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patient exhibits severe damages. However, there is evidence that the tort system provides uneven and inappropriate levels of payments. As noted above, the vast majority of negligent injuries do not lead to a claim. By definition, if injured parties do not file claims, then the tort system provides them with no compensation. Among those claims that are filed, the vast majority shows no signs of an injury or harmful event. If such claimants receive a payout, then the tort system is providing compensation to the wrong people. Even when legitimately injured parties are able to prove negligence, plaintiffs' lawyers routinely take 33 percent and sometimes 40 percent (or more) of that award as payment for legal fees.[35] The unevenness also stems from awards for pain and suffering. Since pain and suffering (or non-economic) damages are intrinsically impossible to measure objectively, the size of such payments varies considerably across homogenous groups of claims (i.e., different amounts for the same injury in different people).

A drawback of the medical liability system is the incentives for unwarranted, or nuisance, lawsuits. The potential for sizeable awards can lead to significant fraud and abuse of the tort system.[36] The large dollar size of successful action, the ability to seek non-economic pain and suffering awards, and the availability of contingency fees for plaintiffs' attorneys all could affect claiming rates. Although the data indicate that the number of claims has not climbed in recent years, these factors could encourage marginal cases to be pursued. Pain and suffering damages, in particular, could supply a powerful incentive to file nuisance claims. The tort system as a whole pays out more for pain and suffering than it does for measurable economic loss,[37] and it has been reported that up to one-half of all payments to individuals in medical malpractice claims are for pain and suffering.[38]

Another shortcoming of the malpractice liability system is the length of time negligently injured parties must wait before receiving payment. According to survey data gathered by Jury Verdict Research, there is a median wait of more than two years (25 months) between the time of the incident and the time the claim is filed. The litigation process, from date of filing to a jury verdict takes the typical claim another two years (26 months). Altogether, injured parties can expect to wait more than four years (51 months) between the time of the alleged malpractice incident and a jury verdict.[39] This prolonged wait has a particularly severe impact on low-income victims of malpractice. Such claimants may lack the financial resources to wait out the process and instead settle more quickly than might be warranted by their injury.

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[35] See Patricia M. Danzon, "Report on Awards for Noneconomic Loss," in *Medical Malpractice Policy Guidebook*, ed. Henry G. Manne (Jacksonville, FL: Florida Medical Association, 1985), 141-142 (reporting a median contingency fee of 38 percent for large medical malpractice claims); and Deborah R. Hensler et al., *Compensation for Accidental Injuries in the United States* (Santa Monica, CA: RAND, 1991), 135-136 (reporting a median contingency fee of 33 percent for accidental injury claims)

[36] Stephen J. Carroll, Allan F. Abrahamse, M. Susan Marquis, and Mary E. Vaiana, *Liability System Incentives to Consume Excess Medical Care* (Santa Monica, CA: RAND, 1995).

[37] Tillinghast-Towers Perrin, 17.

[38] Danzon, "Report on Awards for Noneconomic Loss," 136.

[39] Jury Verdict Research, 19-20.

III. MEDICAL MALPRACTICE AND THE QUALITY OF HEALTH CARE

One of the primary goals of the medical liability system is to improve the quality of health care by penalizing negligent behavior. In order to accomplish this goal, the tort system must exhibit accuracy in both the assignment of negligence and in the size of damage awards. The available data on this aspect of the tort system strongly indicate that there is significant discrepancy between actual acts of negligence and tort-system-assessment of negligence. As previously noted, about 80 percent of malpractice claims exhibit no evidence of malpractice. In fact, most claims are not even tied to any injury.[40] The discordance between claims and negligence makes it very difficult, if not impossible, for health care providers to recognize and thereby avoid negligent behavior.

One study followed a sample of malpractice claims for a period of ten years to identify the relationship between negligence and payments to claimants.[41] The study's authors found that in cases where there was no evidence of negligence, 43 percent of claims resulted in payment for the claimant. By contrast, those claims where there was an injury caused by negligence, only 56 percent ended with payment. This evidence supports the contention that the tort system not only fails to compensate negligent injuries, but also fails to penalize negligent behavior.

Other evidence supports this conclusion. A 1997 study by Bryan Liang shows that doctors have little knowledge of the legal system, largely disagreed with jury verdicts in malpractice cases, and are unable to predict what juries will do in such cases. These findings led Liang to observe:

> If the actors within the incentive structure [i.e., doctors] and the lay agents who assess their behavior [i.e., juries] are under different understandings regarding appropriate versus inappropriate care, it is unlikely that the incentive structure goals of optimal deterrence and cost-effective provision of care will be fulfilled in any meaningful way.[42]

A range of other studies report findings consistent with this conclusion. For example, a 1996 study of family doctors in Florida found that better doctors (those with greater levels of medical knowledge) are more likely to be sued than other doctors.[43] Likewise, multiple studies have reported that good communication skills are more important than quality of care in predicting malpractice claims.[44] Other empirical evidence indicates that damage awards are more a function of injury severity than quality of care.[45]

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[40] Studdert et al., 253; Harvard Medical Practice Study, 7-36.

[41] Troyen A. Brennan, Colin M. Sox, and Helen R. Burstin, "Relation between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation," *New England Journal of Medicine* 335 (1996): 1963-1967.

[42] Bryan A. Liang, "Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department," *Cornell Journal of Law and Public Policy* 7, no. 1 (Fall 1997), note 6.

[43] John W. Ely et al., "Malpractice Claims against Family Physicians: Are the Best Doctors Sued More?" *Journal of Family Practice* 48, no. 1 (January 1999).

[44] Wendy L. Levinson et al., "Physician-Patient Communication: The Relationship with Malpractice Claims among Primary Care Physicians and Surgeons," *Journal of the American Medical Association* 227, no. 7 (February 19, 1997): 553-559; and Philip J. Moore et al., "Medical Malpractice: The Effect of Doctor-Patient Relations on

Taken as a whole, the medical liability system appears to be, quite simply, ineffective at consistently penalizing negligence. Appropriate acts of medical care can easily result in large damage awards, while true acts of negligence go unpunished. As one critic has observed, "It's like a traffic cop giving out lots of tickets to people not speeding and lots of speeders are not getting tickets."[46]

Given the dramatic increase in health care liability, an observer might suppose that health outcomes had deteriorated over the last several years. Ironically, however, the surge in medical malpractice litigation costs has occurred at the same time as a general improvement in key indicators of the health status of Americans. As seen in Table 3, there has been a marked decrease over the last decade in some of the leading causes of death in the U.S.[47] In addition, the infant mortality rate has improved by 25 percent and the average life expectancy at birth has increased by a year and a half.[48] These indicators suggest that health care in the U.S. is generally improving and dispels the notion that widespread negligence in medicine has hurt the overall quality of health care.

Table 3. Mortality Rates, 1990-2000

	1990	2000	Change
Heart Disease*	321.8	257.5	-20.0%
Cancer*	216.0	200.5	-7.2%
Stroke*	65.5	60.2	-8.1%
Accidents*	36.3	33.9	-6.6%
Influenza & Pneumonia*	36.8	24.3	-34.0%
Infant Mortality†	9.2	6.9	-25.0%
Life Expectancy (years)	75.4	76.9	+2.0%

* Age-adjusted death rate per 100,000 population.
† Deaths per 1,000 live births.
Source: U.S. Department of Health and Human Services.

While the above analysis indicates that health care liability fails as an effective deterrent to medical malpractice, an equally strong argument can be made that the liability system actually impedes improvements in the delivery of health care and may even increase the rate of errors. First, to the degree that the threat of legal liability induces doctors to practice defensive medicine, patients are subjected to additional tests and treatments which themselves expose patients to additional risk of injury. Moreover, medical liability can make doctors averse to recommending treatments that might be considered riskier, but that are also more medically appropriate.[49]

Medical Patient Perceptions and Malpractice Intentions," *Western Journal of Medicine* 173, no. 4 (October 2000): 244-250.

[45] Henry S. Farber and Michelle J. White, "Medical Malpractice: An Empirical Examination of the Litigation Process," National Bureau of Economic Research Working Paper 3428 (September 1990) (showing that quality of care explains only a small portion of variance in award amounts, while injury severity exhibits much greater explanatory power); and Brennan, Sox, and Burstin (showing injury severity was more predictive of claims payments than was negligence).

[46] Troyen Brennan, as quoted by Samuel Jan Brakel, "Using What We Know about Our Civil Litigation System: A Critique Of 'Base-Rate' Analysis and Other Apologist Diversions," *Georgia Law Review* 31 (Fall 1996).

[47] Figures are death rates per 100,000 population, adjusted for population age differences over time. Data from the U.S. Department of Health and Human Services, National Center for Health Statistics, as reported in U.S. Census Bureau, *Statistical Abstract of the United States: 2002* (Washington, DC: Government Printing Office, 2002).

[48] U.S. Department of Health and Human Services, National Center for Health Statistics, *National Vital Statistics Report* (various issues).

[49] See generally, Bryan A. Liang, "The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal System," *Journal of Law, Medicine & Ethics* 29 (2001): 346-368.

Second, in many ways, medical liability deters health care providers from recognizing and reporting errors and working to prevent future mistakes. The legal setting in which malpractice claims occur is hostile to efforts to reduce error and improve safety. Current rules of evidence and discovery generally undermine reporting systems needed to systematically identify how and why errors occur.[50] A 2000 report by the Institute of Medicine found that the most important threat to patient safety was not simple human mistakes, negligence or incompetence, but rather human mistakes that result from poor system design, faulty maintenance and inadequate management.[51] Thus, addressing system failures are a crucial aspect to improving patient safety, and legal reform continues to be an inescapable element of such efforts.

The medical malpractice system also exacts a subtler toll on health care by eroding physician morale and damaging the doctor-patient relationship. In a 2002 survey, 87 percent of doctors felt that the overall morale of physicians had fallen in the last five years.[52] Low morale is important because it can reduce job satisfaction among physicians. Indeed, 58 percent of doctors report that their enthusiasm for practicing medicine has declined in the last five years.[53] As a result, doctors are more inclined to retire early or to shift their professions away from patient care. In addition, there is a tendency for malpractice fears to make doctor-patient relationships more adversarial. More than one doctor has reported that excessive litigation has fostered a sense of viewing each patient as a potential malpractice lawsuit rather than a patient in need of help.[54] Together, these trends make it difficult for doctors and patients to establish the kind of personal rapport necessary for better health care.

IV. IMPACT OF THE MEDICAL LIABILITY SYSTEM ON HEALTH CARE COSTS

The problems in the medical liability system impose substantial costs on the U.S. health care system. Most apparent are the direct costs of premiums paid by health care providers. As noted previously, such premiums totaled $21 billion in 2001, and have doubled over the preceding ten years.

The indirect costs of the medical liability system are much larger than malpractice premiums. Principally, these costs manifest as the practice of defensive medicine by doctors and other health care professionals. Defensive medicine is defined as medical care that is primarily or solely motivated by fear of malpractice claims and not by the patient's medical condition alone. The effect can manifest as the prescription of increased diagnosis and treatment procedures beyond what is needed from a purely clinical perspective, and as the avoidance of

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[50] See Liang, "Adverse Event"; and Brian A. Liang, "Error in Medicine: Legal Impediments to U.S. Reform," *Journal of Health Politics, Policy & Law* 24, no. 1 (February 1999): 27-58.

[51] Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, eds., *To Err Is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000), 55.

[52] Kaiser Family Foundation, *National Survey of Physicians* (May 2002), online at http://www.kff.org.

[53] *Ibid.*

[54] For some recent examples, see Joedy McCreary, "Residents Fear for Health Care as West Virginia Surgeons Continue Protest of Insurance Costs," *The Associated Press*, 1/8/2003; Rod Thomson, "In the Medical Malpractice Slugfest, the Patient Inevitably Gets Bruised," *Sarasota Herald-Tribune*, 2/17/2003; and Roberto Kusminsky, Raymond Goldsteen and James P. Boland, "Medical Malpractice Rational Test of No-Fault Patient Care Is Needed," *Charleston Gazette* (West Virginia), 12/14/2002.

procedures which might be appropriate from a clinical standpoint but whose risk-level discourages their use.

A large body of research has accumulated showing that medical malpractice liability causes doctors to practice defensive medicine.[55] In an authoritative study on defensive medicine, Stanford University researchers Daniel Kessler and Mark McClellan found that expanded malpractice liability significantly increased medical expenditures. Specifically, they found "that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications."[56] Based on national health expenditure data, Kessler and McClellan's estimates imply that medical liability reforms could have reduced defensive medicine expenditures by between $69 billion and $124 billion in 2001, or between 3.2 and 5.8 times the amount of malpractice premiums.[57] Importantly, the practice of defensive medicine does not produce measurable health benefits.[58]

Surveys of doctors provide additional evidence of defensive medicine.[59] According to a survey of 1,800 doctors published in the journal *Medical Economics*, more than three out of four (76 percent) doctors report that they practice defensive medicine.[60] In terms of the cost impact of defensive medicine, a large majority (68 percent) of respondents felt that defensive medicine increased the costs of their services by at least 6 percent. Another survey found that 79 percent of doctors order more tests than they would based solely on medical need, and 74 percent refer patients to specialists more often.[61]

A final cost of the medical liability system is the expense of administering the judicial system to handle malpractice claims. These expenses include both the cost of administering a

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[55] Robert J. Rubin and Daniel N. Mendelson, "How Much Does Defensive Medicine Cost?" *Journal of American Health Policy* (July/August 1994): 7-15; A. Russell Localio et al., "Relationship between Malpractice Claims and Cesarean Delivery," *Journal of the American Medical Association* 269, no. 3 (January 20, 1993): 366-273; U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H-602 (Washington, DC: Government Printing Office, 1994); Steven Shavell, "Economic Analysis of Accident Law," National Bureau of Economic Analysis Working Paper 9483 (March 2003); Daniel P. Kessler and Mark B. McClellan, "Medical Liability, Managed Care, and Defensive Medicine," National Bureau of Economic Research, Working Paper 7537 (February 2000); Lisa Dubay, Robert Kaestner, and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics* 18 (1999): 491-522; and Robert Quinn, "Medical Malpractice Insurance: The Reputation Effect and Defensive Medicine," *Journal of Risk and Insurance* 65, no. 3 (1998): 467-484. For an alternative view, see Laura-Mae Baldwin et al., "Defensive Medicine and Obstetrics," *Journal of the American Medical Association* 274, no. 20 (November 22/29, 1995): 1606-1610.

[56] Daniel P. Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine," National Bureau of Economic Analysis Working Paper 5466 (February 1996), 2.

[57] Calculation is based on the health services and supplies component of national health expenditures from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "National Health Expenditures," (2003), online at http://cms.hhs.gov/statistics/nhe/historical.

[58] Kessler and McClellan, "Medical Productivity," 25; Kessler and McClellan, "Defensive Medicine," 33; and Dubay, Kaestner, and Waidmann.

[59] For a review of some older surveys, see U.S. Congress, Office of Technology Assessment, Figure 3-3.

[60] "Once Burned, Twice Defensive," *Medical Economics* 76, no. 14 (July 26, 1999). See also, Berkeley Rice, "Medical Errors: Is Honesty Ever Optional," *Medical Economics* 79, no. 19 (October 11, 2002) (reporting the results of an ethics survey which found that 67 percent of physicians admit to practicing defensive medicine).

[61] Humphrey Taylor, "Most Doctors Report Fear of Malpractice Liability Has Harmed Their Ability to Provide Quality Care," The Harris Poll #22, 5/8/2002.

trial and the cost of providing a framework for filing and settling cases. Overall, medical malpractice cases account for about 12 percent of all tort cases decided by a trial, making such lawsuits the third most common type of tort settled in state courts.[62] However, only a small percentage of claims actually result in a jury trial, as the vast majority are settled out of court prior to trial. A precise estimate of administrative costs has not been done due to data limitations

V. IMPACT OF THE MEDICAL LIABILITY SYSTEM ON ACCESS TO HEALTH CARE

The medical liability system reduces access to health care in the U.S. The first way medical malpractice affects access is by reducing the affordability of health insurance. By increasing expenditures, the system forces premiums higher, which in turn reduces the number of Americans with health insurance. The second impact is to reduce the supply of health care, such as inducing doctors to retire from medicine or to avoid high-litigation specialties or geographic areas.

Demand for Health Insurance: Impact on Affordability

Given the increase in health insurance premiums and costs described above, there will be an impact on the extent of health insurance coverage in the U.S. Generally speaking, there are two pools of people who will be affected. First, some individuals will choose not to purchase insurance due to the increase in premiums. Second, some individuals who would otherwise be willing to pay the higher premiums caused by medical malpractice will lose coverage if their employer decides to no longer offer health insurance as a benefit. The bottom line is that higher costs reduce the affordability and hence the demand for health insurance. Survey data indicate that three-quarters (74 percent) of the uninsured identify high costs as a major reason for going uninsured.[63]

Research also shows that firms' decision to offer health insurance benefits is sensitive to the price of health insurance. Small businesses are even more likely to drop health benefits in response to increased liability costs than are large firms,[64] and employees of small businesses are more likely to be uninsured than are employees of large businesses.[65] A 1997 report by the U.S. General Accounting Office found:

> Particularly for small employers, costs are cited as a key factor in their decision to drop coverage for their workers or to consider offering it. For those employing lower-wage workers, health premiums represent a significant share of total compensation.[66]

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[62] The figure is based on a survey of the nation's 75 largest counties and does not include cases that were settled prior to trial. U.S. Department of Justice, 2.

[63] Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: A Chart Book* (May 2000), 35, online at http://www.kff.org/sections.cgi?section=kcmu.

[64] Jonathan Gruber and Michael Lettau, "How Elastic Is the Firm's Demand for Health Insurance," National Bureau of Economic Research Working Paper 8021 (November 2000).

[65] Kaiser Commission on Medicaid and the Uninsured, 25; and U.S. General Accounting Office, *Health Insurance: Characteristics and Trends in the Uninsured Population*, GAO-01-507T (March 2001), 8.

