American Medical Association
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Trends Report

Health Care Financial Trends Report • Health Policy Group

December 2003

Medical Professional Liability Insurance

The Crisis Continues

Over the past four years, physicians in many parts of the country and in many specialties have faced large and repeated increases in their medical professional liability insurance (PLI) premiums. The impact of these rate increases on patients' access to care, though difficult to quantify, is ultimately predictable. With a significant proportion of payments constrained according to the fee schedules of public and private payors, physicians who cannot pass these cost increases through to payors instead look for ways to limit their legal liability exposure in ways that may tend to reduce patients' access to medical care.

Although anecdotes and survey data document many instances in which physicians have shut down their medical practices temporarily, stopped performing high risk procedures, or permanently relocated their practices (or intend to do so) in response to the PLI crisis, national data sets tend to be of limited value in quantifying those effects and the degree to which they impair patients' access to critical medical services. However, the best available evidence indicates the continuation of adverse liability trends and their adverse impact on patients' access to care. Specifically, those conditions that contribute to the current crisis, including escalation in jury awards, indemnity payments, and PLI premiums, have persisted or in some cases, further deteriorated. At the same time, new evidence links changes in the geographical distribution of physicians to variation in local tort environments, hinting at the nature of the relationship between the way our legal system apportions liability for adverse medical outcomes, on the one hand, and patients' access to care, on the other.

Escalating PLI Manual Rates and Increasing Geographical Rate Variation

Physicians experienced a fourth consecutive year of large rate increases that disproportionately affected specific specialties and markets. Markets in states lacking effective tort reforms tended to experience both the highest rates (Exhibit 1) and the largest rate increases. Though many carriers raised rates across all specialties, the largest rate increases in absolute terms were experienced by specialists, such as obstetricians/gynecologists, who perform high-risk procedures or serve-high risk populations. PLI rates in California, which has capped malpractice awards for non-economic damages at $250,000 since 1976, have remained far below those of otherwise comparable markets in states that do not have caps on non-economic damages (Exhibit 1).

Health Care Financial Trends is a periodic report intended to provide timely analysis of a variety of national data widely used to shape policy and political debates on socioeconomic issues of interest to the AMA and the Federation. The feature topic of this edition of Trends is Medical Professional Liability Insurance. For more information visit our web site at www.ama-assn.org/go/healthpolicy

Exhibit 1: Manual Malpractice Liability Rate Ranges by Specialty by Geography as of July, 2003

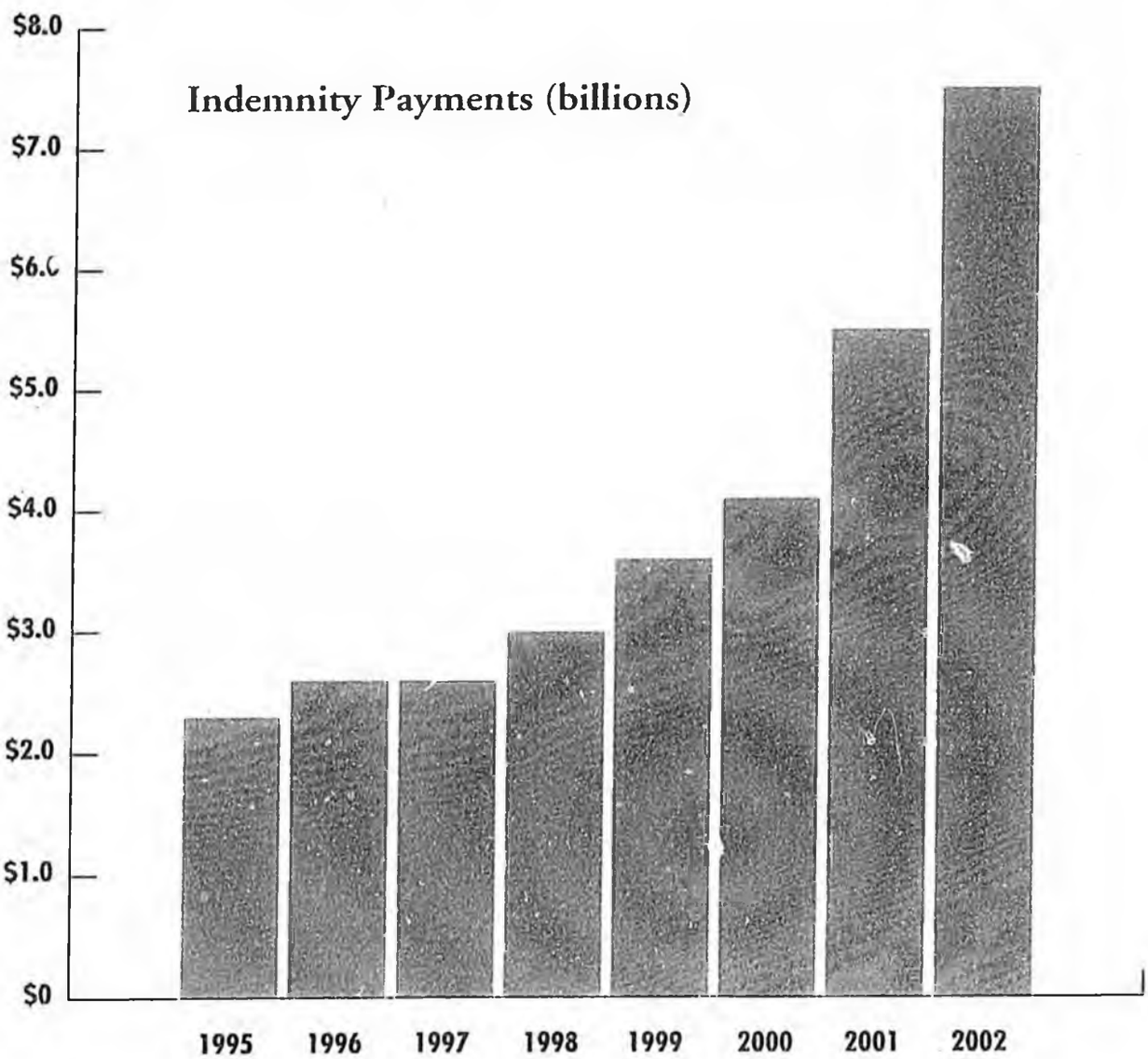
	Low	High
Internists		
Florida (Miami and Ft. Lauderdale areas)	$30,557	$65,697
Michigan (Detroit area)	33,514	50,063
Illinois (Chicago area)	27,836	41,238
Texas (Dallas and Houston areas)	15,122	34,346
Pennsylvania (Philadelphia area)	24,546	29,667
Ohio (Cleveland and Cincinnati areas)	11,445	25,013
Nevada (Las Vegas area)	19,273	23,620
New York (New York City and Long Island areas)	17,974	23,228
California (Los Angeles)	9,510	12,668
General Surgeons		
Florida (Miami and Ft. Lauderdale areas)	108,473	226,542
Michigan (Detroit area)	106,889	154,165
Pennsylvania (Philadelphia area)	100,119	131,348
Texas (Dallas and Houston areas)	50,428	109,668
Illinois (Chicago area)	85,197	98,319
Ohio (Cleveland and Cincinnati areas)	44,256	93,064
Nevada (Las Vegas area)	69,949	85,024
New York (New York City and Long Island areas)	57,423	74,211
California (Los Angeles)	26,600	58,830
Obstetricians/Gynecologists		
Florida (Miami and Ft. Lauderdale areas)	154,670	249,196
Michigan (Detroit area)	133,913	154,165
Pennsylvania (Philadelphia area)	128,114	152,739
Illinois (Chicago area)	130,035	147,023
Nevada (Las Vegas area)	88,586	141,704
Texas (Dallas and Houston areas)	71,611	131,601
New York (New York City and Long Island areas)	95,837	123,853
Ohio (Cleveland and Cincinnati areas)	60,138	120,275
California (Los Angeles)	45,530	77,814

