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

Data

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Results

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

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

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

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

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

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

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

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

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

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

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

Ohio, Oregon, and Texas had provisions that set limits on noneconomic damages in malpractice cases that were struck down by their State Supreme Court, and these limits were in effect for more than 4 years.[8] We estimated our State data model setting our cap variable equal to 1 during the time periods the State law capping noneconomic payments in malpractice cases was in effect for Ohio, Oregon, and Texas in addition to setting it

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

* Cap on total damages.

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

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

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

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

† Cap later passed in 2002 or 2003.

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

Table 2. State data: Variable means

(1985, 1990, 1995 and 2000 data; N = 196)

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

Table 3. State data: Ordinary least squares (OLS) estimates—Number of physicians per 100,000 residents

(1985, 1990, 1995, and 2000 data; N = 196)

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

- Adjusted $R^2 = .52$.

Table 4. State data: Ordinary least squares (OLS) estimates—Number of physicians per 100,000 residents

(1985, 1990, 1995, and 2000 data with dummy time variables; N = 196)

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

- Adjusted $R^2 = .58$.

Table 5. County data: Variable means

(1996, 1997, 1998, 1999, and 2000 data; N =14,640)

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

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

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

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

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

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July 8, 2003

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

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

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

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

DID WEISS DO WRONG?

ing the States

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

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

uring the Premiums

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

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

MEDICAL LIABILITY MONITOR RATE SURVEY DATA
ALABAMA

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

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

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

- Data for different insurers are used for the two comparison years.
- The median value is representative of only general surgery rates because general surgery rates are always higher than internal medicine and lower than OB/GYN.
- Because two carriers are represented in 2002 and only one in 1991, the median value chosen by Weiss (the average of the two general surgery rates) is actually lower than the 1991 rate. However, the actual general surgery rates for the only carrier shown for both years increased – the opposite of Weiss' result.
- The premiums shown are not adjusted for various discounts or surcharges, and do not reflect any dividends which may have been paid back to policyholders, thus reducing their total outlay. Medical malpractice insurers paid substantial dividends in the 1991 era, which had been largely reduced by 2002 due to industry losses.

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

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

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

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

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

ing Claim Costs

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

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

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

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

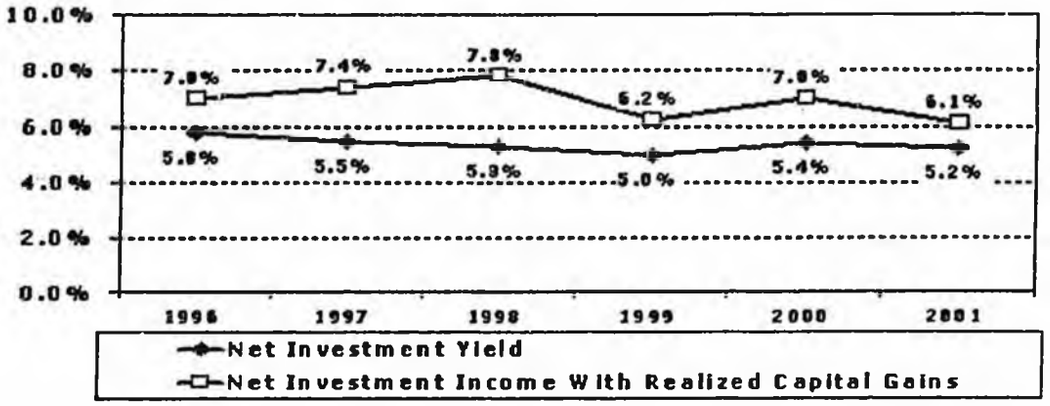
nent Performance

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

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

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

Medical Malpractice Insurance Investment Income



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

USION

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

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

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

Medical Liability Crisis And Access To Care

A Response To The General Accounting Office

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

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

Among its general findings, the GAO confirmed that:

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

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

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

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

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

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

The GAO's measurement of access problems is incomplete. The report uses Medicare claims data to examine changes in the utilization of medical services. Medicare data are inadequate to identify changes in obstetric services because a vast majority of Medicare eligible beneficiaries are beyond reproductive age. Limitations in the data also preclude an assessment of changes in emergency room services. Therefore, the report significantly understates the impact of rising liability insurance premiums because it does not examine the two clinical areas of patient care in which impairment of patient access has been the most severe—obstetric and emergency room services.