[66] U.S. General Accounting Office, *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures*, GAO/HEHS-97-122 (July 1997), 24.

Low wage workers are most vulnerable to such changes. First, such workers frequently work for small businesses, who already are less likely to offer coverage and are the most likely group of firms to drop health benefits in response to higher costs. Second, low wage workers often cannot afford to purchase private health insurance by themselves. Thus, when excessive malpractice litigation pushes up the cost of health insurance, low wage workers often bear the brunt of the impact.

Supply of Health Insurance: Impact on Health Care Providers

High malpractice costs have a detrimental impact on the supply of medical services by health care providers. There is extensive anecdotal evidence that doctors and hospitals have reduced the availability of health care in response to rising malpractice premiums.

- Arizona: The city of Bisbee, along the Mexican border, lost the maternity ward at its local hospital when malpractice rate increases led to four of the city's six obstetricians to stop delivering babies.[67]

- Florida: The number of insurers offering medical malpractice coverage dropped in half (from 40 to 20) over the past decade, pushing premiums up and reducing the availability of coverage.[68] Malpractice insurance premiums in 2002 averaged $201,376 for Ob/Gyns, while the average was $174,268 for general surgeons.[69] The Orlando Regional Medical Center is currently at risk of closing its trauma center due to the lack of neurosurgeons willing to work the emergency room.[70]

- Georgia: A recent study of Georgia physicians projected that 2,800 doctors in the state (or about one in five) would stop providing higher-risk procedures in order to reduce their liability exposure. One in three Ob/Gyns said they would limit their services (including delivering babies), and 11 percent would stop working in emergency rooms. Four percent of the state's doctors reported that high malpractice premiums have led them to retire early or leave the state. Overall, the study reported that malpractice premiums increased between 11 percent and 30 percent in the state.[71]

- Nevada: It has been reported that dozens of doctors have stopped practicing in the state due to the medical liability crisis.[72] The decision by St. Paul Companies to cease writing malpractice insurance left 60 percent of Las Vegas doctors seeking a new insurer, and 10 percent of the city's doctors are expected to quit or relocate as a result.[73] The crisis in Nevada was made particularly clear when the state's only Level 1 trauma center closed

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[67] Tom Gorman, "Physicians Fold under Malpractice Fee Burden," *Los Angeles Times*, 3/4/2002.
[68] John Hillman, "Crisis Coast to Coast: Health-Care Providers and Regulators Urge Medical Liability Reform," *Best's Review*, September 2002.
[69] Smarr.
[70] Margaret Ann Mille, "Manatee Doctors, Nurses Rally for Cap on Malpractice Suits," *Sarasota Herald-Tribune*, 3/1/2003.
[71] Daniel Yee, "Study: Insurance Rates Affect Ga. Care," *The Washington Post*, 1/26/2003.
[72] Joelle Babula, "Doctors Call on Lawmakers to Revamp Liability Laws," *Las Vegas Review-Journal*, 3/5/2003.
[73] Tom Gorman, "Physicians Fold under Malpractice Fee Burden," *Los Angeles Times*, 3/4/2002.

for 10 days in July 2002, during which time the hospital's CEO warned the public to "Drive home carefully."[74]

- New Jersey: Medical liability premiums have been increasing 20 percent to 25 percent annually, and the Medical Society of New Jersey estimates that 3,000 physicians in the state are at risk of losing coverage due to reduced coverage by insurers.[75] Over a period of less than a year, three insurers – the MIIX Group, Phico and the St. Paul Companies – covering 55 percent of the state's doctors stopped writing coverage for malpractice, leaving doctors rushing to find new sources of insurance.[76]

- Pennsylvania: The state's largest malpractice insurer, the Phico Group, has been placed in liquidation, and the MIIX Group and Princeton Insurance have ceased writing new policies.[77] Rising malpractice costs have induced doctors to leave the state, retire early or stop performing certain procedures. Difficulty obtaining malpractice coverage caused Abington Memorial Hospital outside Philadelphia to close its trauma center for almost two weeks.[78] Among doctors hit the hardest, according to Pennsylvania Hospital, are radiologists specializing in mammography. The loss of radiologists in the state has resulted in waiting periods for routine mammographies of up to eight months.[79]

- Texas: Doctors along the Rio Grande river have experienced significant increases in malpractice premiums, with neurosurgeons paying up to $120,000 a year and Ob/Gyns paying up to $100,000 a year for coverage. Numerous surgeons, internists, and the only pediatric surgeon in El Paso have left the city. According to one physician, "The physicians along the Mexican border have a lower percentage of patients who are privately insured, and to have a line item like medical liability insurance go up 100 percent to 300 percent in a year's time is a lot for some practices to swallow."[80]

- West Virginia: High malpractice rates have contributed to about 5 percent of the state's doctors either retiring early or leaving the state. The Charleston Area Medical Center had to pay $2,000 daily in malpractice premium subsidies in order to retain the doctors necessary to keep its trauma center open. After the last emergency room neurosurgeon left Wheeling, the local hospital had to transport trauma patients by helicopter to other emergency rooms. The departure of St. Paul Companies from the malpractice insurance market has forced two-thirds of the state's doctors to seek coverage from other sources.[81]

- Washington: Increased losses forced Washington Casualty Co., the state's largest provider of malpractice coverage to rural hospitals, into receivership. The firm provided

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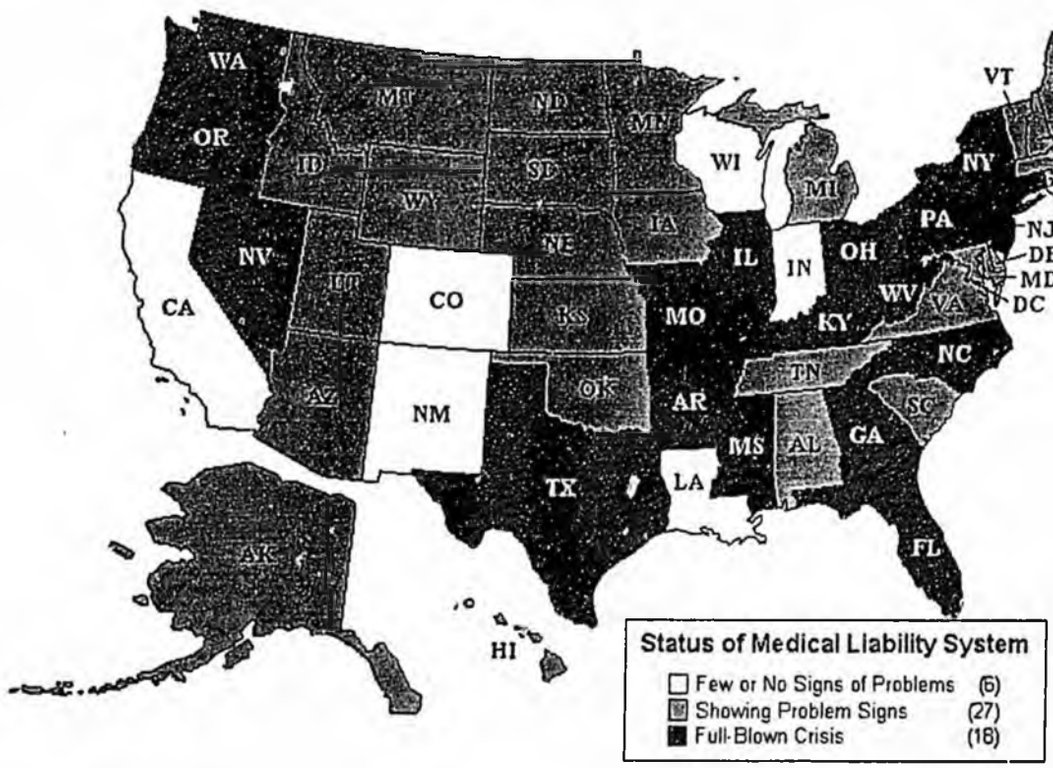
[74] Tony Batt, "UMC Official Says Crisis Is Far from Over," *Las Vegas Review-Journal*, 10/12/2002.
[75] Lynna Goch, "Medical-Malpractice Tort Reform Trouble Spots," *Best's Review*, December 2002.
[76] Joseph B. Treaster, "New Jersey Insurer Is Leaving Many Doctors Scrambling," *New York Times*, 5/10/2002.
[77] Lynna Goch, "Medical-Malpractice Tort Reform Trouble Spots," *Best's Review*, December 2002.
[78] Jeff Mille., "Rendell: Jury Award Caps Fall Short," *Morning Call* (Allentown, PA), 2/11/2003.
[79] Marian Uhlman, "Shortage of Radiologists, Technologists Creating Long Waits," *Philadelphia Inquirer*, 2/11/2003.
[80] John Hillman, "Crisis Coast to Coast: Health-Care Providers and Regulators Urge Medical Liability Reform," *Best's Review*, September 2002.
[81] Frances X. Clines, "Insurance-Squeezed Doctors Folding Tents in West Virginia," *New York Times*, 6/13/2002.

coverage to 46 hospitals and 20 community health clinics in the state, and covered 75 percent of the state's rural hospitals.[82] PedMac, which provides health care services to the poor, reported that its annual malpractice insurance costs increased by 150 percent,[83] and the average cost for malpractice coverage for hospitals increased 60 percent statewide.[84] A survey by the state medical association found that obstetricians have been hit hard, with 19 percent reporting that they have already stopped practicing obstetrics and 8 percent saying they plan to stop in the near future.[85]

Anecdotal evidence is confirmed by empirical evidence. A recent study found that the number of doctors at the state level is sensitive to the malpractice insurance costs: higher premiums reduce the number of practicing physicians.[86] A 1991 study of four Western states reported that medical liability problems resulted in decreased access to obstetric services, an effect found to be particularly harmful to poor women and rural residents.[87]

Figure 3. Problems in Medical Liability in the U.S.



Source: American Medical Association.

[82] Carol M. Ostrom, "Malpractice Insurer Ordered into Receivership by State," *The Seattle Times*, 3/8/2003.
[83] "Bleeding No More," *Puget Sound Business Journal*, 11/22/2002.
[84] Julian Anderson, "Tort & Retort: Doctors Say They're Dogged by Rising Costs of Premiums and Jury Awards, While Attorneys Say It's Not Their Fault," *The Columbian* (Vancouver, WA), 2/9/2003.
[85] Washington State Medical-Education and Research Foundation, *The Impact of Medical Malpractice Insurance and Tort Law on Washington's Health Care Delivery System* (September 2002).
[86] Mark P. Gius, "An Examination of the Determinants of Physician Supply at the State Level," *Journal of Business and Economic Studies* 6, no. 1 (Spring 2000): 73-79.

The American Medical Association (AMA) has identified 18 states in which the medical liability system has created a crisis in health care.[88] Figure 3 displays those states that the AMA considers to be in full-blown crisis. The AMA lists another 26 states and the District of Columbia as showing signs of a serious medical liability problem, but that have not yet progressed to the crisis stage.

VI. FEDERAL REFORM OF THE MEDICAL LIABILITY SYSTEM

Federal reform of the medical liability system consists of several interrelated provisions, described below. While one single change is unlikely to produce dramatic results, the combined effect of all the provisions could bring about meaningful benefits. The impact of the reforms would likely begin to manifest soon after passage into law. However, the complete impact would take time to fully manifest, depending on the actual date of enactment, judicial review and response by the insurance industry

The primary benefits of federal medical malpractice reform include budgetary savings for governments, fewer individuals without health insurance, and reduced national health care expenditures. Additionally, consumers would benefit from improved access to health care, as excessive malpractice premiums would no longer drive health care providers to raise prices, retire early, move out of state or avoid higher-risk specialties. A system less hostile to reporting and reviewing medical errors could also produce a system that would increase the effectiveness of error prevention and patient safety efforts.

Among those groups most benefiting from such changes are women, low-income households, and rural residents. Female patients are often put at a disadvantage in the current system because obstetricians pay some of the highest malpractice insurance rates of any specialty. The result has been fewer obstetricians that are able to afford continuing their obstetricics practice or to accept new obstetricics patients.[89] Low-income households suffer from the high cost of health insurance and are already more likely to lack private health insurance. Lower health insurance premiums would make coverage more affordable for the many working class families who earn too much to qualify for Medicaid.[90] Finally, rural residents generally live in areas with lower rates of physicians per capita. Thus, such residents already have limited options when it comes to health care. The faults of the current medical liability system only further reduce their health care access options.[91] All three groups stand to significantly benefit from reforms in the medical liability system.

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[87] Roger A. Rosenblatt et al., "Tort Reform and the Obstetrics Crisis: The Case of the WAMI States: Washington, Alaska, Montana, and Idaho," *Western Journal of Medicine* 154, no. 6 (June 1991): 693-699.

[88] The most important factor in determining the status of each state is the number of patients losing access to medical care. Other factors include early retirements among physicians, physicians leaving the state or limiting their provision of services, the state's legal and judicial climate, the cost and availability of malpractice insurance, and trends in jury awards and settlements. American Medical Association, "18 States Now in Full-Blown Medical Liability Crisis," Press Release (3/3/2003).

[89] See Rosenblatt et al.; and *supra* notes 67, 69, 71, 79, and 85, and accompanying text.

[90] See U.S. General Accounting Office, *Private Health Insurance*, 24; Gruber and Lettau; Kaiser Commission on Medicaid and the Uninsured, 11-14; and *supra* notes 39, 80 and 83, and accompanying text.

[91] See Rosenblatt et al.; and *supra* note 82 and accompanying text.

Medical liability reform has been attempted on numerous occasions at the state level. Reforms adopted at the state level include a range of policies, including caps on non-economic losses, changes in the statute of limitations, joint and several liability reform, punitive damage limits, and periodic payment of damages, among others. These efforts have yielded mixed results, depending on the strength and type of reforms, as well as whether state courts have overturned or limited some provisions.[92] However, some of the key reforms proposed at the federal level, including the cap on pain and suffering damages, have proven successful at producing savings when implemented.[93]

Perhaps the most successful example of reform at the state level is California. In the early 1970s, California suffered from rapidly escalating malpractice premiums that affected the quality and availability of care in the state. In response, California adopted the Medical Injury Compensation Reform Act (MICRA) in 1975.[94] MICRA contained several provisions, including a $250,000 cap on non-economic damages, binding arbitration on disputes, collateral sources offsets, limits on contingency fees, advance notice of malpractice claims, statute of limitations, and periodic payment of damages.[95] Although California still has problems with its malpractice system (including a high claiming rate), it has not experienced the same rate of growth in malpractice premiums. Over the period 1976-2000, medical malpractice premiums in California increased by 167 percent, while premiums for the rest of the nation rose by 505 percent.[96] This difference in premium growth suggests that similar reform at the federal level could have a potent effect as well.

Components of the Federal Reform

Federal legislation has been introduced in the 108th Congress that would significantly reform the medical liability system in the U.S.[97] The proposed legislation consists of several major provisions, summarized below. Existing state reform provisions would be largely left intact.[98]

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[92] For a state-by-state review of laws, court rulings and reforms, see Cohen; American Tort Reform Association, "Medical Liability Reform" [March 2003], online at http://www.atra.org/show/7338; McCullough, Campbell & Lane, "Summary of Medical Malpractice Law" [March 2003], online at http://www.mcandl.com/states.html; and American Medical Association, "Activity in the States" [March 2003], online at http://www.ama-assn.org/ama/pub/category/7470.html.

[93] See Patricia M. Danzon, *New Evidence on the Frequency and Severity of Medical Malpractice Claims* (Santa Monica, CA: RAND, 1986); Kessler and McClellan, "Defensive Medicine"; and Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reform on Physicians' Perceptions of Medical Care," National Bureau of Economic Analysis Working Paper 6346 (January 1998).

[94] Although MICRA was enacted in 1975, it was not until 1984 and 1985 that the courts upheld the key provisions of the reform.

[95] For a discussion of MICRA, see John Hillman, "The Right Reforms: Experts Call California's Medical Injury Compensation Reform Act a Medical-Liability Role Model," *Best's Review*, December 2002.

[96] Smarr.

[97] Representative James Greenwood (R-PA) introduced H.R. 5, "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003," on March 6, 2003. The U.S. House of Representatives passed the bill on March 12, 2003 by a vote of 229 to 196.

[98] Existing state reforms would be unaffected if they are stronger than the federal reform. In addition, any state limitation on non-economic or punitive damages, even if weaker than the federal reform, would remain unchanged.

- Unlimited Economic Damages: The legislation specifically states that there would be no limit on the amount of economic damages that injured parties can collect. This provision would not change current law.

- Cap on Non-Economic Losses: Awards for non-economic, also called pain and suffering, damages would be limited to $250,000. Currently, limits (if any) on non-economic damages vary by state.

- Statute of Limitations: The legislation would require malpractice lawsuits to be brought within three years of the date the injury manifested, or one year after the claimant discovers (or should have discovered) the injury, whichever occurs first. Children are entitled to exemptions from this limit. Statutes of limitations vary by state, and claims can be initiated years after the injury in many jurisdictions.

- Fair Share Rule (Joint and Several Liability): Each defendant would be liable for damages only in proportion to their share of responsibility. A defendant found to be 30 percent at fault for an injury, for example, would only be required to pay 30 percent of damages. Under current law, liable defendants can be required to pay for 100 percent of damages regardless of their actual share of fault.

- Collateral Sources Offset: Claimants would be permitted to recover claimed damages only once. Currently, claimants have the ability to recover the same damages from multiple sources.[99]

- Lawyers' Contingency Fees: Contingency fee arrangements would be limited to specific rates based on the size of the award, ranging from 40 percent on the first $50,000 to 15 percent of amounts over $600,000. Current practice is for plaintiffs' attorneys to take 33 percent to 40 percent of the total award or settlement as payment.

- Periodic Payment of Damages: Allows payments for future losses (such as expected rehabilitation costs) to be paid out over time rather than an immediate lump-sum payment. Under current law, defendants can be required to make immediate full payment.

- Punitive Damages: Punitive damages would be limited to double the amount of economic damages, or $250,000, whichever is greater. In addition, the bill would set a higher legal requirement before punitive damages can be awarded. Currently, limits (if any) on punitive damages vary by state.