Source: Medical Liability Monitor Vol. 28, No. 10 Oct., 2003. To subscribe or obtain copies, call 312.944.7900 or visit http://www.mlmonitor.com.

Increases in Indemnity Payments

PLI carriers base the premiums they charge physicians principally on their expected loss experience. Exhibit 2 shows that U.S. claims losses (indemnity payments) have escalated dramatically, from less than $2.3 billion in 1995 to over $7.5 billion in 2001, reflecting a cumulative increase of 232% and an annual growth rate of 18.7%. The rate of growth in indemnity payments accelerated since the onset of the current crisis to an annual rate of 26.3% over the period 1998-2002.

Exhibit 2:
Payouts For Malpractice Liability Claims Have Increased Dramatically Since 1995



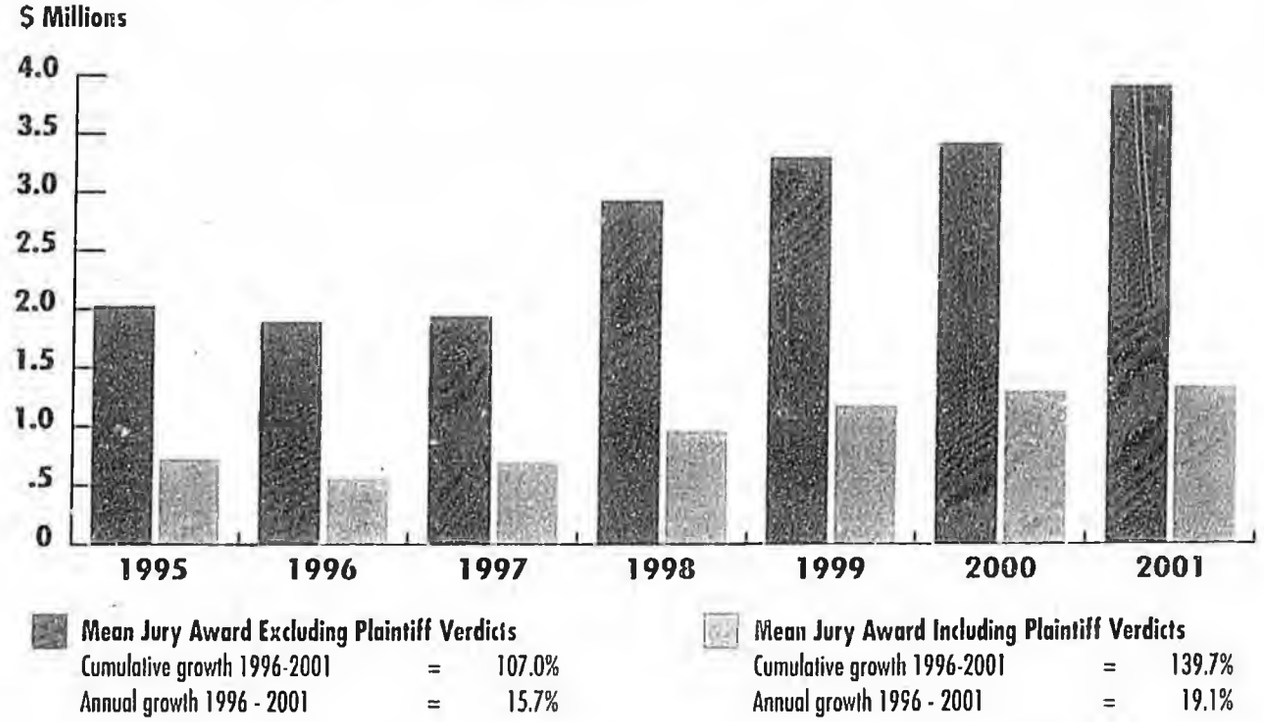
Source: Best's Aggregates & Averages, Property & Casualty, U.S., 2003 Edition, page 364.

Increases in Compensatory Awards

Coinciding with the growth in carriers' indemnity payments and the growth in the premiums they charge physicians has been growth in average medical liability compensatory jury verdict awards (Exhibit 3). Though most claims payments result from settlement negotiations rather than jury awards, jury awards are a key predictor of settlement payments because claimants and defendants use jury award information to estimate liability exposure. As jury verdicts rise, so then do settlement payments rise. Exhibit 3 illustrates the steep recent increase in average jury awards. According to Jury Verdict Research®, as reported in its most recent (2002) release of "Current Award Trends in Personal Injury," average jury awards, excluding the cases won by defendants (i.e., the $0 award cases), grew at an annual rate of 15.7% from 1996-2001, more than doubling over the period.

