAAA

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... Injury Compensation Reform Act (MICRA) package of reforms was enacted in 1975, medical malpractice costs have fallen substantially as a percentage of the U.S. total.

• New York. Individual reform measures were adopted in 1975, 1981, 1985, and 1986. No observable improvement in the state's relative costs has resulted. The New York reforms did not include a cap on damages.

• Ohio. Reforms enacted in 1975 included a cap on damages. The cap was overturned in 1985, after which costs rose dramatically and have remained high.

California

The California loss data (Exhibit 1) illustrate that while the state's proportion of the U.S. physician population has remained relatively stable, its per-

Exhibit 1
Malpractice Loss Payments in California as a Percentage of the U.S. Total, 1975–94

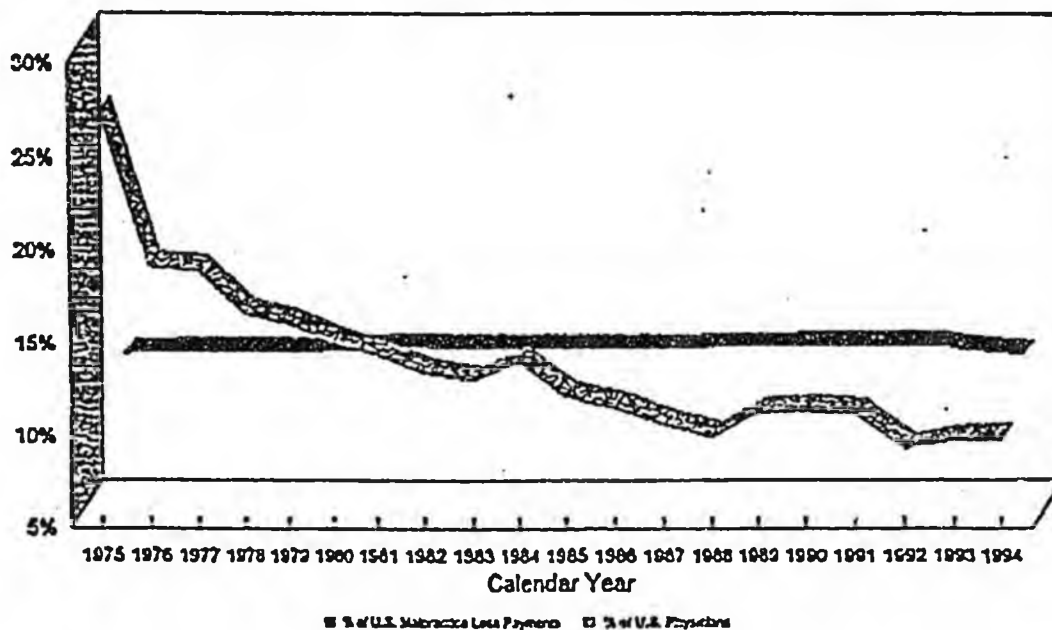
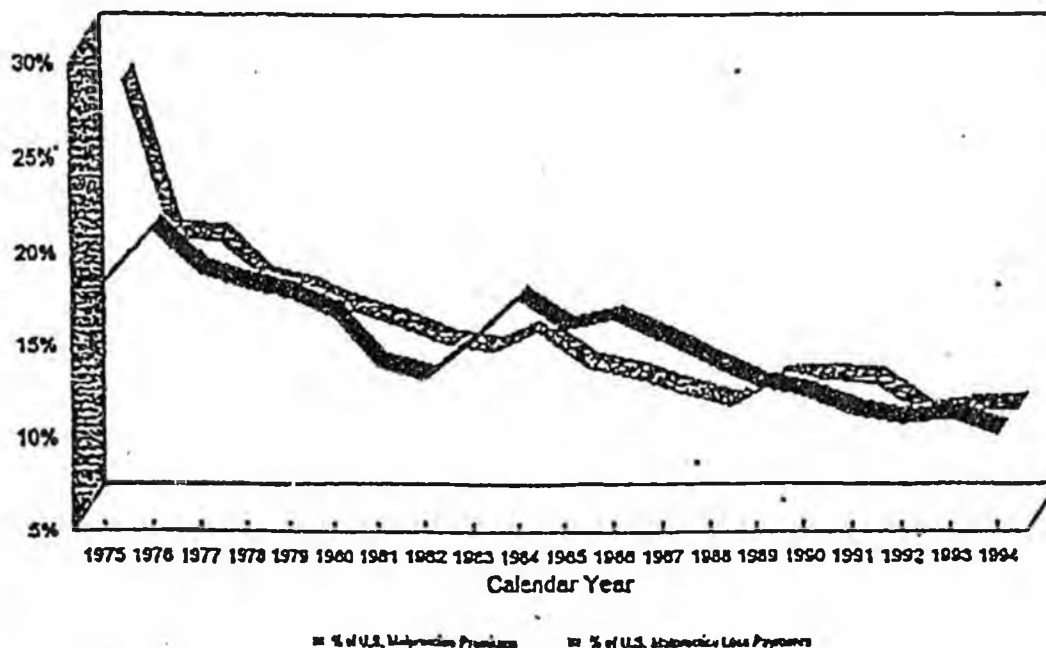


Exhibit 2
Malpractice Premiums and Malpractice Loss Payments in California as a Percentage of the U.S. Total,



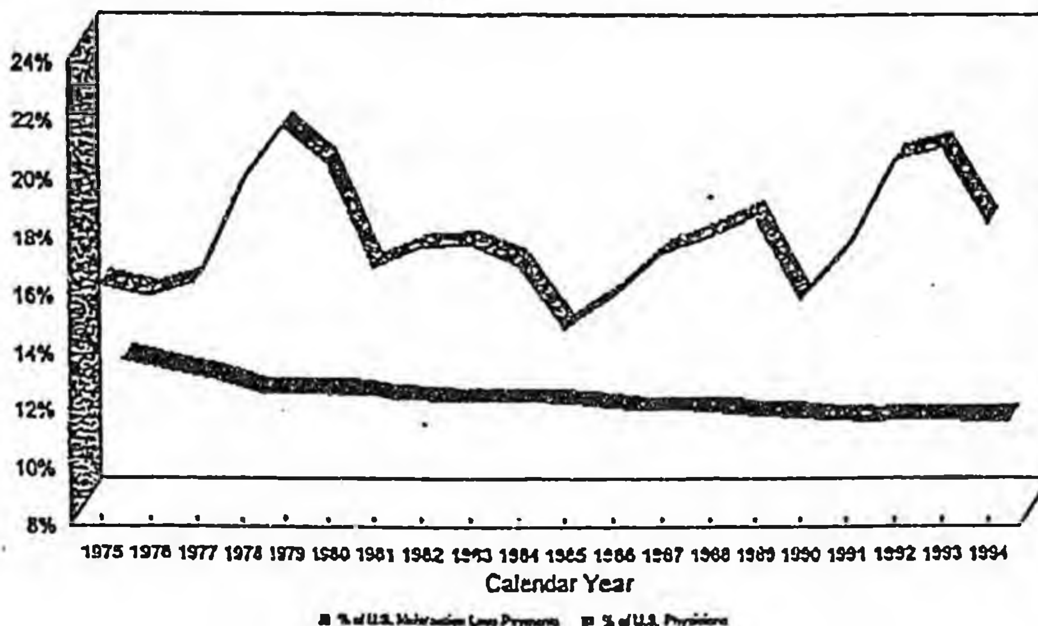
centage of loss payments has dropped dramatically since enactment of the MICRA package of tort reforms. Before MICRA's adoption in 1975, California's percentage of loss payments was significantly higher than its proportion of physicians. By 1981, California's loss payments had dropped and were about even with its percentage of physicians. Since that date, California has continued to benefit from MICRA: Costs continue to drop as a percentage of the U.S. total, even as the percentage of physicians remains stable. Although other factors affect these data, the relationship of decreased relative costs to the timing of reform provides strong evidence for the effectiveness of the MICRA package.

Many opponents of tort reform argue that insurance premiums do not drop after medical malpractice reform. Indeed, costs and premiums normally rise with inflation, and tort reform may only slow the increases. However, the California data show that premiums declined as losses declined. Exhibit 2 compares the paid loss data from Exhibit 1 with California premiums as a percentage of the total U.S. medical malpractice premiums. Although year-to-year fluctuations do occur, premiums have fallen in proportion to the decline in losses. Competition tends to keep companies at an appropriate profit margin, and any extra profits are normally short-lived.

New York

The New York loss experience is shown in Exhibit 3. It shows that the individual tort reform measures implemented in New York did not improve New York's experience relative to that of other states. New York's loss payment percentage does not show any observable pattern of decline or improvement over the 19-year period, despite the various tort reform measures adopted. The New York reforms did not include a cap on damages and were enacted in piecemeal fashion. Therefore, this result supports the merits of a cap on damages and the concept of a package of reforms.

Exhibit 3
Malpractice Loss Payments in New York as a Percentage of the U.S. Total, 1975–94

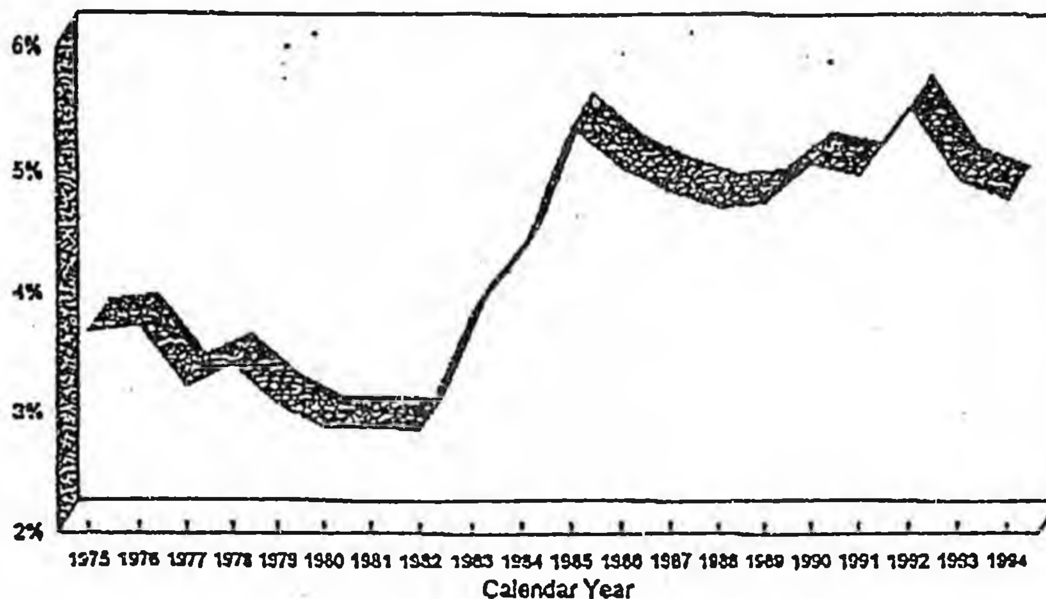


Ohio

The final example is Ohio, with data presented in Exhibit 4. The data show a gradual decline in costs following tort reform in 1975. The Ohio cap on damages came under court challenge in 1982, resulting in sharp increases that reached a peak in 1985 when the cap was finally overturned. Since 1985, costs in Ohio have remained high, with no signs of decreasing. Again, the data appear to support a tort reform package and the specific benefit of a cap on noneconomic damages.

Exhibit 4

Malpractice Loss Payments in Ohio as a Percentage of the U.S. Total, 1975–94



Conclusions

California's experience indicates that properly implemented medical malpractice tort reform can reduce the cost of medical malpractice insurance. After reviewing several states' experience with medical malpractice tort reform and examining studies on the issue, the Academy work group has concluded the following:

- a package of reforms is more likely than individual reforms to achieve savings in malpractice losses and insurance premiums, and
- key among the reforms in the package are a cap on noneconomic awards and a mandatory collateral-source offset rule.

For reform to be effective in reducing costs, the cap on noneconomic awards should be established on a per-medical-injury basis at a level low enough to have an impact (e.g., $250,000). In addition, a mandatory collateral-source offset rule is needed to ensure that double and triple damages cannot be collected through multiple suits. Under this rule, each suit would have to consider damages already paid from other sources.

Although these reforms have been successful in reducing the cost of medical malpractice insurance, elected officials and regulators must still consider the effects of medical malpractice reform on physicians, consumers, health plans, and other interested parties. When considering medical malpractice reform, state and federal officials should weigh the impact on society as a whole and strive for a balanced, comprehensive solution.

AMERICAN ACADEMY *of* ACTUARIES

Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

Hearing on
"Assessing the Need to Enact Medical Liability Reform"

Statement of James Hurley, ACAS, MAAA
Chairperson, Medical Malpractice Subcommittee
American Academy of Actuaries

February 27, 2003

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INTRODUCTION

The American Academy of Actuaries appreciates the opportunity to provide comments on issues related to patient access to health care and, in particular, the availability and pricing of medical malpractice insurance. The Academy hopes these comments will be helpful as Congress considers related proposals.

This testimony discusses what has happened to medical malpractice financial results and its likely effect on rates, tort reform, and some discussion of frequent misconceptions.

MEDICAL MALPRACTICE – WHAT HAS HAPPENED?

The medical malpractice insurance marketplace is in serious turmoil after an extended period of reported of high profitability and competitiveness during the 1990s. This turmoil began with serious deterioration in financial results, continued with some consequences of these results and, at least at this point, gives rise to an uncertain future. Industry-wide financial results reflect a 2001 combined ratio (the measure of how much of a premium dollar is dedicated to paying insurance costs of the company in a calendar year) that reached 153 percent and an operating ratio (reducing the combined ratio for investment income) of about 135 percent; the worst results since separate tracking of this line of business began in 1976. Projections for 2002 are for a lower combined ratio of approximately 140 percent and probable lesser improvement in the operating ratio. This follows 1999 and 2000 operating ratios of 106 percent.

