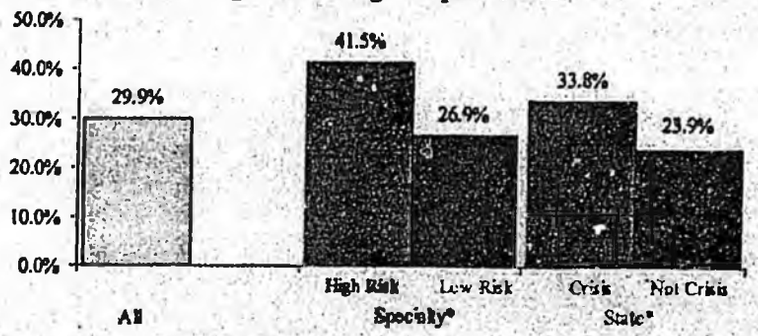
ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672
11245 SENATE LABOR & COMMERCE

Began Referring Complex Cases

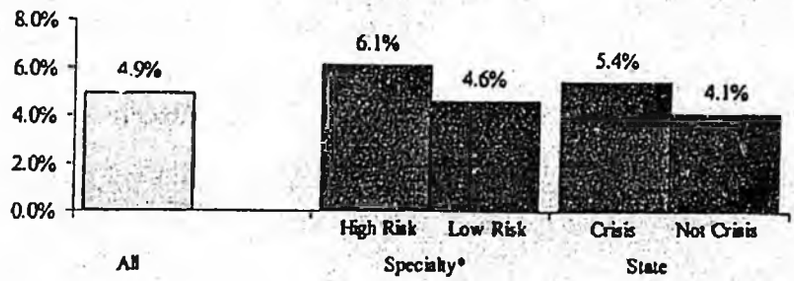


Respondents Indicating that Professional Liability Pressures were Important in the Decision

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

*Significant at p = 0.05

Closed Practice

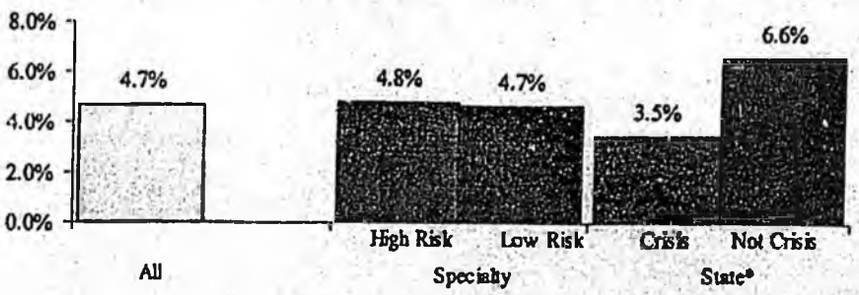


Respondents Indicating that Professional Liability Pressures were Important in the Decision

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

*Significant at p = 0.05

Moved to Different State

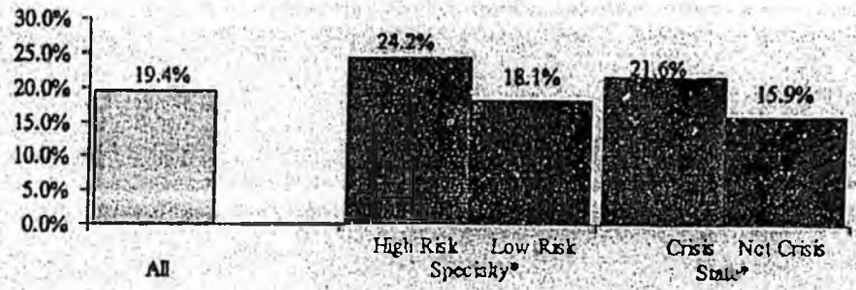


Respondents Indicating that Professional Liability Pressures were Important in the Decision

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

*Significant at p = 0.05

Stopped Providing Certain Services

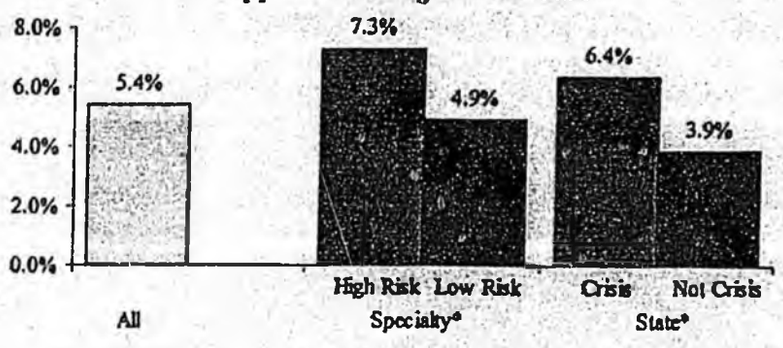


Respondents Indicating that Professional Liability Pressures were Important in the Decision

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

*Significant at p = 0.05

Stopped Providing Patient Care

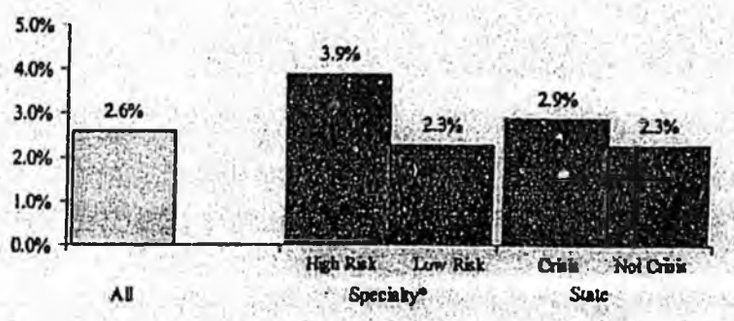


Respondents Indicating that Professional Liability Pressures were Important in the Decision

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

*Significant at p = 0.05

Retired



Respondents Indicating that Professional Liability Pressures were Important in the Decision

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

*Significant at p = 0.05

A New Crisis for the Med Mal Market?

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

By James D. Hurley

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

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

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

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

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

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

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

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

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

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

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

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

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

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

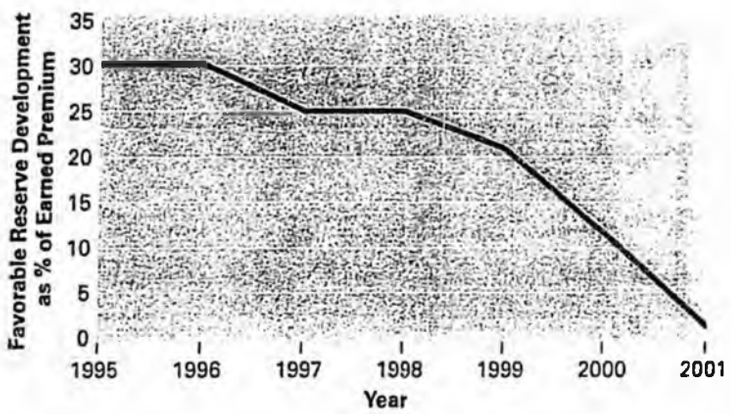
■ **Insurers Expanded Into New Markets.** Given the financial results of the early-to-mid-1990s, some insurers expanded into new markets (with limited information to develop rates). They also became more competitive in existing markets, offering more aggressive premium discounts.