Impact on the Federal Deficit

Medical liability reform would generate significant fiscal savings for the federal government. The budgetary impact results from the general reduction in the cost of health care and would affect both revenues and spending. On the revenue side, the government would

[99] In some cases, the right to subrogation can limit the net collection by the claimant.

collect additional income and payroll taxes. As the cost of tax-exempt employer-provided health benefits falls, employers will pass savings on to their employees in the form of taxable wages and benefits. The initial savings are relatively small, and increase over time as the full impact of the reforms takes hold. According to the Congressional Budget Office (CBO), these effects would result in about $3.0 billion in additional revenues over a ten-year period, including a $925 million boost for Social Security (Table 4).[100]

Government spending would also decrease due to medical liability reform. The primary savings would accrue to the Medicare and Medicaid programs, which would experience lower health care costs. In addition, the federal government would realize savings from lower costs of health benefits for federal employees. Reduced outlays from medical liability reform would total $15.1 billion in savings. Together, the increased revenue and reduced spending would produce more than $18 billion in direct savings over ten years for the federal government. State and local governments would also receive savings of about $8.5 billion over ten years.[101]

Table 4. Direct Budgetary Savings from Medical Liability Reform (millions of dollars)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2013
Income & Medicare Payroll Taxes	10	70	170	210	220	230	250	270	290	330	2,050
Social Security Payroll Taxes	5	20	60	90	100	110	120	130	140	150	925
Subtotal: Revenues	15	90	230	300	320	340	370	400	430	480	2,975
Outlays for Medicare & Medicaid	170	480	910	1,250	1,570	1,820	1,990	2,130	2,220	2,350	14,900
Outlays for federal employees	2	10	20	20	20	30	30	30	30	30	230
Subtotal: Outlays	172	490	930	1,270	1,590	1,850	2,020	2,160	2,250	2,380	15,130
Total Savings	**187**	**580**	**1,160**	**1,570**	**1,910**	**2,190**	**2,390**	**2,560**	**2,680**	**2,860**	**18,105**

Note: Positive numbers indicate budgetary savings of either increased revenue or decreased outlays.
Source: Congressional Budget Office.

The budgetary savings presented in Table 4 only reflect the direct savings from lower medical liability premiums. As noted above, however, the medical malpractice system induces doctors to practice defensive medicine. As the federal liability reforms take hold, there will be a corresponding reduction in the practice of defensive medicine. As previously discussed, the cost of defensive medicine is estimated to be 3.2 to 5.8 times the magnitude of malpractice premiums.[102] Assuming that there is the same proportionate relationship between direct government savings and indirect government savings on defensive medicine, then there would be between $9.3 billion and $16.7 billion in additional budgetary savings in 2013 from reduced defensive medicine.[103] Combined annual budgetary savings from medical malpractice reform

[100] The budget estimates presented here are for H.R. 5. U.S. Congress, Congressional Budget Office, "Cost Estimate for H.R. 5: Help Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act of 2002," 3/10/2003.
[101] U.S. Congress, Congressional Budget Office, "Cost Estimate for H.R. 5," 8.
[102] See *supra* note 57 and accompanying text.
[103] The calculations behind these estimates (in billions) are: $9.26 = $2.86 * 3.24, and $16.67 = $2.86 * 5.83.

would total $12.1 billion to $19.5 billion a year. Over a ten year period (2004-20013), a total of between $67 billion and $106 billion in savings would accrue to the federal government in this manner.

Impact on the Number of Uninsured

By lowering the cost of malpractice insurance and reducing the practice of defensive medicine, medical liability reform will increase the number of Americans with health insurance. Not only does the demand for health insurance vary widely by individual and employer, but also the number of uninsured Americans is itself difficult to quantify.[104] In addition, the reduction in the number of Americans without health insurance will not occur overnight, as it will take time for the full effect of reforms to impact the insurance market. Any estimate of changes in the uninsured population suffers from a number of inherent problems. However, it is possible to arrive estimates based on estimated savings and the sensitivity of consumers to changes in insurance premiums.

The sensitivity of consumers to the price of health insurance is measured by what economists call "elasticity." In the context of this discussion, an elasticity measures the percent change in the purchase of health insurance for a 1 percent change in the price of health insurance. A substantial amount of research has accumulated attempting to quantify health insurance elasticity. Research reviewed for the present study (including surveys of the literature) suggests a range of price elasticities for health insurance.[105] The median of these estimates indicates that a 1 percent decrease in the price of health insurance results in a 0.40 percent increase in the number of insured individuals, or approximately 960,000 people.[106] This figure is notably more conservative than the 0.60 elasticity which CBO has used to estimate the effect of health care proposals.[107]

CBO estimates that the malpractice reforms described above would effect a 0.4 percent decrease in the price of health insurance. Assuming an elasticity of 0.40, the malpractice premium savings alone would, in time, increase the number of Americans with health insurance by approximately 385,000. An elasticity of 0.60 raises the direct impact to 578,000 persons. The estimated price change, however, only includes the savings from lower malpractice

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[104] For example, one in five (18 percent) Medicaid recipients report themselves as uninsured. John Sheils, Lewin Group, Prepared Testimony to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 6/15/1999.

[105] Jean Marie Abraham, William B. Vogt, and Martin S. Gaynor, "Household Demand for Employer-Based Health Insurance," National Bureau of Economic Research Working Paper 9144 (September 2002); David M. Cutler and Richard J. Zeckhauser, "The Anatomy of Health Insurance," National Bureau of Economic Research Working Paper 7176 (June 1999); U.S. Congress, Congressional Budget Office, "Behavioral Assumptions for Estimating the Effects of Health Care Proposals" (November 1993); Willard G. Manning and M. Susan Marquis, *Health Insurance: The Trade-Off between Risk Pooling and Moral Hazard* (Santa Monica, CA: RAND, 1989); Paul J. Feldstein, *Health Care Economics* (Albany, NY: Delmar Publishers, 1993), 149; and M. Susan Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics* 14, no. 1 (May 1995): 47-63.

[106] Based on an estimated insured population of 240.9 million in 2001. U.S. Census Bureau, *Health Insurance Coverage: 2001*, Current Population Report P60-220 (September 2002), 13.

[107] U.S. Congress, Congressional Budget Office, "Behavioral Assumptions."

premiums and does not account for any changes in levels of defensive medicine, which are 3.2 to 5.8 times the magnitude of malpractice premiums.

Since there is no direct estimate of how the federal reform would affect health insurance prices through reduced defensive medicine, a proxy is necessary. The present analysis assumes that defensive medicine costs correlate with changes in the average price of purchasing insurance. Thus, the price effect of a 25 percent to 30 percent reduction in malpractice premiums (as estimated by CBO) would be matched by a similar proportional decrease in defensive medicine. Using this broader approach to estimated savings, the savings from lower malpractice premiums plus lower defensive medicine spending would reduce health insurance premiums by 1.70 percent to 2.73 percent.[108] Based on the 0.40 elasticity discussed above, the total impact of medical malpractice reform would be a reduction in the number of persons without health insurance of 1.6 million to 2.6 million.[109] With an elasticity of 0.60, the effect of the legislation would be to reduce the uninsured population by 2.4 million to 3.9 million persons.

Impact on Total Health Care Expenditures

The medical malpractice reforms described here could produce substantial savings in total spending on health care in the U.S. Public and private national health care expenditures for health services and supplies are projected to rise from $1.4 trillion in 2001 to nearly $2 trillion in 2006.[110] Reform of the medical liability system would generate savings in a number of areas. Kessler and McClellan's research indicates that medical liability reforms, such as those discussed here, would reduce health care spending by 5 percent to 9 percent, without an appreciable impact on health outcomes. Assuming the reforms are fully implemented after three years (i.e., by 2006), the gross savings would range from $99 billion to $178 billion.[111] However, an exact estimate of the net overall change in health care expenditures is difficult to make due to offsetting factors.

Factors that will reduce overall expenditures include lower medical malpractice insurance premiums, direct reductions in the cost of providing care, and reduced spending on defensive medicine. Other changes will result in increased spending on health care. For example, as noted above, a decrease in the average price of health insurance will result in more individuals purchasing health insurance. Although the average cost per policy will decrease, there will be more people buying policies. Similarly, some individuals who currently have health insurance may choose to use any savings to purchase expanded health insurance coverage.

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[108] Reduced spending on defensive medicine translates to an additional price reduction of between 1.30 percent (= 0.4 * 3.24) to 2.33 percent (= 0.4 * 5.83).

[109] These calculations are based on the number of insured Americans in 2001 and assume full implementation of the reforms. The true effects of the reforms may not be fully realized until some point in the future depending on the number of uninsured persons, the actual date of enactment, judicial review and response by the insurance industry. However, since projections of the uninsured population are not available, the only alternative is to estimate the impact as if the reform were fully implemented in 2001. The future impact on the number of uninsured would be proportional to the population when the effects of the reforms are fully realized.

[110] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "National Health Care Expenditures Projections," (2003), online at http://cms.hhs.gov/statistics/nhe/projections-2002.

[111] For comparison purposes, if the reforms had been fully implemented as of 2001, the gross savings would have been $69 billion to $124 billion.

The net effect of these factors will be a reduction in national health care expenditures, although the exact magnitude is unknown. The CBO analysis of medical malpractice reform legislation indicates that approximately 60 percent of gross spending reductions will be offset by increased spending by newly-covered individuals or expanded coverage for currently-insured individuals.[112] A rough approximation of the net reduction in health care expenditures, based on projected 2006 expenditures and assuming fully implemented reforms, puts the total between $39 billion and $71 billion annually.

VII. CONCLUSION

The medical liability system in the U.S. suffers from several major shortcomings that adversely impact the negligently injured as well as the general population. The system fails to achieve either of its central goals: compensation and deterrence. First, the vast majority of negligent injuries do not lead to a claim. By definition, if injured parties do not file claims, then the tort system provides them with no compensation. Second, among those claims that are filed, the vast majority shows no signs of an injury or harmful event. If such claimants receive a payout, then the tort system is providing compensation to the wrong people. Third, when a legitimate claim is filed, the system typically takes years for the injured party to receive anything. Finally, even when legitimately injured parties are able to prove negligence, plaintiffs' lawyers routinely take 33 percent to 40 percent (or more) of that award as payment for legal fees. On balance, it seems clear that the medical liability tort system broadly fails as a means of compensating the negligently injured.

On the second goal – deterrence of negligent behavior – the tort system also fails to achieve its mission. Since most acts of medical malpractice do not result in a claim and most claims are not tied to actual negligence, the tort system is unable to convey to doctors the appropriate signals about the optimal level of care. Moreover, the litigious environment created by the tort system discourages the reporting of mistakes, which impedes efforts to identify and prevent medical errors. In fact, the threat of malpractice litigation induces doctors to practice defensive medicine, subjecting patients to unnecessary treatments and therapy.

This indictment of the tort system serves as the basis for medical liability reform. Reform efforts at the state level have had mixed results, with California being the best example of effective reform. If adopted, the federal reform discussed here could yield budgetary savings of more than $19 billion per year, reduce the number of Americans without health coverage by up to 3.9 million, and lead to an environment that is significantly more receptive to efforts to improve patient safety and reduce medical errors.

Dan Miller
Senior Economist

[112] U.S. Congress, Congressional Budget Office, "Cost Estimate for H.R. 5," 6.

BIBLIOGRAPHY

Abraham, Jean Marie, William B. Vogt, and Martin S. Gaynor. "Household Demand for Employer-Based Health Insurance." National Bureau of Economic Research. Working Paper 9144. September 2002.

American Law Institute. *Restatement (Second) of Torts*. St. Paul, MN: American Law Institute Publishers, 1965.

American Medical Association. "18 States Now in Full-Blown Medical Liability Crisis." Press Release. 3/3/2003.

——. "Activity in the States." [March 2003]. Online at http://www.ama-assn.org/ama/pub/category/7470.html.

American Tort Reform Association. "Medical Liability Reform." [March 2003]. Online at http://www.atra.org/show/7338.

Baldwin, Laura-Mae, L. Gary Hart, Michael Lloyd, Meredith Fordyce, and Roger A. Rosenblatt. "Defensive Medicine and Obstetrics." *Journal of the American Medical Association* 274, no. 20 (November 22/29, 1995): 1606-1610.

Brakel, Samuel Jan. "Using What We Know about Our Civil Litigation System: A Critique Of 'Base-Rate' Analysis and Other Apologist Diversions." *Georgia Law Review* 31 (Fall 1996).

Brennan, Troyen A., Colin M. Sox, and Helen R. Burstin. "Relation between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation." *New England Journal of Medicine* 335 (1996): 1963-1967.

Carroll, Stephen J., Allan F. Abrahamse, M. Susan Marquis, and Mary E. Vaiana. *Liability System Incentives to Consume Excess Medical Care*. Santa Monica, CA: RAND, 1995.

Cohen, Henry. "Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive and Noneconomic Damages." Congressional Research Service. Report RL31692. 2/6/2003.

Conning & Co. *Medical Malpractice Insurance: A Prescription for Chaos*. Hartford, CT: Conning & Co., 2001.

——. *Alternative Markets: An Ever-Evolving Mosaic*. Hartford, CT: Conning & Co., 1999.

Cutler, David M. and Richard J. Zeckhauser. "The Anatomy of Health Insurance." National Bureau of Economic Research. Working Paper 7176. June 1999.

Danzon, Patricia M. *New Evidence on the Frequency and Severity of Medical Malpractice Claims*. Santa Monica, CA: RAND, 1986.

——. "Report on Awards for Noneconomic Loss." In *Medical Malpractice Policy Guidebook*, edited by Henry G. Manne, 132-142. Jacksonville, FL: Florida Medical Association, 1985.

Dubay, Lisa, Robert Kaestner and Timothy Waidmann. "The Impact of Malpractice Fears on Cesarean Section Rates." *Journal of Health Economics* 18 (1999): 491-522.

Ely, John W., Jeffrey D. Dawson, Paul R. Young, Bradley N. Doebbeling, Christopher J. Goerdt, Nancy C. Elder, and Robert S. Olick. "Malpractice Claims against Family Physicians: Are the Best Doctors Sued More?" *Journal of Family Practice* 48, no. 1 (January 1999).

Farber, Henry S. and Michelle J. White. "Medical Malpractice: An Empirical Examination of the Litigation Process." National Bureau of Economic Research. Working Paper 3428. September 1990.

Feldstein, Paul J. *Health Care Economics*. Albany, NY: Delmar Publishers, 1993.

Gius, Mark P. "An Examination of the Determinants of Physician Supply at the State Level." *Journal of Business and Economic Studies* 6, no. 1 (Spring 2000): 73-79.

Goch, Lynna. "Medical-Malpractice Tort Reform Trouble Spots." *Best's Review*, December 2002.

Gruber, Jonathan and Michael Lettau. "How Elastic Is the Firm's Demand for Health Insurance." National Bureau of Economic Research. Working Paper 8021. November 2000.

"Hard Market Wallops Physicians; Average Rate Increases More Than Double Those in 2001," *Medical Liability Monitor* (October 2002).

Harvard Medical Practice Study. *Patients, Doctors and Lawyers: Studies of Medical Injury, Malpractice Litigation and Patient Compensation in New York.* [Cambridge, MA?] 1990.

Hensler, Deborah R., M. Susan Marquis, Allan F. Abrahamse, Sandra H. Berry, Patricia A. Ebener, Elizabeth G. Lewis, E. Allan Lind, Robert J. MacCoun, Willard G. Manning, Jeannette A. Rogowski, and Mary E. Vaiana. *Compensation for Accidental Injuries in the United States.* Santa Monica, CA: RAND, 1991.

Hillman, John. "The Right Reforms: Experts Call California's Medical Injury Compensation Reform Act a Medical-Liability Role Model." *Best's Review*, December 2002.

——. "Crisis Coast to Coast: Health-Care Providers and Regulators Urge Medical Liability Reform." *Best's Review*, September 2002.

Hurley, James. American Academy of Actuaries. Prepared Testimony to the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives. 2/27/2003.

Insurance Information Institute. *The I.I.I. Fact Book 2003.* New York, NY: Insurance Information Institute, 2002.

Jury Verdict Research. *Current Award Trends in Personal Injury: 2002 Edition.* Horsham PA: LRP Publications, 2003.

Kaiser Commission on Medicaid and the Uninsured. *Uninsured in America: A Chart Book.* May 2000. Online at http://www.kff.org/sections.cgi?section=kcmu.

Kaiser Family Foundation. *National Survey of Physicians.* May 2002. Online at http://www.kff.org.

Keeton, W. Page, Dan B. Dobbs, Robert E. Keeton and David G. Owen. *Prosser and Keeton on the Law of Torts.* 5th edition. St. Paul, MN: West Publishing Co., 1984.

Kessler, Daniel P. and Mark B. McClellan. "Medical Liability, Managed Care, and Defensive Medicine." National Bureau of Economic Research. Working Paper 7537. February 2000.

——. "The Effects of Malpractice Pressure and Liability Reform on Physicians' Perceptions of Medical Care." National Bureau of Economic Research. Working Paper 6346. January 1998.

——. "Do Doctors Practice Defensive Medicine." National Bureau of Economic Research. Working Paper 5466. February 1996.

Kohn, Linda T., Janet M. Corrigan and Molla S. Donaldson, eds. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press, 2000.

Levinson, Wendy L., Debra L. Roter, John P. Mullooly, Valerie T. Dull, and Richard M. Frankel. "Physician-Patient Communication: The Relationship with Malpractice Claims

among Primary Care Physicians and Surgeons." *Journal of the American Medical Association* 227, no. 7 (February 19, 1997): 553-559.

Liang, Bryan A. "The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal System." *Journal of Law, Medicine & Ethics* 29 (2001): 346-368.

——. "Error in Medicine: Legal Impediments to U.S. Reform." *Journal of Health Politics, Policy & Law* 24, no. 1 (February 1999): 27-58.

——. "Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department." *Cornell Journal of Law and Public Policy* 7, no. 1 (Fall 1997).