The consequences of these poor financial results are several. Insurers have voluntarily withdrawn from medical malpractice insurance (e.g., St. Paul, writer of approximately nine percent of total medical malpractice insurance premium in 2000) or have selectively withdrawn from certain marketplaces or segments of medical malpractice insurance. In addition, several insurers have entirely withdrawn due to poor financial results (e.g., Phico, MIIX, Frontier, Reciprocal of America, some of which are under regulatory supervision). Overall, premium capacity has been reduced by more than 15 percent. These withdrawals fall unevenly across the states and generally affect those identified as jurisdictions with serious problems more severely than others.

Capacity to write business would have decreased even more if not for the fact that much medical malpractice coverage is written by companies specializing in this coverage, some of whom were formed for this specific purpose.

The future outlook is not positive, at least in the short term. Claim costs are increasing more rapidly now than they were previously. Further, the lower interest rate environment would require higher premium rates, even if losses were not increasing. The combined effect is that there are likely to be more poor financial results and additional rate increases.

Background

Today's premium increases are hard to understand without considering the experiences of the last decade. Rates during this time period often stayed the same or decreased relative to the beginning of the period due to several of the following factors:

- Favorable Reserve Development--Ultimate losses for coverage years in the late 1980s and early 1990s have developed more favorably than originally projected. Evidence of this emerged gradually over a period of years as claims settled. When loss reserves for prior years were reduced, income was contributed to the current calendar years, improving financial results (i.e., the combined and operating ratios). That was the pattern during the middle to late 1990s for 30 provider-owned medical malpractice insurers whose results are shown in Chart A. What is evident from that chart is that favorable reserve development (shown as a percentage of premium) was no longer a significant factor in 2001 for these insurers as the effect approached zero. In contrast to the experience of these provider-owned insurers, the prior-year reserves for the total medical malpractice line of business actually deteriorated in 2000 and in 2001.

- Low Level of Loss Trend--The annual change in the cost of claims (frequency and severity) through most of the 1990s was lower than expected by insurers, varying from state to state and by provider type. This coincided with historically low medical inflation and may have benefited from the effect of tort reforms of the 1980s. Rates established earlier anticipated higher loss trends and were able to cover these lower loss trends to a point. As a result, rate increases were uncommon and there were reductions in several states. This was justified in part because the rates established at the beginning of the last decade proved too high, inasmuch as carriers had assumed higher loss trends.

Insurers responded to the emerging favorable loss trend in different ways. Some held rates stable and paid policyholder dividends or gave premium discounts. Some reduced filed rates. Others increased rates modestly and tried to refine pricing models to improve overall program equity. In general, however, premium adequacy declined in this period. Collected rates came into line with insurers' costs, but competitive actions pushed rates even lower, particularly in some jurisdictions.

- High Investment Yields--During the 1990s, investment returns produced a real spread between fixed income rates of return and economic inflation. Counter to what some may believe, medical malpractice investment results are based on a portfolio that is dominated by bonds with stock investments representing a minority of the portfolio. Although medical malpractice insurers had only a modest holding of stocks, capital gains on stocks also helped improve overall financial results. These gains improved both the investment income ratio and the operating ratio.

- Reinsurers Helped--Many medical malpractice insurers are not large enough to take on the risks inherent in this line of insurance on their own. The additional capacity provided by reinsurers allows for greater availability of medical malpractice. Similar to what was happening in the primary market, reinsurers reduced rates and covered more exposure, making the net results even better.

- Insurers Expanded Into New Markets--Given the financial results of the early-to-mid-1990s, some insurers expanded into new markets (often with limited information to develop rates). They also became more competitive in existing markets, offering more generous premium discounts. Both actions tended to push rates down.

What Has Changed?

Although these factors contributed to the profitability of medical malpractice insurance in the 1990s, they also paved the way for the changes that began at the end of the decade.

- Loss Trend Began to Worsen--Loss cost trends, particularly claim severity, started to increase toward the latter part of the 1990s. The number of large claims increased, but even losses adjusted to eliminate the distortions of very large claims began to deteriorate. This contributed to indicated rate increases in many states.

- Loss Reserves Became Suspect--As of year-end 2001, aggregate loss reserve levels for the industry are considered suspect. Reserve reductions seem to have run their course. As mentioned earlier, the total medical malpractice insurance industry increased reserves for prior coverage year losses in 2000 and 2001, although results vary on a company-by-company basis. Some observers suggest that aggregate reserves will require further increases, particularly if severity trends continue or intensify.

- Investment Results Have Worsened--Bond yields have declined and stock values are down from 1990s highs. The lower bond yields reduce the amount of expected investment earnings on a future policy that can be used to reduce prospective rates. A one percent drop in interest rates can be translated to a premium rate increase of two to four percent (assuming no changes in other rate components) due to the several year delay in paying losses on average. A 2.5 percent drop in interest rates, which has occurred since 2000, can translate into rate increases of between 5 percent and 10 percent. Note that this factor may discourage an insurer from maintaining market presence and also may discourage new entrants.

- The Reinsurance Market Has hardened--Reinsurers' experience deteriorated as their results were affected by increased claim severity and pricing changes earlier in the decade. Because reinsurers generally cover the higher layers of losses, their results are disproportionately influenced by increases in claim severity. This, coupled with the broadly tightened reinsurance market after Sept. 11, has caused reinsurers to raise rates substantially and tighten reinsurance terms for medical malpractice.

The bottom line is that these changes require insurers to increase rates if they are to preserve their financial health and honor future claim payments.

The Results

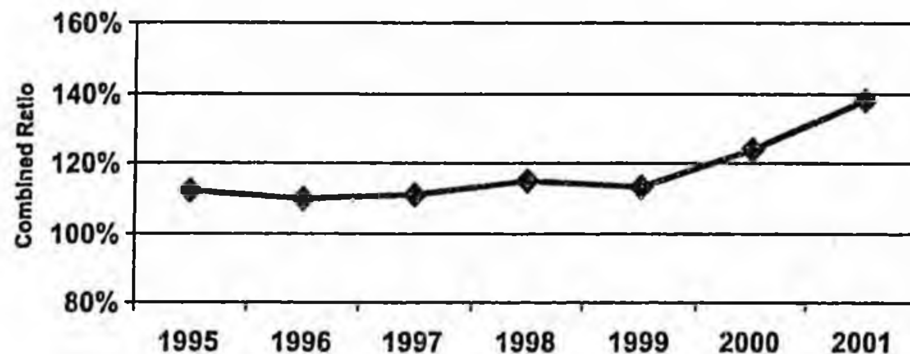
To obtain a better understanding of the effect of these changing conditions, we focus on the results of 30 specialty insurers that are primarily physician owned or operated and that write primarily medical malpractice business. Their results reflect the dynamics of the medical malpractice line. This sample represents about one-third of the insured exposures in the United States.

These insurers, achieving more favorable financial results than that of the total industry, showed a slight operating profit (four percent of premiums) in 2000. This deteriorated to a 10-percent operating loss in 2001 (see Chart B).

There are two key drivers of these financial results:

- Insurance Underwriting--For these companies, a simplified combined ratio was calculated by dividing calendar year loss and loss adjustment and underwriting expenses by premium. The combined ratios were 124 percent and 138 percent in 2000 and 2001, respectively. That means in 2001, these insurers incurred $1.38 in losses and expenses for each $1.00 of premium. The preceding five years were fairly stable, from 110 percent to 115 percent. Deterioration of the loss and loss adjustment expense ratio drove these results; the underwriting expense ratio remained relatively constant (see Chart C).

CHART C: COMBINED RATIO



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- Investment Income--Pre-tax investment income (including realized capital gains and losses) derives from policyholder-supplied funds invested until losses are paid as well as from the company capital ('surplus'). The ability of investment income to offset some of the underwriting loss is measured as a percentage of earned premiums. This statistic declined during the measurement period from the mid-40 percent to the mid-30 percent level and, in 2001, to 31 percent (see Chart D).

  This offset will continue to decline because (i) most insurer-invested assets are bonds, many of which were purchased before recent lower yields, and interest earnings do not yet fully reflect these lower yields; and (ii) the premium base is growing due to increased rates and growth in exposure. Invested assets are not increasing as rapidly as premium and, therefore, investment income as a percentage of premium will decline.

The effect of these results on surplus is reflected in Chart E, which shows the percent change in surplus from one year to the next. Surplus defines an insurer's capacity to write business prospectively and to absorb potential adverse loss development on business written in prior years (see Chart E).

TORT REFORM

Some states enacted tort reform legislation after previous crises as a compromise between affordable health care and an individual's right to seek recompense. The best known is the Medical Injury Compensation Reform Act or MICRA, California's tort reform package. Since MICRA's implementation in 1975, California has experienced a more stable marketplace and lower premium increases than have most other states.

Tort reform has been proposed as a solution to higher loss costs and surging rates. Many are suggesting reforms modeled after California's MICRA, although some have cautioned against modifying the MICRA package. The Academy, which takes no position for or against tort reforms, has previously reviewed and commented on this subject. Based on research underlying the issue, we observe the following:

- A coordinated package of tort reforms is more likely than individual reforms to achieve savings in malpractice losses and insurance premiums.
- Key among the reforms in the package are a cap on non-economic awards (on a per-event basis and at some level low enough to have an effect; such as MICRA's $250,000) and a mandatory collateral source offset rule.
- Such reforms may not assure immediate rate reductions, particularly given the size of some increases being implemented currently, as the actual effect, including whether or not the reforms are confirmed by the courts, will not be immediately known.
- These reforms are unlikely to eliminate claim severity (or frequency) changes but they may mitigate them. The economic portion of claims is not affected if a non-economic cap is enacted. Thus rate increases still will be needed.
- These reforms should reduce insurer concerns regarding dollar awards containing large, subjective non-economic damage components and make the loss environment more predictable.
- Poorly crafted tort reforms could actually increase losses and, therefore, rates.

FREQUENT MISCONCEPTIONS

In closing, it might be helpful to address some frequent misconceptions about the insurance industry and medical malpractice insurance coverage.

Misconception 1: "Insurers are increasing rates because of investment losses, particularly their losses in the stock market."

As we have pointed out, investment income plays an important role in the overall financial results of insurers, particularly for insurers of medical professional liability, because of the long delay between payment of premium and payment of losses. The vast majority of invested assets are fixed-income instruments. Generally, these are purchased in maturities that are reasonably consistent with the anticipated future payment of claims. Losses from this portion of the invested asset base have been minimal, although the rate of return available has declined.

Stocks are a much smaller portion of the portfolio for this Group, representing about 15 percent of

invested assets. After favorable performance up through the latter 1990s, there has been a decline in the last few years, contributing to less favorable investment results and overall operating results. Investment returns are still positive, but the rates of return have been adversely affected by stock declines and more so by lower fixed income investment yields.

In establishing rates, insurers do not recoup investment losses. Rather, the general practice is to choose an expected prospective investment yield and calculate a discount factor based on historical payout patterns. In many cases, the insurer expects to have an underwriting loss that will be offset by investment income. Since interest yields drive this process, when interest yields decrease, rates must increase.

Misconception 2: "Companies operated irresponsibly and caused the current problems."

Financial results for medical liability insurers have deteriorated. Some portion of these adverse results might be attributed to inadequate knowledge about rates in newly entered markets and to being very competitive in offering premium discounts on existing business. However, decisions related to these actions were based on expectations that recent loss and investment markets would follow the same relatively stable patterns reflected in the mid-1990s. As noted earlier, these results also benefited from favorable reserve development from prior coverage years. Unfortunately, the environment changed on several fronts — loss cost levels increased, in several states significantly; the favorable reserve development ceased; investment yields declined; and reinsurance costs jumped.

While one can debate whether companies were prudent in their actions, today's rate increases reflect a reconciliation of rates and current loss levels, given available interest yields. There is no added cost for past mispricing. Thus, although there was some delay in reconciling rates and loss levels, the current problem reflects current data.

Misconception 3: "Companies are reporting losses to justify increasing rates."

This is a false observation. Companies are reporting losses primarily because claim experience is worse than anticipated when prices were set. Several companies have suffered serious adverse consequences given these financial results, including liquidation or near liquidation. Phico, MIIX, Frontier and, most recently, the Reciprocal of America, are all companies forced out of the business and in run-off due to underwriting losses. Further, the St. Paul Cos., formerly the largest writer of medical malpractice insurance, is now in the process of withdrawing from this market. One reason for

this decision is an expressed belief that the losses are too unpredictable to continue to write the business.

The Academy appreciates the opportunity to provide an actuarial perspective on these important issues and would be glad to provide the subcommittee with any additional information that might be helpful.