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

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

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

Exhibit 1
Favorable Loss Reserve Development Has Ceased



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

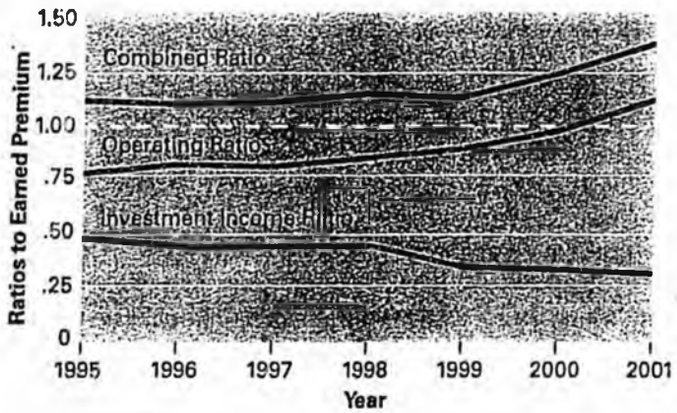
■ **The Reinsurance Market Has Hardened.** Reinsurers' experience deteriorated as their results were affected by increased claim severity and pricing changes earlier in the decade. Because reinsurers generally cover the higher layers of exposure, their results are disproportionately influenced by increases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

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

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

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

Exhibit 2
Results Deteriorated Over the Last Three Years



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

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

There are two key drivers of these financial results:

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

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

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

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

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

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

Other factors militate against a similar crisis for insurers:

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

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

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

History of Med Mal Crises

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

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

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

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

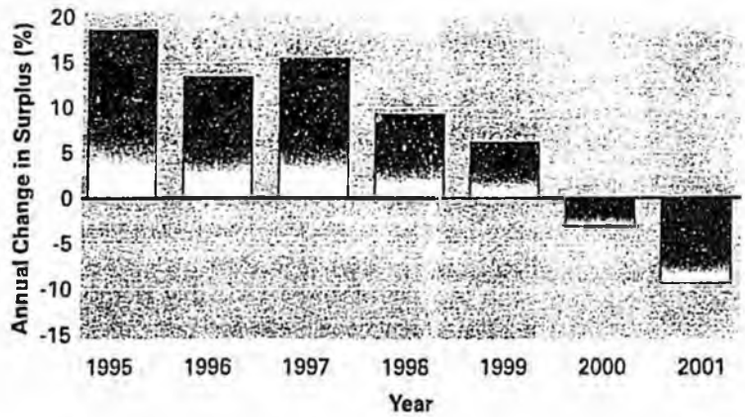
However, the decline in interest rates requires a rate increase, even if loss costs aren't a problem. Prior rates were built anticipating higher prospective investment income as an offset and this is now unlikely to be achieved. Although not affecting rates, equity market declines are similar to prior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

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

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

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

Exhibit 3
Surplus Declined in 2000 and 2001



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

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

Lou

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

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

America's Medical Liability Crisis
Sample Q&A

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

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

Q: How are patients being affected?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q: What is the AMA asking patients to do?

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

A Surgical Fix for Medical Malpractice

Reforms Work Best as a Package, Study Shows

By Jeffrey Speicher

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

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

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

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

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

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

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

A Package Deal

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

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

American Academy of Actuaries Bi-Monthly

FIGURE 1

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

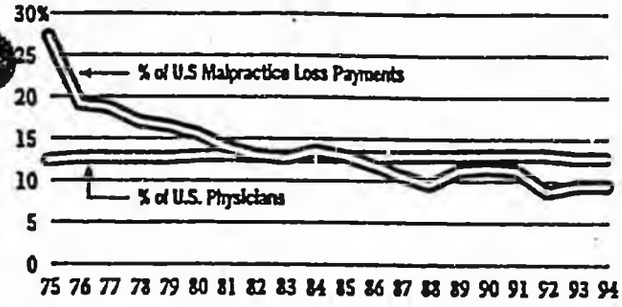
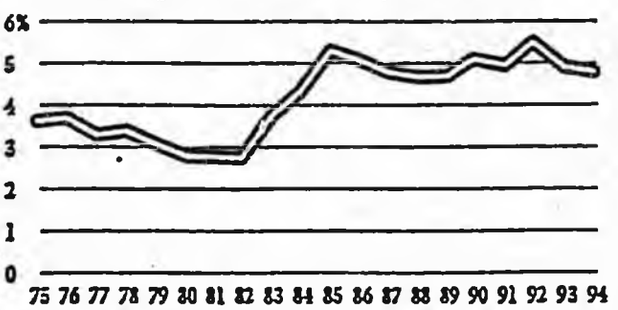


FIGURE 2

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



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

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

Above all, the Academy report warns against piecemeal or faulty changes. Loss experience in New York shows that the individual tort reform measures adopted in that state over the past two decades did not improve costs relative to the U.S. total. "Poorly crafted malpractice reform—either individual measures that are too limited or broad transformations that are too far-reaching—can have unintended consequences that drive up costs," says Hurley.

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

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

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

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

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

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

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

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

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

An Offer You Can't Refuse

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

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

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

> Medical malpractice is a nightmare of useless circularity.

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

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

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

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

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

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

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

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

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

Fall
1996

ISSUE BRIEF
AMERICAN ACADEMY of ACTUARIES

Medical Malpractice Tort Reform: Lessons from the States

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

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

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

Findings

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

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

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

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

AMERICAN ACADEMY of ACTUARIES
1100 Seventeenth Street NW 7th Floor Washington, DC 20036
Tel 202 223 8196 Fax 202 872 1948

Wilson W. Wyatt, Jr., Executive Director
Christine M. Cassidy, Director of Public Policy
Ken Krehbiel, Director of Communications
David F. Rivera, Legislative and Regulatory Specialist
Jeffrey Speicher, Manager of Member Communications

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

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

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

California

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

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

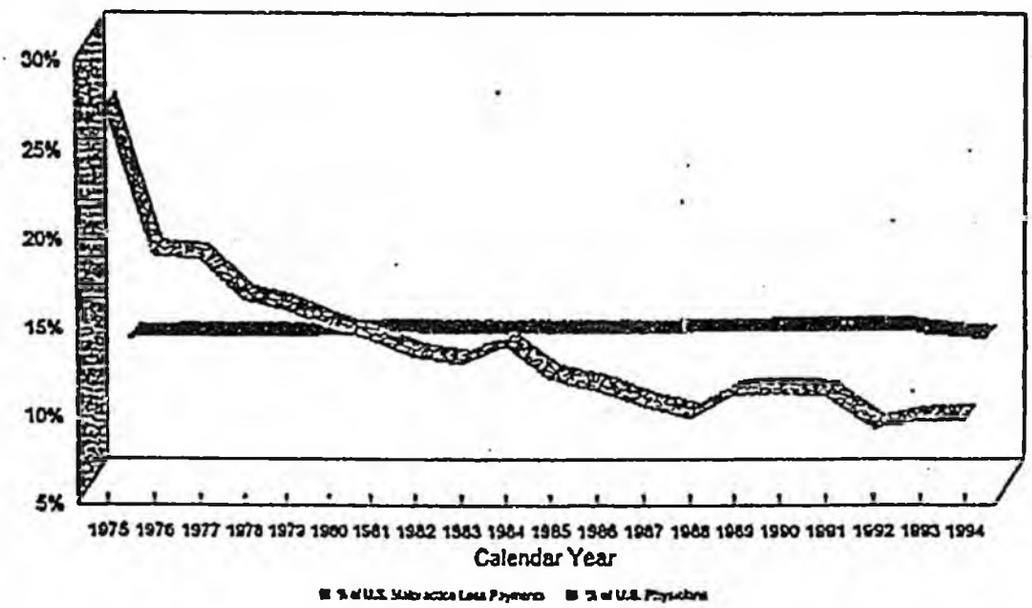
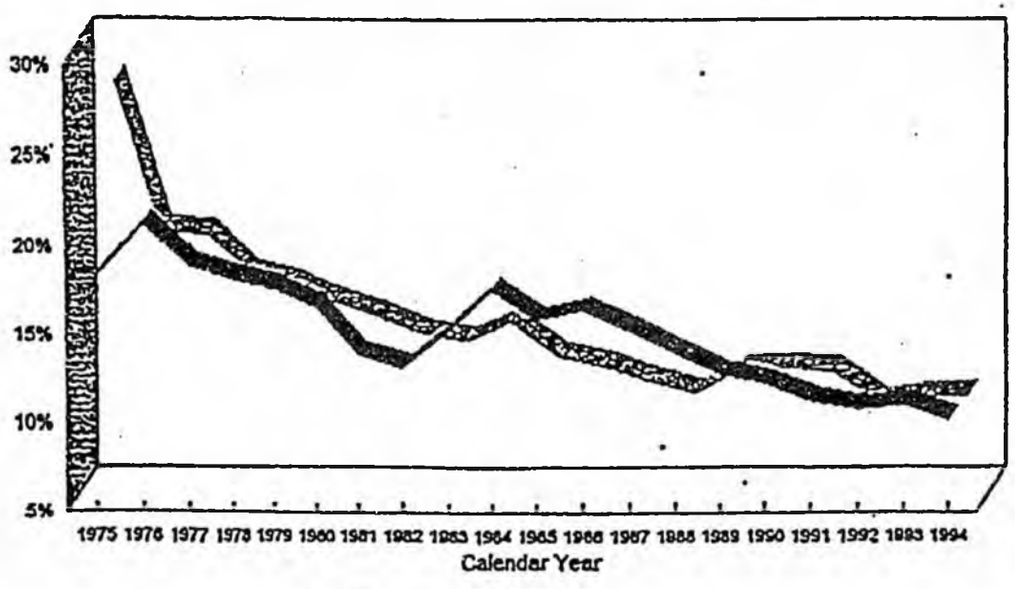