To date, the AMA, in conjunction with its federation of state medical associations, has identified 19 states in a liability crisis. The GAO investigated access problems in only five of those states. In each of those states it found examples of reduced access to hospital-based services. We believe that the GAO would have found similar access to care problems if it had examined the other 14 crisis states. In fact, the GAO did not

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

U.S. Department of Health and Human Services

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

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

March 3, 2003

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

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INTRODUCTION

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

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

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

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

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

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

THE CRISIS AFFECTS ALL AMERICANS

1. Access to Care is Threatened

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Quality of Care is Jeopardized

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

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

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

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

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

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

The Litigation System Does Not Promote Quality of Care

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

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

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

malpractice litigation."[47]

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

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

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

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

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

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

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

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

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

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

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

3. Health Care Costs are Increased

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

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

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

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

II. THE LITIGATION SYSTEM IS RESPONSIBLE FOR THE CRISIS

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

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

Although most cases do not actually go to trial, it costs a significant amount of money to defend each claim--expenses on claims settled in 200 averaged $39,819.[64] Data from states that maintain this information demonstrate the rapid rate of increase in recent years. Between 1999 and 2001, the average expense, per defendant, in a medical litigation case in Illinois increased 30.3% (from $14,855 to $19,363).[65] In the period 1980 to 1984, the average defense cost in Missouri was $4,700; in the period 1995 and 1999, it increased to almost $19,000--an increase of more than 300% percent.[66]

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

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

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

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

TABLE 1. Mega Awards In States Without Caps

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

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

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

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

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

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

III. THE LITIGATION SYSTEM DOES NOT BENEFIT THE INJURED PATIENT

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

Most victims of medical error do not file a claim--one comprehensive study found that only 1.53% of those who were injured by medical negligence even filed a claim.[25] When a patient does decide to go into the litigation system, only a very small number recover anything. Most claims--57-70%--result in no payment to the patient.[26, 27] One study found that only 8-13% of cases filed went to trial; and only 1.2-1.9% resulted in a decision for the plaintiff.[28]

The results are as arbitrary for patients as they are for providers. When there are recoveries, they often are based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status (educated, attractive patients recover more than others).[29]

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

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

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

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

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

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

IV. AS A RESULT, INSURANCE PREMIUMS ARE RISING RAPIDLY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. INSURERS ARE LEAVING THE MARKET

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

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

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

whose carriers have departed the market.[24]

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

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

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

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

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

TABLE 6. Comparison of States with Caps to States without Meaningful Non-Economic Caps (Average Highest Premium Increase)

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

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

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

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

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

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

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

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

TABLE 7: Malpractice Liability Rate Ranges by Specialty by Geography as of October 2002

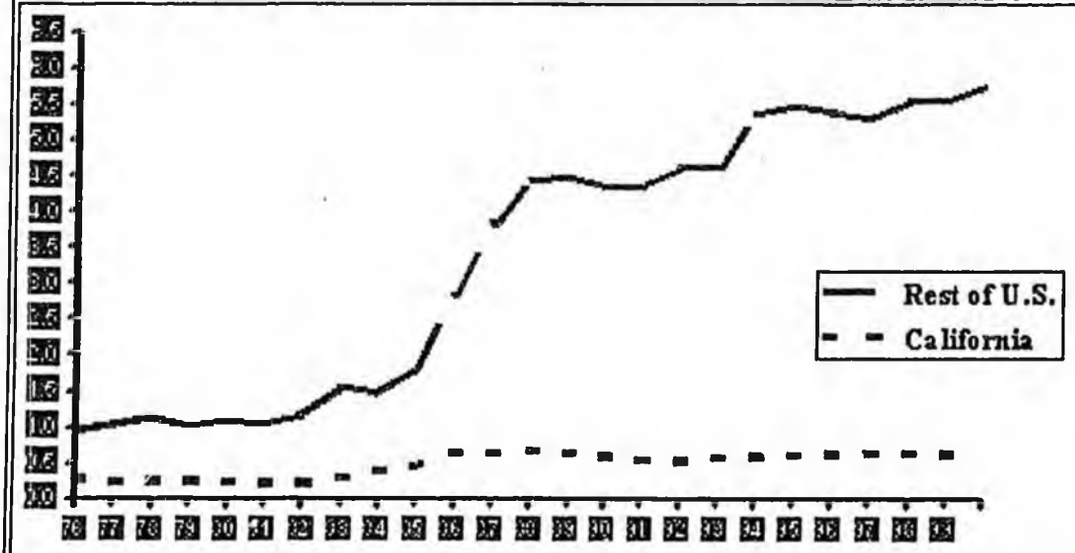
	Cap on Non-Economic Damages	Low	High
INTERNISTS			
State Wide Data			
Wisconsin	$350,000	$4,500	$6,000
Montana	$250,000	7,000	7,900
Utah	$250,000	7,900	10,600
Hawaii	$350,000	7,100	7,100
Connecticut	No cap	7,400	13,800
Washington	No cap	6,700	9,800
Metropolitan Area Data			
California (Los Angeles area)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