Localio, A. Russell, Ann G. Lawthers, Joan M. Bengston, Liesi E. Herbet, Susan L. Weaver, Troyen A. Brennan, and J. Richard Landis. "Relationship between Malpractice Claims and Cesarean Delivery." *Journal of the American Medical Association* 269, no. 3 (January 20, 1993): 366-273

Localio, A. Russell, Ann G. Lawthers, Troyen A. Brennan, Nan M. Laird, Liesi E. Herbert, Lynn M. Peterson, Joseph P. Newhouse, Paul C. Weiler and Howard H. Hiatt. "Relation between Malpractice Claims and Adverse Events Due to Negligence." *New England Journal of Medicine* 325, no. 4 (July 1991): 245-251.

Manning, Willard G. and M. Susan Marquis. *Health Insurance: The Trade-Off between Risk Pooling and Moral Hazard.* Santa Monica, CA: RAND, 1989.

Marquis, M. Susan and Stephen H. Long. "Worker Demand for Health Insurance in the Non-Group Market." *Journal of Health Economics* 14, no. 1 (May 1995): 47-63.

McCullough, Campbell & Lane. "Summary of Medical Malpractice Law." [March 2003]. Online at http://www.mcandl.com/states.html.

"Medical Liability Rates Continue Their upward Swing," *Medical Liability Monitor* (October 2001).

Moore, Philip J., Nancy E. Adler, Patricia A. Robertson, Lee H. Hilborne, and Steven I. Kwon. "Medical Malpractice: The Effect of Doctor-Patient Relations on Medical Patient Perceptions and Malpractice Intentions." *Western Journal of Medicine* 173, no. 4 (October 2000): 244-250.

"Once Burned, Twice Defensive," *Medical Economics* 76, no. 14 (July 26, 1999).

Quinn, Robert. "Medical Malpractice Insurance: The Reputation Effect and Defensive Medicine." *Journal of Risk and Insurance* 65, no. 3 (1998): 467-484.

Rice, Berkeley. "Medical Errors: Is Honesty Ever Optional." *Medical Economics* 79, no. 19 (October 11, 2002)

Rosenblatt, Roger A., Randall R. Bovbjerg, Amanda Whelan, Laura-Mae Baldwin, Gary L. Hart, and Constance Long. "Tort Reform and the Obstetrics Crisis: The Case of the WAMI States: Washington, Alaska, Montana, and Idaho." *Western Journal of Medicine* 154, no. 6 (June 1991): 693-699.

Rubin, Robert J. and Daniel N. Mendelson. "How Much Does Defensive Medicine Cost?" *Journal of American Health Policy* (July/August 1994): 7-15

Shavell, Steven. "Economic Analysis of Accident Law." National Bureau of Economic Research. Working Paper 9483. March 2003.

Sheils, John. Lewin Group. Prepared Testimony to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. 6/15/1999.

Smarr, Lawrence E. Physician Insurers Association of America. Prepared Testimony to the Committee on the Judiciary, U.S. Senate. 2/11/2003.

Studdert, David M., Eric J. Thomas, Helen R. Burstin, Brett I.W. Zbar, E.J. Orav, and Troyen A. Brennan, "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care* 38 (2000): 250-260.

Taylor, Humphrey. "Most Doctors Report Fear of Malpractice Liability Has Harmed Their Ability to Provide Quality Care." The Harris Poll #22, 5/8/2002.

Thomas, Eric J., David M. Studdert, Helen R. Burstin, E. John Orav, Timothy Zeena, Elliot J. Williams, K. Mason Howard, Paul C. Weiler and Troyen A. Brennan. "Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado." *Medical Care* 38 (March 2000): 261-271.

Tillinghast-Towers Perrin. *U.S. Tort Costs: 2002 Update – Trends and Findings on the Costs of the U.S. Tort System.* New York, NY: Tillinghast-Towers Perrin, 2003.

U.S. Census Bureau. *Health Insurance Coverage: 2001.* Current Population Report P60-220. September 2002.

——. *Statistical Abstract of the United States: 2002.* Washington, DC: Government Printing Office, 2002.

U.S. Congress, Congressional Budget Office. "Cost Estimate for H.R. 5: Help Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act of 2002." 3/10/2003.

——. "Behavioral Assumptions for Estimating the Effects of Health Care Proposals." November 1993.

U.S. Congress, Office of Technology Assessment. *Defensive Medicine and Medical Malpractice.* OTA-H-602. Washington, DC: Government Printing Office, 1994.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. "National Health Accounts." 2003. Online at http://cms.hhs.gov/statistics/nhe/historical.

——. "National Health Care Expenditures Projections." 2003. Online at http://cms.hhs.gov/statistics/nhe/projections-2002.

U.S. Department of Health and Human Services, National Center for Health Statistics. *National Vital Statistics Report.* Various issues.

U.S. Department of Health and Human Services, Office of the Inspector General. *Managed Care Organization Nonreporting to the National Practitioner Data Bank: A Signal for Broader Concern.* OEI-01-99-00690. May 2001.

U.S. Department of Justice, Bureau of Justice Statistics. *Tort Trials and Verdicts in Large Counties, 1996.* NCJ 179769. Washington, DC: Bureau of Justice Statistics, 2000.

U.S. Department of Labor, Bureau of Labor Statistics. "Consumer Price Index." [March 2003]. Online at http://www.bls.gov/cpi/home.htm.

U.S. General Accounting Office. *Health Insurance: Characteristics and Trends in the Uninsured Population.* GAO-01-507T. March 2001.

——. *National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability.* GAO-01-130. November 2000.

——. *Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures.* GAO/HEHS-97-122. July 1997.

——. *Medical Liability: Impact on Hospital and Physician Costs Extends Beyond Insurance.* GAO/AIMD-95-169. September 1995.

Washington State Medical-Education and Research Foundation. *The Impact of Medical Malpractice Insurance and Tort Law on Washington's Health Care Delivery System.* September 2002.

HEARTBEAT

The "Pulse" of ALASKA STATE MEDICAL ASSOCIATION MEMBERS Volume 105 Nov/Dec 2003

Informed Consent
Recent Supreme Court Decision

A recent Alaska Supreme Court decision may impact how you provide informed consent.

Marsingill v. O'Malley (Supreme Court No. 5-9859, Opinion No. 5643, dated 11/22/02), according to several Anchorage defense attorneys, may provide for new standards for providing informed consent with a potential impact on the delivery of care in Alaska.

Attorney Howard Lazar wrote a letter to ASMA physician officers that expressed his analysis of this case, advice he would provide to physicians, and a suggestion that the issues raised be addressed by the Legislature.

The case, which was the subject of the decision, involved a call at night to a physician. The physician recommended that the patient go to the ER, but the patient chose not to go and subsequently lost consciousness and suffered permanent injuries. The basic issue was that a recommendation to go to the emergency room constituted a "treatment" and therefore needed appropriate informed consent. The most far-reaching corollary is that the Supreme Court stated that the informed consent must be in terms of what a "reasonable patient" would want to know about the treatment.

Mr. Lazar states in part, in his letter of 12/19/02, to ASMA's officials:

"...How does this affect physician's practice and what a physician needs to do from this point forward? First, we must start with the idea that the overwhelming support of your peers concerning the appropriateness of any advice you give to a patient will not be enough to prevent you from having to go through a trial concerning that advice. In every instance and for virtually everything you do, you must first look to what the mythical "reasonable patient" would want to know. That can apply to telephone conversations, conversations in the hospital, or conversations in your office with your patients. I believe the most immediate concern involves the same situation Dr. O'Malley was involved with here – the telephone call in the middle of the night. Unfortunately, what is lost in all of this is that it doesn't really look to what a reasonable physician would say to a patient when confronted with a complaint over the telephone. Virtually anything you tell the patient can be misconstrued, and if the patient decides not to follow advice you provide, you can conceivably be held responsible for that patient's failure to follow that advice. Regardless of the nature of the complaint, if you decide to take a telephone call, I recommend a graduated approach with the ultimate goal being for the patient to report to the emergency department virtually every time you receive such a call. I would provide the patient with all conceivable scenarios with the reported symptoms until the patient agreed to go to the emergency department. I would specifically include statements to the effect that there is a reasonable chance the patient could die or suffer serious bodily harm by failing to go to the emergency department. I would have a dictaphone available at all times to enable you to document for your records what actually transpired in any of those telephone conversations. The safest method might simply be to inform the patient at the commencement of the telephone conversation that you are recording the conversation for purposes of your records, and then simply placing the tape of that conversation in your medical record, with transcription only occurring in the event there was a dispute that developed over the contents of the conversation. This method would not work if you were away from the home or office.

Alternatively, I would instruct answering services to simply play a pre-recorded message to all patients who call to the effect that any complaint they have may be serious, cannot be diagnosed on the telephone, and that they should proceed immediately to the emergency department for evaluation by an emergency physician. Using that approach, no questions can possibly exist concerning what transpired within the confines of the telephone conversation and there can be no "acquiescence".

Both approaches lessen a physician's ability to have a meaningful interaction with his patient in the context of reported complications or symptoms. Both approaches may dramatically affect patient census in the emergency department and will undoubtedly cause unnecessary visits to the emergency department by patients who truly do not need to go. Eventually, this approach may cause patients to cease calling physicians giving the limited meaningful information they can be provided. Unfortunately, I cannot see any alternative given the court's decision...."

ASMA recommends that you contact both your professional liability insurance company and your attorney to seek guidance regarding "informed consent" in your practice in light of this decision.

The issues involved are important and ASMA is exploring ways, including legislation, to resolve them.

* * *

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PROFESSIONAL ISSUES

Where does money go in malpractice cases?

Quick View. Nov. 3, 2003.

In a typical tort case, costs are broken down this way:

Plaintiff attorneys	19%
Recovery (economic losses)	22%
Recovery (noneconomic losses)	24%
Defense attorneys	14%
Administrative costs	21%

Source: Tillinghast-Towers Perrin, as published in a study by the Center for Legal Policy at the Manhattan Institute, "Trial Lawyers Inc., a Report on the Lawsuit Industry in America 2003"

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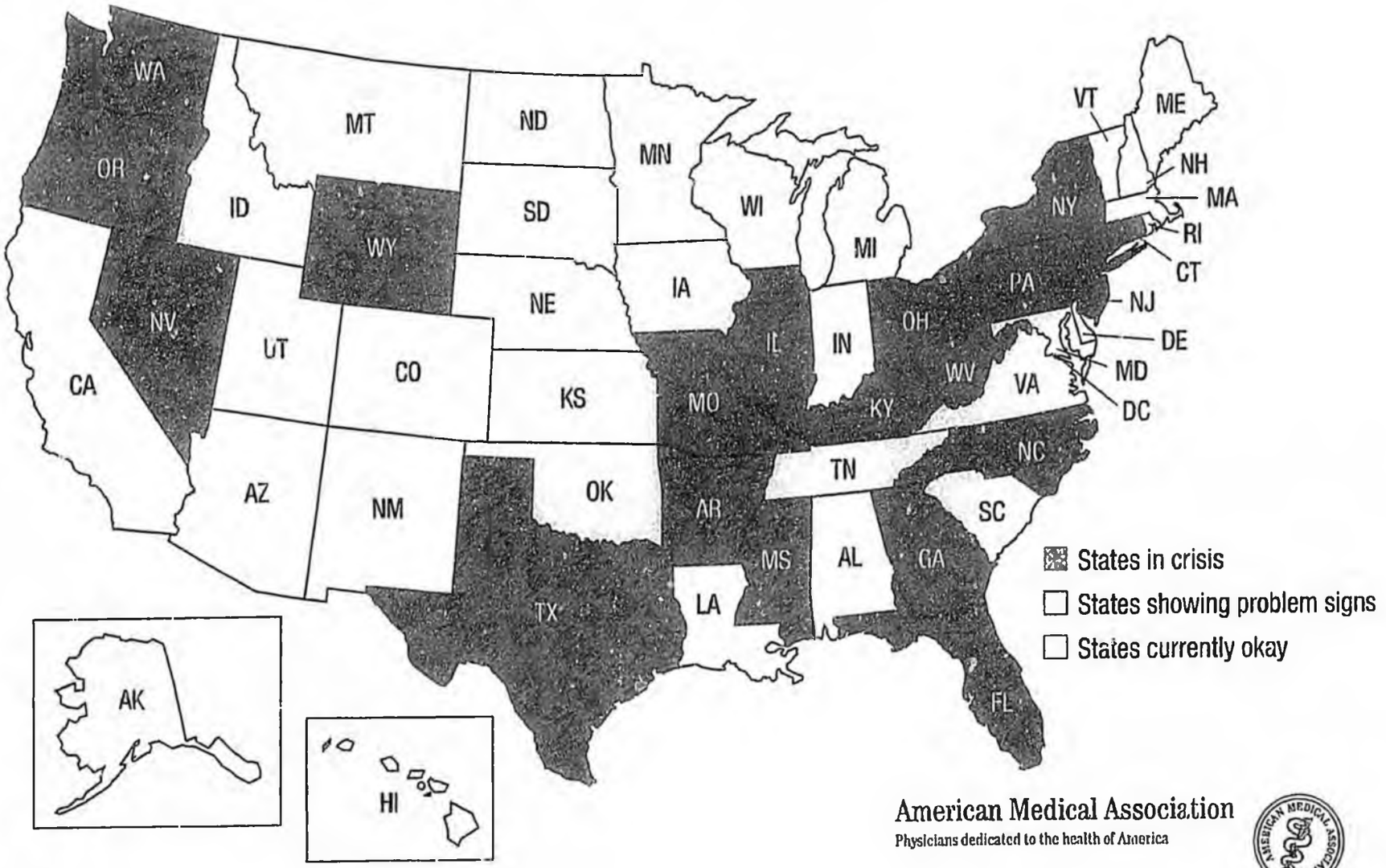
America's Medical Liability Crisis: A National View



American Medical Association
Physicians dedicated to the health of America

July 2003

AMA - Medical Malpractice Environment from a Practitioners Viewpoint
AMA has ranked the states in terms of their members ability to obtain Professional Liability coverage at an affordable rate –

States in Crisis –	States Showing Problem Signs	States OK
Arkansas	Alabama	California
Connecticut	Alaska	Delaware
Florida	Arizona	Indiana
Georgia	Delaware	Louisiana
Illinois	Hawaii	New Mexico
Kentucky	Idaho	Wisconsin
Mississippi	Iowa	
Missouri	Kansas	
Nevada	Maine	
New Jersey	Maryland	
New York	Massachusetts	
North Carolina	Michigan	
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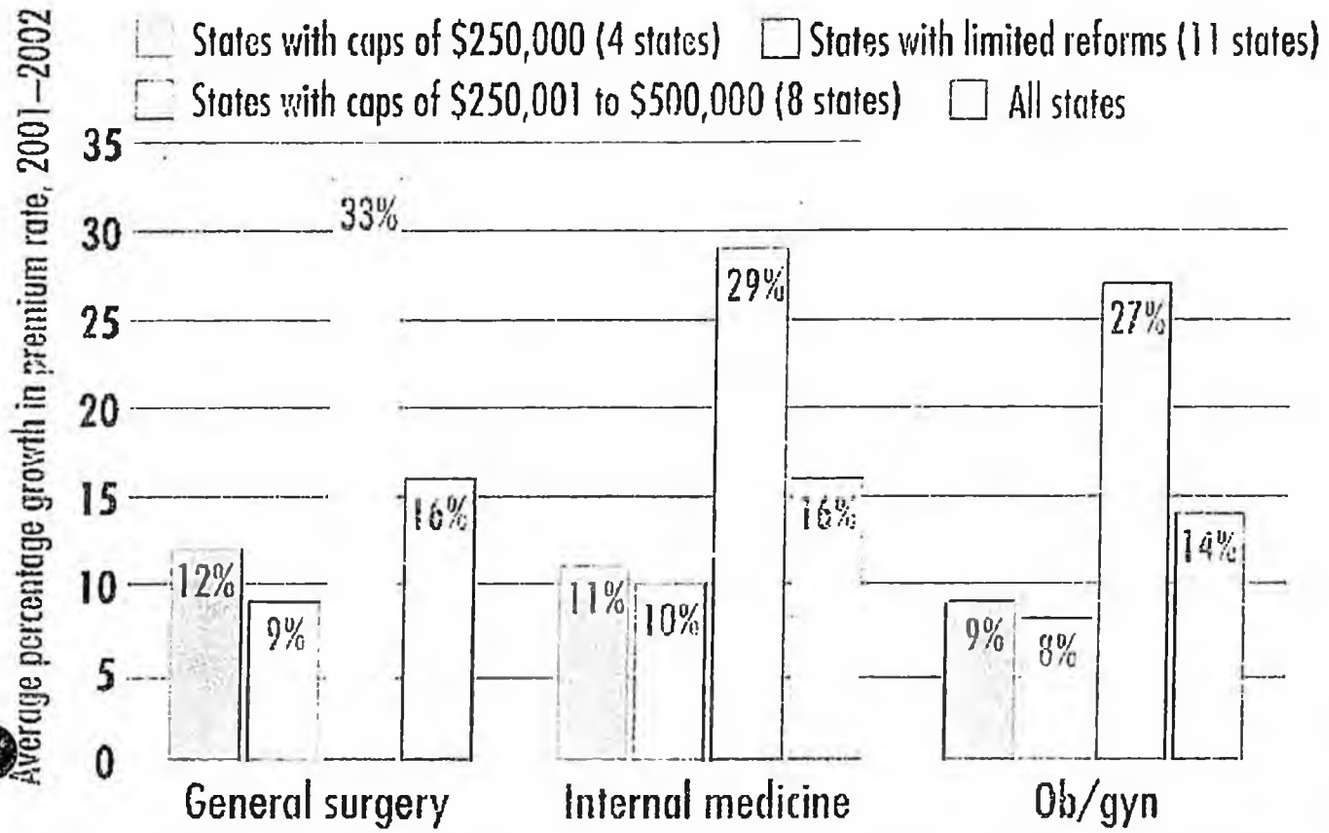
	South Dakota	
	Tennessee	
	Utah	
	Vermont	
	Virginia	

STATE TORT REFORMS SLOW PREMIUM GROWTH

Recent premium growth was lower for three physician specialties in states with noneconomic damage caps



Note: GAO analysis of Medical Liability Monitor base premium rates, excluding discounts, rebates and surcharges, reported for the specialties of general surgery, internal medicine and ob/gyn. Premiums are adjusted for inflation to 2002 drivers.