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STATEMENT

OF THE

PHYSICIAN INSURERS ASSOCIATION OF AMERICA

Presented by
Richard E. Anderson, M.D., Chairman
The Doctors' Company

Before the

Subcommittee on Health
Committee on Energy and Commerce
U.S. HOUSE OF REPRESENTATIVES

Regarding:
"Harming Patient Access to Care:
Implications of Excessive Litigation"

Wednesday, July 17, 2002

2

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Wednesday July 17, 2002

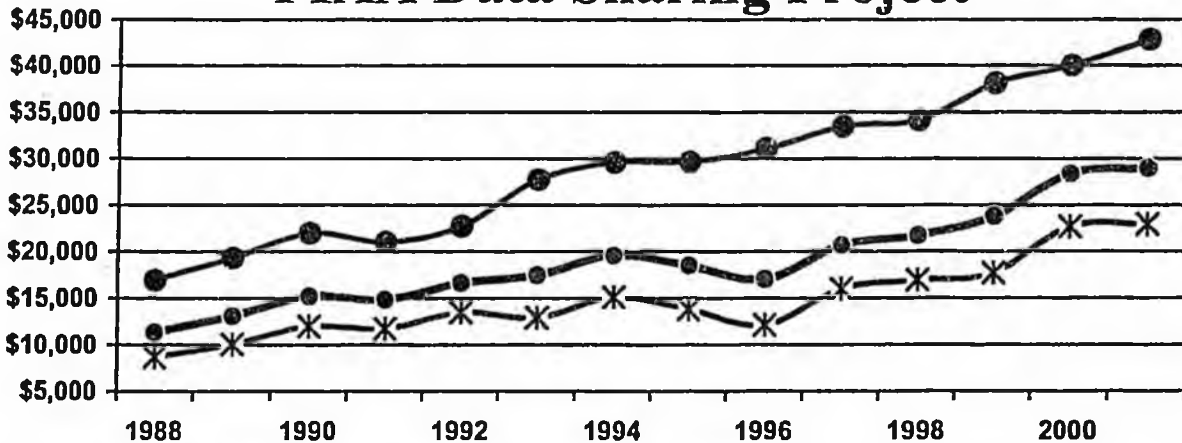
Chairman Bilirakis, Representative Brown and members of the subcommittee, thank you for this opportunity to present to you today our views on the implications of excessive litigation and the need for Federal health care litigation reform. My name is Richard Anderson and I am an oncologist with more than 25 years experience practicing cancer medicine in California. I am also Chairman of The Doctors' Company one of the 45 doctor-owned and/or operated medical liability insurers that comprise the Physician Insurers Association of America (PIAA). Collectively, the PIAA companies insure over 60% of the Nation's practicing physicians. At last count, PIAA companies insured more than 277,000 doctors and 1,100 hospitals. On behalf of our member companies and their insureds, the PIAA has always supported health care liability reform that will more equitably and rapidly compensate patients who have received substandard care, but which at the same time will also limit frivolous lawsuits and increase access to health

care.

BACKGROUND

Despite stunning advances in scientific knowledge, medicine remains more of an art than science because human beings are not machines. Sadly, the tide of litigation against America's doctors has risen even faster. Approximately one of every six practicing physicians faces a malpractice claim every year. In high-risk specialties such as obstetrics, orthopedics, trauma surgery and neurosurgery, there is one claim for each doctor every 2 ½ years. However, fully 70% of these tens of thousands of cases are found to be without merit. Nonetheless, every single case requires a costly legal defense. Nationally, as the chart below shows, these loss adjustment expenses average $22,967 per defendant. Those cases that go all the way through trial before a vindicating defense verdict average $85,718 per defendant.[1] [See chart below] The Doctors' Company itself, for example, has spent more than $400 million defending claims that ultimately were shown to be without merit.

Average Expense Payment Values
PIAA Data Sharing Project



[1]PIAA Data Sharing Project, May 2002.

ROOTS OF THE CURRENT ENVIRONMENT

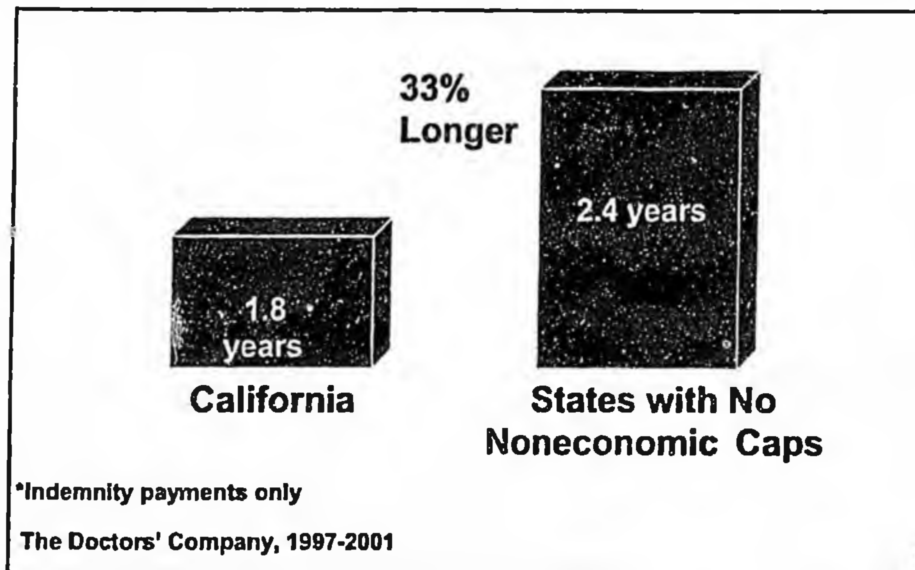
Medical liability claims were fairly uncommon until the 1970s. In the 40 year period between 1935 and 1975, 80% of all medical malpractice lawsuits were filed in the last five years of that period.[2] Massive losses between 1970 and 1975 forced many commercial insurers to conclude that the practice of medicine was an uninsurable risk, and they simply refused to provide malpractice insurance at any price. This resulted in a "crisis of availability" to which providers responded emergently. Doctors contributed their own funds as capital to support the efforts of their state medical and hospital associations, among others, to start as many as 100 provider owned specialty carriers across the country. Dubbed "bed pan mutuals" by their commercial competitors (many of whom had fled the market), these upstarts were not expected to succeed where the giant commercials could not find success. Because their primary mission is to provide a service, and because they were entirely committed to remaining present even in the most difficult markets, these companies have succeeded and are the basis of the PIAA. As one example, The Doctors' Company was formed by doctors, for doctors in 1976, and today insures more than 25,000 doctors throughout the nation.

A LITIGIOUS SOCIETY GROWS

A second crisis emerged in the early 1980's, known as a "crisis of affordability." Insurers faced ever-mounting losses, with rampant increases in paid claim frequency (number of paid claims) and severity (amount of indemnity payment). PIAA data shows that on average it takes 5 ½ years for an insurer to

close a malpractice claim after the date of the incident.[3] There is often a long lag before the claim is reported. The majority of the delay, however, comes because of the inefficiencies of the tort system. California enacted the Medical Injury Compensation Reform Act of 1975 (MICRA) which largely eliminates the lottery aspect of malpractice litigation in that state. The Doctors' Company data reveals that claims are settled in one-third less time than the national average. [See chart below] This result not only decreases the cost of litigation, but it means injured patients are indemnified much faster in California.

MICRA Reduces Average Time to Settlement



During much of the 1990s, PIAA companies exercised their fiduciary responsibility to wisely invest the premium deposits of their policyholders, who benefited from the rising bond markets. These returns were used not to line the pockets of the companies, but to subsidize the premium rates being charged to

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[2]Professional Liability in the '80s, Report 1, American Medical Association, 10, 84, p4.

policyholders so that they could remain affordable. It was the policy holders (health care providers) who reaped the financial benefits.

It must be noted that insurance is a highly regulated industry. Every state department of insurance, as well as the national rating agencies, closely monitors both the kinds and qualities of investments. Virtually no medical liability insurance company has experienced net investment losses. In fact, 80% of investments by PIAA companies are in high-grade bonds. What has happened is that investment yields have declined due to falling interest rates and are no longer available to subsidize premium rates to the extent they once did. In other words, premium rates must now more closely match the actual cost of losses. The combination of these factors created "the perfect storm" for medical liability insurers.

THE PERFECT STORM

During this same time period, claim frequency and severity continued to increase. In addition, reinsurance costs rose significantly in relation to the increase in loss costs. The insurance system was able to accommodate even this inexcusable volume of litigation as long as the size of the few valid claims was predictable. Unfortunately, in the past few years there has been an explosion in the cost of individual claims. Texas has seen a $268,000,000 verdict. A number of states have witnessed verdicts in excess of $100,000,000. The city of Philadelphia alone has recorded multiple verdicts in excess of $50,000,000 in just the past two years. Four claims in Arkansas totaled $98,000,000 in just the past year. According to PIAA data [shown on next chart], during the period 1991 to 2001, the percentage

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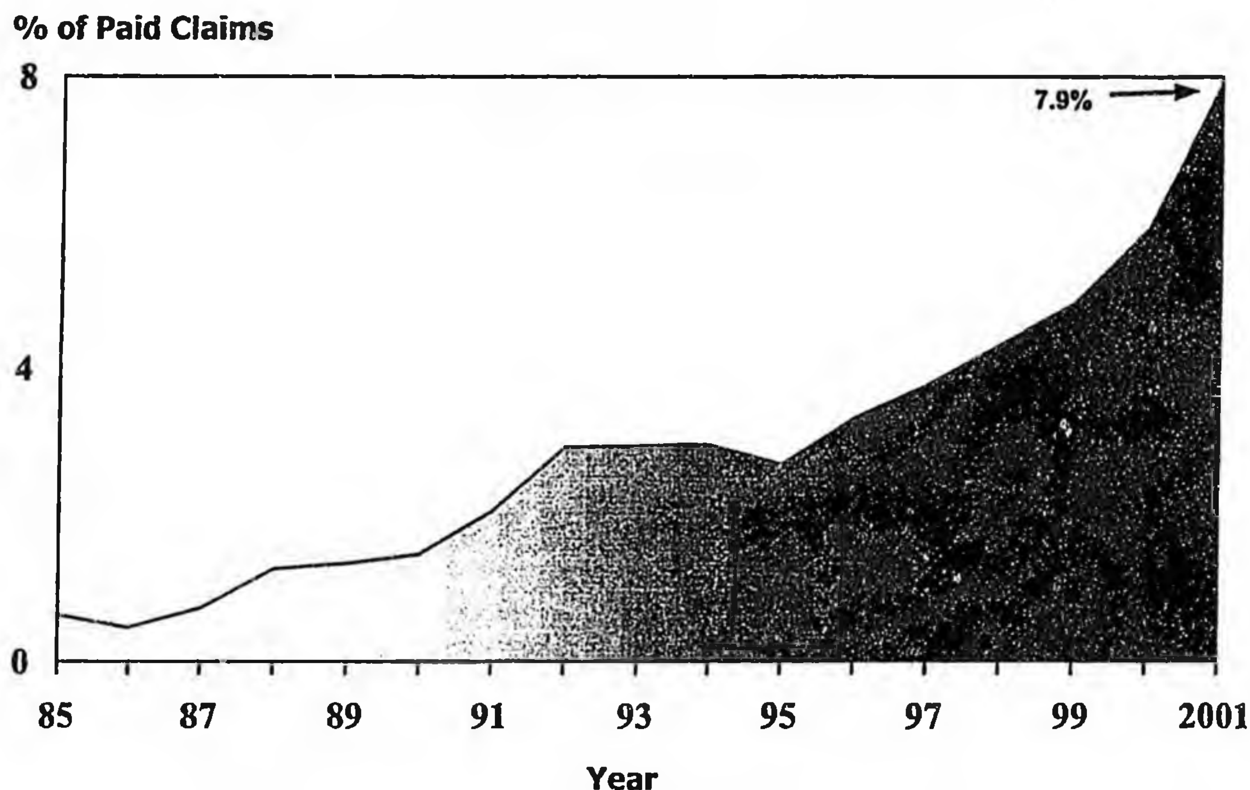
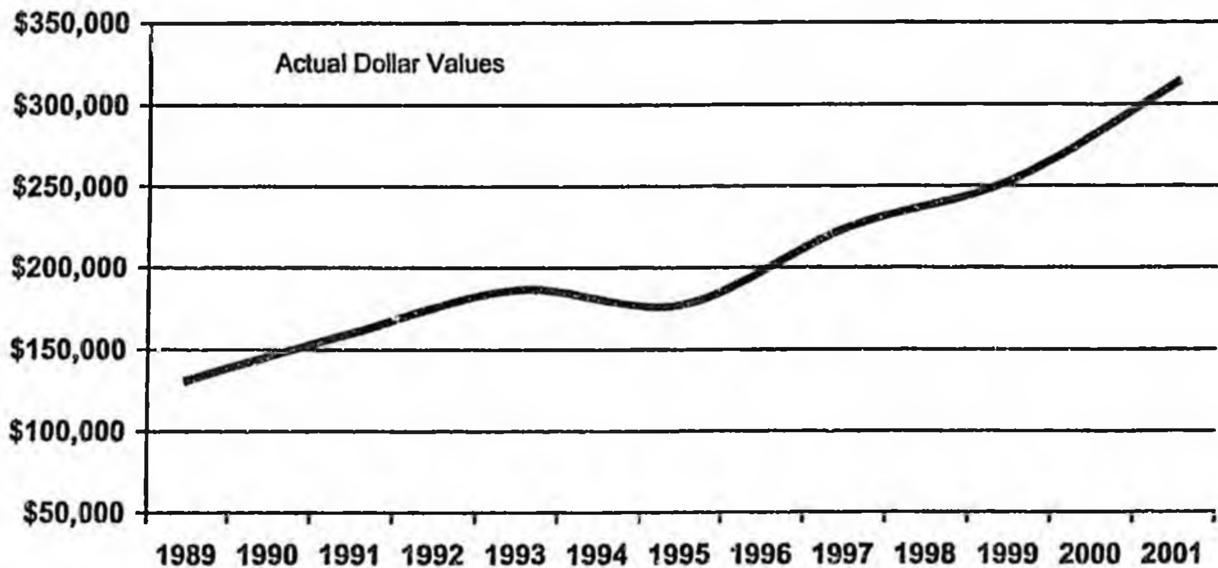
[3]PIAA Data Sharing Project, December, 2001.

of claims costing in excess of $1 million dollars increased nearly four-fold. Insurance is not magic. If society expects insurers to pay unlimited awards, it should expect those who are insured to pay corresponding premiums. As premiums rise so must the cost of health care. Since health care today is a zero sum game, these costs increases mean corresponding decreases in ***access*** to health care.