Some have suggested that increases in the average award yield an exaggerated picture of the legal system's contribution to growth in PLI rates. They believe that the growth is overstated when the calculation omits the cases won by defendants. However, when one chooses to look at the average in consideration of all cases, including those won by defendants, one sees comparable growth rates. This is consistent with data from the Physician Insurers Association of America, which show that the rate at which physicians win those malpractice suits that go to verdict has been stable, at about 80%, over the past 15 years. So while the argument may be effective at diverting attention from the role of the judicial system in driving up claims costs, it has no bearing on the only two factors that are relevant to that issue: the large increases in indemnity payments (Exhibit 2) and the large rate of growth in average jury awards, no matter how that growth rate is calculated (Exhibit 3).

Exhibit 3:
Mean Medical Liability Compensatory Jury Verdict Awards, 1995-2001



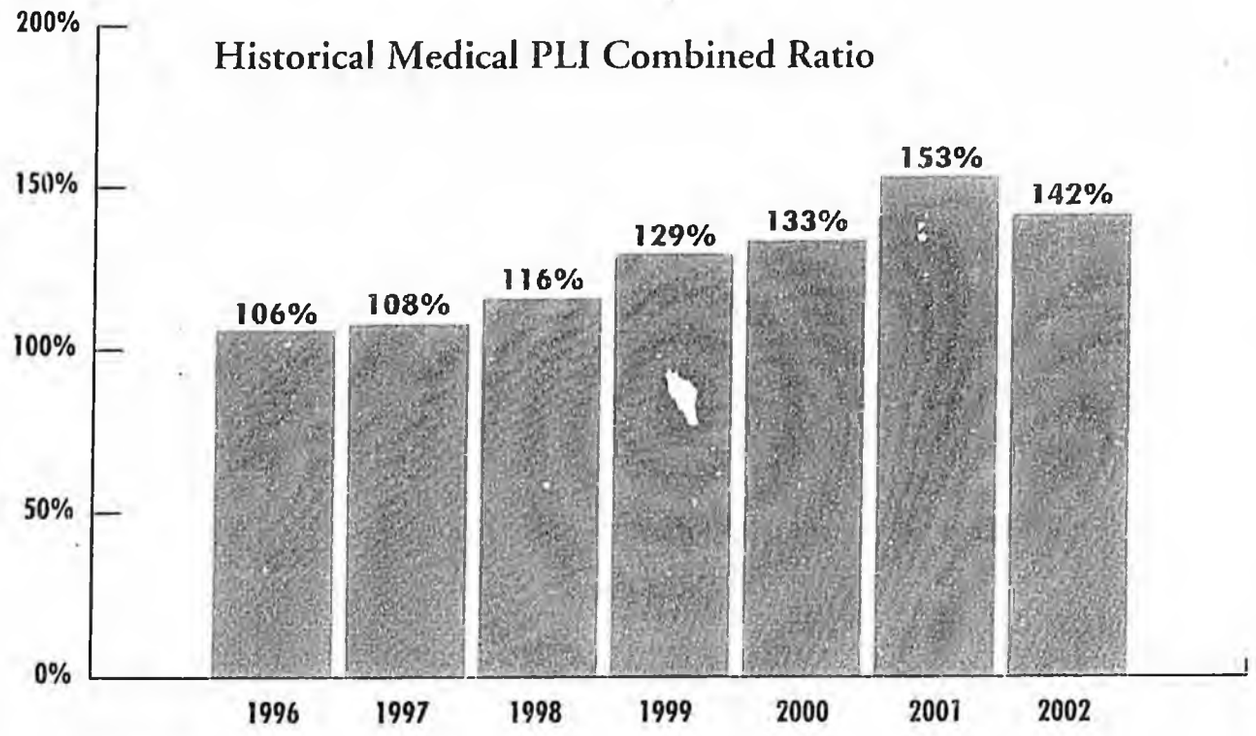
Insurers Continue to Lose Money on PLI

With claims payments rising rapidly, even large increases in premiums are not enough to restore the medical malpractice insurance business to profitability over the short run. Although the recent rate increases have led to a decline in the industry's rate of unprofitability, Exhibit 4 shows that the combined ratio remains near its historically highest (worst) level, with carriers collectively having paid out $1.42 for every dollar of premium revenue they collected in 2002.

The loss ratios in Exhibit 4 exclude carriers' performance on investments in the capital markets (primarily in the bond market). Though some have indicated that investment losses explain the carriers' large rate increases and unprofitability, the fact is that their returns on those investments have been positive in every year and stable, ranging from 4.5% to 5.4% in each of the past five years (AM Best Aggregates & Averages, Property and Casualty, 2003 Edition, p. 335). This is confirmed by the U.S. General Accounting Office, which found in its recent report on the drivers of PLI premium increases that "none of the (insurance) companies experienced a net loss on investments" (GAO 03-702, p. 25) and "insurers are not charging and profiting from excessively high premium rates" (GAO 03-702, p. 32).

Because PLI insurers must set their rates in consideration of their investment income, the impact of these investments is to lower PLI premiums, not raise them. Even with this additional stream of revenue, however, the failure of recent rate increases to catch up with escalation in claims payments ultimately portends future rate increases, as carriers attempt to restore their PLI lines to profitability.