Source: General Accounting Office

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PROFESSIONAL ISSUES

Tort crisis spreads, few signs of abating

But reforms enacted in some states did provide a few bright spots in 2003.

By Tanya Albert, *AMNews* staff. Dec. 8, 2003.

Rallies to express outrage over medical liability insurance rates. Marathon legislative sessions debating tort reform. Countless calls and letters to lawmakers explaining that high rates and fewer insurers to choose from are detrimental for physicians already seeing low payments from Medicare, Medicaid and managed care.

It's been a busy year for physicians battling the medical liability insurance crisis. And doctors in many states say they are in a worse position as 2003 draws to a close than they were when the year started.

With this article
- Most states in or approaching a liability crisis
- Setting limits
- See related content
- Topic: Liability crisis
- Regional news: States

Local newspapers in Missouri, Illinois, Wyoming and other states carry stories about physicians closing their doors. The AMA added seven states to its crisis list, bringing the total to 19.

And next year is shaping up to be more of the same.

"Over this past year, the crisis, in regard to access to care for patients, has worsened," said AMA President Donald J. Palmisano, MD, who has spent the year crisis-crossing the nation stumping for tort reform. "Without meaningful reforms, the crisis will get worse, and patient access to care will continue to decrease."

5 states in 2003 enacted reforms with caps on

After seeing initial signs of such problems this year, Maryland, Wyoming, Missouri, Illinois and Kentucky fear that they are on the verge of even bigger headaches in 2004.

"Joliet, Kankakee, you name it. It's all over the

noneconomic damages.

state," said Illinois State Medical Society President William E. Kobler, MD.

In November, two neurosurgeons in Rockford, Ill., announced that they were giving up practice. A number of physicians have given up obstetrics, and anesthesiologists and neurosurgeons have stopped practicing in parts of southern Illinois.

Obstetricians and neurosurgeons in Missouri have seen the impact as well. In early 2003, there were 98 neurosurgeons practicing, said David F. Jimenez, MD, president of the Missouri State Neurosurgical Society. As he gears up for another study of the situation, he expects to find at least 10% fewer practicing in the state now.

"It's definitely affecting care," Dr. Jimenez said.

In Maryland, several insurance companies have left, obstetricians in rural areas are leaving, and the shore area has lost some of its most experienced OBs, said T. Michael Preston, Maryland State Medical Society executive director. For the first time, none of the graduates from the University of Maryland School of Medicine went into obstetrics, he said. Neither that school nor Johns Hopkins School of Medicine filled their OB residency slots on the first round.

19 states are in a medical liability crisis.

"We're on the cusp of a real crisis here," Preston said.

In Wyoming, the state Legislature-created Wyoming Healthcare Commission found that there hasn't yet been a mass exodus of physicians, but physicians are slowly and steadily leaving the state.

And in Kentucky, obstetrical care is increasingly difficult to find. Family physician Steven Sartori, MD, is part of an eight-physician group that had to give up obstetrics. They were the only physicians delivering babies at Knox County Hospital in Barbourville, which boasts a new nursery and new labor and delivery rooms.

"The place is beautiful, and now it's sitting empty," Dr. Sartori said. "Patients are having to drive farther for care."

Caps pass in five states

Physicians in 2003 saw an increase in the public's and lawmakers' awareness of the problems created when liability insurance becomes unaffordable or unavailable. And they succeeded in getting reforms that included caps passed in five states.

"It's a gain over the previous year when only three states passed a cap," said Kathryn Moore, director of state legislation for the American

College of Obstetricians and Gynecologists.

Texas passed comprehensive reforms that included the $250,000 cap on noneconomic damages that physicians say is essential to controlling costs. Voters then approved a constitutional amendment so that the law won't be subject to court challenges.

Legislatures in Idaho and West Virginia reduced existing noneconomic damage caps to the coveted $250,000 mark. Florida adopted a $500,000 cap for physicians in most cases, and Oklahoma established a $300,000 cap for care involving pregnant women and for emergency care.

Although tort reform doesn't mean instant relief, Texas doctors say they believe an end is in sight.

"Every physician in Texas got six inches taller," said Texas orthopedic surgeon David Teuscher, MD, vice president of the Jefferson County Medical Society.

"Physicians are practicing with a little more relief now," added Juan Jimenez, MD, a general surgeon from McAllen, who was active in getting Texas' tort reform passed.

On the 2004 agenda

Doctors will continue pushing tort reform at state and federal levels.

Legislative battles are expected in Maryland, Missouri, Connecticut, Washington and Kentucky, to name a few. And many are hoping for relief on the federal level because state laws make it too difficult to put meaningful reform in place. Several states need a constitutional change to enact a cap on damages. Others, such as Illinois, have a Supreme Court that has struck down reforms in the past and is nearly guaranteed to strike it down again.

A federal bill with a $250,000 cap passed the House in the spring, but a similar bill failed in the Senate. The AMA and others expect the bill to come back before the Senate in 2004.

"The pressure," Dr. Palmisano said, "is going to build to do something very quickly as states continue to melt down."

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ADDITIONAL INFORMATION:

Most states in or approaching a liability crisis

The American Medical Association this year added seven states -- Arkansas, Connecticut, Illinois, Kentucky, Missouri, North Carolina and Wyoming -- to its list of states that are in a medical liability insurance crisis, bringing the total to 19.

The Association in 2003 also elevated two states -- Hawaii and Rhode Island -- to the "showing problem signs" category. As the year draws to a close, that leaves six states that are considered to be "OK" because of tort reforms in place.

In crisis: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, Wyoming

Showing problem signs: Alabama, Alaska, Arizona, Delaware, Hawaii, Idaho, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia

Currently OK: California, Colorado, Indiana, Louisiana, New Mexico, Wisconsin

Source: American Medical Association

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Setting limits

The AMA considers a $250,000 cap on noneconomic damages essential to tort reform. Here's how state legislatures that enacted tort reform in 2003 handled these "pain and suffering" damages caps.

Florida adopted a $500,000 cap for individual physicians in most cases and a $1 million cap that one or more plaintiffs can collect against multiple physicians.

Idaho rolled back an existing $400,000 cap to $250,000. Starting July 1, 2004, that cap will be adjusted annually based on the average annual wage.

Oklahoma established a $300,000 cap for pregnancy, labor and delivery or immediate postpartum care cases; and emergency department care or follow-up medical services. It sunsets in five years.

Texas passed a $250,000 cap per claimant, no matter how many defendant physicians. Voters later approved a constitutional change that

makes the cap constitutional.

West Virginia reduced an existing $1 million cap to $250,000 for most cases. The limit will be adjusted annually for inflation up to $375,000 per occurrence.

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Worsening of Med Mal Market Expected to Continue in 2003 – Rate Increases Likely

by **Medical PL Symposium Recap Article**

Deterioration in operating profitability, weakened capitalization, inadequate loss reserves and greater retention levels continue to wreak havoc on the medical malpractice market, making it more challenging for those insurers willing to write new business, panelists told the PLUS Medical PL Symposium.

Victor T. Adamo, JD, president, ProAssurance Corporation, noted that premium increases and stricter underwriting decisions have added more pressure and more staff demands. "For the survivors in the business, there is the burden of constantly conveying bad news," he said. "Investments no longer provide a major advantage in long-tail lines. For reinsurers, it means more business and less relationship."

According to Adamo, rate adequacy is critical to companies avoiding price-driven markets and there are also regulatory barriers. "Unreasonable regulators are causing time-consuming approval and review processes."

Adamo explained that there is over $1 billion of displaced premium in the market and that it is unclear whether small start-ups may be able to grow surplus enough to make a meaningful contribution to capacity. "A financial crunch restricts capital growth."

Looking at hospital medical professional liability from the excess insurers' perspective, Judy Hart, executive vice president, Endurance Specialty Insurance, Ltd., said that volatility never seems to go away, but is increasing further. "Next to earthquake insurance, medical malpractice is the most dangerous line of insurance."

According to Hart, for 2003, there are further rating downgrades, additional retrenchment and withdrawal from the market and continued pricing and retention increases. "There is also new capacity and greater consideration of alternative options by clients with predictable loss exposure. Increased risk financing expenditures will cause greater clinical risk management and proactive claims defense."

Hart noted that the tort system is out of control. "Tort costs in the U.S. consumed two percent of GDP annually on average since 1990 and is expected to rise 2.4 percent of GDP by 2005," she said. "The tort system is extremely inefficient. Only 20 percent of the tort dollar compensates victims for economic losses and at least 58 percent of every tort dollar never reaches the victim."

Hart, who sees med mal as a market "correction" rather than a "crisis," said that the sophistication of the plaintiff's bar, a trial bar flush with cash and an erosion of tort reform to accept junk science have been factors driving severity. "There are some deep judicial 'pits' and a jury desensitization to 'deep pockets syndrome.' There are also some corporations that just do really dumb things."

In order to meet the challenges, Hart says first-rate underwriting and claims management knowledge are needed. "This is a great opportunity to learn from our mistakes. World class selling and negotiation skills are critical and health care specialists with technical expertise who can rise to the top will make a difference."

Matthew G. Fay, FCAS, MAAA, senior vice president, Converium, predicted that the medical malpractice market was going to get worse before it got better. "Loss ratios will continue to deteriorate," he said. "Reserve deficiency will wreak havoc on income statements and hurt companies. That's why it's so important to stay up to date."

Fay said that with the hardening of the market more reserve strengthening is on the way. "Increases on the primary side weren't enough and will continue to drive rates up higher," he said. "Without tort reform, there will be a more severe second round of rate increases. The industry has done a tremendous amount of work to get us back in place, but we have to pay more attention to rates."

Looking at the provider/captive market perspective, Anthony Mercurio, managing director, Marsh Healthcare Practice, said that there are differences in the hard market today than in the past that compound the problems. "In the past, most insurance buyers were imbedded in a cost-plus system. Today, it's not true. We're not going to be as elastic as we were in the past."

Mercurio said that there are alternatives in the market such as self-funding, group captives, PRUE captives and others. "While we're not immune from increased severity and lower investment returns on funded assets, ROI expectations are lower. In addition, many have engaged in a focused effort to reduce losses, most have lean budgets and have a camaraderie among their members that is very impressive."

Mercurio added that tort reform needs to be implemented at the grass roots level. "It has to start with doctors."

The panel was moderated by Paul A. Greve, Jr., RPLU, Senior Vice President at Willis Healthcare Practice.

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Medical Professional Liability - Not for the Faint of Heart

by **Deborah Ropelewski**

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

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

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

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

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

A SUSTAINED ESCALATION OF UNDERWRITING LOSSES

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

- A study done for the U.S. Department of Health & Human Services (HHS) dated July, 2002(3), indicates that the average award rose 76% in the period from 1996 to 1999. The median award increased 6.7% from 1998 to 1999, and another 43% in 1999-2000, or from roughly $750,000 to $1,140,000 in the two-year period from 1998-2000.

- The HHS study(3) notes that Jury Verdict Research data(3) reflects that the average jury award went from $1,140,000 in 1994 to $3,480,000 in 2000- a whopping 305% increase!

- The PIAA Data Sharing Project(4) illustrates that in 1985 less than 10% of all paid claims were

over $250,000; by 2001 the number had jumped to over 40%. Likewise, less than 5% of all paid claims in 1985 were over $500,000, but this had increased to over 25% by 2001.

A DECLINE IN INVESTMENT INCOME

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

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

- The average number of months from the date an incident occurs until trial had dropped from 61 months in 1994 to 45 months by the year 2000.

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

AN EPIDEMIC OF NATIONAL PROPORTIONS

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

The states "in crisis" share several key characteristics:

- These were states where the lead carriers exited the business – St. Paul, MIIX, PHICO, Frontier, Reciprocal of America/Doctors Insurance Reciprocal, etc.

- Many of these states have seen their claims severity magnified in the excess layers; a good example of this is Mississippi. The HHS Study indicates that before 1995, MS had no awards over $9,000,000. Since 1995, MS has had 21 verdicts at or over $9,000,000.

- These states have seen practice patterns changing as a result – the physicians are practicing more defensive medicine, MDs are abandoning high risk procedures, leaving the state, or even retiring from practice altogether.

EMERGING MARKETPLACE ISSUES

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

The companies that remain simply do not have the capacity to write all the business that is made available to them. Many that had enjoyed low Written Premium-to-Surplus ratios in the recent past now find their surplus stretched to an extent that they would have never thought possible, and much of that is just due to rating actions in the past few years that have significantly increased the written premiums on their existing books of business. This has been exacerbated by deteriorating results

due to development on prior years, and the companies have had difficulty in finding ways to increase surplus to finance additional premium growth. Primary insurers have returned to underwriting discipline and find themselves having to carefully and consciously allocate what surplus they do have available, if any.

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

SO WHAT IS THE REINSURERS' RESPONSE?

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

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

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

- One-year contracts only. After 9/11, multi-year contracts, even those with provisions for annual re-negotiation, quickly became unavailable.

- Increased "Per loss" and "Clash" retentions.

- Reduce (or even eliminate) coverage for ECO/XPL losses – i.e. if they were covered at 90% in previous contracts, that is reduced to 80% or even lower.

- Imposition of aggregate limits of liability or loss ratio caps.

- Flat rate contracts moved to loss-sensitive rating mechanisms, with a Provisional Premium expressed as a percentage of the underlying premium charged initially; subsequently premium is adjusted based on the actual experience in the reinsurance layer.

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

In conclusion, the key reinsurers that are dedicated to the Medical Professional Liability industry have made a renewed commitment to underwriting and pricing integrity and discipline over the past few years. One of their primary responsibilities going forward will be to monitor and evaluate the ongoing financial viability of their reinsureds, as reflected in responsive rate actions, their loss projections based on prior years' losses, and investment income assumptions, among other

measures. Given the current climate and experience in our industry it is unlikely that the MPL reinsurance market will become significantly less restrictive in the near future.

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

END NOTES:

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

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The Rising Cost of Medical Malpractice Claims – A Look behind the Numbers

by **Dawn Dinkins**

It has been well publicized that jury awards in medical malpractice suits have skyrocketed in recent years. The trend toward rising awards is supported by the 2000 Edition of Jury Verdict Research's Current Awards Trends in Personal Injury, which indicates that the median medical malpractice award increased from $500,725 in 1997 to $800,000 in 1999, an increase of 60%. 45% of awards are now over $1,000,000. Settlements showed a similar trend, with median settlements climbing from $400,000 in 1997 to $650,000 in 1999 - a growth of over 60%. According to the study, median awards were highest in childbirth cases ($2,000,000), medication error cases ($636,844), and failure to diagnose cases ($625,000). Even more alarming is the fact that the award mean almost doubled from $1.9 million in 1997 to $3.4 million in 1999. There is no question that loss severity in medical malpractice claims has increased significantly, even though frequency for the most part has remained flat. However, identifying the reasons why awards are so much higher is difficult. Experts point to several factors, such as managed care, the nursing home crisis and public attitudes as some of the reasons behind the escalating severity.

Managed Care: The conversion to managed care has profoundly affected the loss results in medical malpractice. According to a new study by Conning & Co., "Medical Malpractice Insurance, A Prescription for Chaos 2001," the short answer as to what is behind the increasing verdicts is managed care. The study indicates that the shift in health care delivery to cost-contained managed care has moved medical malpractice from "a world dominated by committed medical acts to one of omitted ones." Claims for alleged failure to diagnose are one of the leading causes of action today. Increased outpatient treatment under managed care has placed more responsibility on patients to ensure that they are taking the appropriate medication. This has shifted the burden away from healthcare professionals and has resulted in increased large losses for medication errors.

Another significant driver of adverse loss trends is the erosion of communication with patients within all sectors of the healthcare system. Primary care physicians are pushed to see more patients, negatively impacting the quality of care. The loss of intimate relationships between patients and their doctors due to the limited time being spent during visits has contributed to the increased number of suits for failure to diagnose and medication errors. Studies have shown that physicians who spend more time with their patients are less likely to be sued. However, since increasing the time spent with each patient decreases the number of patients that can be seen, it is unlikely that many physicians whose incomes are suffering as a result of managed care will change their ways.

Nursing Homes and Hospitals: According to the Conning & Co. study, nursing homes have experienced what may be the medical malpractice equivalent of the "perfect storm." Florida has been especially problematic, with loss costs per occupied bed rising to $6,283 in 1999 - eight times the national average of $809 (source: 2001 AON Worldwide Actuarial study of nursing homes.) The same study indicates that the average size of a nursing home claim in Florida in 2000 was $455,000, three times higher than the rest of the country. Texas was a close second with an average value of $399,000. (The average value for the rest of the country was $112,000.) Verdicts have been stunning, with awards easily topping the eight to nine figure range. Legislative changes such as establishing minimum quality of care standards and strong patient's bill of rights, (Florida and Texas), difficulties in attracting and retaining qualified staff, and the easy availability of Internet access to information about nursing homes and physicians' medical malpractice histories have fueled the frequency and severity of losses. There is already evidence that the problems of Florida

and Texas are spreading to other states like California, Arkansas and Mississippi. With the aging population, the negative publicity surrounding nursing homes and aggressive trial lawyers, nursing home losses will continue to be a veritable "black hole" for medical malpractice insurers.

While nursing homes have experienced rapid increases in verdict/settlement values, hospitals are also experiencing similar difficulties. A study done by the Medical Underwriters of California in 1999 found that despite a cap of $250,000 for non-economic damages, there was a record high thirty-eight awards or settlements of $1 million or more. Thirty-one of those cases arose from incidents involving hospitals. The average indemnity loss was $4,047,341, which was more than double the average of the prior year of $1,227,536. Hospitals are targets by trial attorneys due to the higher limits they typically carry, making them a "deep pocket." Most physicians do not have coverage of more than $1,000,000; thus trial attorneys will seek to involve the hospital in the hopes of tapping the larger policy. The Conning & Co. study also notes that hospitals face growing exposure due to the increased use of emergency rooms as replacements for primary care physicians for many patients. This has shifted the focus of medical malpractice claims from physicians to ERs.