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

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

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

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



SOURCE: NAIC Profitability Study, 2000.

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

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

1. Establish a Fair, Predictable, and Timely Process

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

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

- Improve the ability of all patients who are injured by negligence to get quicker, unlimited compensation for their "economic losses," including the loss of the ability to provide valuable unpaid services like care for children or a parent.
- Ensure that recoveries for non-economic damages could not exceed a reasonable amount ($250,000).
- Reserve punitive damages for cases that justify them--where there is clear and convincing proof that the defendant acted with malicious intent or deliberately failed to avoid unnecessary injury to the patient--and avoid unreasonable awards (anything in excess of the greate of two times economic damages or $250,000).
- Provide for payment of a judgment over time rather than in one lump sum--and thus ensure that the money is there for the injured patient when needed.
- Ensure that old cases cannot be brought years after an event when medical standards may have changed or witnesses' memories have faded, by providing that a case may not be brought more than three years following the date or injury or one year after the claimant discovers or, with reasonable diligence, should have discovered the injury.
- Informing the jury if a plaintiff also has another source of payment for the injury, such as health insurance.
- Provide that defendants pay any judgment in proportion to their fault, not on the basis of how deep their pockets are.

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

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

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

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

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

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

2. Improve Health Care Quality Through Litigation Reform

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

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

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

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

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

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

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

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

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

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

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

- The National Nosocomial Infections Surveillance System, operated by the Centers for Disease Control, receives voluntary reports from hospitals on hospital-acquired infections. It has reduced these infections by 34%. The system works because federal law assures participating hospitals that information supplied by them will be kept confidential.

- MedWatch is a voluntary Medical Products Reporting System operated by the Food and Drug Administration. Adverse events concerning medical devices and drugs may be reported to it to identify problem areas. Names of the reporting doctors and hospitals, and the name of patients involved, are not releasable under the Federal Freedom of Information Act.

- The Department of Veterans Affairs maintains a Patient Safety Reporting System to learn about issues related to patient safety. To encourage reporting, federal law provides that reports relating to new safety ideas, close calls, or unexpected serious injury are confidential and privileged. This is based on the successful system operated by the National Aeronautics and Space Administration for aviation safety reporting.

- New York State operates the New York Patient Occurrence Reporting and Tracking System. Adverse events are reported to it. New York State law prevents disclosure of reports under the state's freedom of information law.

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

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

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

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

VIII. IT IS SPECIOUS TO BLAME INSURERS FOR THE CRISIS

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

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

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

litigation system is not causing the crisis.

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

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

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

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

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

SOURCE: Brown Brothers Harriman & Co., 2002.

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

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

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

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

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

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

CONCLUSION

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

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

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

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Caps on Damages

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

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

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

Caps on Damages - Summary of State Laws and Legal Challenges

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

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

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

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

Arizona-None - Constitution prohibits limiting recoverable damages

Arkansas-None

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

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

Connecticut-None

Delaware-None

D.C.-None

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

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

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

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

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

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

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

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

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

Iowa-None

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

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

Kentucky- None. Constitution prohibits cap on damages.

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

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

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

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

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

Minnesota-None

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

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

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

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

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

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

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

New Jersey-None

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

New York-None

North Carolina-None

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

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

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

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

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

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

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

Rhode Island-None

South Carolina-None

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

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

Tennessee-None

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

$500,000 cap on all civil damages for wrongful death, indexed for inflation since 1977. The cap does not apply to medical, hospital, and custodial care received before judgment or required in the future. In 2002 the cap reached approximately $1.4 million. (1977, limited by 1990 court decision)

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

Utah-$250,000 cap on noneconomic damages for causes of action existing before July 1, 2002. $400,000 cap on noneconomic damages for causes of action existing on or after July 1, 2002 and before July 1, 2003. Indexed annually for inflation thereafter. (1986, 2001)