Exhibit 2
Malpractice Premiums and Malpractice Loss Payments in California as a Percentage of the U.S. Total,



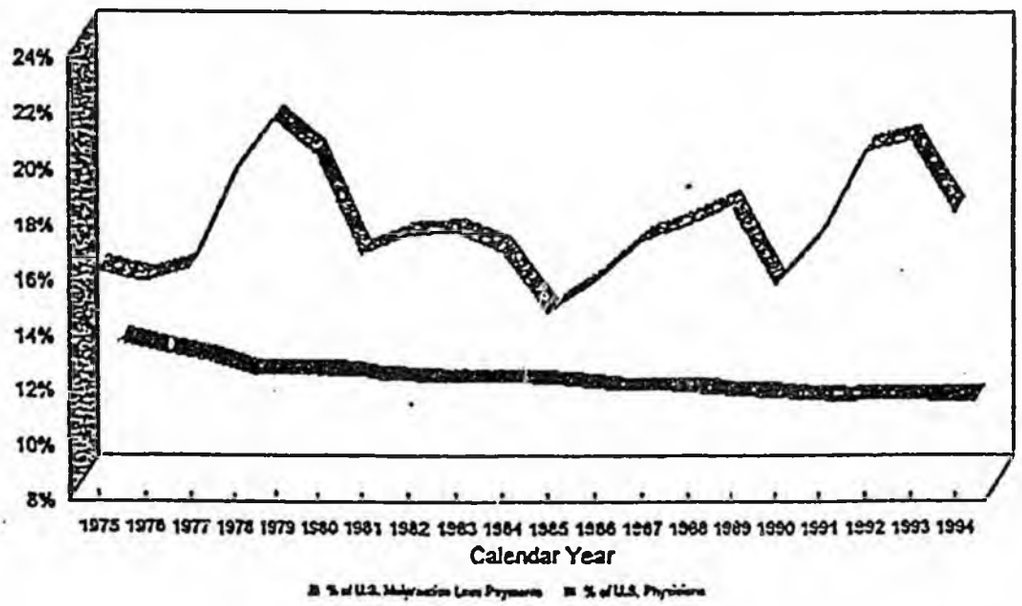
centage of loss payments has dropped dramatically since enactment of the MICRA package of tort reforms. Before MICRA's adoption in 1975, California's percentage of loss payments was significantly higher than its proportion of physicians. By 1981, California's loss payments had dropped and were about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

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

New York

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

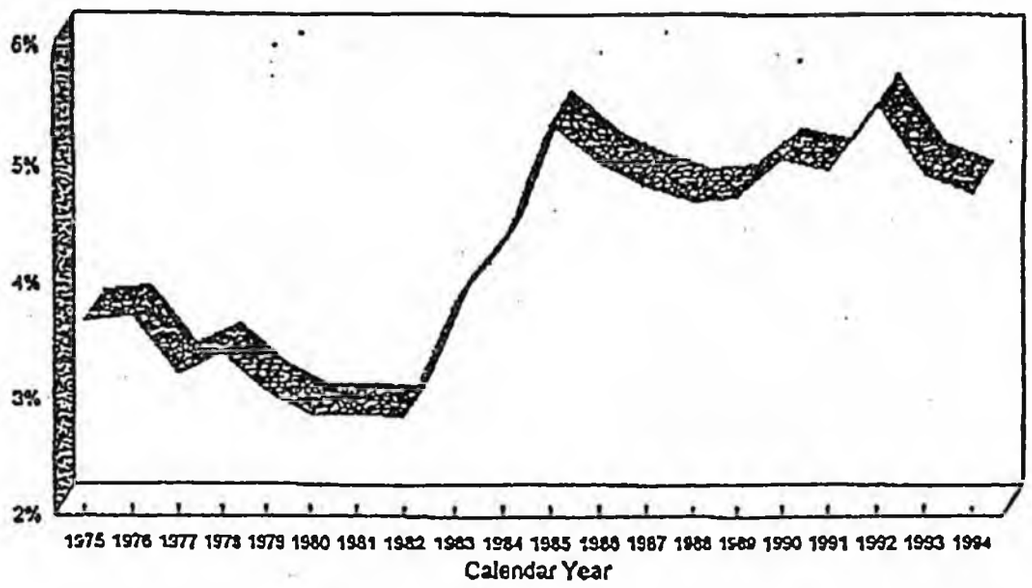
Exhibit 3
Malpractice Loss Payments in New York as a Percentage of the U.S. Total, 1975–94



Ohio

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

Exhibit 4
Malpractice Loss Payments in Ohio as a Percentage of the U.S. Total, 1975–94



Conclusions

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

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

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

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

AMERICAN ACADEMY *of* ACTUARIES

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

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

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

February 27, 2003

The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

1100 Seventeenth Street NW Seventh Floor Washington, DC 20036 Telephone 202 223 8196 Facsimile 202 872 1948
www.actuary.org

INTRODUCTION

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

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

MEDICAL MALPRACTICE – WHAT HAS HAPPENED?

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

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

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

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

Background

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

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

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

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

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

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

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

What Has Changed?

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

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

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

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

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

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

The Results

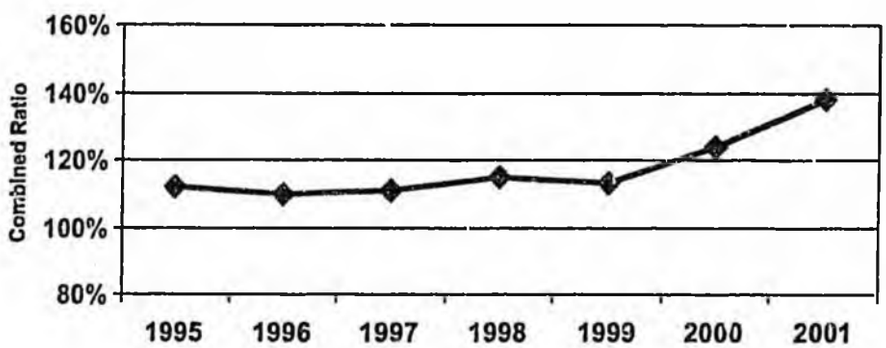
To obtain a better understanding of the effect of these changing conditions, we focus on the results of 30 specialty insurers that are primarily physician owned or operated and that write primarily medical malpractice business. Their results reflect the dynamics of the medical malpractice line. This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

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

There are two key drivers of these financial results:

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

CHART C: COMBINED RATIO



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

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

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

TORT REFORM

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

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

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

FREQUENT MISCONCEPTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Physician Insurers Association of America
2275 Research Blvd., Suite 250, Rockville, MD 20850
Telephone (301) 947-9000 Fax (301) 947-9090