Exhibit 4:
PLI Carriers Continue to Lose Money on their PLI Business



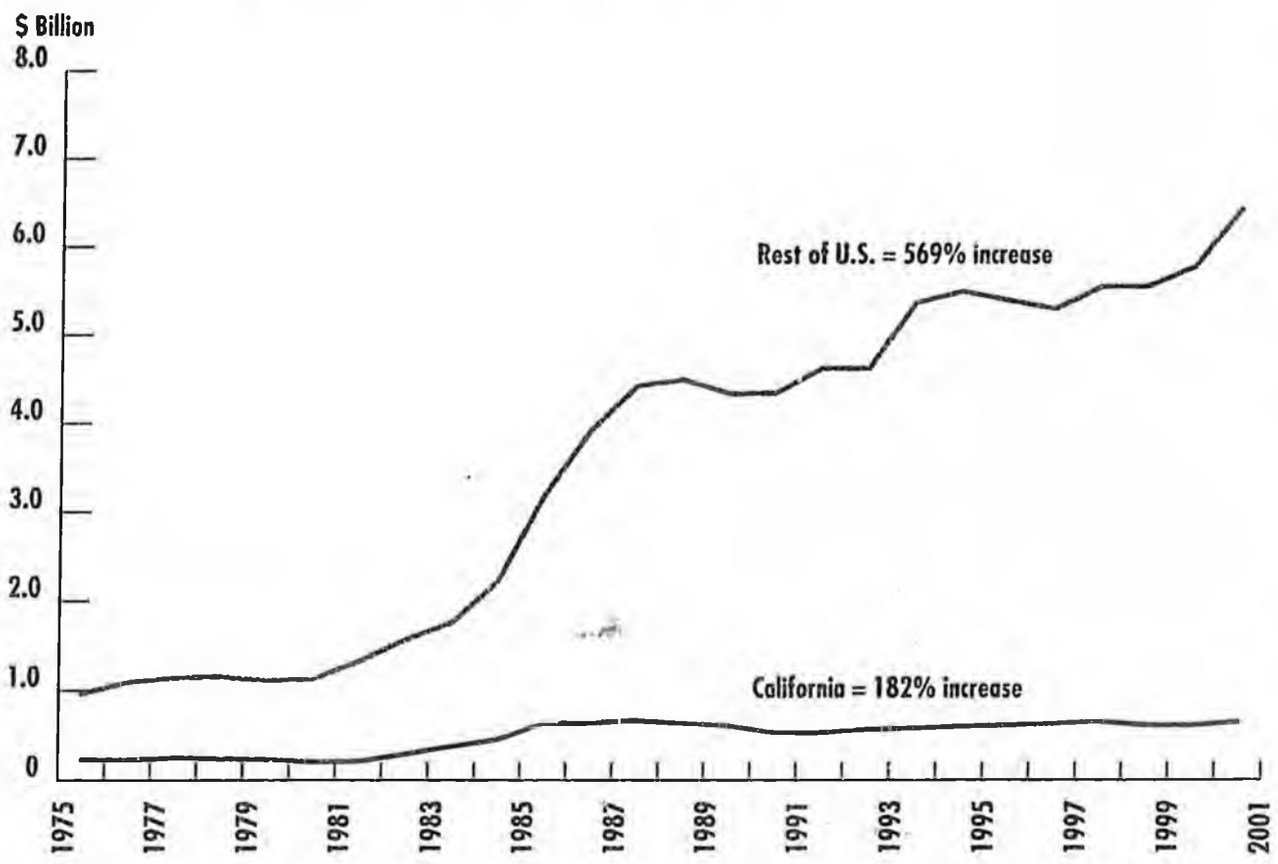
Source: Best's Aggregate and Averages: Property-Casualty, U.S., 2003 Edition, p. 364.

The Influence of Tort Reform

In the interest of preserving patients' access to physicians, some state governments have tried to keep a lid on growth in PLI premiums through a variety of tort reforms. California's Medical Injury Compensation Reform Act (MICRA) provides the model that is most frequently heralded by advocates of medical liability reform. Including a $250,000 hard cap (no exceptions; not indexed for inflation) on non-economic damage awards, a sliding scale for the contingency fees of plaintiffs' attorneys, a collateral source offset rule, and other reform measures, MICRA has been in place long enough to provide a basis for general inferences about the potential long-range impact of certain tort reforms.

Exhibit 5 shows a dramatic level of variation in the rates of growth in total premiums for California versus the rest of the U.S. Since MICRA was enacted in 1976, total medical liability premiums collected by licensed carriers throughout the U.S., as reported by the National Association of Insurance Commissioners, grew at over three times the rate they did in California. This comparatively low level of growth for California's medical liability insurance premiums has culminated in the wide disparity between the manual PLI rates of California and the PLI rates of those states that lack effective tort reform, as illustrated by the table of rates presented in Exhibit 1.

Exhibit 5:
MICRA Has Kept the Lid on Premium Growth in California



Source: National Association of Insurance Commissioners Reports on Profitability by Line by State, 1976-2001.

Long-Term Impacts of Liability and Loss Trends

While escalating jury awards, indemnity payments, and PLI premiums all represent links in a causal chain, the ultimate outcomes of concern are the quality of care patients receive and their access to that care. Numerous peer-reviewed academic studies document the adverse impact of our medical liability system both on medical cost (defensive medicine costs) and on patient safety (risks associated with defensive medicine practices; provider incentives to avoid disclosure of dangerous errors and system failures). However, there has been little hard evidence of a more direct nature regarding the impact of liability and loss trends on patients' access to care, until recently.

Access to Care: Beyond the Anecdotes

The relationship between increases in PLI rates and patients' access to care is extremely difficult to quantify for two reasons. First, existing data sets do not capture relatively current information that can be used to discern how physicians respond to increases in their PLI premiums. Second, conventional measures of patients' access to care are not sensitive enough to detect important changes occurring at the specific levels of individual specialties within individual markets. Unfortunately, the absence of statistical evidence of impaired access to care has been construed by some as an indicator that impairment of access has not yet occurred. However, the absence of evidence need not be mistaken for the evidence of absence, and a recent study by the Agency for Healthcare Research and Quality helps to make the connection between tort reform and its impact on patients' access to care more explicit.

The 2003 AHRQ study took advantage of circumstances that lend themselves to a natural experiment. In 1970, before any states had enacted damage caps for medical liability awards, there was an approximately even distribution of physicians per capita between the group of states that would eventually adopt damage caps and the group of states that still had not adopted caps by the year 2000. AHRQ examined how that distribution varied over time between the two groups of states. Controlling for other variables found to influence the supply of physicians, the study demonstrated that by the year 2000, states with damage caps had 12% more physicians per capita than the group of states that did not enact damage caps.