Public Attitude: Jury attitude toward the medical community is perhaps the most obvious factor influencing the size of verdicts. This is due in part to the negative public perception of managed care and the publicity generated by large medical malpractice verdicts, which have made the public aware of the vulnerability of health-care professionals. Some juries appear to be replacing the applicable standard of care with an expectation of perfect care, feeling that physicians should be able to diagnose and treat all medical conditions regardless of a patient's prior history or lack of symptoms. However, on a more fundamental level it is clear that juries today have become desensitized as to the value of $1 million. Multi-million dollar verdicts are more common today and are on the minds of jurors when deciding damages.

While verdicts are high and the factors driving severity costs are not easily solved, insurers can mitigate the cost of medical malpractice claims through aggressive use of alternative dispute resolutions. The use of mock juries and shadow juries can be a useful tool in the evaluation of damages and defense strategies. Strong communication with insureds during the life of the claim is crucial and will go a long way toward achieving good resolutions. However, adhering to strict underwriting guidelines will weed out many problematic risks and therefore prevent these claims from occurring – the best way for insurers to limit their exposure.

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Greater Risk Control Measures, Tort Reform Will Improve Hospital Professional Liability Market

by **Medical PL Symposium Recap Article**

Dramatically higher premium increases and risk retention requirements have added financial pressures to an industry segment that is already strained. Facilities are going bare, self-insuring or reducing limits of coverage. It is only through greater risk control measures, prudent underwriting and tort reform that hospital professional liability will recover, panelists told the PLUS Medical PL Symposium.

James D. Hinton, vice president, Risk & Insurance, HCA, Inc., noted that the physician malpractice crisis has had a tremendous impact on hospitals. "Hospitals are requested to lower or eliminate insurance requirements and more physicians are going bare in Texas and Florida," he said. "Physicians are relocating, retiring early or curtailing their practice," he added. "Hospital recruiting costs are up, service cutbacks are being made in some situations and employment of physicians is trending up again."

According to Hinton, the market has seen dramatically higher retentions, a formation of new captives and risk retention groups and insurance costs rising faster than hospital revenues. "For buyers, there is a tremendous amount of frustration," he said. "There is little evidence of underwriter judgment and little differention of risks. In addition, there are too many data requests, which are often irrelevant and there is diminished value of long term relationships."

Hinton noted that the crisis in the medical malpractice market is not an insurance problem. "They're not at fault. It is the legal system and astronomical jury awards that need to be addressed."

Going forward, the outlook for HPL underwriting should be positive, Hinton said. "Loss results will improve because of patient safety initiatives, a renewed focus on loss prevention and tort reform. Severity is impacting the market. That's where tort reform can make a huge difference for hospitals."

Using Ohio as a paradigm of what is happening in the med mal market throughout the country, D. Brent Mulgrew, J.D., executive director, Ohio State Medical Association, noted that malpractice insurance rates in Cleveland are among the highest in the nation. "Physicians are frustrated," he said. "They feel the system has been unresponsive and mismanaged. We all are potential patients. If we fail, the system will crash."

According to Mulgrew, the impact has resulted in increased expenses. "Revenue remains flat to declining. There has also been a decreased access to patient care. Ninety-six percent of doctors are discontinuing some procedures, 15 percent are leaving for less litigious areas and 51 percent are quitting the practice altogether."

Mulgrew noted that the passage of SB 281 may help. The bill, which limits non-economic damage awards in the vast majority of cases to $350,000, also requires attorney contingency fees to be reviewed by a probate court if the fees exceed the non-economic damage awards. "SB 281 removes joint and several liability. In most cases, a physician who is named in a suit will only be held liable for the portion of the claim for which the doctor may be responsible."

Mulgrew said that SB 179 also provides a broader base of peer review protections and allows

health care entities outside the traditional hospital setting to establish peer review committees. "The activities are protected from discovery during litigation."

The impact of these bills, according to Mulgrew, will not mean a reduction in rates or trends. "There will be a selective underwriting of risks and specialties and a creation of new non-standard market options."

Looking at the long-term care liability impact, Michael R. Walton, president, AMWINS HealthCare, noted that liability insurance availability and affordability issues are severe. "There is a continued aggressiveness of plaintiffs' attorneys in soliciting cases and extraordinary jury awards."

According to Walton, the "broad brush" underwriting approach being used is inappropriate. "Many suffer for the sins of a few," he said, adding, "risk assessment tools and methodologies are inaccurate, faulty and subjective. Base rates are set according to geographical location, facility size, and percentage of more acute residents. Minimal or no consideration is given toward the level of quality care orthe type of ownership."

Walton noted deficiencies in hospitals include failure to follow physicians' orders, failure to treat, physical or verbal abuse, medication error, failure to monitor adequately and failure to diagnose. He said there are also concerns with the analysis and accuracy of Online Survey, Certification and Reporting (OSCAR) data. "Simple counts of survey deficiencies can be misleading unless the scope, severity and type of each deficiency is considered," he said. "In a recent analysis of 16,698 OSCAR assessments, six percent of facilities report total census numbers not equal to the total number of residents calculated from other OSCAR items."

Walton said that there are better ways to measure quality and risk. "OSCAR analysis can be improved by using geographical adjustment, severity adjustment, focus on litigation risks and other methods," he said. "We need to utilize advanced methods of assessing, managing and defending the long-term care quality and associated risk and we need to eliminate the subjectivity in the data. We are making advancements with underwriters in this area."

The panel was moderated by Sarah Lawhorne, Esq., deputy insurance commissioner of Pennsylvania.

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Emerging Trends In Medical Professional Liability

by **Edwin Scherlis**

INTRODUCTION

As we enter the new millenium, we note that the traditional lawsuits against doctors for medical malpractice are not only increasing, but other healthcare providers and related entities are being drawn into the fray.

We note with considerable interest that managed healthcare has become so prevalent in most areas that the health maintenance organizations ("HMOs") are being named as defendants by injured claimants along with the doctors and the hospitals. The HMOs have attempted to limit the scope of their liability by pleading that ERISA, the federal statute relating to job-related benefits, should supersede state law as we know it. At this point, these attempts have been failing and the courts have ruled that claims relating to the quality of medical care do not fall within the scope of ERISA. The HMOs and other managed care entities have arguably invited the constant attack where medical malpractice has occurred because of their advertising ("We hire only the best and most competent physicians..."), their capitation agreements (doctors are forced to see too many patients...), and bonus agreements (save money on referrals and diagnostic tests and share in the savings at the end of the year...). Because the people, who are developing an animosity toward the HMOs, sit in our juries, we can anticipate verdicts directly against the managed care providers in the future.

Who among us has not seen the statistics reflecting the "aging of America." The growing number of geriatrics in our society will not only place a strain on our Social Security system, but will require an enormously expanded health system in the nature of nursing homes, hospices, assisted living facilities, convalescent homes, and the like. With the growth of these residential care units comes the need for qualified staffing, competent medical care, and active paramedical care. It, therefore, follows that accidents and mistakes will increase and this will expand the number and type of claims and lawsuits filed against these facilities. We are witnessing this trend already.

The law relating to the duties and obligations of nursing homes and similar facilities is now developing beyond the simple "duty of reasonable care." Medicare patients are entitled to certain protections as set forth in the federal statutes. Each state has statutes, rules, and regulations which must be followed by the personnel at each facility. Superimposed upon these obligations are the obvious facts that the residents of these facilities require significant care and monitoring but that staffing problems invite mistakes and malpractice.

The liability of hospitals has similarly been expanded by many courts. While at one time those physicians with staff privileges at hospitals were obliged to bear responsibility alone for acts and omissions committed on the hospital premises, hospitals now face corporate liability independent of that of the physician for negligent acts which take place within its four walls. In many instances, the hospital has become almost a guarantor of the quality of care to be provided by the physician.

The concept of liability rising out of "informed consent" cases is similarly on the rise. In situations where the best medicine was practiced, a physician may still face liability if the patient can prove that there was some risk or alternative which was not discussed prior to the procedure. In addition, the nature of activity that requires informed consent has been expanded. At one time it was limited to surgical procedures but has now been extended to blood transfusions, angiography, and other

procedures which are traditionally non-surgical.

While the basic legal requirements necessary for a successful plaintiff remain the same (duty-breach-damages), the manner in which the claimant can reach the jury has been eased by the court. At one time the plaintiff had the burden of proof of demonstrating that the patient would have refused the operative procedure had all risks been known. Now, the healthcare provider faces responsibility for all problems relating to the surgery, whether it was performed properly or not, even when the material risks were not discussed with the patient beforehand. The patient need not testify that he or she would have refused the treatment.

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Turmoil in the Medical Malpractice Insurance Market

by **Paul Greve, Jr., JD, RPLU**

The medical malpractice insurance industry has been in a state of turmoil in the last two years. Premiums have skyrocketed for institutional and individual providers thereby affecting the delivery of health care services in a number of states. Not since the 1970s have the national news media devoted so much coverage to the subject of medical malpractice. There have been featured reports on the network evening news, articles in the Wall Street Journal, USA Today, and other major newspapers, and periodical coverage in publications such as Forbes and U.S. News & World Report. Physicians have organized widely reported demonstrations in support of tort reform in Ohio, Florida, and Texas.(1)

Nationally, soaring verdicts and settlements have caused a significant deterioration of many carriers' results. Jury attitudes and the failure of tort reform in the majority of states have contributed to the poor results. The product was underpriced in the mid-to-late 1990s simultaneous with the rise in claim severity.(2) Investment income is down significantly since the mid-1990s, thereby exacerbating the pressure on carriers' bottom lines. Reserve redundancy has been virtually eliminated as a method to improve results, with a number of carriers needing to strengthen reserves. Medical malpractice insurance is the worst performing line of property/casualty insurance, according to A.M. Best.(3) The industry's combined ratio was 139% in 2001 and projected to go higher in 2002.(4)

The medmal insurance industry's struggles were highlighted when the largest writer of malpractice insurance by premium volume, St. Paul, announced its withdrawal in December 2001. PHICO, once a major player nationally, was placed in liquidation by Pennsylvania regulators in February. The elimination of these two carriers caused a marked reduction in capacity, especially at the primary insurance level. A number of other malpractice carriers have received significant ratings downgrades by A.M. Best since the beginning of this year, including SCPIE, MIIX, and ROA. Those carriers still able to write new business became swamped with potential new account volume and some have had to curtail their underwriting due to an imbalance of premium to surplus. Over the last few years there has also been more turnover in the executive suites of malpractice carriers than ever before.

Hospitals and physicians have found coverage difficult to find and very expensive in certain states, particularly: Nevada, West Virginia, Pennsylvania, Florida, and Texas, among others. Certain physician specialties have been more severely impacted by adverse national loss trends, such as emergency medicine, obstetrics, and radiology. Primary care physicians have seen many claims alleging failure to diagnose. There have been bona fide reports of curtailed services, especially deliveries in rural areas, due to the cost of malpractice insurance.(5) The AMA has published a list of twelve states where physicians are leaving the practice of medicine, taking early retirement, or discontinuing high-risk services: Washington, Oregon, Nevada, Texas, Mississippi, Georgia, Florida, West Virginia, Ohio, Pennsylvania, New York, and New Jersey.(6) Institutional insureds have been dramatically affected, especially nursing homes. Coverage for nursing homes is very difficult to find and more expensive than other segments of medical malpractice insurance.(7)

Malpractice insurance carriers have responded in a number of ways in an attempt to restore profitability. These include withdrawal from this line of insurance, double to triple digit rate increases, restrictive underwriting of certain classes of business and in certain territories, raising

attachment points/mandating deductibles, and offering lower limits of liability.

In the 1970s and 1980s, malpractice insurance industry results improved with tort reform initiatives and rate increases. Many industry experts are not as hopeful for tort reform in 2002, due to the political power of the trial bar and a judiciary that has often ruled unfavorably on the constitutionality of such legislation. Without tort reform, it will be very difficult for carriers to know that the premiums charged in 2002 will be adequate to pay claims over the typical 3-5 year time frame for malpractice claims resolution. There currently is a federal tort reform bill that was introduced in Congress in April. It is modeled on California's MICRA legislation, especially a $250,000 cap on pain and suffering.(8) The bill faces the significant hurdle of passage by a Democratic-controlled U.S. Senate.

If we try to use a crystal ball and project future industry trends, what are some of the negative and positive factors medical malpractice carriers must face?

Negative Factors

Rate Adequacy. Only time will tell whether the substantial rate increases being taken will restore profitability in the long term. There is at least some concern that they are being offset by the dramatic rise in the number of large awards and settlements.

Jury Attitudes. Juries appear to be far less reluctant to give large awards due to such societal influences as lottery winnings and sports salaries. There has also been the negative influence of publicity about medical errors. Thus, the industry faces the recent and unprecedented problem of "frequency of severity": The rapidly escalating number of large awards.

The Failure of Tort Reform. Very few states have a favorable tort climate due to the absence of legislation or case law overturning tort reform. The prospects for federal tort reform are not promising in the near term.

Inadequate Medicare/Medicaid Reimbursement. Nursing homes and hospitals struggle with providing adequate staffing while physicians may try to increase patient volume. Both scenarios can potentially reduce patient safety. Inadequate reimbursement squeezes insureds at the same time that their expenses soar from increased malpractice premiums. Less money is also available for needed patient safety initiatives.

Rapidly Rising Health Care Costs. These are again rising much faster than inflation, and affect indemnity payments to injured patients.

Migration to the Plaintiff's Bar. Many rising stars in defense firms have left to go to the plaintiff's side where they need not keep track of their billable time nor seek permission for travel to depositions, etc. The potential for large awards with 40-50% in fees to the plaintiff's lawyer is a huge incentive to switch sides. The scarcity of capable defense lawyers could become a serious issue in the future.

Positive Factors

The Cyclical Nature of Medical Malpractice. Certainly there have been peaks and valleys since the mid-1970s, and the industry results were actually substantially worse in the mid-1980s than today. Medical malpractice then became the most profitable line of property-casualty insurance. History would seem to indicate that profitability could be restored in time.

Renewed Emphasis on Pricing, Terms, and Conditions. Many carriers lost this discipline in the 1990s in an effort to obtain market share. It is hoped that mandatory deductibles and higher attachment points will require providers to increase their efforts to reduce patient injuries. More providers will consider some degree of self-insurance than ever before, voluntarily or involuntarily.

The Influx of New Capital. The number of new companies entering this line is encouraging. Most are providing additional reinsurance and excess lines capacity, although they are being selective as to new business and attachment points. Ease of entry is a factor here since primary insurance

requires far more of a commitment in the way of resources and regulatory compliance. Some of these markets have stated an intention to enter the primary insurance market in time.

Frequency Is Flat. Loss costs are being driven by severity. Jury Verdict Research reported a 43% rise in the median medical malpractice award between 1999 and 2000, hitting the highest median ever of $1 million.(9) There does not appear to be any significant national increase in claims volume.

Renewed Efforts at Tort Reform. Carriers are increasing their efforts and are being joined at the state and national level by health care industry organizations with significant clout, such as state medical societies and hospital associations, the American Medical Association and the American Hospital Association. The argument that must successfully be made to federal and state legislators is that the lack of tort reform in many states will adversely impact the availability and affordability of health care services such as obstetrics and trauma.

Increased Focus on Patient Safety. The future has never been more promising for proven risk management initiatives. Evidence-based patient safety standards and emerging technologies, such as the use of bar coding for medication administration or computerized physician order entry, hold the promise of reducing the incidence of patient injuries.

Many in the malpractice insurance industry think that a return to stability is at least two years away. While the two most critical factors in restoring stability may be adequate pricing and tort reform, all carriers will be influenced in some way by these negative and positive factors over the next two years.

FOOTNOTES:

1. BestWire Services, "More than 1,000 Rally in Florida for Med-Mal Bill", A.M. Best News, 7/16/02.

2. Zimmerman, R. and Oster, C., "Insurers" Price Wars Contributed to Doctors Facing Soaring Costs", Wall Street Journal, June 24, 2002, p. 1.

3. Chordas, Lori, "A Downward Spiral", Best's Review,August 2001, pp. 65-69.

4. Taylor, M. "Cashing in on a Crisis", Modern Healthcare, June 10, 2002, pp. 30-32.

5. Friess, S., "Malpractice Gets Costlier", USA Today, April 9, 2002, p. 7D.

6. Marcus, M.B., "Healthcare's Perfect Storm", U.S. News & World Report, July 1, 2002, pp. 39-40.

7. Author Unknown, "Well Capitalized, New Capacity is Needed to Overcome Financial Crisis in Long-Term Care Market", PLUS Journal, May 2002, pp. 12-13.

8. Lovern, E., "A Good Time for Reform?", Modern Healthcare, April 29, 2002, p. 12.

9. Albert, T., " Liability Insurance Crisis: Bigger Awards Just One Factor", American Medical Association News, April 15, 2002, pp. 1-6, May 1, 2002, amednews.com

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GOVERNMENT & MEDICINE

Texas tort reform vote signals lower liability rates

Physicians believe a constitutional amendment will ease the state's medical liability crisis.

By Damon Adams, *AMNews* staff. Oct. 6, 2003.

Passage of a Texas medical malpractice ballot initiative appears likely to produce the impact physicians desired -- a decrease in liability premiums. And doctor groups hope that the measure's success will spur similar action in other states.

"It's going to send a message all over the nation that it can be done. This will give greater impetus to other states," said AMA President Donald J. Palmisano, MD. The AMA contributed $100,000 to support the initiative, called Proposition 12.

With this article
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The measure amends the Texas Constitution to allow caps on noneconomic damages in medical malpractice lawsuits. Within days of the vote, some insurers announced plans to reduce liability insurance rates.