STATEMENT

OF THE

PHYSICIAN INSURERS ASSOCIATION OF AMERICA

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

Before the

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

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

Wednesday, July 17, 2002

STATEMENT
OF THE
PHYSICIAN INSURERS ASSOCIATION OF AMERICA

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

Before the

Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

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

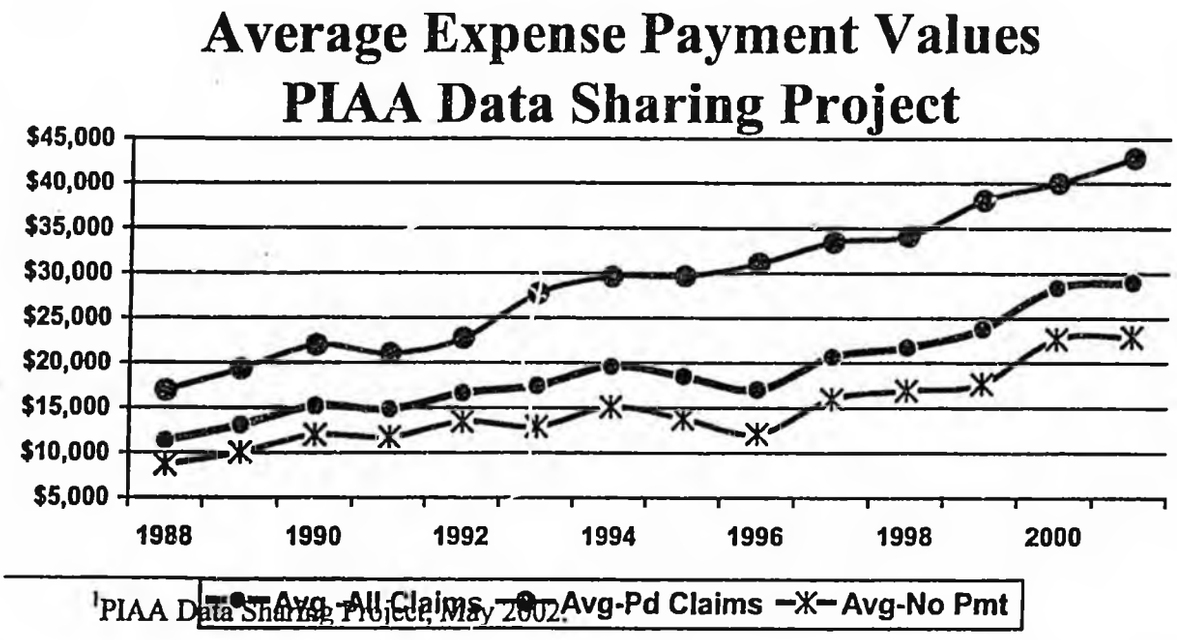
Wednesday July 17, 2002

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

care.

BACKGROUND

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



[1] PIAA Data Sharing Project, May 2002.

ROOTS OF THE CURRENT ENVIRONMENT

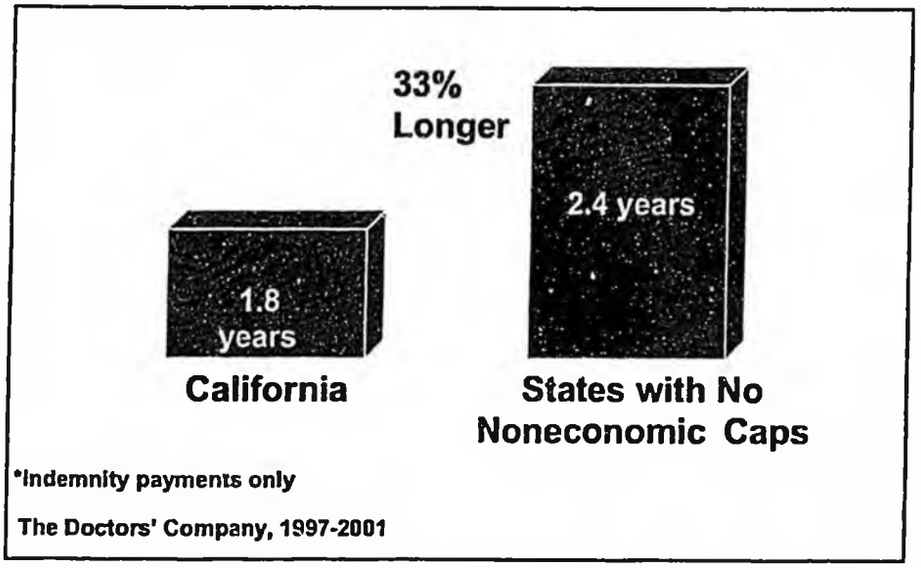
Medical liability claims were fairly uncommon until the 1970s. In the 40 year period between 1935 and 1975, 80% of all medical malpractice lawsuits were filed in the last five years of that period.[2] Massive losses between 1970 and 1975 forced many commercial insurers to conclude that the practice of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