Update: Health Insurance Coverage and Costs

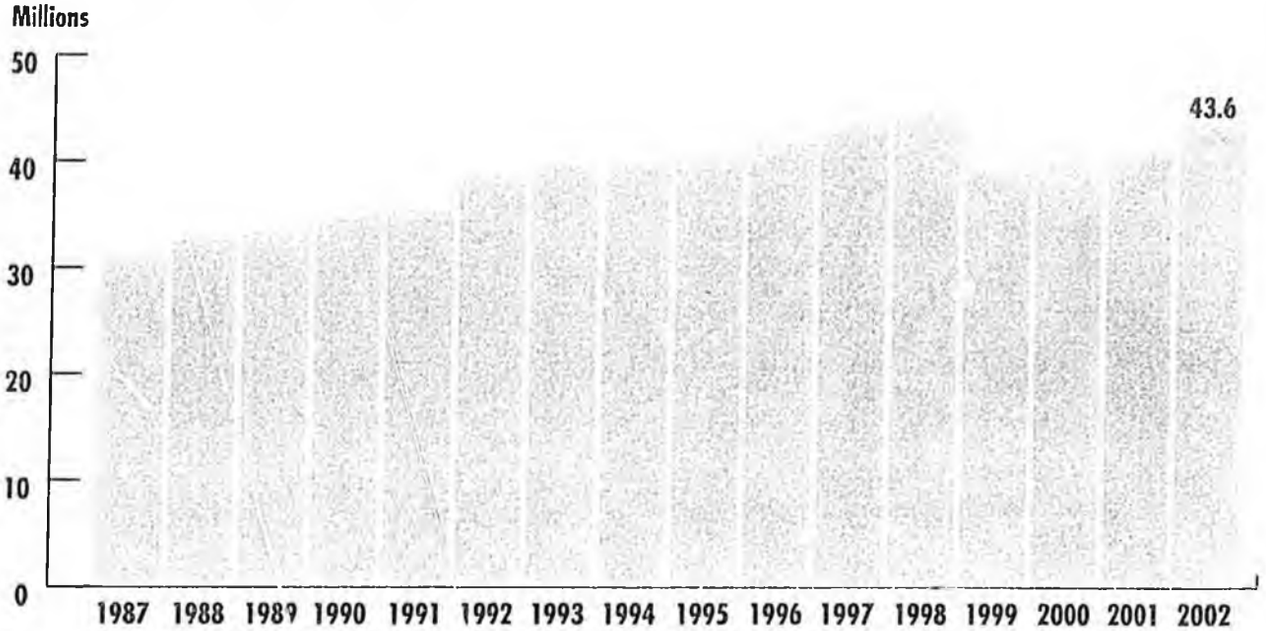
Growth in the Uninsured Population

Data recently released by the U.S. Census Bureau from its Current Population Survey, and illustrated in Exhibit 6, show that the uninsured population increased from 41.2 million to 43.6 million from 2001 to 2002. The 2.4 million increase represents the largest year-to-year rise in the number of uninsured people over the past ten years. The count of 43.6 million uninsured people is intended to reflect the number of people who lacked health insurance throughout all of 2002. The total also represents the second highest annual count in history, and represents 15.2% of the general population of the U.S. The most noteworthy characteristic of the upward trend in the uninsured population is that, through economic times both good and bad, it was almost unrelenting. The lone exception occurred in 1999, when the uninsured population decreased for the one and only time over the period 1987-2002. However, 62% of that 5 million person decline was attributable to a change in the Census Bureau's data collection methodology. The big picture take-away, however, is that the robust, high-employment economy of the U.S. throughout the 1990s failed to stem the general trend of growth in the uninsured population.

The Cost of Health Insurance

Of all the factors that drive growth in the size of the uninsured population, the most familiar to employers are the increases in the costs of coverage. The cost of health insurance continued to grow at double-digit annual rates for the third consecutive year. In the most recent release of their annual Employer Health Benefits Survey, the Kaiser Family Foundation and the Health Research and Educational Trust reported that the average premium for employer-sponsored, family health insurance coverage increased 13.9% from 2002 to 2003, to $9,068.

Exhibit 6:
U.S. Uninsured Population, 1987-2002



Source: U.S. Census Bureau Current Population Survey.

Note: The count for each year is intended to represent the number of individuals who were uninsured over the entire term of each year's one-year reference period.

Changes in the Characteristics of the Uninsured

Of perhaps even greater concern to policymakers are the changing characteristics of the uninsured population. Exhibit 7 shows that, since 1993, the fastest growing segments of the uninsured population are comprised of those who reside in middle- and upper-income households. Although the majority of the uninsured are still members of low-income households, the number of the uninsured who are members of households with annual incomes of less than $25,000 actually decreased by 17% over the past 10 years. According to the National Center for Policy Analysis, "about three-quarters of the rise in the number of uninsured over the past four years has been among households earning more than $50,000 per year, and almost half of that has occurred among households earning more than $75,000 per year. In fact, almost one third of the uninsured now live in households with annual incomes above $50,000 and one in five live in households earning more than $75,000." These findings appear to imply that employment, which is directly related to household income, has come to confer less and less protection over recent years against being uninsured.

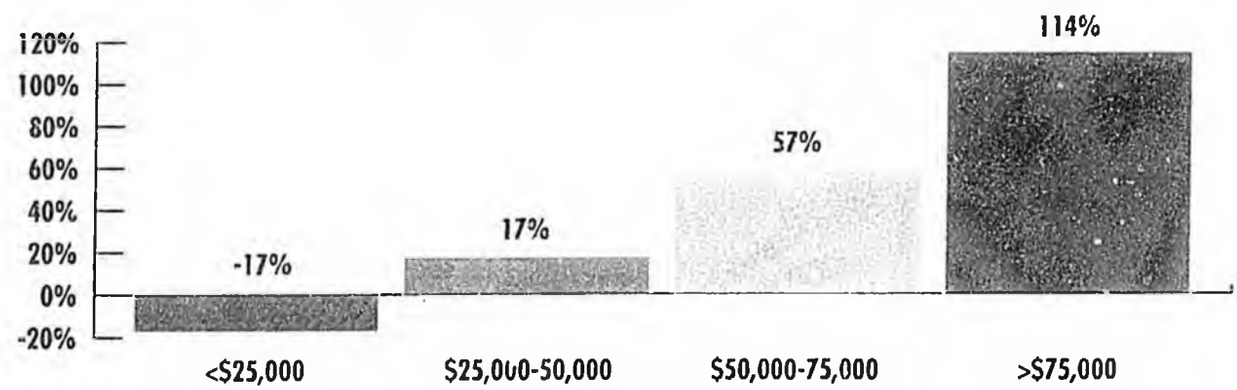
This supposition is consistent with a recent study, "The Growing Share of Uninsured Workers Employed by Large Firms," released by the Commonwealth Fund in October 2003. The main finding of the study was that in 2001, 26% (almost 10 million) of the uninsured population worked for large firms (i.e., firms with 500 or more employees) or were dependents of workers employed by large firms. The study also found that coverage rates for employees of large firms fell from 75% to 68% between 1987 and 2001. It would appear that, over time, employment by a large firm also has become less and less of a guarantee of having health insurance, particularly for those employed in low-wage jobs.