Those are the largest claims. What about the size of the average claim? PIAA data shows that the average indemnity payment in 2001 was more than $310,000, a 60% increase in the last five years. As the next chart shows, the average malpractice payment is rising precipitously. With it, the sum of the

malpractice claims paid rises. In New York and Pennsylvania alone nearly $1 billion was paid in 2000.



*Per defendant - many claims have more than one defendant

**Data reported for year 2000 incomplete at time of analysis.

THE CURRENT SITUATION

As the new millennium began, insurers who were not able to weather the storm began to experience poor financial results. Expressed differently, a number of companies that felt that they could provide insurance for less than its cost learned the inevitable lesson. Several, such as PHICO, PIE and Reliance, have ceased

all underwriting operations. In December of last year, long-time industry leader St. Paul announced that due to unsustainable losses and the "unfavorable tort environment" the company would no longer write new medical liability coverage and it would not renew the policies of its 42,000 physicians, 750 hospitals and 73,000 other health care providers. Though St. Paul is a commercial carrier and not a member of PIAA, it is telling that the largest company in the industry for the better part of two decades feels that it can no longer afford the risk of insuring the practice of medicine. Companies remaining in the market have had no choice but to take the rate increases necessary to insure survival.

Conning & Co. estimates that malpractice insurers will pay out approximately $1.40 for every premium dollar collected in 2001 and 2002. Even with the projected rate increases, Conning & Co. still projects insurers will pay out $1.35 for each dollar collected in 2003 (Conning Report on Medical Malpractice Insurance, April 2002). PIAA data reveals that since 1990, claims costs have risen annually by 6.9%, nearly three times the rate of inflation.

IN CONCLUSION

The average claim payment has increased by 60% over the past five years. The cost of the most expensive claims has exploded in a manner that is absolutely unprecedented. If judgments are to be unlimited, than the premiums need to increase accordingly to pay for those judgments. With absolute certainty, this money will be taken out of our healthcare system and compound the severe access to care issues that we all face today.

Several spurious arguments have been put forth by those with an interest in continuing the tsunami of medical malpractice litigation. First, it has been deceptively argued that stock market losses are the real driver of price increases. In fact, investments by insurance companies are highly regulated and controlled by each state department of insurance and closely monitored by the rating agencies. Insurance companies continue to gain funds from their investments and use those funds to offset even higher malpractice premium rates. As income from investments decreases, however, premiums must more closely match losses.

Second, it is argued that insurance companies should have raised rates sooner. There may be some truth to this. However, *it is difficult to understand how having today's sky-high rates earlier would make them more palatable.*

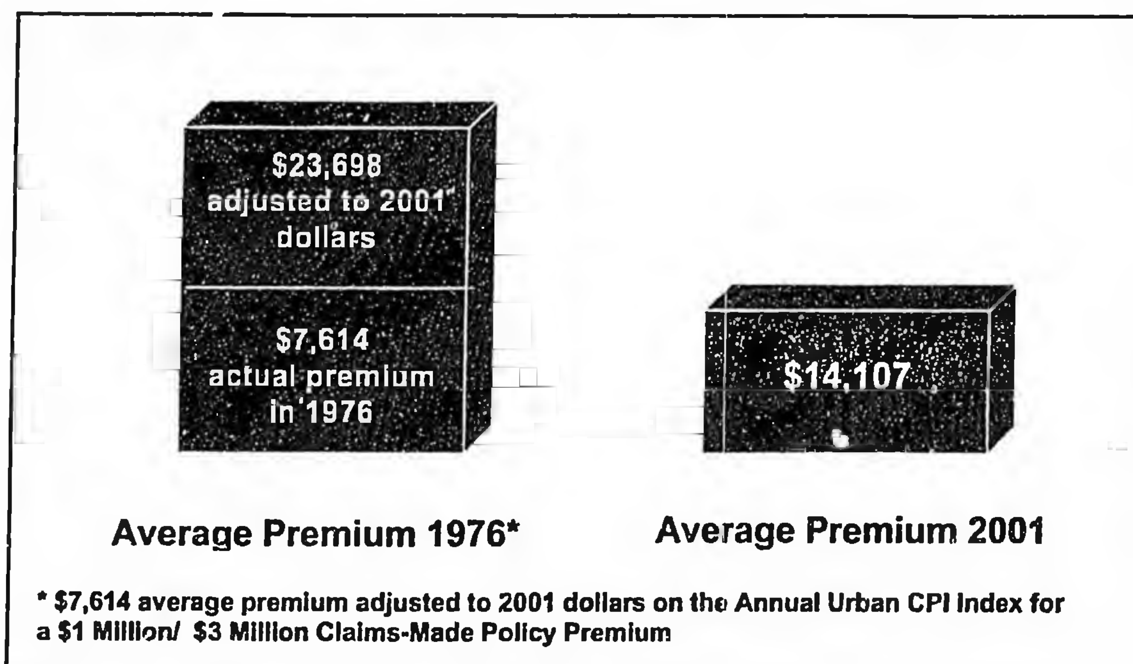
Third, it is argued that insurance companies fail to settle claims when they should, and are therefore, exposed to astronomic jury verdicts. Again, reality is quite different. In most cases, it is the physician, not the company, who must make any settlement decision. Remember that doctors are found to be without fault in approximately 8 out of 10 malpractice trials. Should these cases have been settled?

Finally, there are those who argue for a state run medical liability system. Allow me to point out that the majority of state run malpractice programs have gone bankrupt, or charge premiums that are much higher than those charged by PIAA companies. In New York, premiums are actually set by the Department of Insurance, not by individual companies, and New York rates are among the highest in the nation.

THERE IS A "TRIED AND TRUE" SOLUTION

California has 27 years of experience with the MICRA statutes. We know, we do not have to speculate, that tort reform works. Since 1975, The Doctors Company malpractice premium rates in California have decreased by 40% in constant dollars. [See chart below] This is true despite the fact that there has not been and is not today any limit on actual damages awarded.

MICRA Helps Reduce California Medical Liability Premium Rates by 40%



We know, we do not speculate, that claims settle about 33% faster in California than the rest of the nation because the lottery aspect of non-economic damages has been controlled.

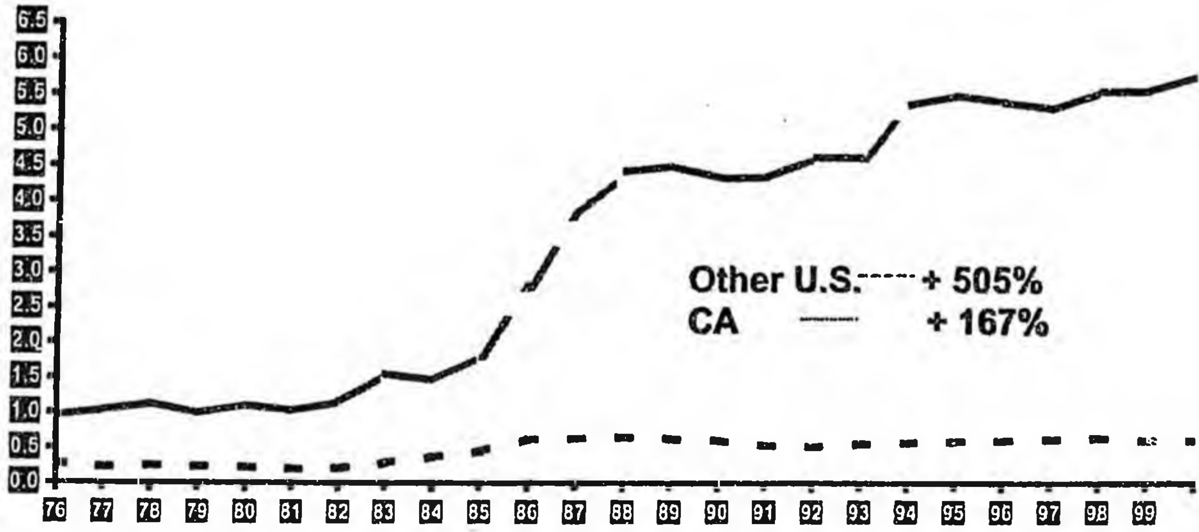
We know, we do not speculate, that even very large judgments can be accommodated by the insurance system because they can be paid on an annual basis over the intended period of compensation, not as a single jackpot.

We know, we do not speculate, that injured patients actually take home a significantly higher percentage of awards in California because there is an upper limit on attorney contingency fees. In many areas, more than 40% of a malpractice award goes directly into the pocket of the plaintiff's attorney. In California, MICRA contains a limitation on this fee. An attorney winning a $1 million claim must be satisfied with a legal fee of $221,000.

We know, we do not speculate, that MICRA has not limited access to attorneys. California remains a litigious state and according to The Doctors Company data the frequency of malpractice cases in the state is 50% higher than the national average.

California passed effective tort reforms and its providers have been able to weather this liability crisis well. These same reforms are found in H.R. 4600, the Help Efficient, Accessible, Low-cost, and Timely Healthcare Act of 2002 (the HEALTH Act). The PIAA and The Doctors Company fully support the provisions of this act, which when signed into law, will provide the same protections to patients across the United States as found in California for over a quarter century. The next chart, which was compiled from data reported to the National Association of Insurance Commissioners, speaks volumes about MICRA's effectiveness:

Savings from MICRA Reforms
California vs. U.S. Premiums 1976 - 2000



We thank members of the Committee and their staff for holding this important hearing and inviting us to testify. We look forward to working with you to make the health care liability system fairer for everyone. I will be happy to answer any questions you might have.

This article will be published in Vol. 10, Issue 4 of the Journal of Reinsurance and is reprinted with permission of the Intermediaries & Reinsurance Underwriters Association.

Medical Professional Liability - *Not for the Faint of Heart*

Medical Professional Liability is one of the most dangerous lines of insurance, second only to earthquake (property) coverage

by Deborah Ropelewski, CPCU, ARM, ARe, Division Sr. VP, Gallagher Healthcare Insurance Services, Inc.

The 2003 Conning Research and Consulting Study- "*Medical Malpractice- Anatomy of a Crisis 2003*" (2)-identified four key dimensions to the ongoing financial crisis being experienced by the Medical Professional Liability (MPL) industry:

1. **A sustained escalation of underwriting losses,**
2. **A decline in investment income,**
3. **An epidemic of national proportions, and**
4. **There are emerging marketplace issues as carriers withdraw from the business and suffer rating downgrades.**

It goes on to say "Barring significant and rapid reform, we forecast no end to the industry's current financial problems. If, as expected, industry combined ratios remain at or near 2001 levels, the cumulative impact of a multiyear period of underwriting losses will be to deplete the industry's capital."

The A.M. Best 2003 Property/Casualty Review Preview (1) proclaimed that "Given the continued deterioration in operating profitability, weakened capitalization, uncertainty in the adequacy of loss reserves because of the heightened severity of claims and adverse trends, increased reinsurance costs and greater retention levels, A.M. Best views the outlook for the medical malpractice sector as negative." And if that's not enough to scare you, The Insurance Information Institute, based on A.M. Best's combined ratio data, estimates that Medical Professional Liability is one of the most dangerous lines of insurance, second only to earthquake (property) coverage.

Perhaps it would help to take a closer look at the four issues that the Conning study (2) has identified, in order to glean a further understanding of what is happening in the MPL industry today:

1. A sustained escalation of underwriting losses-

The Conning study (2) makes the observation that "the root cause of today's crisis can be found in severity, i.e., a higher level of loss per paid claim." Whether you look at the data from the PIAA data-sharing project or individual company data, it will typically bear out the fact that frequency has either remained flat or even declined over the last few years. The Conning Study (2) indicates that the frequency, measured in terms of number of claims per 1000 doctors, declined from a high of 57 per 1000 doctors in 1996, to less than 50 per 1000 doctors in 2001. Severity, however, is quite another matter:

- A study done for the U.S. Department of Health & Human Services (HHS) dated July, 2002 (3), indicates that the **average** award rose 76% in the period from 1996 to 1999. The **median** award increased 6.7% from 1998 to 1999, and another 43% in 1999-2000, or from roughly $750,000 to $1,140,000 in the two-year period from 1998-2000.
- The HHS study (3) notes that Jury Verdict Research data (3) reflects that the **average** jury award went from $1,140,000 in 1994 to $3,480,000 in 2000- a whopping 305% increase!

Gallagher Healthcare Insurance Services

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- The PIAA Data Sharing Project [4] illustrates that in 1985 less than 10% of all paid claims were over $250,000; by 2001 the number had jumped to over 40%. Likewise, less than 5% of all paid claims in 1985 were over $500,000, but this had increased to over 25% by 2001.

2. A decline in investment income-

Lower interest rates continue to depress the companies' investment income, and the days in which investment income could help to offset, at least partially, the underwriting losses are becoming a distant memory.

Not only are the returns so much lower than those enjoyed in years past, but the timeframe within which a company may invest the funds until the resolution of a claim is being compressed over time, further reducing the flow of investment income. Jury Verdict Research, as noted in the HHS study [3] reports that:

- The average number of months from the date an incident occurs until trial had dropped from 61 months in 1994 to 45 months by the year 2000.
- The average number of months from filing of a suit to date of trial had dropped from 36 months to 24 months in the same period. In many states this is the direct result of the "fast track" measures that have been enacted to bring cases to trial on a more timely basis.

3. An epidemic of national proportions-

Data published by the American Medical Association in March 2003 [5] depicting availability issues for MPL indicates that they consider Washington, Oregon, Nevada, Texas, Mississippi, Georgia, Florida, New York, Pennsylvania, Ohio, and West Virginia to be states "in crisis". Most other states, with nine possible exceptions, are considered to be "showing problem signs". "Problem signs" can be a euphemism for either affordability or availability.