A LITIGIOUS SOCIETY GROWS

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

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

MICRA Reduces Average Time to Settlement



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

---

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

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

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

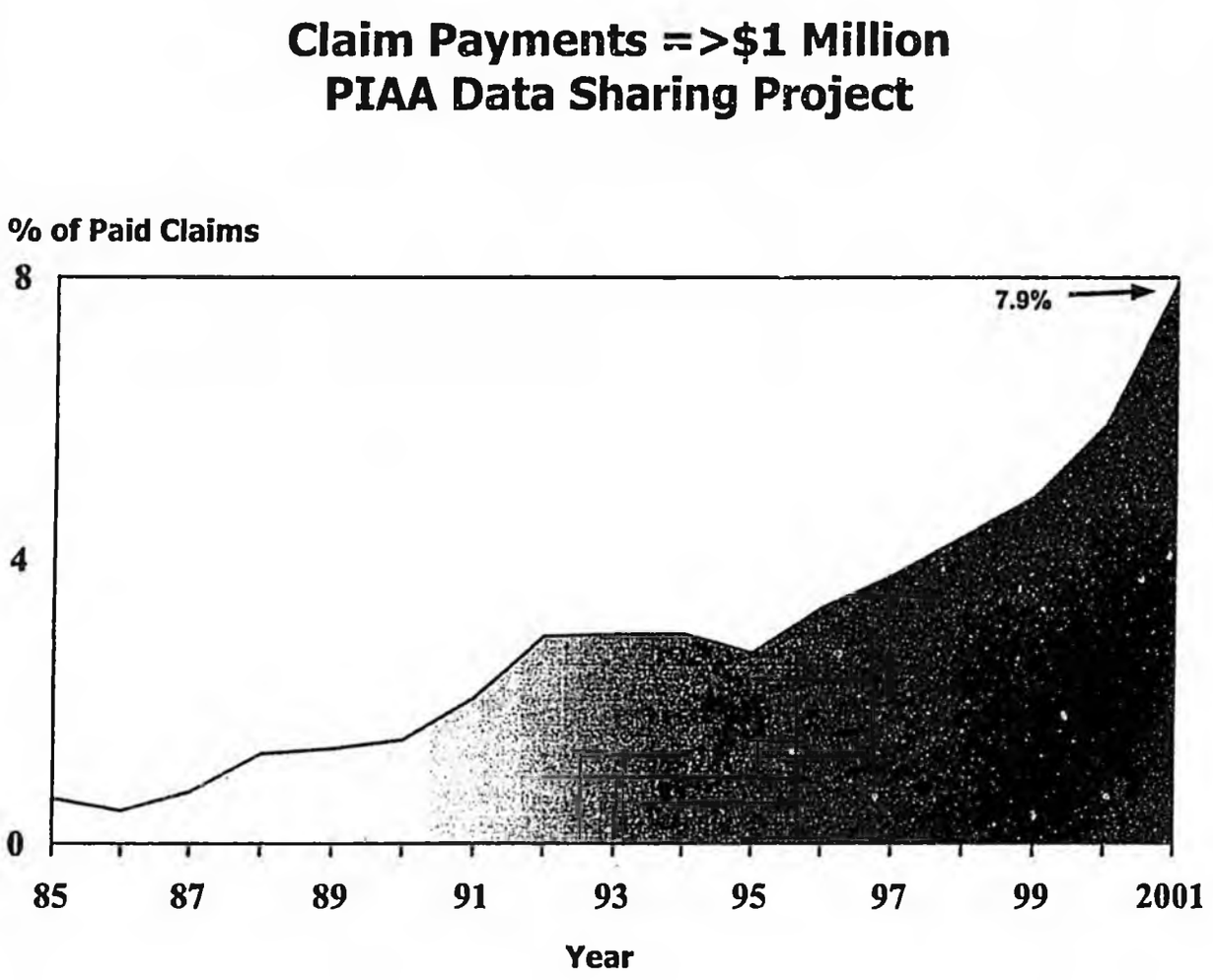
THE PERFECT STORM

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

---

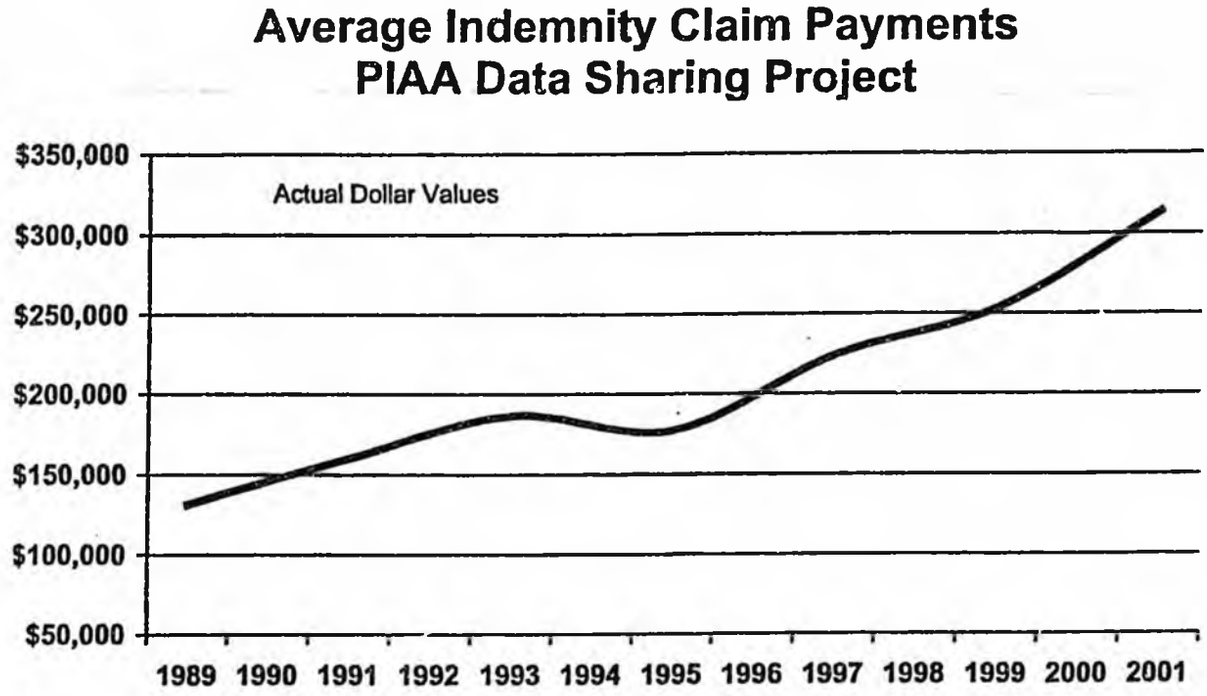
[3]PIAA Data Sharing Project, December, 2001.

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



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

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



*Per defendant - many claims have more than one defendant

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

THE CURRENT SITUATION

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

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

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

IN CONCLUSION

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

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

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

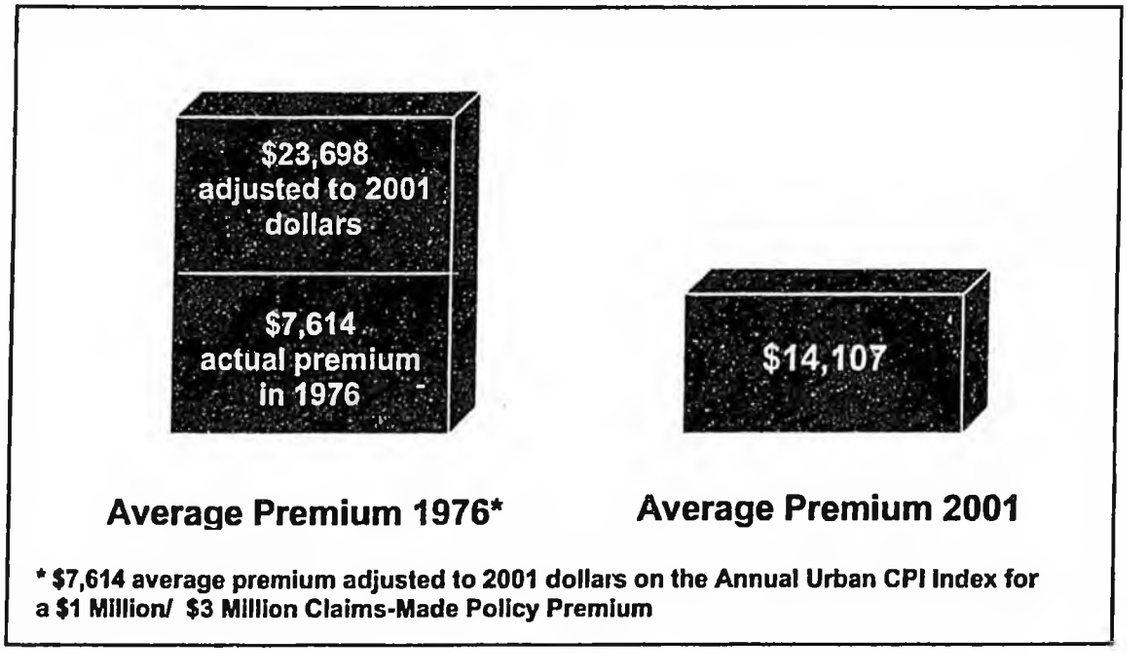
Third, it is argued that insurance companies fail to settle claims when they should, and are therefore, exposed to astronomic jury verdicts. Again, reality is quite different. In most cases, it is the physician, not the company, who must make any settlement decision. Remember that doctors are found to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

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

THERE IS A "TRIED AND TRUE" SOLUTION

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

MICRA Helps Reduce California Medical Liability Premium Rates by 40%



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

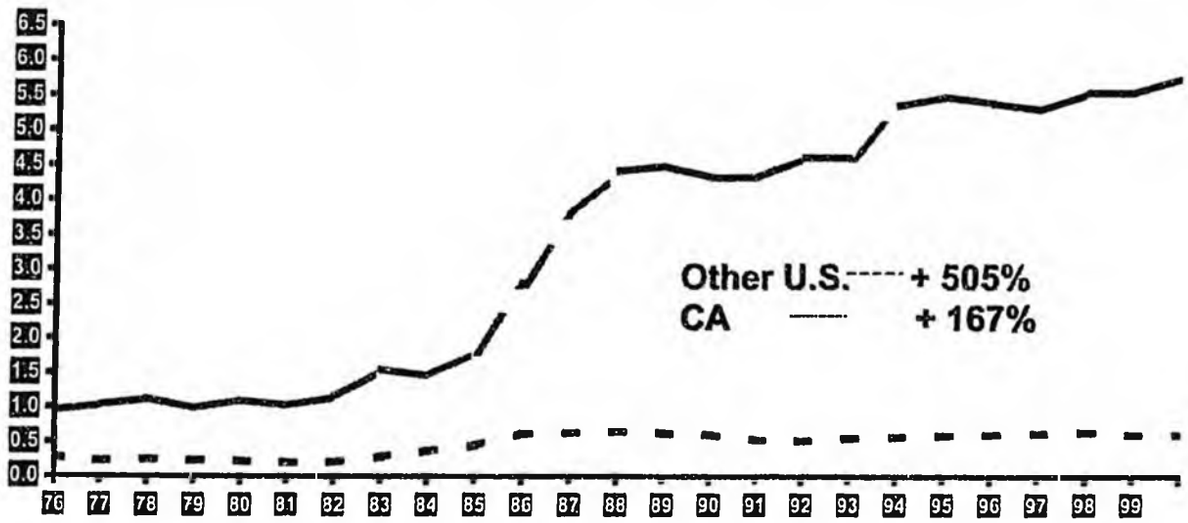
We know, we do not speculate, that even very large judgments can be accommodated by the insurance system because they can be paid on an annual basis over the intended period of compensation, not as a single jackpot.