Policy Implications

One important hypothesis is consistent with the preceding findings about the economic context of the growth trend in the uninsured population and the characteristics of the uninsured population: the link between employment and sponsorship of coverage may impose a significant hindrance to any policy initiative intended to reduce the uninsured population. Furthermore, that barrier may be in the form of a progressively declining upper bound to the proportion of the population that is able to obtain health insurance.

Proposals that aim to substantially reduce the size of the uninsured population may have little prospect for success unless they incorporate mechanisms for moving away from the link between health insurance and employment. The AMA proposal for health insurance reform recognizes this important principle and thus its strategy focuses on empowering patients with the resources, authority, and opportunity to choose between individual and employer-sponsored options for health insurance coverage.

Exhibit 7:
Change in the Uninsured Population by Household Income, 1993-2002



Source: U.S. Census Bureau Current Population Survey, as presented in National Center for Policy Analysis Brief Analysis No. 460, Oct. 7, 2003.

Note: The current distribution of the uninsured population by household income segments, from lowest to highest, is 34%, 34%, 16%, and 17%, respectively.

Data Sources and Descriptions

Professional Liability Insurance

AMA Survey Data – The AMA, with the assistance of 33 state/specialty medical societies, recently conducted a National Physician Survey on PLI, in which a national random sample of physicians reported their intentions for adapting their practices in response to increases in their PLI premiums (p.1). Detailed findings from the survey are posted on the Health Policy page of the AMA's website (http://www.ama-assn.org/ama1/x-ama/upload/mm/363/plisurvey2003.pdf) on a for-members-only basis.

Medical Liability Monitor (MLM) – MLM publishes annually updated manual rates for three specialties – internal medicine; general surgery; obstetrics/gynecology – reflecting the middle and extremes of the rate class risk spectrum (Exhibit 1). Rates are further stratified by state or substate district and carrier. The manual rates, reflecting mature claims-made policies with $1MM/$3MM coverage limits, are a proxy for premiums. MLM data do not reflect variation in premiums that is due to surcharges for adverse claims experience, and they do not reflect discounts due to qualifications, affiliations, or exclusions from scope of covered practice.

AM Best Aggregates & Averages, Property and Casualty – AM Best tracks the financial performance of individual insurance carriers by line based on the information licensed carriers provide in the financial statements they file with the National Association of Insurance Commissioners. Best publishes its findings, including aggregate losses (Exhibit 2) and combined ratios (Exhibit 4), at the product line level, in its annually compiled Aggregates & Averages.

Jury Verdict Research (JVR) Reports – JVR tracks professional liability indemnity payments through annual reports of mean and median settlements and awards (Exhibit 3) based on the sample of jury verdict reports contained in its proprietary database. JVR data warrant careful interpretation. They are based on a sample of verdict reports that, according to JVR, adequately reflect jurisdictional variation in award and settlement amounts. They are not specific to specialties and they do not separately account for award and settlement amounts attributable to physicians, institutions, and nonphysician practitioners. Reductions of awards on appeal or negotiation are not reflected in the data. Although time lags between alleged occurrences and payouts (e.g., 1999 median for all malpractice claims was 45 months) are significant, the effect of these lags on current conditions is unknown.

Physician Insurers Association of America (PIAA) – This organization is a trade association of more than 60 medical PLI companies owned and operated by physicians and dentists. Collectively, these companies cover about 60% of U.S. private practice physicians. PIAA data are specific to the physician component of PLI indemnity payments. The costs are actual, not based on proxies, estimates, or preliminary judgments. The historical defendant win rate of 80% was calculated on the basis of data from exhibits 6A-2 and 6A-4 of the PIAA Claim Trend Analysis, 2002 Edition. PIAA claims trend data are based on a survey of about 20 of its member carriers.

U.S. General Accounting Office (GAO) – The GAO is an agency of the federal government that examines the use of public funds, evaluates federal programs and activities, and provides analyses, options, recommendations, and other assistance to help the U.S. Congress make effective oversight, policy, and funding decisions.

National Association of Insurance Commissioners (NAIC) – NAIC reports profitability measures by insurance line for licensed carriers, aggregated to the state and national levels (Exhibit 5), in its annual Reports on Profitability by Line by State. These voluntarily reported data are estimated to reflect 95% of all premiums written in the United States. They exclude financial data of self-insured health plans, estimated by one private source to account for more than half the total market. Although they are specific to the medical PLI product line, these measures of profitability are based on losses that include payouts on behalf of physicians and institutions. Caution is advised when drawing inferences about the physician-specific segment of the PLI industry.

Agency for Healthcare Research and Quality (AHRQ) – AHRQ is the health services research arm of the U.S. Department of Health and Human Services. AHRQ specializes in major areas of health care research including quality improvement and patient safety; outcomes and effectiveness of care; health care organization and delivery systems; and health care costs and sources of payment. AHRQ's July 2003 study titled "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians," used multivariate regression techniques to isolate the impact of tort reform on physicians' choice of practice location.

Health Insurance Costs and Coverage

Current Population Survey (CPS) – The annual March Supplement of the U.S. Census Bureau's CPS, the source of official U.S. statistics on health insurance coverage (Exhibits 6 and 7), is a survey of 60,000 households. Respondents are asked if they had any of various types of private or public health insurance in the previous calendar year. Since 2000, if they answer "no" for every type of coverage, they are then also asked to verify that they had no coverage at any time during the previous calendar year. The effect of adding this verification question to the survey was to decrease the 1999 count of the uninsured from 42.1 million to 39.0 million. The CPS is relatively timely, statistically reliable, and can be highly stratified due to the extremely large sample size. The Congressional Budget Office (CBO) speculates that CPS overestimates the number of people who are uninsured all year, indicating that the CPS estimate more closely tracks other surveys' estimates of the number of uninsured at a given point in time, rather than their estimates of the number of people who lacked coverage for the entire year.

Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) Employer Health Benefits Annual Survey –This survey yields time-series data regarding employer-sponsored health insurance access, take-up and coverage rates, premiums, and plan choice. Statistics are typically stratified by such variables as employer share, firm size and geography. Estimated average cost of employer-sponsored health insurance coverage is based on coverage for a family of four and reflects premiums across all plan types (i.e., conventional, HMO, PPO, and POS).