The states "in crisis" share several key characteristics-

- These were states where the lead carriers exited the business- St. Paul, MIIX, PHICO, Frontier, Reciprocal of America/Doctors Insurance Reciprocal, etc.
- Many of these states have seen their claims severity magnified in the excess layers; a good example of this is Mississippi. The HHS Study indicates that before 1995, MS had no awards over $9,000,000. Since 1995, MS has had 21 verdicts at or over $9,000,000.
- These states have seen practice patterns changing as a result- the physicians are practicing more defensive medicine, MDs are abandoning high risk procedures, leaving the state, or even retiring from practice altogether.

4. Emerging marketplace issues-

There have been several waves of companies leaving the MPL marketplace since the mid-to-late 1990s. The first round included PIE, PIC, and ICA, among others. PHICO and Frontier were taken over by regulators in August 2001, and in December 2001 St. Paul made the monumental announcement that they would no longer write MPL business. According to A.M. Best's August 5, 2002 Statistical Study [6], St. Paul was the second largest writer of MPL, with almost $600 million in 2001 written premium. Their announcement was followed by the demise of Reliance, Reciprocal of America/Doctors Insurance Reciprocal, and Washington Casualty. In all, over $1 Billion of premium was displaced by these departures. Most recently, OHIC, MLMIC, and Princeton were downgraded by A.M. Best, with negative outlooks.

The companies that remain simply do not have the capacity to write all the business that is made available to them. Many that had enjoyed low Written Premium-to-Surplus ratios in the recent past now find their surplus stretched to an extent that they would have never thought possible, and much of that is just due to rating actions in the past few years that have significantly increased the written premiums on their existing books of business. This has been exacerbated by deteriorating results due to development on prior years, and the companies have had difficulty in finding ways to increase surplus to finance additional premium growth. Primary insurers have returned to underwriting discipline and find themselves having to carefully and consciously allocate what surplus they do have available, if any.

At the PLUS MPL Symposium in March, 2003, Matthew Fay, FCAS, MAAA, Senior Vice President and Chief Underwriting Officer for Converium, predicted that loss ratios and, therefore, the market would continue to deteriorate before things began to improve. Mr. Fay believes that the severity trends that many companies are utilizing for their projections are inadequate, in light of increasing medical costs and claim trends. Because of the negative effect of compounding, if the assumed trend is off by even a few percentage points, it can significantly understate the amount of reserve strengthening that is required. In addition, he believes that many companies are using overly optimistic interest rate assumptions, which further distort their projections.

So what is the Reinsurers' response?

As with the primary companies that they reinsure, the reinsurers are also tightening their underwriting, claims, and financial scrutiny of the companies they choose to reinsure. For new clients, pre-quote underwriting, claims, and in some cases, financial audits have become a prerequisite to doing business. At the same time, even existing clients are experiencing a more aggressive audit timetable than they have seen in the past.

Virtually all working layer- usually defined as the first $1 or $2 million of coverage- MPL reinsurance is provided in the form of Excess of Loss reinsurance. Most of the contracts include a "per loss" cover that applies on an "each and every loss" basis, and a "Clash" provision for those instances in which more than one insured and/or policy may be involved in the same medical incident. Primary programs are seldom written on a quota share basis except in rare instances. Even then, it is most commonly utilized on fronted programs, which are in and of themselves few and far between in the current marketplace.

Some typical changes or restrictions in terms currently being seen include:

- One-year contracts only. After 9/11, multi-year contracts, even those with provisions for annual re-negotiation, quickly became unavailable.
- Increased "Per loss" and "Clash" retentions
- Reduce (or even eliminate) coverage for ECO/XPL losses- i.e. if they were covered at 90% in previous contracts, that is reduced to 80% or even lower
- Imposition of aggregate limits of liability or loss ratio caps
- Flat rate contracts moved to loss-sensitive rating mechanisms, with a Provisional Premium expressed as a percentage of the underlying premium charged initially; subsequently premium is adjusted based on the actual experience in the reinsurance layer.

That being said, in 2003 we have seen some isolated cases of reinsurance terms easing slightly, if a reinsured company has remained relatively stable, in terms of exposures, AND their Written (and, therefore, Earned) Premium has significantly increased due to the underlying rate increases, reduced reliance on discounting, etc. For companies such as this, a few may actually have seen some relief in the Provisional and the Minimum Rates, which are expressed as a percentage of premium for these Excess of Loss Contracts. That is, given a stable exposure base, a lower percentage of a significantly higher Written Premium still yields higher Minimum, Provisional, and Maximum Premiums.

In conclusion, the key reinsurers that are dedicated to the Medical Professional Liability industry have made a renewed commitment to underwriting and pricing integrity and discipline over the past few years. One of their primary responsibilities going forward will be to monitor and evaluate the ongoing financial viability of their reinsureds, as reflected in responsive rate actions, their loss projections based on prior years' losses, and investment income assumptions, among other measures. Given the current climate and experience in our industry it is unlikely that the MPL reinsurance market will become significantly less restrictive in the near future.

Footnotes:
1. "*2003 Property/Casualty Review Preview*", A.M. Best Company, Inc.
2. "*Medical Malpractice- Anatomy of a Crisis in 2003*", Conning Research & Consulting, Inc., 2003.
3. "*Confronting the New Health Care Crisis: Improving Health Care Quality And Lowering Costs By Fixing Our Medical Liability System*", U. S. Department of Health & Human Services, July 24, 2002.
4. "*2002 PIAA Data Sharing Project*", Physician Insurers Association of America.
5. "*The New Medical Malpractice Crisis*", Mello, Studdert, Brennan; *New England Journal of Medicine*, June 5, 2003.
6. *Med-Mal Premiums Barely Keeping Pace*", A.M. Best Company, Inc., August 5, 2002.

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PROFESSIONAL ISSUES

Liability insurance crisis: Bigger awards just one factor

Lower interest rates and a highly competitive insurance market also contributed to today's medical malpractice mess.

By Tanya Albert, *AMNews* staff. April 15, 2002.

The latest statistics confirm what many physicians already suspect: Jury verdicts in medical malpractice cases continue to soar.

Plaintiffs lose the majority of cases that go before a jury. But when they win, an increasing number win big.

With this article
- Jury awards kept going up...
- Going to trial

The median medical malpractice awards were up nearly 43% between 1999 and 2000, according to Jury Verdict Research data released in late March. The Pennsylvania-based company gathers information on verdicts and awards from cases involving physicians, hospitals and other health care entities nationwide.

The fourth straight annual jump means that the median award -- the middle award value when the awards are listed in ascending order -- hit the $1 million mark in 2000. That's nearly double what it was in 1996, when the median award was $503,000, according to the statistics.

"There are jurisdictions where it is manifesting itself as a crisis," said Jim Hurley, an actuary with Tillinghast-Towers Perrin who looks at medical malpractice issues. "But it is not a crisis nationwide yet."

Physicians in Pennsylvania, West Virginia, Mississippi and Nevada have been the hardest hit by medical malpractice woes. The large jury awards coincide with other volatile factors that have some calling the situation "the perfect storm."

And it's unlikely physicians will see any relief this year.

Medical liability insurers continue to pull out of some markets or set narrow guidelines defining the physicians they are willing to insure. Interest rates remain low. And jury awards show no sign of coming under control. In March, a Florida jury said a physician, a physician's assistant and nursing staff were negligent in caring for a patient who ended up with a brain injury and awarded her $78.5 million.

"I fear it's not heading in a great direction for doctors," said James Saxton, a lawyer and chair of the health litigation group for Stevens & Lee in Pennsylvania.

For doctors, that translates into higher liability insurance rates and, for some, difficulty finding insurance at all.

How costs got here

Increasing jury verdicts shoulder only some of the blame for rising liability insurance rates. But other factors that influence insurance cost are also going haywire.

Insurance experts say those factors include low interest rates, which translate into a lower return on investments insurers make to cover claims and rate increases to compensate for realities in the market throughout the 1990s. Rates were underpriced and held in a highly competitive market. In the haste to expand into new states, some insurers initially priced their products incorrectly because they did not completely understand the market.

The 2000 median malpractice award was $1 million; the 1996 median award was $503,000.

"It's a perfect storm," Hurley said.

Some of the storm damage to date: PHICO Insurance Co. is in liquidation. Princeton Insurance Co. announced it would leave the Pennsylvania market. The St. Paul Companies pulled out of the medical liability market nationwide.

"And that's just a sampling of what's going on," said Tim Saunders, vice president of claims for the Illinois State Medical Inter-Insurance Exchange. "This is a unique cycle."

While jury verdicts are just one piece of the puzzle, they are an area with room for improvement in most states, insurance companies and physicians say.

It's difficult to pinpoint exactly why jury awards are going up. Some say jurors are desensitized to what constitutes a significant sum of money thanks to lottery and game show winnings in the tens of millions of dollars. Specific to the medical profession, jurors may be acting out of an anger toward managed care or a desire to send a message about their dismay with health care in general.

And despite Jury Verdict Research data showing that settlements went down 16% between 1999 and 2000, many companies say the amount they settle cases for continues to rise.

"We win the vast majority of cases we take to verdict," said Walt Davis, Mutual Insurance Co. of Arizona's vice president of claims. "Of the verdicts that go to the plaintiff, many of them come in under our last offer. However, each year we get hit with one higher award than expected. Based on our verdicts and the verdicts and settlements of others, it is costing a lot more to settle cases."

Damage caps could offer relief

One way to curb the unpredictable verdicts and the rising settlements that inevitably follow are limits on the amount of noneconomic damages juries can award. The AMA and other physician organizations are encouraging states to pass laws that would limit damages.

Proponents of these laws point to California's $250,000 cap on noneconomic awards as one of the main reasons the state hasn't seen jury verdicts spiral out of control.

"You don't have the emotion-laden blockbuster verdicts," said Ron Neupauer, vice president of underwriting for Medical Insurance Exchange of California. "There have been large awards, but they aren't those unpredictable, out-of-the-blue-sky awards."

MIEC insures physicians in California, Idaho, Alaska, Nevada and Hawaii. Neupauer said the company had been forced to raise rates outside California, but that rates had remained stable in that state.

"Overall, the California experience is better than it is next door in Nevada," he said. "You can't say medicine here is better or the attorneys in other states are better."

"The sky's the limit in most states," said Robert Hartwig, chief economist for the Insurance Information Institute.

"The jury is allowed to come up with any amount, and, unfortunately, the theory of deep pockets often prevails."

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ADDITIONAL INFORMATION:

Jury awards kept going up...

The median jury award -- the middle value among awards listed in ascending order -- increased nearly 43% between 1999 and 2000. It's up 100% since 1995.
1995: $500,000
1996: $474,536
1997: $503,000
1998: $733,900
1999: $700,000
2000: $1,000,000

... But settlements went down

The median settlement in 2000 was nearly 16% below 1999's level.
1995: $350,000
1996: $375,000
1997: $400,000
1998: $500,000
1999: $592,074
2000: $500,000

Note: Statistics for years prior to 2000 may not match numbers previously reported for that year. Statistics for previous years are updated with new information that may come after a report is published.

Source: Jury Verdict Research report "Medical Malpractice: Verdicts, Settlements and Statistical Analysis"

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Going to trial

Compensatory award medians for most commonly claimed liability situations between 1994 and 2000 are significantly higher than the settlement medians for the same time period.

	Compensatory award median	Settlement median
Childbirth	$2,050,000	$750,000
Cancer diagnosis	$1,000,000	$500,000
Delayed treatment	$1,000,000	$665,000
Diagnosis	$750,000	$462,500
Medication	$668,000	$235,000
Lack of informed consent	$500,000	n/a*
Nonsurgical treatment	$400,688	$250,000
Negligent surgery	$355,000	$325,000
Negligent supervision	$147,750	$200,000

* Settlement median unavailable.

Source: Jury Verdict Research report "Medical Malpractice: Verdicts, Settlements and Statistical Analysis"

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ATRA Tort Reform Record

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December 31, 2003

The Tort Reform Record is published each June and December to record the accomplishments of the latest legislative year. It includes a two-page, state-by-state summary of the ATRA-supported reforms enacted by the states since 1986.

Please note: The Record lists tort reforms enacted since 1986; it does not list legislative reforms enacted prior to 1986, the year of ATRA's founding.

For each issue included in the Record, ATRA provides issue papers and model legislation.

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Tort Reform Record

At-A-Glance

	Punitive Damages	Joint & Several Liability	Prejudgment Interest	Collateral Source Rule	Noneconomic Damages	Product Liability	Class Action Reform	Attorney Retention Sunshine	Appeal Bond Reform	Jury Service Reform
Alabama	X			X	◈		X			
Alaska	X	X	X	X	X					
Arizona	X	X		X						X
Arkansas	X	X							X	
California	X	X				X			X	
Colorado	X	X	X	X	X	X	X	X	X	
Connecticut		X		X						
Delaware										
District of Columbia										
Florida	X	X		X	X	X			X	
Georgia	X	X	X	◈		X	X		X	
Hawaii		X		X	X					
Idaho	X	X		X	X				X	
Illinois	◈	X		X	◈	◈				
Indiana	X			X		X			X	
Iowa	X	X	X	X		X				
Kansas	X			◈	X			X	X	
Kentucky	X	X		X					X	
Louisiana	X	X	X			X	X		X	X
Maine			X	X		X				
Maryland					X					
Massachusetts		X								
Michigan		X	X	X	X	X			X	
Minnesota	X	X	X	X	X				X	
Mississippi	X	X			X	X			X	
Missouri	X	X	X	X					X	
Montana	X	X		X	X	X				

◈ Denotes state where reform was struck down as unconstitutional and no additional reforms are in place.