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

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

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

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



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

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

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

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

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

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

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

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

Gallagher Healthcare Insurance Services

A SUBSIDIARY OF ARTHUR J. GALLAGHER & CO

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

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

1. A sustained escalation of underwriting losses-

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

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

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

2. A decline in investment income-

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

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

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

3. An epidemic of national proportions-

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

The states "in crisis" share several key characteristics-

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

4. Emerging marketplace issues-

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

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

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

So what is the Reinsurers' response?

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

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

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

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

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

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

Footnotes:

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

Deb Ropelewski, CPCU, ARM, ARe
Division Senior Vice President
Gallagher Healthcare Insurance Services
Direct Dial Number: (615)279-7216
ph. (615)292-2286 x216; fax (615)292-8421
E-mail: Deborah_Ropelewski@ajg.com

amednews.com
THE NEWSPAPER FOR AMERICA'S PHYSICIANS

PROFESSIONAL ISSUES

Liability insurance crisis: Bigger awards just one factor

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

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

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

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

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

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

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

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

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

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

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

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

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

How costs got here

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

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

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

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

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

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

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

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

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

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

Damage caps could offer relief

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

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

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

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

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

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

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

Back to top.

ADDITIONAL INFORMATION:

Jury awards kept going up...

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

... But settlements went down

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

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

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

Back to top.

Going to trial

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

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

* Settlement median unavailable.

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

Back to top.

ATRA Tort Reform Record

1101 Connecticut Avenue, NW • Suite 400 • Washington, DC 20036
(202) 682-1163 • Fax (202) 682-1022 • www.atra.org

December 31, 2003

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

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

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

CONTENTS

Tort Reform Record

At-A-Glance

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

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

Tort Reform Record

At-A-Glance

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

*Tennessee abolished joint and several liability by judicial decision

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

THE RULE OF JOINT AND SEVERAL LIABILITY

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

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

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

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

ALASKA

1988—Proposition Two

Barred application of the rule of joint and several liability in the recovery of all damages through a ballot initiative on November 8, 1988.

ARIZONA

1987—SB 1036

Barred application of the rule of joint and several liability in the recovery of all damages, except in cases of intentional torts and hazardous waste.

The Arizona Court of Appeals upheld the constitutionality of this statute in Church v. Rawson Drug & Sundry Co., No. 1 CA-CV 90-0357, October 1, 1992.

ARKANSAS

2003—HB 1038

Modified repeal of joint and several liability instead of complete repeal, whereby defendants who are found to be 1 percent to 10 percent at fault will only be responsible for the percentage of damage caused, defendants who are 11 percent to 50 percent at fault could have their share of a judgment increased up to an additional 10% if a co-defendant is unable to pay its share of a judgment, and defendants who are 51% to 99% at fault could have their share of a judgment increased up to an additional 20% if a co-defendant is unable to pay its share of the judgment. The reform applies to all

GEORGIA

1987—HB 1

Barred application of the rule of joint and several liability in the recovery of all damages when a plaintiff is assessed a portion of the fault.

HAWAII

1994—HB 1088

Barred application of the rule of joint and several liability in the recovery of all damages from all governmental entities.

1986—SB S1

Barred application of the rule of joint and several liability in the recovery of noneconomic damages from defendants found to be 25% or less at fault. The reform does not apply to auto, product, or environmental cases.

IDAHO

1990—HB 744

Defined the term "acting in concert," as used in SB 1223 (below), as pursuing a common plan or design that results in the commission of an intentional or reckless tortious act.

1987—SB 1223

Barred application of the rule of joint and several liability in the recovery of all damages, except in cases of intentional torts, hazardous waste, and medical and pharmaceutical products.

ILLINOIS

1995—HB 20

Barred application of the rule of joint and several liability in the recovery of all damages.

Held unconstitutional by the Illinois Supreme Court in Best v. Taylor Machine Works, Inc., December 1997.

1986—SB 1200

Barred application of the rule of joint and several liability in the recovery of noneconomic damages from defendants found to be 25% or less at fault. The reform does not apply to auto, product, or environmental cases.

IOWA

1997—HF 693

Provided that defendants found to be 50% or more at fault are jointly liable for economic damages only.

1985

Barred application of the rule of joint and several liability in the recovery of all damages from defendants who are found to be less than 50% at fault.

1989—HB 1171

Provided that the rule of joint and several liability only applies to the extent necessary for the injured party to receive 50% of his or her recoverable damages.

MISSOURI

1987—HB 700

Barred application of the rule of joint and several liability in the recovery of all damages when a plaintiff is assessed a portion of the fault.

MONTANA

1997—HB 571

Retained the current system of modified joint and several liability, where joint liability does not apply to defendants found to be less than 50% at fault. Revised the comparative negligence statute to permit the allocation of a percentage of liability to defendants who settle or are released from liability by the plaintiff. Allowed those defendants to intervene in the action to defend against claims affirmatively asserted.

1997—HB 572

Barred application of the rule of joint and several liability in the recovery of all damages.

Takes effect only if HB 571 is held unconstitutional.

1995—SB 212

Restored the joint and several liability reforms of 1987, which had been weakened by the Montana Supreme Court. Provided procedural safeguards to allow joint liability to apply only when a defendant is found to be more than 50% at fault.

1987—SB 51

Barred application of the rule of joint and several liability in the recovery of all damages from defendants found to be 50% or less at fault.

NEBRASKA

1991—LB 88

Modified the rule of joint and several liability by replacing the slight-gross negligence rule with a 50/50 rule, in which the plaintiff wins if the plaintiff's responsibility is less than the responsibility of all the defendants; Barred application of the rule of joint and several liability in the recovery of noneconomic damages.

NEVADA

2002—AB 1

Barred application of the rule of joint and several liability in the recovery of noneconomic damages for medical liability claims.

OHIO

1996—HB 350

Barred application of the rule of joint and several liability in the recovery of all damages from defendants found to be less than 50% at fault. Barred application of the rule of joint and several liability in the recovery of noneconomic damages from defendants found to be more than 50% at fault.

Held unconstitutional in *Ohio Academy of Trial Lawyers v. Sheward*, August 1999.

1987—HB 1

Barred application of the rule of joint and several liability in the recovery of noneconomic damages when the plaintiff is also assessed a portion of the fault.

OREGON

1995—SB 601

Barred application of the rule of joint and several liability in the recovery of all damages, except where the defendants is determined to be insolvent within one year of the final judgment. In those cases, a defendant less than 20% at fault would be liable for no more than two times her original exposure and a defendant more than 20% liable would be liable for the full amount of damages.

1987—SB 323

Barred application of the rule of joint and several liability in the recovery of noneconomic damages. Barred application of the rule of joint and several liability in the recovery of all damages, where the defendant is found to be less than 15% at fault.

PENNSYLVANIA

2002—SB 1089

Barred application of the rule of joint and several liability in the recovery of all damages, except when a defendant has not: (1) been found liable for intentional fraud or tort; (2) been held more than 60% liable; (3) been held liable for environmental hazards, or; (4) been held civilly liable as a result of drunk driving.

SOUTH DAKOTA

1987—SB 263

Provided that "any party who is allocated less than 50% of the total fault allocated to all parties may not be jointly liable for more than twice the percentage of fault allocated to that party."