National Center for Policy Analysis (NCPA) – The NCPA is a nonprofit, nonpartisan public policy research organization, established in 1983. The NCPA's goal is to develop and promote private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

The Commonwealth Fund – The Fund is a private foundation that supports independent research on health and social issues and makes grants to improve health care practice and policy. The Fund is dedicated to helping people become more informed about their health care, and improving care for vulnerable populations such as children, elderly people, low-income families, minority Americans, and the uninsured. The Fund's national program areas are improving health insurance coverage and access to care and improving the quality of health care services.

How do escalating PLI rates affect patients' access to care?

Look inside for answers to your questions about PLI markets, and for up-to-date findings about the growing number of patients without health insurance.

To learn more about how PLI premium growth and other socioeconomic factors impact medical practice, visit the AMA's Health Policy Web site at: http://www.ama-assn.org/go/healthpolicy

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Medical Malpractice Myths vs. Truths

Myth #1: The only thing that Governor Bush and reform proponents want are caps.

Reality: Governor Bush's reform package is based on the 60 recommendations of the Governor's Task Force. It offers a comprehensive approach to improve patient safety, enhance physician discipline, stabilize the insurance market, and create more fairness in lawsuits.

Myth #2: People hurt in medical mishaps would be limited to $250,000 in compensation.

Reality: Governor Bush's proposal only has a cap on non-economic damages, which are arbitrary, subjective and currently without guidelines. Economic damages (the injured person's medical costs, lost wages and earning potential) will remain unlimited and should be distributed quicker, because they won't be tied up in court battles over non-economic damages.

Myth #3: Trial lawyers oppose caps because caps take money from injured parties.

Reality: Non-economic damage awards are a significant source of income for trial lawyers. Today, injured parties receive less than 50% of the premium dollars paid from insurance coverage, with attorneys receiving most of the rest. Injured parties will receive fair compensation more quickly under the Governor's proposal.

Myth #4: Caps on non-economic damages don't lower rates or protect healthcare.

Reality: Caps make losses more predictable, bringing risk stability for insurance rates. The nationally recognized actuarial firm Milliman USA said payments for non-economic damage are "one of the primary drivers" of Florida's crisis. A task force of independent university leaders cited the cap as an important factor in lowering rates and protecting healthcare availability.

Myth #5: The Governor's reform package will not lead to insurance rate rollbacks.

Reality: Governor Bush proposes a 20% rate rollback if lawmakers pass the reform package intact. The state's largest medical liability insurer has already committed to comply with the rollback.

Myth #6: Mandatory Insurance Rate Rollbacks, not Caps, stabilized the market in California.

Reality: $250,000 caps on non-economic damages passed in California in 1975 and were upheld by the CA courts in 1985. A year later, the amount of losses dropped and premiums stabilized. The mandatory rate rollback didn't take effect until 1989. By then, losses were already lower, premiums were more stable and insurers were returning savings to doctors.

Despite the fact that California has more than twice as many practicing physicians, it has approximately the same number of medical malpractice cases and pays less in total claims than Florida currently does. From 1991 to 2001, California had an increase in payouts of 47%, while Florida had an increase of a whopping 141%. During the same period, the number of paid claims in California dropped by 2.5%, while Florida had an increase of 82%.

Myth #7: This crisis is caused by bad or incompetent doctors.

Reality: Each year in Florida, one out of 18 doctors is sued. In high-risk specialties like neurosurgery or Ob/Gyn, nearly every doctor is sued. The legal climate is to blame - frequency of claims and "per premium" losses per Florida doctors are 36% and 50% higher than national average, respectively.

Myth #8: Bad stock market investments by insurers are the cause of this crisis.

Reality: In Florida, insurance companies can invest a maximum of 15% of their assets in the stock market. Florida's largest medical liability insurer has not had more than 9/10 of one percent invested in the stock market since 1995.

Myth #9: Proposed rollback will only decrease rates for physicians in low risk specialties.

Reality: The Governor's proposal is intended to give savings to all specialties. The state's largest insurer has already committed to give savings equally in each specialty, and the Governor will continue to challenge all insurers to do the same.

Myth #10: Florida citizens don't support reasonable caps on medical liability awards.

Reality: Sixty-eight percent of Floridians support capping non-economic damages at $250,000, according to a statewide poll conducted in May by *The St. Petersburg Times, The Miami Herald and The Palm Beach Post*

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(File 4 of 7)

National Studies & Material

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 ic 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 rville, Md. The study adjusted for the impact of multiple factors that may affect the physician supply, such as per capita in come 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 o 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.

uments 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 ation 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.

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 n'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.

tudies 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.

ER SILVERMAN

e Editor, Practice Trends

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 obstetrician/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

[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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July 8, 2003

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 000, 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 o 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 ve 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 le effects of the caps.[5]

uring 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 east 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 ge 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	38,073
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 business there. Weiss' analysis gives no weight to the actual amount of insurance sold by the various companies in any state, nor does it reflect its 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 ig 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 ibit 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

In 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).

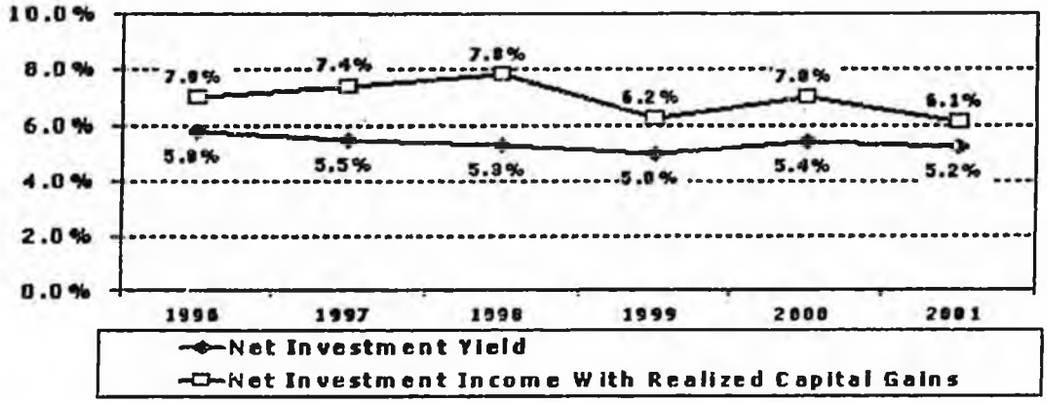
nent Performance

In 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.