For example, Texas Medical Liability Trust, the state's largest medical liability insurer, said it would cut premiums 12% beginning Jan. 1, 2004.

"We believe the 12% [reduction] is really just the start," said W. Thomas Cotten, president and CEO of physician-owned TMLT, which has about 10,800 policyholders. "Hopefully, the number of carriers will increase so there will be more sources of competition. With that competition, carriers will need to reduce their rates."

The Doctor's Company, a medical liability insurer based in Napa, Calif., plans at least a 12% reduction on $1 million policies in Texas, said Richard E. Anderson, MD, company chair. With 2,000 physician policies in the state, the insurer is looking at other potential savings to doctors and hopes to write more policies, he said.

"I guarantee the rates will be lower than they otherwise would have been," Dr. Anderson said.

State Rep. Joe Nixon said insurers' premium cuts would save doctors about $100 million a year.

Now that the amendment has passed, state leaders said, some doctors will feel secure enough to go back to practicing high-risk procedures. Medical students and practicing doctors will be less likely to leave Texas, said Charles W. Bailey Jr., MD, president of the Texas Medical Assn. and a Houston plastic surgeon.

"The real winners of this election are the people of Texas, who can be more certain that their doctor will be there for them when they're sick or injured," he added.

But opponents of the measure said it strips juries of their power and gives it to special interests. They are watching to see if insurers follow through on promises to lower rates.

"There is no guarantee that's going to happen," said Abby Sandlin, deputy director of Texas Watch, a group that is part of Texans Against Proposition 12. "We've had empty promise after empty promise from insurers over the decades. Now is the time they are going to have to put up."

The Medical Protective Co. in Fort Wayne, Ind., is still exploring whether to change its rates.

"We are assessing the impact this will have on our rates," said John Novaria, spokesman for the company, which has 7,000 physician policyholders in Texas.

Heading off a legal challenge

Earlier this year, the Texas Legislature passed a law placing a $750,000 cap on noneconomic damages in medical malpractice lawsuits. It limited an individual physician's liability to $250,000.

Knowing the law would face a legal challenge, legislators called for a ballot measure, Proposition 12, to ratify the Legislature's cap on noneconomic damages in civil lawsuits. A similar cap was passed in 1977, but after a legal challenge, the Texas Supreme Court found it unconstitutional.

Some liability insurers already plan to

Supporters and opponents of Proposition 12 waged media campaigns to woo voters. The two camps spent more than $13 million on television commercials and mailings. About 12% of Texas' 12 million registered voters cast

cut rates 12%.

ballots Sept. 13. The measure passed narrowly, with 51% supporting it and 49% opposing it.

Supporters said the amendment means the cap would survive any legal challenge.

"I'm extremely relieved we came out on the positive side of it. It was a very intense media campaign," Dr. Bailey said. "The key thing is it will at least hold premiums at their current level so we can stop this escalation."

The passage of Proposition 12 will benefit Texas' liability insurance market in other ways, proponents said. "The stability in the state will allow other medical insurers an opportunity to come sell their policies in Texas," said Nixon, who sponsored the legislation on damage caps.

Since the vote, the Texas Dept. of Insurance said no insurers had contacted the agency about coming back to a state that once had 17 medical liability insurers and now has only a handful left. That likely will change.

"We fully expect that companies will return to Texas," said department spokesman Jim Hurley.

But for some doctors, it's too late.

"The doctors that already left or have gone out of practice will not go back into practice," said David Schneider, MD, president of the Texas Academy of Family Physicians. "Once you've made that decision to change your life, you won't come back."

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ADDITIONAL INFORMATION:

Voters have spoken

The ballot question for Proposition 12: "The constitutional amendment concerning civil lawsuits against doctors and health care providers, and other actions, authorizing the Legislature to determine limitations on noneconomic damages." The results:

In favor: 51%
Against: 49%
Statewide voter turnout: 12.2%

Source: Texas Secretary of State

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Texas Medical Assn. information on Proposition 12
(www.texmed.org/prop12/yes.asp)

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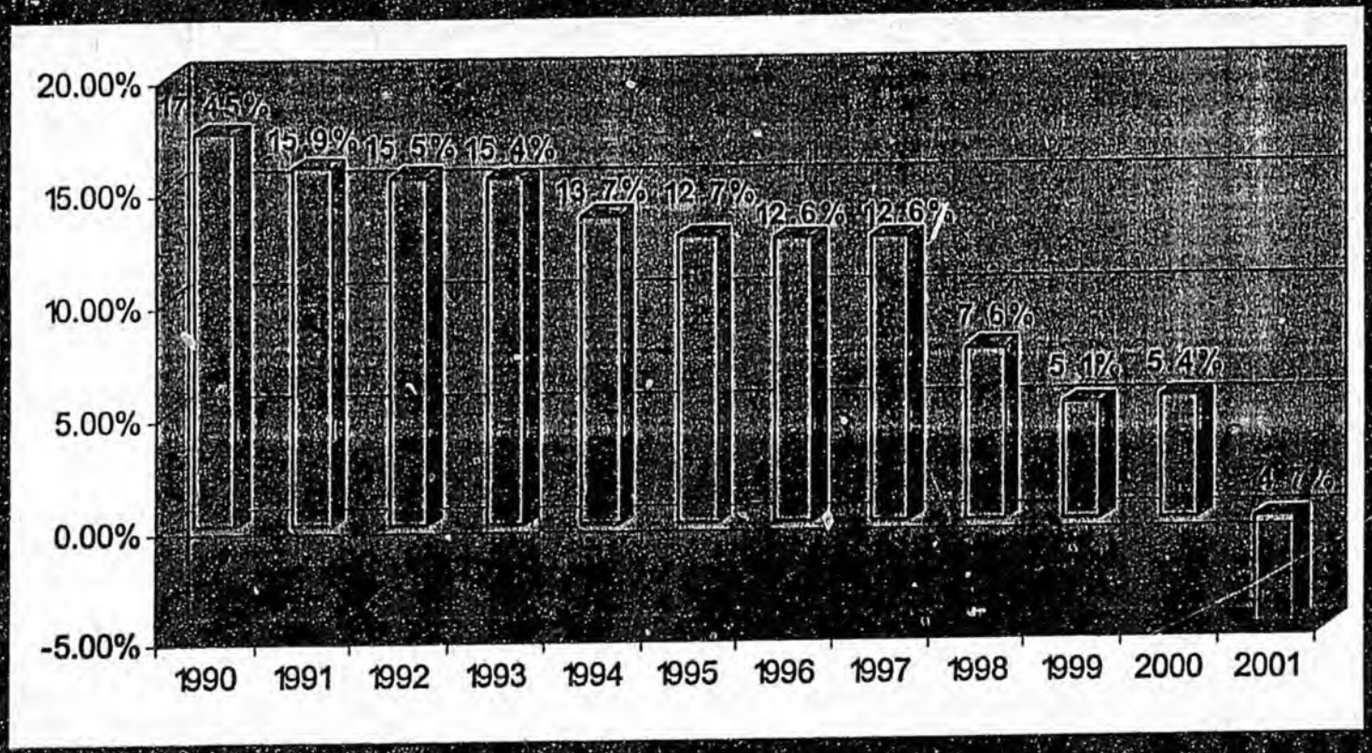

Source: U.S. General Accounting Office analysis of National Association of Insurance Commissioners Data

Malpractice Premium Comparison by State

1970	California	Florida	Nevada	United States
Total premium	$228,451,000	$18,357,000	$1,978,000	$1,182,000,000
1970 Pop.	19,971,069	6,791,418	488,738	203,302,031
% US Pop.(1)	9.8%	3.3%	0.2%	100.0%
% US Premium	19.3%	1.6%	0.2%	100.0%
Premium /Person	**$11.44**	**$2.70**	**$4.05**	**$5.81**
1980				
Total premium	$629,448,000	$173,522,000	$3,311,000	$3,435,000,000
1980 Pop. (2)	23,667,764	9,746,961	800,508	226,542,199
% US Pop.	10.4%	4.3%	0.4%	100.0%
% US Premium	18.3%	5.1%	0.1%	100.0%
Prem. Dollars (3)	$327,312,960	$90,231,440	$1,721,720	$1,786,200
% Change Prem. Dollars (3)	43.3%	391.5%	-13.0%	51.1%
Premium /Person	**$26.60**	**$17.80**	**$4.14**	**$15.16**
Premium /Person (3)	**$13.83**	**$9.26**	**$2.15**	**$7.88**

Source: NAIC Insurance Company Profitability Reports 1976 to 2000; US Census; CPI Calculator

(1) 1970 Census
(2) 1980 Census
(3) Adjusted for Inflation per CPI
(4) 2000 Census

Malpractice Premium Comparison by State

	California	Florida	Nevada	United States
Total Premium	$609,712,000	$505,535,000	$508,000,000	$5,549,552,000
Population	33,871,648	15,982,378	1,998,259	281,421,906
% US Pop. (4)	12.0%	5.7%	0.7%	100.0%
% US Premium	11.0%	9.1%	9.2%	100.0%
Prem. Dollars (3)	$201,204,960	$166,826,550	$167,640,000	$1,831,352,160
% Change since 1976 in Premium Dollars (3)	**-11.9%**	**808.8%**	**8375.2%**	**54.9%**
% Change since 1986 in Premium Dollars (3)	**-38.5%**	**84.9%**	**9636.8%**	**2.5%**
Premium/ Person	**$18.00**	**$31.63**	**$254.22**	**$19.72**
Premium/Person (3)	$5.94	$10.44	$83.89	$6.51
% Change in Premium/Person	**-51.9%**	**386.2%**	**2072.9**	**111.9%**

Source: NAIC Insurance Company Profitability Reports 1976 to 2000; US Census; CPI Calculator

(1) 1970 Census
(2) 1980 Census
(3) Adjusted for Inflation per CPI
(4) 2000 Census

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PROFESSIONAL ISSUES

Physicians feel double-digit pain as liability rates continue to rise

Some doctors are seeing bigger bills than reflected in the raw numbers as companies continue to eliminate discounts and tighten underwriting.

By Tanya Albert, *AMNews* staff. Nov. 10, 2003.

Internists, general surgeons and obstetrician-gynecologists in the Miami area are paying the highest professional liability insurance rates for those specialties in the nation, according to a new report.

The next highest rates for those specialties are found in Michigan, Illinois, Texas and Pennsylvania.

With this article
- Pain scale
- Taking the hit
- How low did they go
- See related content
- Topic: Liability crisis

Nationwide, rates are on the rise. More than half of the internists, general surgeons and ob-gyns out there -- 58.2% to be exact -- saw double-digit insurance rate increases of 10% to 49% between 2002 and 2003.

Slightly more than 1% of those specialists saw increases of 100% or more.

But there is some good news: 22.6% of physicians in those three specialties saw no increase, and some saw a decrease in rates over the past year.

The lowest rates in the nation for internists, general surgeons and ob-gyns are in Idaho, Minnesota, Nebraska, South Dakota and Richmond, Va.

Liability insurance payout rates are increasing

This is according to the latest state of the union for medical liability insurance rates from "2003 Rate Survey" by the *Medical Liability Monitor*. The data, which the monthly newsletter has collected annually since 1991, are based on 641 rates insurance companies

7% a year. reported that can be compared with 2002 data. Companies report their mature claims-made manual rates in effect July 1 with $1 million/$3 million limits.

The information collected from 40 insurance companies provides the most comprehensive look at the amount physicians are paying for their insurance. The report also offers a glimpse at what doctors can expect in the coming year. And 2004 doesn't look to be much better than its most recent predecessors. About 83% of the companies surveyed believe they will need additional large increases next year, according to the report. Many of those companies believe those increases will be in the double digits although they hope they won't be as high as they have been in recent years.

"The rate survey shows what we expected," said Larry Smarr, president of the Physician Insurers Assn. of America. "And I agree with the headline [on the report] 'No end in sight.' "

Rates will continue to rise because they are based on losses that companies pay out, and right now that number is rising 7% annually, he said. On top of that, low interest rates force insurers to collect more money through premiums.

But raw numbers don't tell the whole story, *Medical Liability Monitor* editor Barbara Dillard said.

More expensive, harder to get

In addition to increases in rates, physicians are seeing fewer discounts than they once did.

"Discounts for risk management have gone away," Smarr said. So too have dividends that physician-owned companies historically have offered doctors to help offset premiums.

58% of internists, ob-gyns and general surgeons saw liability insurance hikes of 10% to 49% from 2002 to 2003.

The *Medical Liability Monitor* survey also notes that companies are increasingly requiring physicians to buy tail coverage that may once have been included in premiums and that some companies are limiting corporate coverage.

"All of these things mean that a bill that an individual doctor is getting this year may be an even bigger increase for him than it looks on the rate survey," Dillard said.

In addition, physicians are finding it more difficult to find insurance.

In all, 14 companies who responded to the survey said they withdrew or severely restricted new writings in some states. And companies that are staying in the market are continuing to restrict who they will cover.

According to the *Monitor's* survey of 40 companies:

- 73.5% said they are tightening their underwriting.
- 48.6% said they are not renewing more physicians than they did last year.
- 20% said they are restricting coverage in one form or another, such as no longer covering punitive damages.

As rates keep rising and insurance becomes harder to find, physicians and insurers continue to push their state legislatures and Congress to enact tort reform that includes a $250,000 noneconomic damages cap. This, they believe, will help stabilize insurance rates.

Insurers have stopped offering discounts for risk management.

The survey showed states without noneconomic damages caps generally saw larger rate increases than states with caps. For example, ob-gyns, internists and general surgeons in Pennsylvania saw a 25.8% to 73% increase in rates; those specialists in Illinois saw a 25% to 50% increase and New York physicians saw a 7.3% to 12.7% hike.

In states with caps, Indiana and Louisiana physicians saw a 3.9% to 21.8% increase and Colorado physicians saw a 12.7% to 38% increase, the survey showed. Some Wisconsin physicians saw as much as a 12.7% increase, but some saw a 14.2% decrease. Wisconsin adopted reforms, including a patient compensation fund, in 1975. It added a $350,000 adjustable noneconomic damages cap in 1995 that now stands at $410,000.

"We had the foresight to do something for the people and they look after us," said Ft. Atkinson, Wis., orthopedic surgeon Walter Moritz, MD, who helped craft the original Wisconsin legislation and is vice chair of the state's patient compensation fund. "It's fantastic to be in Wisconsin and practicing medicine."

The medical community looks toward California tort reform as the gold standard when trying to get laws passed elsewhere. Some California doctors in the three specialties on which the survey focused saw no increase in rates between 2002 and 2003, but some saw as much as a 54% hike in one year.

Even so, California physicians still pay significantly less than counterparts in other states. For example, internists in Dade County, Fla., paid 133.7% more for their insurance than internists in Los Angeles, according to the survey. General surgeons in Dade County paid 285.1%

more than their counterparts in Los Angeles and ob-gyns in Dade County paid 220.2% more than ob-gyns in Los Angeles.

At the state and federal levels, "we need tort reform," Smarr said.

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ADDITIONAL INFORMATION:

Pain scale

A comparison of liability rates for internists, general surgeons and obstetrician-gynecologists for 2002 and 2003 shows that some actually fell 16%, while others soared 144.2%. Of the 641 rates that were compared, most showed increases.

- 1.2% of insurers increased rates 100% or more.
- 1.1% increased 70% to 99%.
- 3.7% increased 50% to 69%.
- 26.8% increased 25% to 49%.
- 31.4% increased 10% to 24%.
- 13.1% increased 1% to 9%.
- 20.3% kept rates the same.
- 2.3% decreased rates.

Note: Percentages have been rounded.

Source: Medical Liability Monitor, 2003 Rate Survey

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Taking the hit

Of the states with the highest liability insurance rates for select specialties, Florida, Illinois and Pennsylvania are on the AMA's list of crisis states. Michigan is listed as a state showing problems.

	2002	2003	Increase
Internists			
Florida (Dade County)	$56,153	$65,697	17%
Michigan (Wayne County)	$45,761	$50,063	9.4%
Illinois (Cook County)	$31,722	$41,238	30%

General surgeons			
Florida (Dade County)	$174,268	$226,542	30%
Michigan (Wayne County)	$107,139	$154,165	43.9%
Pennsylvania (Philadelphia)	$104,388	$131,348	25.8%
Obstetrician-gynecologists			
Florida (Dade County)	$201,376	$249,196	24%
Michigan (Wayne County)	$140,917	$154,165	9.4%
Pennsylvania (Philadelphia)	$116,388	$152,730	31.2%

Source: *Medical Liability Monitor*, 2003 Rate Survey

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How low did they go

States with the lowest medical liability rates for specific specialties.