TEXAS

2003—HB 4

Defendant pays only assessed percentage of fault unless defendant is 50% or more responsible.

Defendants can designate (as opposed to join) other responsible third parties whose fault contributed to causing plaintiff's harm

In toxic tort cases, the threshold for joint and several liability raised from 15% to 50%.

1994—SF 35

Amended the joint and several liability reform passed in 1986. Defined when an individual is at fault. Specified the amount of damages recoverable in cases where more than one party is at fault. Clarified the relationship between fault and negligence.

1986—SB 17

Barred application of the rule of joint and several liability in the recovery of all damages.

□□□

THE COLLATERAL SOURCE RULE

The collateral source rule of the common law says that evidence may not be admitted at trial to show that plaintiffs' losses have been compensated from other sources, such as plaintiffs' insurance, or worker compensation. As a result, for example, 35% of total payments to medical malpractice claimants are for expenses already paid from other sources.

Twenty-three states have modified or abolished the collateral source rule. Two states have had reforms struck down as unconstitutional and have not enacted additional reforms.

ALABAMA

1987

Permitted the admissibility of evidence of collateral source payments.

ALASKA

1986—SB 337

Permitted the admissibility of evidence of collateral source payments. Provided for awards to be offset with broad exclusions.

ARIZONA

1993—SB 1055

Extended the existing collateral source legislation from medical malpractice issues to other forms of liability litigation. Under this legislative approach, a jury would not be bound to deduct the amounts paid under a collateral source provision, but would be free to consider it in determining fair compensation for the injured party.

COLORADO

1986—SB 67

Permitted the admissibility of evidence of collateral source payments. Provided for awards to be offset with broad exclusions.

CONNECTICUT

1986—HB 6134

Permitted the admissibility of evidence of collateral source payments. Provided for awards to be offset with broad exclusions.

FLORIDA

1986—SB 465

Provided for awards to be offset with broad exclusions.

The Florida Supreme Court upheld the collateral source provision as constitutional in Smith v. Department of Insurance, 507 So.2d 1080 (Fla. 1987).

The $150,000 threshold for the admissibility of collateral sources into evidence was held unconstitutional by the Kansas Supreme Court in Thompson v. KFB Insurance Company, Case No. 68452 (1993).

KENTUCKY

1988—HB 551

Mandated that juries be advised of collateral source payments and subrogation of rights of collateral payers.

MAINE

1990

Provided for awards to be offset by collateral source payments, where the collateral sources have not exercised subrogation rights within 10 days after a verdict for the plaintiff.

MICHIGAN

1986—HB 5154

Permitted the admissibility of evidence of collateral source payments after the verdict and before judgment is entered. Permitted courts to offset awards, as long as a plaintiff's damages are not reduced by more than the amount awarded for economic damages.

MINNESOTA

1986—SB 2078

Permitted the admissibility of evidence of collateral source payments only for the court's review. Provided for awards to be offset by collateral source payments, unless the source of reimbursement has a subrogation right.

MISSOURI

1987—HB 700

Permitted the admissibility of evidence of collateral source payments, but provided that a defendant who presents collateral source payments as evidence waives his right to a credit against the judgment for that amount.

MONTANA

1987—HB 567

Permitted the admissibility of evidence of collateral source payments, unless the source of reimbursement has a subrogation right under state or federal law. Required a court to offset damages over $50,000.

NEW JERSEY

1987—SB 2703, SB 2708

Provided for awards to be offset by collateral source payments other than workers' compensation and life insurance benefits.

PUNITIVE DAMAGES

Punitive damages are awarded not to compensate a plaintiff, but to punish a defendant for intentional or malicious misconduct and to deter similar future misconduct. While punitive damages awards are infrequent, their frequency and size have grown greatly in recent years. More importantly, they are routinely asked for today in civil lawsuits. The difficulty of predicting whether punitive damages will be awarded by a jury in any particular case, and the marked trend toward astronomically large amounts when they are awarded, have seriously distorted settlement and litigation processes and have led to wildly inconsistent outcomes in similar cases. ATRA recommends four reforms:

- Establishing a liability "trigger" that reflects the intentional tort origins and quasi-criminal nature of punitive damages awards - "actual malice."
- Requiring "clear and convincing evidence" to establish punitive damages liability.
- Requiring proportionality in punitive damages so that the punishment fits the offense.
- Enacting federal legislation to address the special problem of multiple punitive damages awards; This would protect against unfair overkill, guard against possible due process violations, and help preserve the ability of future claimants to recover basic out-of-pocket expenses and damages for their pain and suffering.

Thirty-three states have reformed punitive damages laws. One state had reforms struck down as unconstitutional and has not enacted additional reforms.

ALABAMA

1999—SB 137

In non-physical injury cases:

1) General rule: Limited the award of punitive damages to the greater of three times the award of compensatory damages or $500,000.

2) For businesses with a net worth of less than $2 million: Limited the award of punitive damages to $50,000 or 10% of net worth up to $200,000, whichever is greater.

In physical injury cases: Limited the award of punitive damages to the greater of three times the award of compensatory damages or $1.5 million.

Prohibited application of the rule of joint and several liability in actions for punitive damages, except for wrongful death actions, actions for intentional infliction of physical injury, and class actions.

Provided that the limit on punitive damages will be adjusted on January 1, 2003 and increased at three-year intervals in accordance with the Consumer Price Index.

1987

Required a plaintiff to show by "clear and convincing" evidence that a defendant acted with "wanton" conduct.

Limited punitive damages to the greater of $250,000 or three times compensatory damages, not to exceed $1,000,000.

Provided for bifurcated proceedings for punitive damages.

CALIFORNIA

1987—SB 241

Required a plaintiff to show by "clear and convincing" evidence that a defendant acted with oppression, fraud, or malice.

Required the determination of awards for punitive damages to be made in a separate proceeding, allowing evidence of defendants' financial conditions only after a finding of liability.

COLORADO

2003—HB 1186

Prohibited a plaintiff from filing a claim for punitive damages unless the claim can show evidence of willful or wanton action that would justify such a claim.

1991—HB 1093

Expanded the 1990's prohibition against seeking punitive damages in cases in which FDA-approved drugs are administered by a physician to include medically prescribed drugs or products used on an experimental basis (when such experimental use has not received specific FDA approval) and when the patient has given informed consent.

1990—HB 1069

Provided that punitive damages may not be alleged in a professional negligence suit until discovery is substantially completed.

Provided that discovery cannot be reopened without an amended pleading.

Provided that physicians cannot be liable for punitive damages because of the bad outcome of a prescription medication, as long as it was administered in compliance with current FDA protocols.

Prohibited punitive damages from being assessed against a physician because of the act of another unless she directed the act or ratified it.

1986—HB 1197

Provided that an award for punitive damages may not exceed an award for compensatory damages. Permitted a court to reduce a punitive damages award if deterrence can be achieved without the award. Permitted a court to increase a punitive damages award to three times an award for compensatory damages if misbehavior continues during trial.

Required one-third of punitive damages awards to be paid to the state fund.

The Colorado Supreme Court held the state fund portion of this statute unconstitutional in Kirk v. The Denver Publishing Company, 15 Brief Times Reporter, No. 88SA405, September 23, 1991.

IDAHO

2003—HB 92

Limited the award of punitive damages to the greater of three times the award of compensatory damages or $250,000.

Raised the standard for the imposition of punitive damages to "clear and convincing evidence"

1987—SB 1223

Required a plaintiff to show by a preponderance of evidence that a defendant's conduct was "oppressive, fraudulent, wanton, malicious or outrageous."

ILLINOIS

1995—HB 20

Limited the award of punitive damages to three times the award of economic damages.

Prohibited the award of punitive damages absent a showing that conduct was engaged in "with an evil motive or with a reckless indifference to the rights of others."

Required the determination of awards for punitive damages to be made in a separate proceeding.

Held unconstitutional by the Illinois Supreme Court in Best v. Taylor Machine Works, Inc., December 1997.

1986—SB 1200

Prohibited plaintiffs from pleading punitive damages in an original complaint.