Vermont-None

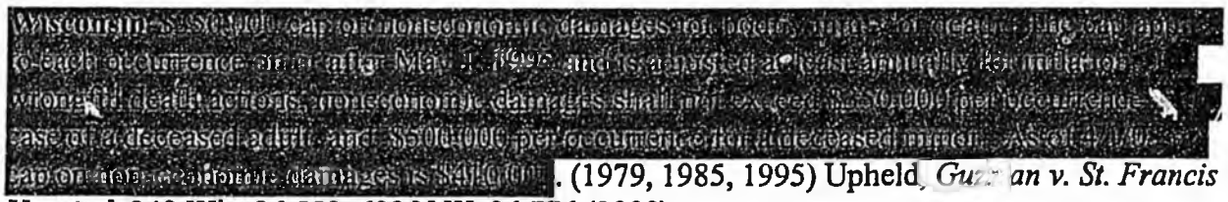
Virginia-$1.5 million cap on total damages for acts occurring on or after July 1, 2002. The cap is increased by $50,000 annually beginning on or after July 1, 2000 and before July 1, 2006. On July 1, 2007 and July 1, 2008 the cap is increased by $75,000. The last increase shall be for July 1, 2008. (1976, 1977, 1983, 1999, 2001) Upheld, *Etheridge, et.al. v. Medical Center Hospitals*, 237 Va. 87, 376 S.E.2d 525 (Va. 1989).

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

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

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

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



. (1979, 1985, 1995) Upheld *Guzman v. St. Francis Hospital,* 240 Wis. 2d 559, 623 N.W. 2d 776 (2000).

Wyoming-None - Constitution prohibits caps

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

Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

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

Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

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

Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

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

Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

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

Constitutional Challenges to State Non-economic Damages Caps Caselaw
October, 2003

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

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

MIEC GROUP

NOV 14 20[illegible]

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

Memo

Date: November 11, 2003

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

From: Ron Neupauer Ron

Re: Medical Liability Monitor 2003 Rate survey

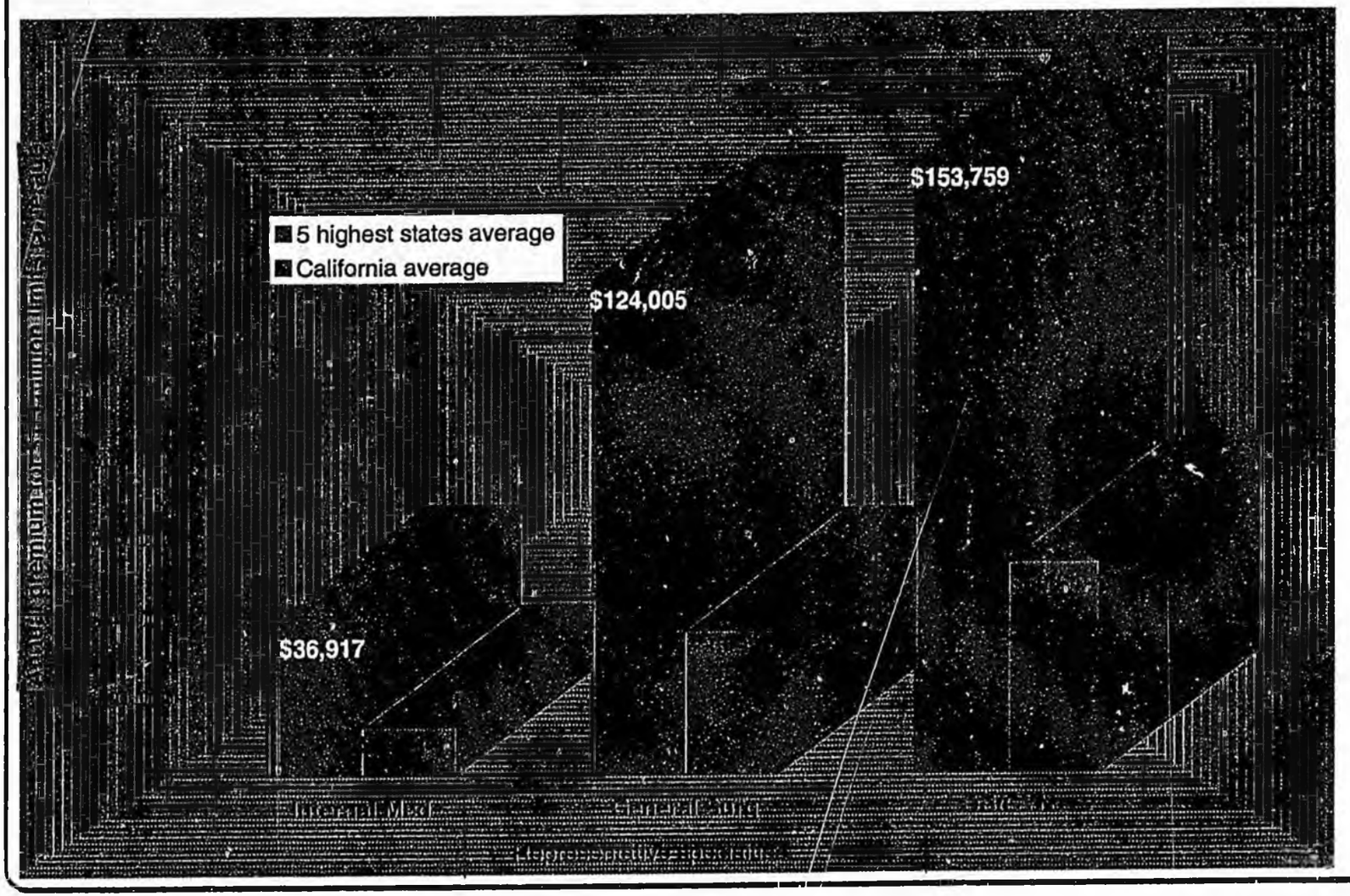
Each year, Medical Liability Monitor asks leading medical liability insurers in each state to supply current malpractice insurance rate information for three representative medical specialties: Internal medicine, general surgery, and ob/gyn. They are asked to give rates for $1/3 million limits, mature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