Tort Reform Record

At-A-Glance

	Punitive Damage	Joint & Several Liability	Prejudgment Interest	Collateral Source Rule	Noneconomic Damage	Product Liability	Class Action Reform	Attorney Retention Sunshine	Appeal Bond Reform	Jury Service Reform
Nebraska		X	X							
Nevada	X	X			X				X	
New Hampshire	X	X	X		◈	X				
New Jersey	X	X		X		X			X	
New Mexico		X								
New York	X	X		X						
North Carolina	X					X			X	
North Dakota	X	X		X	X	◈		X		
Ohio	X	X		X	X	X	X		X	
Oklahoma	X		X	X	X				X	
Oregon	X	X		X	◈					
Pennsylvania		X								
Rhode Island			X							
South Carolina	X									
South Dakota	X	X								
Tennessee*									X	
Texas	X	X	X		X	X	X	X	X	
Utah	X	X								X
Vermont		X								
Virginia	X							X	X	
Washington		X			◈					
West Virginia		X			X				X	
Wisconsin	X	X			X				X	
Wyoming		X								

*Tennessee abolished joint and several liability by judicial decision

◈ Denotes state where reform was struck down as unconstitutional and no additional reforms are in place.

THE RULE OF JOINT AND SEVERAL LIABILITY

Joint and several liability is a theory of recovery that permits the plaintiff to recover damages from multiple defendants collectively, or from each defendant individually. In a state that follows the rule of joint and several liability, if a plaintiff sues three defendants, two of whom are 95 percent responsible for the defendant's injuries, but are also bankrupt, the plaintiff may recover 100 percent of her damages from the solvent defendant that is 5 percent responsible for her injuries.

The rule of joint and several liability is neither fair, nor rational, because it fails to equitably distribute liability. The rule allows a defendant only minimally liable for a given harm to be forced to pay the entire judgment, where the co-defendants are unable to pay their share. The personal injury bar's argument in support of joint and several liability—that the rule protects the right of their clients to be fully compensated—fails to address the hardship imposed by the rule on co-defendants that are required to pay damages beyond their proportion of fault.

ATRA supports replacing the rule of joint and several liability with the rule of proportionate liability. In a proportionate liability system, each co-defendant is proportionally liable for the plaintiff's harm. For example, a co-defendant that is found by a jury to be 20% responsible for a plaintiff's injury would be required to pay no more than 20% of the entire settlement. More moderate reforms that ATRA supports include: (1) barring the application of joint and several liability to recover non-economic damages; and (2) barring the application of joint and several liability to recover from co-defendants found to be responsible for less than a certain percentage (such as 25%) of the plaintiff's harm.

Thirty-eight states have modified the rule of joint and several liability.

ALASKA

1988—Proposition Two

Barred application of the rule of joint and several liability in the recovery of all damages through a ballot initiative on November 8, 1988.

ARIZONA

1987—SB 1036

Barred application of the rule of joint and several liability in the recovery of all damages, except in cases of intentional torts and hazardous waste.

The Arizona Court of Appeals upheld the constitutionality of this statute in Church v. Rawson Drug & Sundry Co., No. 1 CA-CV 90-0357, October 1, 1992.

ARKANSAS

2003—HB 1038

Modified repeal of joint and several liability instead of complete repeal, whereby defendants who are found to be 1 percent to 10 percent at fault will only be responsible for the percentage of damage caused, defendants who are 11 percent to 50 percent at fault could have their share of a judgment increased up to an additional 10% if a co-defendant is unable to pay its share of a judgment, and defendants who are 51% to 99% at fault could have their share of a judgment increased up to an additional 20% if a co-defendant is unable to pay its share of the judgment. The reform applies to all

GEORGIA

1987—HB 1

Barred application of the rule of joint and several liability in the recovery of all damages when a plaintiff is assessed a portion of the fault.

HAWAII

1994—HB 1088

Barred application of the rule of joint and several liability in the recovery of all damages from all governmental entities.

1986—SB S1

Barred application of the rule of joint and several liability in the recovery of noneconomic damages from defendants found to be 25% or less at fault. The reform does not apply to auto, product, or environmental cases.

IDAHO

1990—HB 744

Defined the term "acting in concert," as used in SB 1223 (below), as pursuing a common plan or design that results in the commission of an intentional or reckless tortious act.

1987—SB 1223

Barred application of the rule of joint and several liability in the recovery of all damages, except in cases of intentional torts, hazardous waste, and medical and pharmaceutical products.

ILLINOIS

1995—HB 20

Barred application of the rule of joint and several liability in the recovery of all damages.

Held unconstitutional by the Illinois Supreme Court in Best v. Taylor Machine Works, Inc., December 1997.

1986—SB 1200

Barred application of the rule of joint and several liability in the recovery of noneconomic damages from defendants found to be 25% or less at fault. The reform does not apply to auto, product, or environmental cases.

IOWA

1997—HF 693

Provided that defendants found to be 50% or more at fault are jointly liable for economic damages only.

1985

Barred application of the rule of joint and several liability in the recovery of all damages from defendants who are found to be less than 50% at fault.

1989—HB 1171

Provided that the rule of joint and several liability only applies to the extent necessary for the injured party to receive 50% of his or her recoverable damages.

MISSOURI

1987—HB 700

Barred application of the rule of joint and several liability in the recovery of all damages when a plaintiff is assessed a portion of the fault.

MONTANA

1997—HB 571

Retained the current system of modified joint and several liability, where joint liability does not apply to defendants found to be less than 50% at fault. Revised the comparative negligence statute to permit the allocation of a percentage of liability to defendants who settle or are released from liability by the plaintiff. Allowed those defendants to intervene in the action to defend against claims affirmatively asserted.

1997—HB 572

Barred application of the rule of joint and several liability in the recovery of all damages.

Takes effect only if HB 571 is held unconstitutional.

1995—SB 212

Restored the joint and several liability reforms of 1987, which had been weakened by the Montana Supreme Court. Provided procedural safeguards to allow joint liability to apply only when a defendant is found to be more than 50% at fault.

1987—SB 51

Barred application of the rule of joint and several liability in the recovery of all damages from defendants found to be 50% or less at fault.

NEBRASKA

1991—LB 88

Modified the rule of joint and several liability by replacing the slight-gross negligence rule with a 50/50 rule, in which the plaintiff wins if the plaintiff's responsibility is less than the responsibility of all the defendants; Barred application of the rule of joint and several liability in the recovery of noneconomic damages.

NEVADA

2002—AB 1

Barred application of the rule of joint and several liability in the recovery of noneconomic damages for medical liability claims.

Ohio

1996—HB 350

Barred application of the rule of joint and several liability in the recovery of all damages from defendants found to be less than 50% at fault. Barred application of the rule of joint and several liability in the recovery of noneconomic damages from defendants found to be more than 50% at fault.

Held unconstitutional in *Ohio Academy of Trial Lawyers v. Sheward*, August 1999.

1987—HB 1

Barred application of the rule of joint and several liability in the recovery of noneconomic damages when the plaintiff is also assessed a portion of the fault.

Oregon

1995—SB 601

Barred application of the rule of joint and several liability in the recovery of all damages, except where the defendants is determined to be insolvent within one year of the final judgment. In those cases, a defendant less than 20% at fault would be liable for no more than two times her original exposure and a defendant more than 20% liable would be liable for the full amount of damages.

1987—SB 323

Barred application of the rule of joint and several liability in the recovery of noneconomic damages. Barred application of the rule of joint and several liability in the recovery of all damages, where the defendant is found to be less than 15% at fault.

Pennsylvania

2002—SB 1089

Barred application of the rule of joint and several liability in the recovery of all damages, except when a defendant has not: (1) been found liable for intentional fraud or tort; (2) been held more than 60% liable; (3) been held liable for environmental hazards, or; (4) been held civilly liable as a result of drunk driving.

South Dakota

1987—SB 263

Provided that "any party who is allocated less than 50% of the total fault allocated to all parties may not be jointly liable for more than twice the percentage of fault allocated to that party."

Texas

2003—HB 4

Defendant pays only assessed percentage of fault unless defendant is 50% or more responsible.

Defendants can designate (as opposed to join) other responsible third parties whose fault contributed to causing plaintiff's harm

In toxic tort cases, the threshold for joint and several liability raised from 15% to 50%.

Wyoming

1994—SF 35

Amended the joint and several liability reform passed in 1986. Defined when an individual is at fault. Specified the amount of damages recoverable in cases where more than one party is at fault. Clarified the relationship between fault and negligence.

1986—SB 17

Barred application of the rule of joint and several liability in the recovery of all damages.

□□□

THE COLLATERAL SOURCE RULE

The collateral source rule of the common law says that evidence may not be admitted at trial to show that plaintiffs' losses have been compensated from other sources, such as plaintiffs' insurance, or worker compensation. As a result, for example, 35% of total payments to medical malpractice claimants are for expenses already paid from other sources.

Twenty-three states have modified or abolished the collateral source rule. Two states have had reforms struck down as unconstitutional and have not enacted additional reforms.

ALABAMA

1987

Permitted the admissibility of evidence of collateral source payments.

ALASKA

1986—SB 337

Permitted the admissibility of evidence of collateral source payments. Provided for awards to be offset with broad exclusions.

ARIZONA

1993—SB 1055

Extended the existing collateral source legislation from medical malpractice issues to other forms of liability litigation. Under this legislative approach, a jury would not be bound to deduct the amounts paid under a collateral source provision, but would be free to consider it in determining fair compensation for the injured party.

COLORADO

1986—SB 67

Permitted the admissibility of evidence of collateral source payments. Provided for awards to be offset with broad exclusions.

CONNECTICUT

1986—HB 6134

Permitted the admissibility of evidence of collateral source payments. Provided for awards to be offset with broad exclusions.

FLORIDA

1986—SB 465

Provided for awards to be offset with broad exclusions.

The Florida Supreme Court upheld the collateral source provision as constitutional in Smith v. Department of Insurance, 507 So.2d 1080 (Fla. 1987).

The $150,000 threshold for the admissibility of collateral sources into evidence was held unconstitutional by the Kansas Supreme Court in Thompson v. KFB Insurance Company, Case No. 68452 (1993).

KENTUCKY

1988—HB 551

Mandated that juries be advised of collateral source payments and subrogation of rights of collateral payers.

MAINE

1990

Provided for awards to be offset by collateral source payments, where the collateral sources have not exercised subrogation rights within 10 days after a verdict for the plaintiff.

MICHIGAN

1986—HB 5154

Permitted the admissibility of evidence of collateral source payments after the verdict and before judgment is entered. Permitted courts to offset awards, as long as a plaintiff's damages are not reduced by more than the amount awarded for economic damages.

MINNESOTA

1986—SB 2078

Permitted the admissibility of evidence of collateral source payments only for the court's review. Provided for awards to be offset by collateral source payments, unless the source of reimbursement has a subrogation right.

MISSOURI

1987—HB 700

Permitted the admissibility of evidence of collateral source payments, but provided that a defendant who presents collateral source payments as evidence waives his right to a credit against the judgment for that amount.

MONTANA

1987—HB 567

Permitted the admissibility of evidence of collateral source payments, unless the source of reimbursement has a subrogation right under state or federal law. Required a court to offset damages over $50,000.

NEW JERSEY

1987—SB 2703, SB 2708

Provided for awards to be offset by collateral source payments other than workers' compensation and life insurance benefits.

PUNITIVE DAMAGES

Punitive damages are awarded not to compensate a plaintiff, but to punish a defendant for intentional or malicious misconduct and to deter similar future misconduct. While punitive damages awards are infrequent, their frequency and size have grown greatly in recent years. More importantly, they are routinely asked for today in civil lawsuits. The difficulty of predicting whether punitive damages will be awarded by a jury in any particular case, and the marked trend toward astronomically large amounts when they are awarded, have seriously distorted settlement and litigation processes and have led to wildly inconsistent outcomes in similar cases. ATRA recommends four reforms:

- Establishing a liability "trigger" that reflects the intentional tort origins and quasi-criminal nature of punitive damages awards - "actual malice."
- Requiring "clear and convincing evidence" to establish punitive damages liability.
- Requiring proportionality in punitive damages so that the punishment fits the offense.
- Enacting federal legislation to address the special problem of multiple punitive damages awards; This would protect against unfair overkill, guard against possible due process violations, and help preserve the ability of future claimants to recover basic out-of-pocket expenses and damages for their pain and suffering.

Thirty-three states have reformed punitive damages laws. One state had reforms struck down as unconstitutional and has not enacted additional reforms.

ALABAMA

1999—SB 137

In non-physical injury cases:

1) General rule: Limited the award of punitive damages to the greater of three times the award of compensatory damages or $500,000.

2) For businesses with a net worth of less than $2 million: Limited the award of punitive damages to $50,000 or 10% of net worth up to $200,000, whichever is greater.

In physical injury cases: Limited the award of punitive damages to the greater of three times the award of compensatory damages or $1.5 million.

Prohibited application of the rule of joint and several liability in actions for punitive damages, except for wrongful death actions, actions for intentional infliction of physical injury, and class actions.

Provided that the limit on punitive damages will be adjusted on January 1, 2003 and increased at three-year intervals in accordance with the Consumer Price Index.

1987

Required a plaintiff to show by "clear and convincing" evidence that a defendant acted with "wanton" conduct.

Limited punitive damages to the greater of $250,000 or three times compensatory damages, not to exceed $1,000,000.

Provided for bifurcated proceedings for punitive damages.

CALIFORNIA

1987—SB 241

Required a plaintiff to show by "clear and convincing" evidence that a defendant acted with oppression, fraud, or malice.

Required the determination of awards for punitive damages to be made in a separate proceeding, allowing evidence of defendants' financial conditions only after a finding of liability.

COLORADO

2003—HB 1186

Prohibited a plaintiff from filing a claim for punitive damages unless the claim can show evidence of willful or wanton action that would justify such a claim.