In 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 les 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.
mony 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.
rnia 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 hen the trial bar's constitutional challenges of the law were finally silenced.
ial 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

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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.

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 [illegible]rance 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 Dalias, 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 that 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.[25] 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.[26, 27] 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.[28]

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).[29]

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.[22] The number of medical liability insurance companies active in Florida dropped from 66 in the late 1990s to only 12 in 2002.[23] 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 other 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

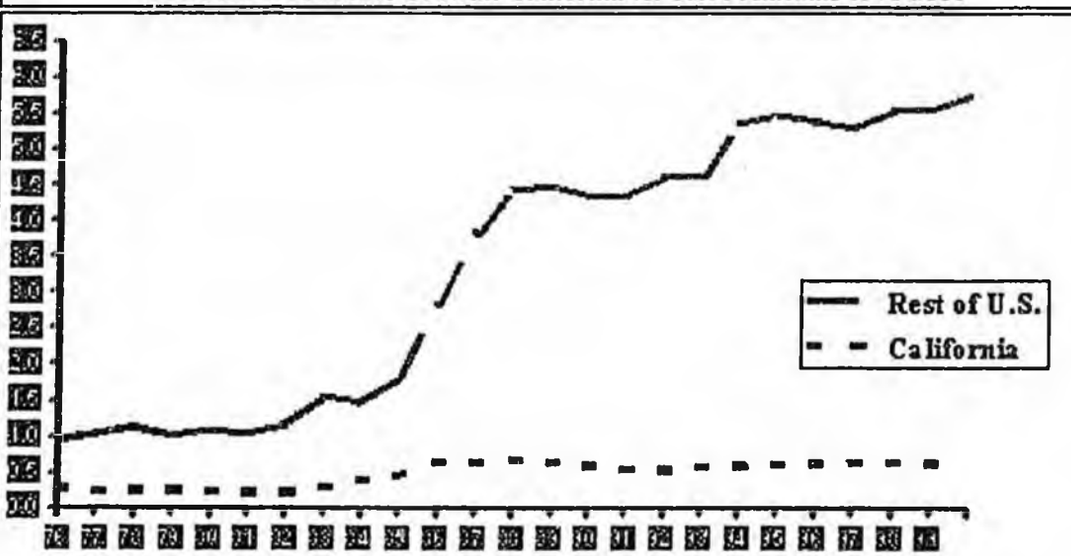
	Cap on Non-Economic Damages	Low	High
INTERNISTS			
State Wide Data			
Wisconsin	$350,000	$4,500	$6,000
Montana	$250,000	7,000	7,900
Utah	$250,000	7,900	10,600
Hawaii	$350,000	7,100	7,100
Connecticut	No cap	7,400	13,800
Washington	No cap	6,700	9,800
Metropolitan Area Data			
California (Los Angeles area)	$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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99. 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.

100. Zuckerman, Stephen, Bovbjerg, Randall R., and Sloan, Frank, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," Inquiry 27: 167-182, Summer 1990.

101. Analysis from the Council of Economic Advisors, July 2002.

102. O'Connell, Jeffrey, "Offers that Can't be Refused," 1977 Northwestern University Law Review 589 (1982); Moore, Henson; O'Connell, Jeffrey, "Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss," 44 Louisiana Law Review 1267 (1984); Moore, Henson; Hoff, John, "H.R. 3084: A More Rational Compensation System for Medical Malpractice," 49 Law and Contemporary Problems 117 (Spring 1986). A Statement by the Committee for Economic Development, "Breaking the Litigation Habit," 2000. A Bill to implement this approach was first introduced by Rep. Henson Moore and Rep. Richard Gephardt in 1987, H.R. 5400, 98th Congress.

103. Walter Olson, "Delivering Justice," ***Wall Street Journal*** Opinion, February 27, 2003.

104. "Learning from our Mistakes: Quality Grand Rounds, a New Case-Based Series on Medical Errors and Patient Safety," Annuals of Internal Medicine, Volume 136, Number 11, June 4, 2002.

105. IOM Report, "To Err is Human: Building a Safer Health System," 2000.

106. Statement of the Physician Insurers Association of America before a joint hearing of the US Senate Judiciary Committee and Health, Education, Labor and Pensions Committee, February 11, 2003.

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.

108. Ramacahandran, Raghu, "Did Investments Affect Medical Malpractice Premiums?," Brown Brothers Harriman & Company, January 21, 2003.

109. 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.

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 or specific in

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 acts. (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 a wrongful death action with two or more claimants or beneficiaries, the judgment 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 in cases where the plaintiff is a quadriplegic, 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 decisions and permanently incapable of independently performing the activities of normal daily living, or the plaintiff has suffered permanent loss or damage to a reproductive organ resulting in the inability to procreate. The noneconomic damages shall not exceed $500,000. As of 2002 the $280,000 cap is $340,706 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 inflation; as of 2003 the cap is $557,011. (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

[redacted]

[redacted] (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).

[redacted] (1986, 2001)

Vermont-None

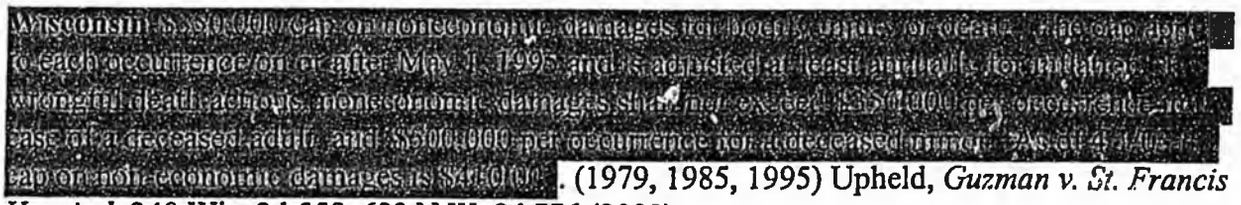
[redacted] (1976, 1977, 1983, 1999, 2001) Upheld, *Etheridge, et.al. v. Medical Center Hospitals*, 237 Va. 87, 376 S.E.2d 525 (Va. 1989).

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*)*.



. (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.*