	2002	2003	Increase
Internists			
Nebraska	$2,786	$2,786	0%
Virginia (Richmond)	$2,920	$2,920	0%
Minnesota	$2,700	$3,375	25.0%
General surgeons			
Minnesota	$8,717	$8,717	0%
Virginia (Richmond)	$9,384	$9,384	0%
Nebraska	$9,474	$9,474	0%
Obstetrician-gynecologists			
South Dakota	$13,325	$14,662	10.0%
Virginia (Richmond)	$14,907	$14,907	0%
Nebraska	$12,674	$16,194	27.8%

Source: *Medical Liability Monitor*, 2003 Rate Survey

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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

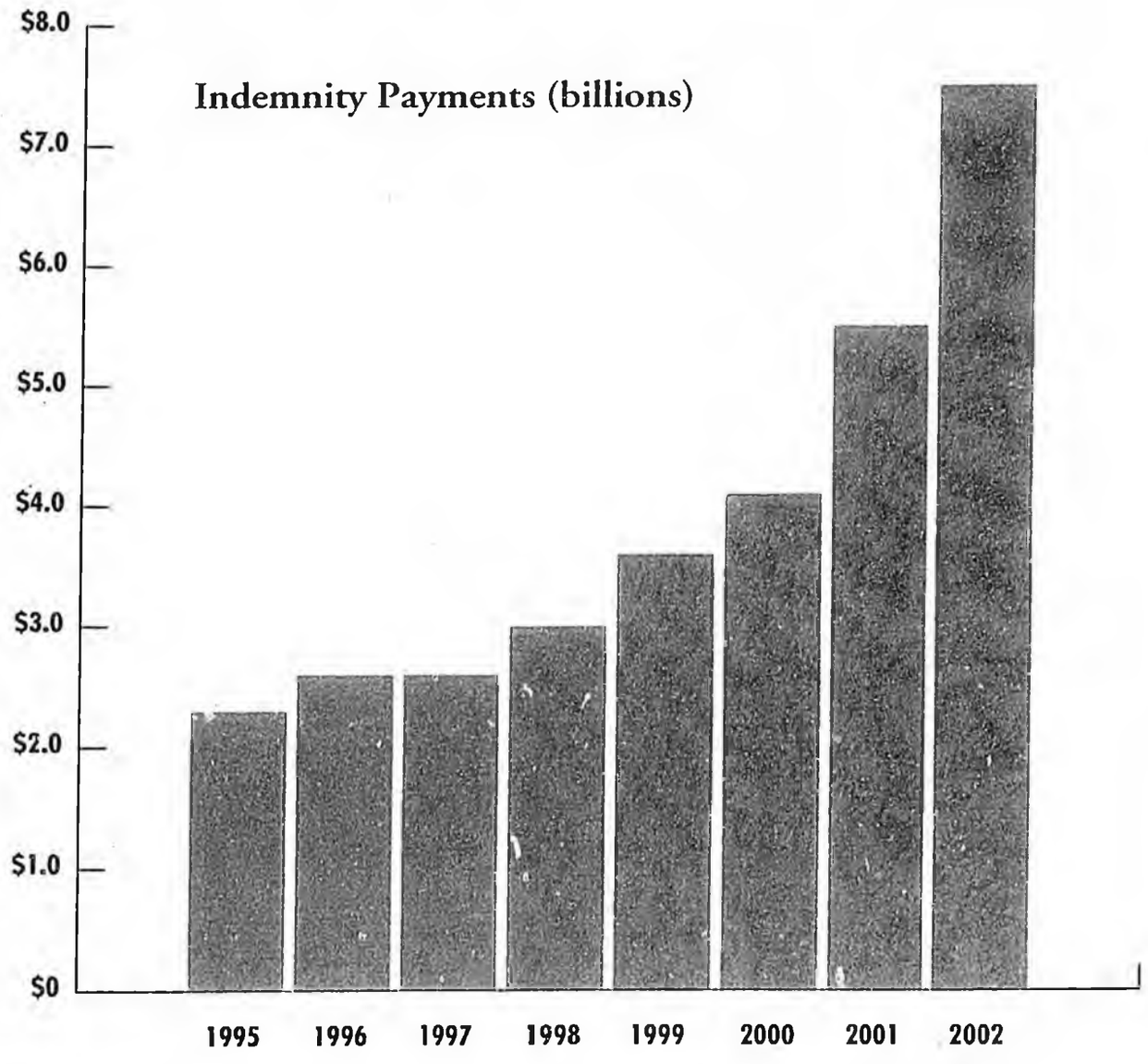
	Low	High
Internists		
Florida (Miami and Ft. Lauderdale areas)	$30,557	$65,697
Michigan (Detroit area)	33,514	50,063
Illinois (Chicago area)	27,836	41,238
Texas (Dallas and Houston areas)	15,122	34,346
Pennsylvania (Philadelphia area)	24,546	29,667
Ohio (Cleveland and Cincinnati areas)	11,445	25,013
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	152,730
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



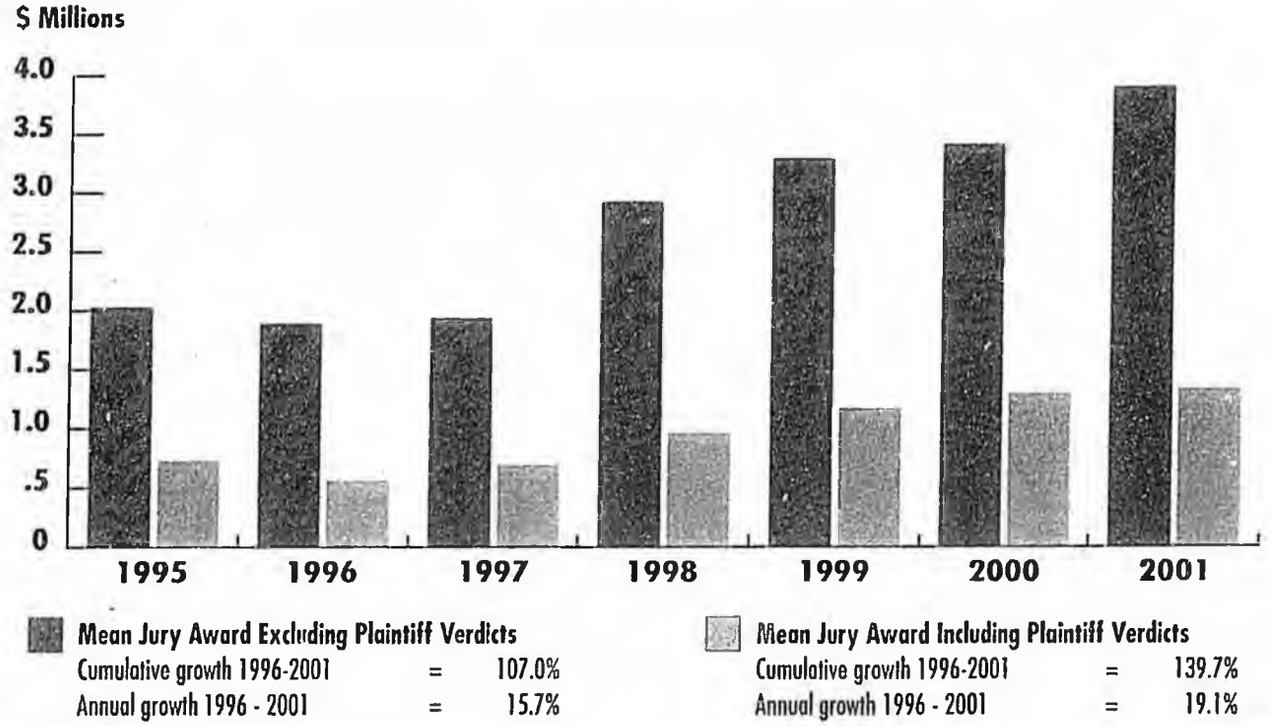
Source: Best's Aggregates & Averages, Property & Casualty, U.S., 2003 Edition, page 364.

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



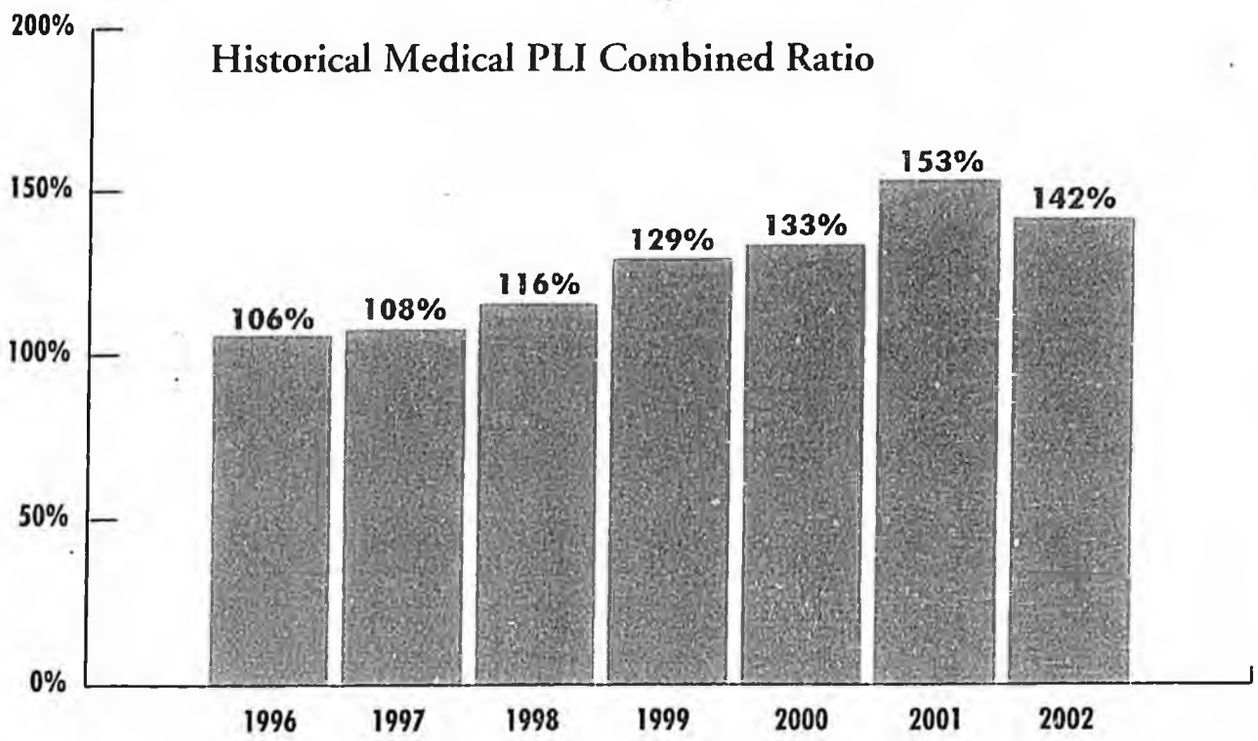
Insurers Continue to Lose Money on PLI

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



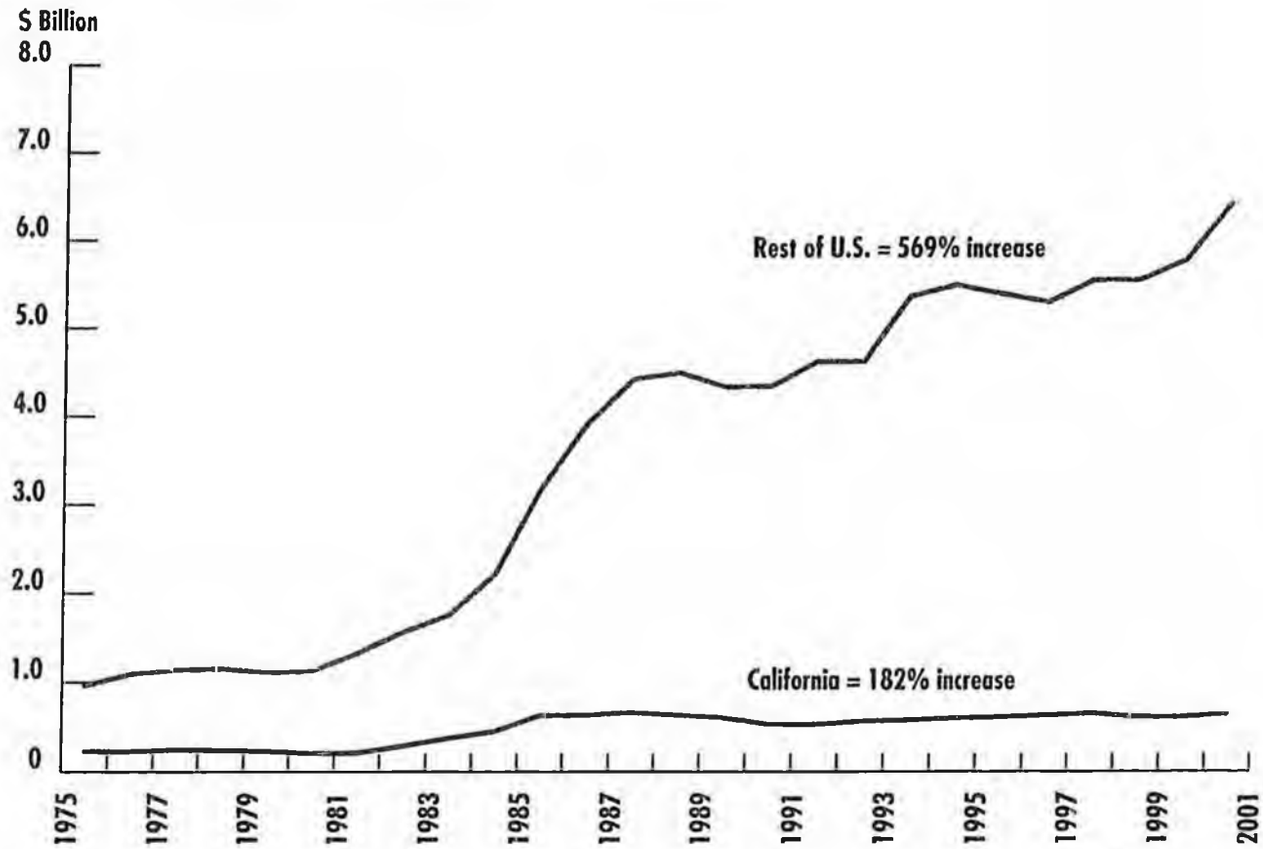
Source: Best's Aggregate and Averages: Property-Casualty, U.S., 2003 Edition, p. 364.

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

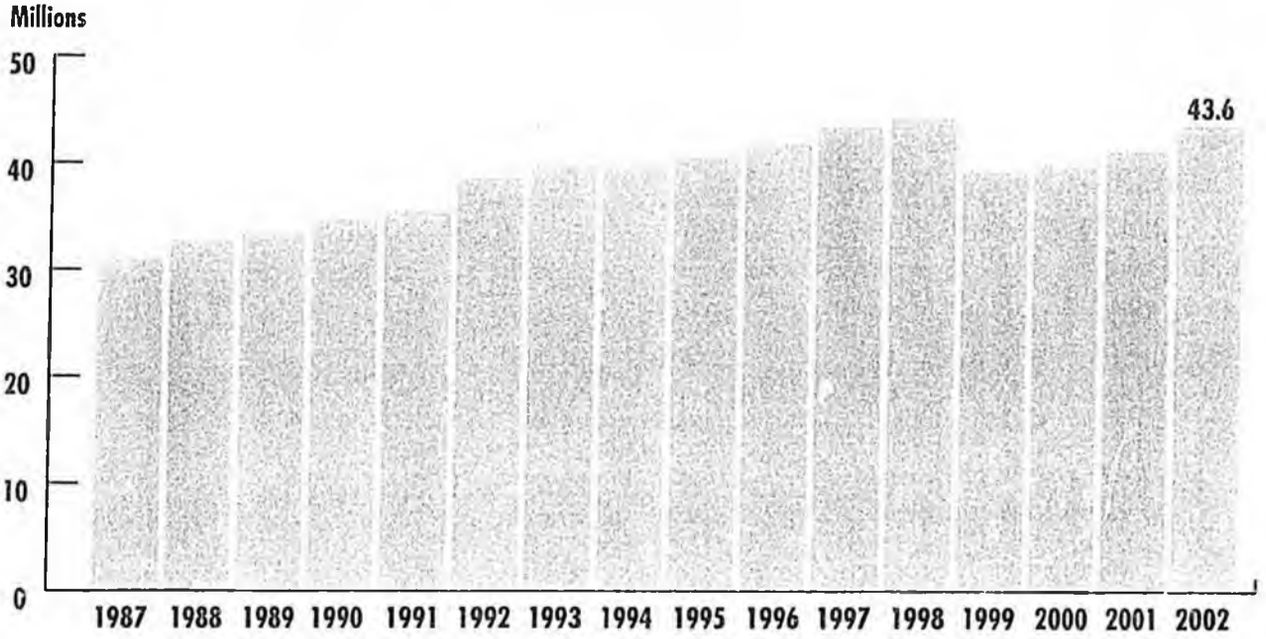
Growth in the Uninsured Population

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.

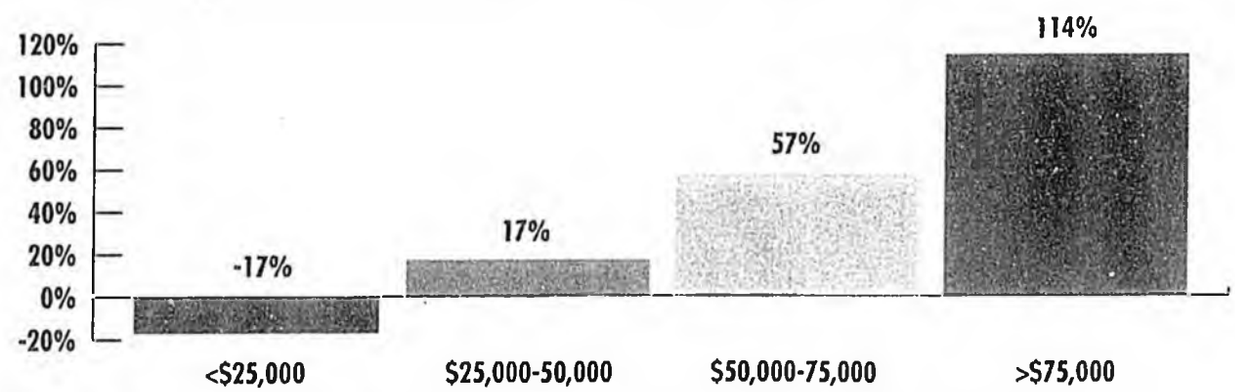
This supposition is consistent with a recent study, "The Growing Share of Uninsured Workers Employed by Large Firms," released by the Commonwealth Fund in October 2003. The main finding of the study was that in 2001, 26% (almost 10 million) of the uninsured population worked for large firms (i.e., firms 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 adopting 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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TrendsReport

Health Care Financial Trends Report
is produced by the

AMA Health Policy Group
Division of Socioeconomic Policy Development

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www.ama-assn.org/go/healthpolicy

KED:03-508:1.5M:12/03

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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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 nce 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 tville, 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 syste . 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.

ments 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 tion 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

te Editor, Practice Trends

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

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July 3, 2003

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Abstract

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

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

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

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

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

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

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And, last year another article reported:

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

Background

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

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

Methodology

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

One recent newspaper article maintains:

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

And another adds:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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