1991—HB 1093

Expanded the 1990's prohibition against seeking punitive damages in cases in which FDA-approved drugs are administered by a physician to include medically prescribed drugs or products used on an experimental basis (when such experimental use has not received specific FDA approval) and when the patient has given informed consent.

1990—HB 1069

Provided that punitive damages may not be alleged in a professional negligence suit until discovery is substantially completed.

Provided that discovery cannot be reopened without an amended pleading.

Provided that physicians cannot be liable for punitive damages because of the bad outcome of a prescription medication, as long as it was administered in compliance with current FDA protocols.

Prohibited punitive damages from being assessed against a physician because of the act of another unless she directed the act or ratified it.

1986—HB 1197

Provided that an award for punitive damages may not exceed an award for compensatory damages. Permitted a court to reduce a punitive damages award if deterrence can be achieved without the award. Permitted a court to increase a punitive damages award to three times an award for compensatory damages if misbehavior continues during trial.

Required one-third of punitive damages awards to be paid to the state fund.

The Colorado Supreme Court held the state fund portion of this statute unconstitutional in Kirk v. The Denver Publishing Company, 15 Brief Times Reporter, No. 88SA405, September 23, 1991.

IDAHO

2003—HB 92

Limited the award of punitive damages to the greater of three times the award of compensatory damages or $250,000.

Raised the standard for the imposition of punitive damages to "clear and convincing evidence"

1987—SB 1223

Required a plaintiff to show by a preponderance of evidence that a defendant's conduct was "oppressive, fraudulent, wanton, malicious or outrageous."

ILLINOIS

1995—HB 20

Limited the award of punitive damages to three times the award of economic damages.

Prohibited the award of punitive damages absent a showing that conduct was engaged in "with an evil motive or with a reckless indifference to the rights of others."

Required the determination of awards for punitive damages to be made in a separate proceeding.

Held unconstitutional by the Illinois Supreme Court in Best v. Taylor Machine Works, Inc., December 1997.

1986—SB 1200

Prohibited plaintiffs from pleading punitive damages in an original complaint.

Required a subsequent motion for punitive damages to show at a hearing a reasonable chance that the plaintiff will recover an award for punitive damages at trial.

Required a plaintiff to show that the defendant acted "willfully and wantonly."

Provided discretion to the court to award punitive damages among the plaintiff, the plaintiff's attorney, and the State Department of Rehabilitation Services.

INDIANA

1995—HB 1741

Limited the award of punitive damages to the greater of three times the award of compensatory damages or $50,000.

Required 75% of punitive damage awards to be paid to the state fund.

The Kentucky Supreme Court held the "clear and convincing" evidence standard that conduct constituted oppression, fraud or malice unconstitutional in Terri C. Williams v. Patricia Lynn Herald Wilson, No. 96-SC-1122-DG, April 16, 1998.

LOUISIANA

1996—HB 20

Repealed the statute that authorized punitive damages to be awarded for the wrongful handling of hazardous substances. (The Louisiana courts had established precedents substantially expanding liability based upon the repealed statute.)

MINNESOTA

1990—Minn. Stat. Sec. 549.20

Required a plaintiff to show that a defendant acted with "deliberate disregard." (The former standard required only a showing of "willful indifference.")

Required the determination of awards for punitive damages to be made in a separate proceeding at the request of the defendant.

Granted trial and appellate judges the power to review all punitive damages awards.

1986—SB 2078

Prohibited plaintiffs from pleading punitive damages in an original complaint. Required a plaintiff to make a *prima facie* showing of liability before an amendment of pleadings is permitted by the court.

MISSISSIPPI

1993—HB 1270

Required a plaintiff to prove punitive damages by "clear and convincing" evidence.

Required the determination of awards for punitive damages to be made in a separate proceeding.

Prohibited the award of punitive damages in the absence of compensatory awards.

Prohibited the award of punitive damages against an innocent seller.

Established factors for the jury to consider when determining the amount of a punitive damages award.

MISSOURI

1987—HB 700

Required the determination of awards for punitive damages to be made in a separate proceeding. Permitted the jury to set the amount for punitive damages if, in the first stage, the jury finds a defendant liable for punitive damages. Permitted the admissibility of evidence of a defendant's net worth only during the proceeding for the determination of punitive damages.

NEW HAMPSHIRE

1986—HB 513

Prohibited the award of punitive damages.

NEW JERSEY

1995—SB 1496

Limited the award of punitive damages to the greater of five times the award of compensatory damages or $350,000.

The reform does not apply to cases involving bias crimes, discrimination, AIDS testing disclosure, sexual abuse, and injuries caused by drunk drivers.

1987—SB 2805

Required a plaintiff to show that a defendant acted with "actual malice" or "wanton and willful disregard" for the rights of others.

Required the determination of awards for punitive damages to be made in a separate proceeding.

Provided for an FDA government standards defense to punitive damages.

The reform does not apply to cases involving environmental torts.

NEW YORK

1992—SB 7589

Required that 20% of all punitive damages awards be paid to the New York State General Fund.

NORTH CAROLINA

1995—HB 729

Limited the award of punitive damages to the greater of three times the award of compensatory damages or $250,000. The reform does not apply to cases where the defendant caused the injury by driving while impaired.

Required a plaintiff to show by "clear and convincing" evidence that a defendant was liable for compensatory damages and acted with fraud, malice, willful or wanton conduct.

Required the determination of awards for punitive damages to be made in a separate proceeding at the request of the defendant.

NORTH DAKOTA

1997—HB 1297

Required a plaintiff to show by a preponderance of the evidence that a defendant acted with oppression, fraud, or actual malice before a moving party may amend pleadings and claim punitive damages.

OKLAHOMA

1995—SB 263

Codified factors that the jury must consider in awarding punitive damages.

Provided that when a jury finds by "clear and convincing" evidence that the defendant:

1) Acted in "reckless disregard for the rights of others," the award is limited to the greater of $100,000 or actual damages awarded; or

2) Acted intentionally and with malice, the award is limited to $500,000; two times the award of actual damages; or the increased financial benefit derived by the defendant or insurer as a direct result of the conduct causing injury.

The limit does not apply if the court finds evidence *beyond a reasonable doubt* that the defendant acted intentionally and with malice in conduct life-threatening to humans.

1986—SB 488

Limited the award of punitive damages to the award of compensatory damages, unless a plaintiff establishes her case by "clear and convincing" evidence, in which case no limit applies.

OREGON

1995—SB 482

Required 40% of punitive damages awards to be paid to the prevailing party, 60% to the state fund, and no more than 20% to the attorney of the prevailing party.

Required a plaintiff to show by "clear and convincing" evidence that a defendant "acted with malice or has shown a reckless and outrageous indifference to a highly unreasonable risk of harm and has acted with a conscious indifference to the health, safety and welfare of others."

Provided for court review of jury-awarded punitive damages.

Barred the claiming of punitive damages in an original complaint. Required a plaintiff to show a *prima facie* case for liability before amending a complaint to include a punitive damages claim.

1987—SB 323

Required a plaintiff to prove punitive damages by "clear and convincing" evidence.

Provided an FDA standards defense to punitive damages.

SOUTH CAROLINA

1988

Required a plaintiff to prove punitive damages by "clear and convincing" evidence.

SOUTH DAKOTA

1986—SB 280

Required a plaintiff to prove by "clear and convincing" evidence that a defendant acted with "willful, wanton, or malicious" conduct.

NONECONOMIC DAMAGES

Damages for noneconomic losses are damages for pain and suffering, emotional distress, loss of consortium or companionship, and other intangible injuries. These damages involve no direct economic loss and have no precise value. It is very difficult for juries to assign a dollar value to these losses, given the minimal guidance they customarily receive from the court. As a result, these awards tend to be erratic and, because of the highly charged environment of personal injury trials, excessive.

ATRA believes that the broad and basically unguided discretion given juries in awarding damages for noneconomic loss is the single greatest contributor to the inequities and inefficiencies of the tort liability system. It is a difficult issue to address objectively because of the emotions involved in cases of serious injury and because of the financial interests of plaintiffs' lawyers.

Eighteen states have modified the rules for awarding noneconomic damages. Five states have had reforms struck down as unconstitutional and have not enacted additional reforms.

ALABAMA

1987

Limited the award of noneconomic damages to $250,000 in medical liability cases.

The Supreme Court of Alabama found the limit on noneconomic damages unconstitutional in Moore v. Mobile Infirmary Association, 592 So. 2d 156 (1991).

ALASKA

1997—HB 58

Limited the award of noneconomic damages to the greater of $400,000 or the injured person's life expectancy in years multiplied by $8,000, unless the plaintiff "suffers severe permanent physical impairment or severe disfigurement," in which case noneconomic damages are limited to the greater of $1,000,000 or the injured person's life expectancy multiplied by $25,000.

1986—SB 337

Limited the award of noneconomic damages for injuries other than physical impairment or disfigurement to $500,000.

COLORADO

2003—HB 1012

Limited the award of noneconomic damages to $300,000 in medical liability cases.

1988— SB 143

Limited the total award of damages to $1,000,000, of which no more than $250,000 can be for noneconomic damages.

1990—HB 574

Removed the 1992 sunset to the $400,000 limit on noneconomic damages enacted in 1987.

1987—SB 1223

Limited the award of noneconomic damages to $400,000; provided a sunset in June 1992.

ILLINOIS

1995—HB 20

Limited the award of noneconomic damages in all civil actions to $500,000 per plaintiff, indexed for inflation.

Held unconstitutional by the Illinois Supreme Court in Best v. Taylor Machine Works, Inc., December 1997.

KANSAS

1988—HB 2692

Limited the award of noneconomic damages to $250,000.

1987

Limited the award of damages for pain and suffering to $250,000. The reform does not limit the award of other noneconomic damages.

MARYLAND

2001—HB 714

Provided that an individual driving a motor vehicle that is not covered by insurance is considered to have waived the right to recover noneconomic damages under specified circumstances.

1994—SB 283

Limited the award of noneconomic damages in wrongful death actions to $500,000, where there is one beneficiary, and $700,000, where there are two or more beneficiaries. (The legislation somewhat countered the effect of the *Streidel* decision, which held that Maryland's $350,000 limit on noneconomic damages did not apply in wrongful death actions.)

1987—SB 237

Limited the award of noneconomic damages in public entity lawsuits to $200,000 per person and $500,000 per incident.

1986—SB 558

Limited the award of noneconomic damages to $500,000.

The Court of Special Appeals of Maryland upheld the constitutionality of the noneconomic damages limit in Potomac Electric Co. v. Smith, 79 Md. App. 591, 558 A.2d 768 1989.

OHIO

2003—SB 281

Limited the award of noneconomic damages in medical malpractice cases to $350,000, with a provision to allow the cap to rise to $1 million, depending on the severity of the injuries and the number of plaintiffs involved in the suit.

1997—HB 350

Limited the award of noneconomic damages to the greater of $250,000 or three times economic damages to a maximum of $500,000, unless there is a finding that a plaintiff suffered:

1) a permanent and severe physical deformity; or

2) a permanent physical functional injury that permanently prevents her from being able to independently care for herself and perform life sustaining activities.

If a plaintiff establishes the criteria set forth above, noneconomic damages are limited to the greater of $1 million or $35,000 times the number of years remaining in the plaintiff's expected life.

Held unconstitutional by the Ohio Supreme Court in Ohio Academy of Trial Lawyers v. Sheward, August 1999.

OKLAHOMA

2003—SB 629

Limited the award of noneconomic damages to $350,000 in cases involving pregnancy (labor, delivery, and post partum period) as well as emergency care.

OREGON

1987—SB 323

Limited the award of noneconomic damages to $500,000.

The Oregon Supreme Court declared the $500,000 limit on noneconomic damages unconstitutional in the case of Larkin v. Senco Products, Inc. — P.2d. —, 1999 WL 498088 Or. July 15, 1999.

TEXAS

2003—H.J.R. 3 (PROPOSITION 12)

Constitutional amendment that provided the Texas Legislature with the authority to place limits on noneconomic damages.

2003—HB 4

Limited the award of noneconomic damages in medical malpractice cases to $250,000 against all doctors and health care practitioners and a $250,000 per-facility cap against health care facilities such as hospitals and nursing homes, with an overall cap of $500,000 against health care facilites, creating in effect an overall limit of noneconomic damages in medical malpractice cases of $750,000.

PREJUDGMENT INTEREST

In the absence of an applicable statute or rule, the courts generally applied the traditional common law rule that prejudgment interest was not available in tort actions since the claim for damages was unliquidated. In an effort to compensate tort plaintiffs for the often-considerable lag between the event giving rise to the cause of action, or filing of the lawsuit, and the actual payment of the damages, many state legislatures have enacted laws that provide for or allow prejudgment interest in particular tort actions or under particular circumstances. In addition to seeking to compensate the plaintiff fully for losses incurred, the goal of such statutes is to encourage early settlements and to reduce delay in the disposition of cases, thereby lessening congestion in the courts. Although well-intended, the practical effects of prejudgment interest statutes can be inequitable and counter-productive. Prejudgment interest laws can, for example, result in over-compensation, hold a defendant financially responsible for delay it may not have caused, and impede settlement.

At a time when policymakers are attempting to lower the cost of the liability system in an equitable and just manner, prejudgment interest laws that currently exist and new proposals should be reviewed to ensure that they are structured fairly and in a way designed to foster settlement. At a minimum, the interest rate should reflect prevailing interest rates by being indexed to the treasury bill rate at the time the claim was filed and an offer of judgment provision should be included.

Fourteen states have enacted prejudgment interest reforms.

ALASKA

1997—HB 58

Set prejudgment interest rates at the Twelfth Federal Reserve District's discount rate plus 3%.

Prohibited the assessment of prejudgment interest for future damages and punitive damages.