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

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

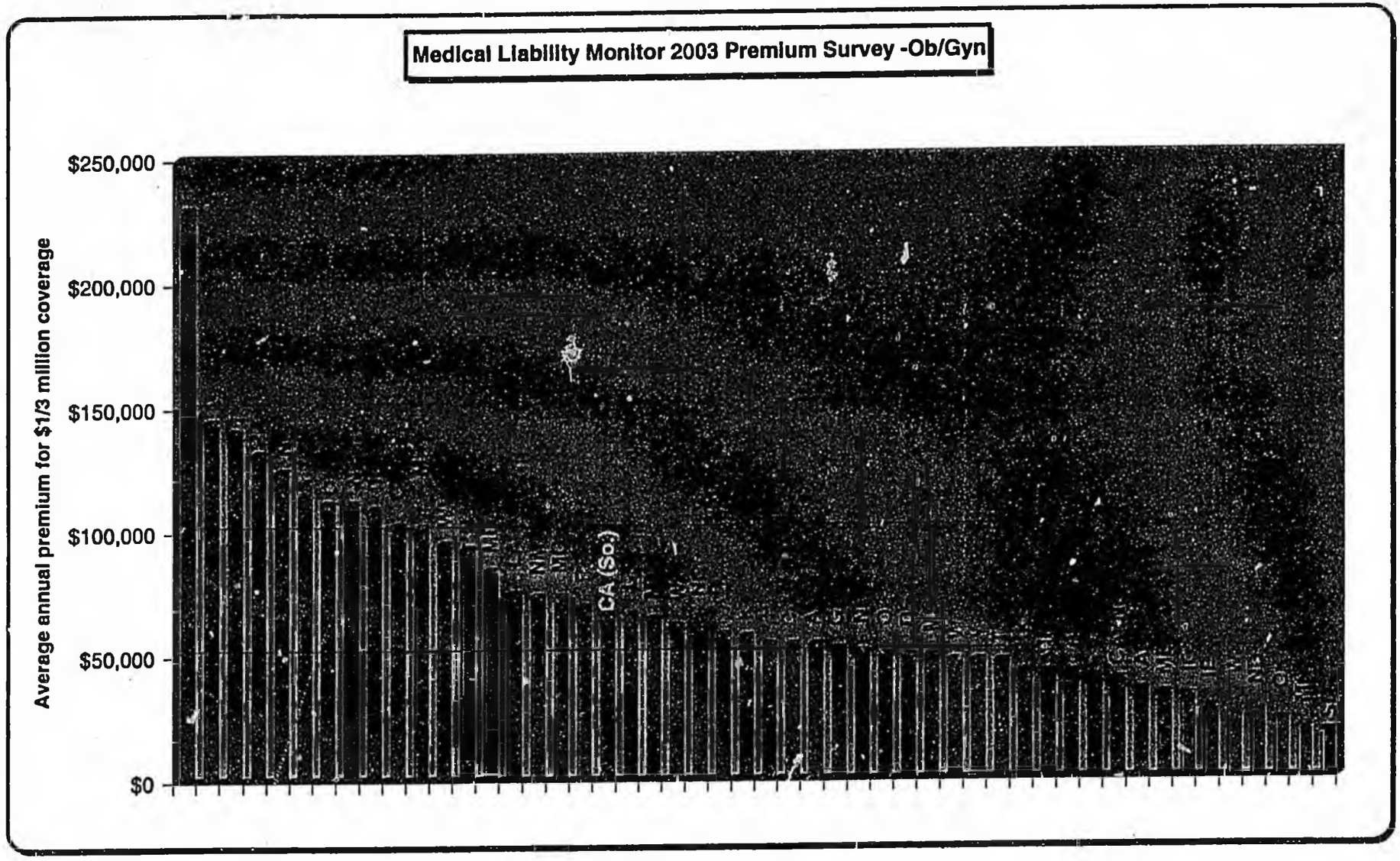
Please let me know if you have questions or comments about this survey.