COLORADO

1995—SB 165

Limited the amount of prejudgment interest that can be assessed between accrual of the action and filing of the claim to below the $1,000,000 limit on the total amount recoverable in medical liability claims.

GEORGIA

2003—HB 792

Set prejudgment interest rates at the Federal Reserve's prime interest rate plus 3%.

IOWA

1997—HF 693

Set prejudgment interest rates at the U.S. Treasury Rate plus 2%.

1987—SF 482

Prohibited the assessment of prejudgment interest for future damages. (Other interest accrues from the date of commencement of the actions at a rate based on the U.S. Treasury Bill.)

1986—SB 488

Prohibited the assessment of prejudgment interest on punitive damages awards.

Set the prejudgment interest rate at 4% above the rate on the U.S. Treasury Bill.

RHODE ISLAND

1987—HB 5885

Set the prejudgment interest rate at the U.S. Treasury Bill rate. Provided that interest accrues from the date the lawsuit is filed.

TEXAS

2003—HB 4

Set the prejudgment interest rate to the New York Federal Reserve prime rate, with a floor of 5% and a ceiling of 15%.

1987—SB 6

Limited the period during which prejudgment interest may accrue if the defendant has made an offer to settle.

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PRODUCT LIABILITY

Product liability law is meant to compensate persons injured by defective products and to deter manufacturers from marketing such products. It fails, however, when it does not send clear signals to manufacturers about how to avoid liability or holds manufacturers liable for failure to adopt a certain design or warning even if the manufacturers neither know, nor could have anticipated, the risk.

Fifteen states have enacted laws specifically to address product liability. Three states have had reforms struck down as unconstitutional and have not enacted additional reforms.

CALIFORNIA

1986—SB 241

Confirmed that under California law, products like foods high in cholesterol, alcohol, and cigarettes, which are inherently unsafe and which ordinary consumers know to be unsafe, should not be the basis for product liability lawsuits.

COLORADO

2003—SB 03-231

Provided that a product liability action could not be taken against a manufacturer or seller of a product if the product was used in a manner other than which the product was intended and which could not reasonably have been expected.

Provided for an innocent seller provision which prohibits product liability action against parties who were not the manufacturer of the product.

FLORIDA

1999—HB 775

Provided a 12-year statute of repose for products with a useful life of 10 years or less, unless the product is specifically warranted a useful life longer than 12 years.

Provided a 20-year statute of repose for airplanes or vessels in commercial activity, unless the manufacturer specifically warranted a useful life longer than 20 years.

The reform does not apply to cases involving improvements to real property, including elevators and escalators; latent injury cases; and cases where the manufacturer, acting through its officers, directors or managing agents, took affirmative steps to conceal a known defect in the product.

GEORGIA

1987—HB 1

Permitted only one award of punitive damages to be assessed against any given defendant in product liability cases.

Provided that a manufacturer of a product shall not be liable for damages proximately caused by a characteristic of the product's design, if the manufacturer proves that at the time the product left his control:

1) he did not know and, in light of then-existing reasonably available scientific and technological knowledge, could not have known of the design characteristic that caused the damage;

2) he did not know and, in light of then-existing reasonable available scientific and technological knowledge, could not have known of the alternative design identified by the plaintiff; or

3) the alternative design identified by the plaintiff was not feasible, in light of then-existing reasonably available scientific and technological knowledge or existing economic practicality.

MAINE

1996—LD 346

Provided that "subsequent remedial measures" or steps taken after an accident to repair or improve the site of injury are not admissible as evidence of negligence.

MICHIGAN

1995—SB 344

Barred application of the rule of joint and several liability in product liability cases.

Provided statutory defenses to product liability claims, including adherence to government standards, FDA standards, and sellers' defenses. Provided an absolute defense, where the plaintiff was found to be at least 50% at fault due to intoxication or a controlled substance.

Limited the award of noneconomic damages in product liability cases not involving death or loss of vital bodily function to $280,000; Limited the award of noneconomic damages in such cases to $500,000.

1995—HB 4508

Provided venue control in product liability cases.

MISSISSIPPI

1993—HB 1270

Required product liability cases to be based on a design, manufacturing or warning defect, or breach of an express warranty, which caused the product to be unreasonably dangerous.

Provided that a product that contains an inherently dangerous characteristic is not defective if the dangerous characteristic cannot be eliminated without substantially reducing the product's usefulness or desirability and the inherent characteristic is recognized by the ordinary person with ordinary knowledge common to the community.

Provided that a product's design is not defective if the harm results from an inherent characteristic of the product that is known to the ordinary person who uses or consumes it.

Provided that a manufacturer or seller is not liable for a design defect if the harm results from an *unavoidably unsafe aspect* of a product and the product was accompanied by an *adequate warning*.

Provided that the state of the art provision does not apply if the court makes all of the following determinations:

1) that the product is egregiously unsafe;

2) that the user could not be expected to have knowledge of the product's risk; and

3) that the product has little or no usefulness.

Provided that a manufacturer or seller in a warning-defect case is not liable if an *adequate warning* is given. (An adequate warning is one that a reasonably prudent person in the similar circumstances would have provided.) Established a rebuttable presumption that a government (FDA) warning is adequate.

NORTH CAROLINA

1995—HB 637

Expressly provided that there shall be no strict liability in tort for product liability actions.

Provided statutory defenses to product liability claims, including assumption of the risk.

NORTH DAKOTA

1995—HB 1369

Established a ten-year statute of repose in product liability actions.

Provided a government standards defense.

Prohibited the award of punitive damages, when a manufacturer complies with government standards.

The 10-year statute of repose was found unconstitutional in Dickie v. Farmers Union Oil Co., 2000 ND 111 (N.D. May 25, 2000).

OHIO

1996—HB 350

Amended product liability law to include additional requirements for establishing liability.

Prohibited expanding theories of liability, including enterprise liability.

Adopted a fifteen-year statute of repose in product liability cases, absent latent harm or fraud.

Held unconstitutional by the Ohio Supreme Court in Ohio Academy of Trial Lawyers v. Sheward, August 1999.

Class Action Reform

Once considered a tool of judicial economy that aggregated many cases with similar facts, or similar complaints into a single action, class actions are now often considered a means of defendant extortion. Today, some class actions are meritless cases in which thousands, or millions, of plaintiffs are granted class status, sometimes without even notifying the defendant. In many of these cases, the victimized consumers often receive pennies, or nearly-worthless coupons, while plaintiffs' counsel receives millions in legal fees. State class action reformcan more equitably balance the interests of plaintiffs and the defendant.

Six states have reformed their laws pertaining to class actions

Alabama

1999—SB 72

Set procedures to certify class actions.

Codified Supreme Court rulings to ensure that a defendant receives adequate notice prior to class certification.

Provided for an immediate appeal of any order certifying a class or refusing to certify a class, and for an automatic stay of matters in the trial court pending such appeal.

Colorado

2003—HB 03-1027

Provided for the interlocutory appeal of class action certification.

Georgia

2003—HB 792

Updated Georgia class action laws by providing for detailed procedures for class action cases.

Specified factors under which a court may decline to exercise jurisdiction in a cause of action of a nonresident occurring outside the state.

Louisiana

1997—HB 1984

Updated Louisiana class action laws by providing objective definitions of class action terms, and detailed procedures for class action cases.

Ohio

1998—HB 394

Provided for the interlocutory appeal of class action certification.

ATTORNEY RETENTION SUNSHINE

In state recoupment litigation against the tobacco industry, most states retained plaintiffs' personal injury lawyers on a contingent fee basis to assist them with their litigation. Unfortunately, many of these contracts, inked without competitive bidding, and with little or no outside oversight, were rife with political favoritism, inside dealing, and in at least one case, amid the stench of corruption. Many of these billion-dollar fees (which bore little or no relation to the value of the work performed) are being strategically reinvested into the political process, and into still more litigation. Attorney "sunshine" legislation requires legislative approval of most large contingent fee contracts, and reasserts the legislature's oversight of "regulation through litigation."

Five states have adopted this proposal.

COLORADO

2003—SB 03-086

Required monthly reports by outside counsel to include number of hours worked, court costs incurred, and to provide such data in aggregate from the effective date of the contingent fee contract.

Required, at the conclusion of representation, outside counsel to provide the state with a statement of hours worked and fees recovered through a contract for legal services between the state and outside counsel. Provided that in no instance shall the state pay fees, even on a contingent fee basis, in excess of $1,000 per hour.

KANSAS

2000—HB 2627

Required open and competitive bidding for all contingent fee contracts for legal services between the state and outside counsel, where fees and services exceed $7,500

Required proposed contracts for legal services between the state and outside counsel in excess of $1,000,000 to be submitted to the legislative budget committee for approval.

Required, at the conclusion of representation, outside counsel to provide the state with a statement of hours worked and fees recovered through a contract for legal services between the state and outside counsel. Provided that in no instance shall the state pay fees, even on a contingent fee basis, in excess of $1,000 per hour.

NORTH DAKOTA

1999—SB 2047

Required an emergency commission of the legislature to approve the attorney general's appointment of a special assistant attorney general in a case in which the amount of the controversy exceeds $150,000.

APPEAL BOND REFORM

According to Lawyer's Weekly USA, the total amount of 1999's top ten jury verdicts was three times higher than 1998's level, and 12 times higher than the 1997 total. While many of these verdicts are overturned or reduced on appeal, defendants in many states are required to post an appeal bond sometimes equal to 150 percent of the verdict in question. In an era when billion-dollar verdicts are no longer uncommon, appealing an outrageous verdict can force a company or an industry into bankruptcy. Appeal bond waiver legislation limits the size of an appeal bond when a company is not liquidating its assets or attempting to flee from justice.

Twenty-five states have adopted this proposal.

ARKANSAS

2003 —HB 1038

Limited the amount a defendant can be required to pay to secure the right to appeal to $25 million.

CALIFORNIA

2003 — AB 1752

Limited the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal to $150 million and applies to all judgments in civil litigation regardless of legal theory.

COLORADO

2003—HB 1366

Limited the amount a defendant can be required to pay to secure the right to appeal to $25 million.

FLORIDA

2003—S 2826

Limited the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal to $100 million.

2000 —HB 1721

Limited the amount a defendant can be required to pay to secure the right to appeal punitive damages awards in class actions to the lesser of 10% of the defendants net worth or $100 million.

The reform applies in out-of-state judgments during the stay period only.

Provided that a court will rescind the limit if an appellee proves by a preponderance of the evidence that the party for whom the bond to stay execution has been limited is purposefully dissipating or diverting assets outside of the ordinary course of business for the purpose of avoiding ultimate payment of the judgment.

MINNESOTA

2003—HF 750

Limited the amount a defendant can be required to pay to secure the right to appeal to $25 million.

MISSISSIPPI

2001

The Mississippi Supreme Court, acting on its own motion, imposed a $100 million limit on the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right
to appeal large punitive damages verdicts.

MISSOURI

2003—SB 242

Limited the amount a defendant can be required to pay to secure the right to appeal to $50 million.

NEVADA

2001 —AB 576

Limited the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal to $50 million.

NEW JERSEY

2003—SB 2738

Limited the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal to $50 million.

NORTH CAROLINA

2003 —SB 784

Limited the amount a defendant can be required to pay to secure the right to appeal to $25 million regardless of legal theory. Provided that foreign judgments cannot be executed in North Carolina if appeal is pending in a foreign jurisdiction or the judgment has been stayed by the court that rendered it and a bond has been posted.

2000 —SB 2

Limited the amount a defendant can be required to pay to secure the right to appeal to $25 million.

Provided that limits on bond appeals for out-of-state judgments apply during the stay period only.

West Virginia

2001—SB 661

Limited the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal to $200 million.

Provided that an appeal bond may not exceed $100 million for compensatory damages and $100 million in punitive damages.

Wisconsin

2003—AB 548

Limited the amount a defendant can be required to pay to secure the right to appeal to $100 million.

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JURY SERVICE REFORM

The right to a trial by a jury of one's peers is one most Americans support and take for granted. Recently, however, our juries are becoming less and less representative of the community. Some studies indicate that up to 20% of those summoned for jury duty do not respond and some jurisdictions have an even higher no-show rate. Occupational exemptions, flimsy hardship excuses, lack of meaningful compensation, long terms of service and inflexible scheduling results in a jury pool that makes it difficult for working Americans to serve on a jury and disproportionately excludes the perspectives of many people who understand the complexity of issues at play during trial. ATRA supports legislation to improve the jury system so that defendants and plaintiffs alike receive a fair trial.

- Eliminating occupational exemptions that give allow members of certain professions to opt-out from jury service.

- Ensuring that only those who experience true hardship are excused from jury service.

- Providing jurors flexibility in scheduling their service and guaranteeing potential jurors they will not spend more than one day at the courthouse unless they are selected to serve on a jury panel.

- Protecting employees from any adverse action in the workplace due to their responding to a juror summons.

- Establishing a lengthy trial fund, financed by a nominal court filing fee, to pay jurors who serve on long civil trials.

Three states have enacted reform.

ARIZONA

2003—H.B. 2520

Required all people to serve on juries unless they experience undue or extreme physical or financial hardship.

Established a lengthy trial fund from a modest filing fee to compensate jurors a minimum of $40 and a maximum of $300 per juror, per day for trials lasting more than 10 days, starting on the eleventh day of trial. In such circumstances, jurors would also be eligible to retroactively collect at least $40 but not more than $100 per day from the fourth day to the tenth day of service.

Provided for employee protection by prohibiting an employer to require an employee to use annual or sick leave for the time spent in the jury service process. In addition, it prohibited employers to dismiss or in any other way penalize employees for responding to a jury service summons.

Provided for protection of small business owners by requiring the court to postpone the service of an employee if another employee of that business is already serving on a jury.

Allowed for one automatic postponement from service.