Physician owned insurers malpractice premium comparison - 2003



summaries Chart 1025

11/11/03


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

Date: September 23, 2003

Media Contact: Chuck Moran
Pennsylvania Medical Society
(717) 558-7820

For Immediate Release

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

Milliman USA study proves caps work

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

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

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

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

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

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

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

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

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Milliman USA
Consultants and Actuaries

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

MILLIMAN USA ANALYSIS SEES SAVINGS FOR PROFESSIONAL MEDICAL MALPRACTICE COSTS

Examines Large States Using Caps on Non-Economic Damages

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

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

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

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

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

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

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

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

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Milliman USA

Consultants and Actuaries

NPDB* Loss Data for 15 Largest States and Nationwide

NPDB* Public Use Data File

*NPDB refers to the National Practioners Data Base

9/1/90-4/30/01

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

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

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

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

Lou

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

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

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

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

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

Please let me know if you have any questions.

Daniel

Daniel Blaney-Koen

American Medical Association
Field Communications Manager
Phone: (312) 464-4415
Cell: (312) 543-6929
daniel_blaney-koen@ama-assn.org

American Medical Association
Physicians dedicated to the health of America

FOR IMMEDIATE RELEASE **April 3, 2003**

AMA SURVEY SHOWS PATIENTS LOSING ACCESS TO CARE

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

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

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

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

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

Top line survey findings include:

- 64.8 percent of America's high-risk specialists have made changes to their practice, including no longer providing emergency and trauma care, performing high-risk surgical procedures, delivering babies, and more.
- 92.4 percent of high-risk specialists said that liability pressures were important in their decision to stop providing certain services.
- 41.5 percent of high-risk specialists began referring complex cases; 34 percent of physicians surveyed in AMA crisis states began referring complex cases compared to 24 percent in non-crisis states.

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

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

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

For more information, please contact:

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

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

Lou

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

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

National Physician Survey on Professional Medical Liability

April 2003

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

Key Survey Findings

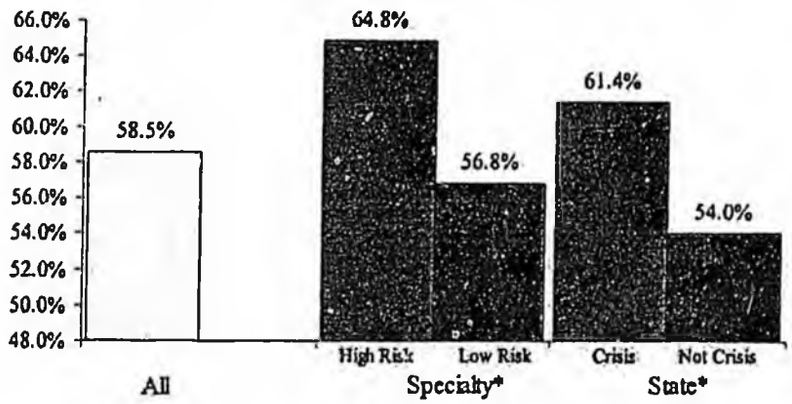
Respondents were asked if they had made each of a number of practice changes in the last two years. Overall, 53% of physicians indicated that they had made at least one of the changes listed. The practice changes that were most often reported were: began referring complex cases (30%) and stopped providing certain services (19%). Practice changes were generally made more often among the physicians in high risk specialties and those in crisis states.

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

Methodology

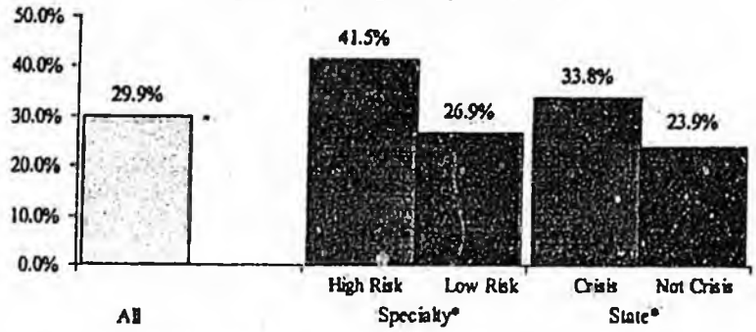
In the fall of 2002 the American Medical Association began a telephone survey of a random sample of physicians with practices in 24 national specialty societies and 50 state medical associations. The survey was conducted online and asked about professional medical liability insurance coverage and practice changes made in the last two years. This report presents results of the practice changes reported by 3,420 physicians.

Made Any Practice Change



*Significant at p = 0.05

Began Referring Complex Cases

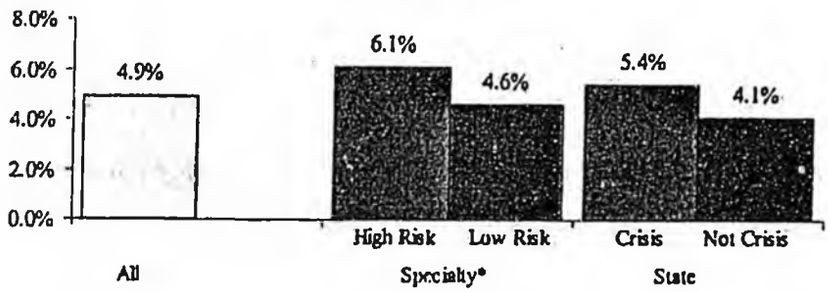


Respondents Indicating that Professional Liability Pressures were Important in the Decision

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

*Significant at p = 0.05

Closed Practice

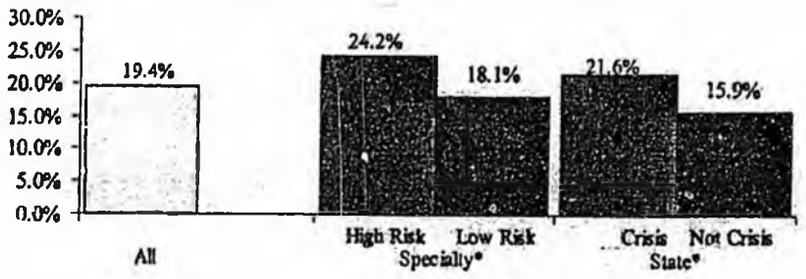


Respondents Indicating that Professional Liability Pressures were Important in the Decision

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

*Significant at p = 0.05

Stopped Providing Certain Services

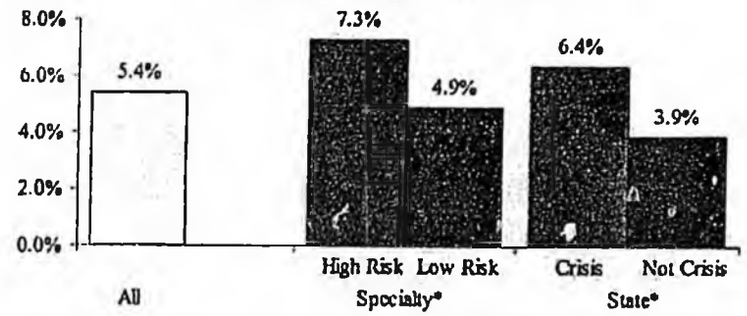


Respondents Indicating that Professional Liability Pressures were Important in the Decision

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

*Significant at p = 0.05

Stopped Providing Patient Care

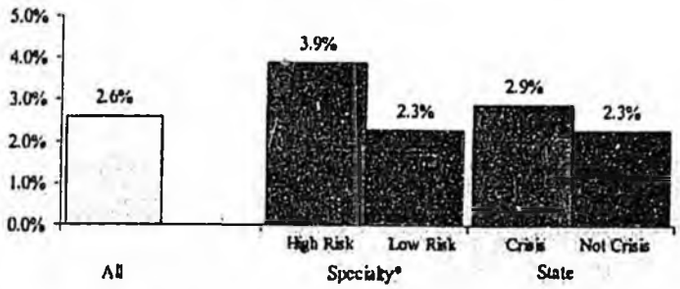


Respondents Indicating that Professional Liability Pressures were Important in the Decision

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

*Significant at p = 0.05

Retired



Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty		State*	
	High Risk	Low Risk	Crisis	Not Crisis
73.6%	74.6%	73.2%	80.4%	66.6%

*Significant at p = 0.05

Lou

From: "Sara Thran" <Sara_Thran@ama-assn.org>
To: <asma@alaska.net>; <Jclark@csms.org>; <koos@isms.org>; <nelson@isms.org>; <white@kyma.org>; <WTA@kyma.org>; <cmcmullen@mag.org>; <JScott@medone.org>; <lmariner@medone.org>; <Shanbacker@msdc.org>; <Sgreenhoe@msms.org>; <PDWeber@msnj.org>; <RSeligson@ncmedsoc.org>; <DOwens@osma.org>; <tjc@wsma.org>; <swacker@wyomed.org>
Cc: "Daniel Blaney-Koen" <Daniel_Blaney-Koen@ama-assn.org>; "Jim Rodgers" <Jim_Rodgers@ama-assn.org>; "Kathy Kuntzman" <Kathy_Kuntzman@ama-assn.org>; "Mindy Schneiderman" <Mindy_Schneiderman@ama-assn.org>; "Teresa Marchiori" <Teresa_Marchiori@ama-assn.org>
Sent: Wednesday, March 26, 2003 1:21 PM
Attach: PLI newsletter.doc
Subject: National PLI survey results

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

National Physician Survey on Professional Medical Liability

March 2003

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

Key Survey Findings

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

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

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

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

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

Table 1. Statistics on Premium Variables

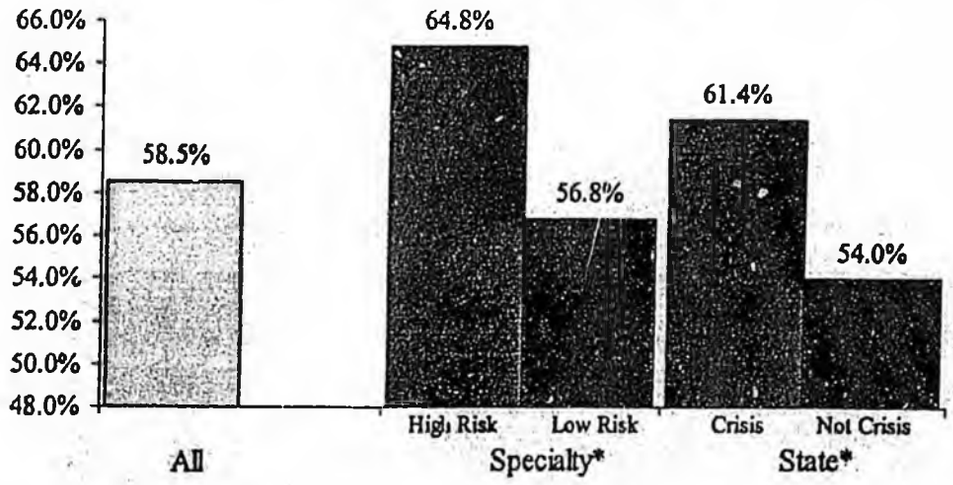
	Mean	Median	25th Percentile	75th Percentile
2001 PLI Premium	16,300	10,000	6,000	20,000
2002 PLI Premium	20,900	12,000	7,000	25,000
2003 PLI Premium	26,900	15,000	8,000	33,000
$ Increase in PLI Premium 2001 to 2002	5,300	2,000	400	6,000
$ Increase in PLI Premium 2002 to 2003	6,800	2,100	0	7,400
% Increase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

Table 2. Means of Premium Variables

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

*Significant at p = 0.05

Made Any Practice Change



*Significant at p = 0.05