Required a subsequent motion for punitive damages to show at a hearing a reasonable chance that the plaintiff will recover an award for punitive damages at trial.

Required a plaintiff to show that the defendant acted "willfully and wantonly."

Provided discretion to the court to award punitive damages among the plaintiff, the plaintiff's attorney, and the State Department of Rehabilitation Services.

INDIANA

1995—HB 1741

Limited the award of punitive damages to the greater of three times the award of compensatory damages or $50,000.

Required 75% of punitive damage awards to be paid to the state fund.

The Kentucky Supreme Court held the "clear and convincing" evidence standard that conduct constituted oppression, fraud or malice unconstitutional in Terri C. Williams v. Patricia Lynn Herald Wilson, No. 96-SC-1122-DG, April 16, 1998.

LOUISIANA

1996—HB 20

Repealed the statute that authorized punitive damages to be awarded for the wrongful handling of hazardous substances. (The Louisiana courts had established precedents substantially expanding liability based upon the repealed statute.)

MINNESOTA

1990—Minn. Stat. Sec. 549.20

Required a plaintiff to show that a defendant acted with "deliberate disregard." (The former standard required only a showing of "willful indifference.")

Required the determination of awards for punitive damages to be made in a separate proceeding at the request of the defendant.

Granted trial and appellate judges the power to review all punitive damages awards.

1986—SB 2078

Prohibited plaintiffs from pleading punitive damages in an original complaint. Required a plaintiff to make a *prima facie* showing of liability before an amendment of pleadings is permitted by the court.

MISSISSIPPI

1993—HB 1270

Required a plaintiff to prove punitive damages by "clear and convincing" evidence.

Required the determination of awards for punitive damages to be made in a separate proceeding.

Prohibited the award of punitive damages in the absence of compensatory awards.

Prohibited the award of punitive damages against an innocent seller.

Established factors for the jury to consider when determining the amount of a punitive damages award.

MISSOURI

1987—HB 700

Required the determination of awards for punitive damages to be made in a separate proceeding. Permitted the jury to set the amount for punitive damages if, in the first stage, the jury finds a defendant liable for punitive damages. Permitted the admissibility of evidence of a defendant's net worth only during the proceeding for the determination of punitive damages.

NEW HAMPSHIRE

1986—HB 513

Prohibited the award of punitive damages.

NEW JERSEY

1995—SB 1496

Limited the award of punitive damages to the greater of five times the award of compensatory damages or $350,000.

The reform does not apply to cases involving bias crimes, discrimination, AIDS testing disclosure, sexual abuse, and injuries caused by drunk drivers.

1987—SB 2805

Required a plaintiff to show that a defendant acted with "actual malice" or "wanton and willful disregard" for the rights of others.

Required the determination of awards for punitive damages to be made in a separate proceeding.

Provided for an FDA government standards defense to punitive damages.

The reform does not apply to cases involving environmental torts.

NEW YORK

1992—SB 7589

Required that 20% of all punitive damages awards be paid to the New York State General Fund.

NORTH CAROLINA

1995—HB 729

Limited the award of punitive damages to the greater of three times the award of compensatory damages or $250,000. The reform does not apply to cases where the defendant caused the injury by driving while impaired.

Required a plaintiff to show by "clear and convincing" evidence that a defendant was liable for compensatory damages and acted with fraud, malice, willful or wanton conduct.

Required the determination of awards for punitive damages to be made in a separate proceeding at the request of the defendant.

NORTH DAKOTA

1997—HB 1297

Required a plaintiff to show by a preponderance of the evidence that a defendant acted with oppression, fraud, or actual malice before a moving party may amend pleadings and claim punitive damages.

OKLAHOMA

1995—SB 263

Codified factors that the jury must consider in awarding punitive damages.

Provided that when a jury finds by "clear and convincing" evidence that the defendant:

1) Acted in "reckless disregard for the rights of others," the award is limited to the greater of $100,000 or actual damages awarded; or

2) Acted intentionally and with malice, the award is limited to $500,000; two times the award of actual damages; or the increased financial benefit derived by the defendant or insurer as a direct result of the conduct causing injury.

The limit does not apply if the court finds evidence *beyond a reasonable doubt* that the defendant acted intentionally and with malice in conduct life-threatening to humans.

1986—SB 488

Limited the award of punitive damages to the award of compensatory damages, unless a plaintiff establishes her case by "clear and convincing" evidence, in which case no limit applies.

OREGON

1995—SB 482

Required 40% of punitive damages awards to be paid to the prevailing party, 60% to the state fund, and no more than 20% to the attorney of the prevailing party.

Required a plaintiff to show by "clear and convincing" evidence that a defendant "acted with malice or has shown a reckless and outrageous indifference to a highly unreasonable risk of harm and has acted with a conscious indifference to the health, safety and welfare of others."

Provided for court review of jury-awarded punitive damages.

Barred the claiming of punitive damages in an original complaint. Required a plaintiff to show a *prima facie* case for liability before amending a complaint to include a punitive damages claim.

1987—SB 323

Required a plaintiff to prove punitive damages by "clear and convincing" evidence.

Provided an FDA standards defense to punitive damages.

SOUTH CAROLINA

1988

Required a plaintiff to prove punitive damages by "clear and convincing" evidence.

SOUTH DAKOTA

1986—SB 280

Required a plaintiff to prove by "clear and convincing" evidence that a defendant acted with "willful, wanton, or malicious" conduct.

NONECONOMIC DAMAGES

Damages for noneconomic losses are damages for pain and suffering, emotional distress, loss of consortium or companionship, and other intangible injuries. These damages involve no direct economic loss and have no precise value. It is very difficult for juries to assign a dollar value to these losses, given the minimal guidance they customarily receive from the court. As a result, these awards tend to be erratic and, because of the highly charged environment of personal injury trials, excessive.

ATRA believes that the broad and basically unguided discretion given juries in awarding damages for noneconomic loss is the single greatest contributor to the inequities and inefficiencies of the tort liability system. It is a difficult issue to address objectively because of the emotions involved in cases of serious injury and because of the financial interests of plaintiffs' lawyers.

Eighteen states have modified the rules for awarding noneconomic damages. Five states have had reforms struck down as unconstitutional and have not enacted additional reforms.

ALABAMA

1987

Limited the award of noneconomic damages to $250,000 in medical liability cases.

The Supreme Court of Alabama found the limit on noneconomic damages unconstitutional in Moore v. Mobile Infirmary Association, 592 So. 2d 156 (1991).

ALASKA

1997—HB 58

Limited the award of noneconomic damages to the greater of $400,000 or the injured person's life expectancy in years multiplied by $8,000, unless the plaintiff "suffers severe permanent physical impairment or severe disfigurement," in which case noneconomic damages are limited to the greater of $1,000,000 or the injured person's life expectancy multiplied by $25,000.

1986—SB 337

Limited the award of noneconomic damages for injuries other than physical impairment or disfigurement to $500,000.

COLORADO

2003—HB 1012

Limited the award of noneconomic damages to $300,000 in medical liability cases.

1988— SB 143

Limited the total award of damages to $1,000,000, of which no more than $250,000 can be for noneconomic damages.

1990—HB 574

Removed the 1992 sunset to the $400,000 limit on noneconomic damages enacted in 1987.

1987—SB 1223

Limited the award of noneconomic damages to $400,000; provided a sunset in June 1992.

ILLINOIS

1995—HB 20

Limited the award of noneconomic damages in all civil actions to $500,000 per plaintiff, indexed for inflation.

Held unconstitutional by the Illinois Supreme Court in Best v. Taylor Machine Works, Inc., December 1997.

KANSAS

1988—HB 2692

Limited the award of noneconomic damages to $250,000.

1987

Limited the award of damages for pain and suffering to $250,000. The reform does not limit the award of other noneconomic damages.

MARYLAND

2001—HB 714

Provided that an individual driving a motor vehicle that is not covered by insurance is considered to have waived the right to recover noneconomic damages under specified circumstances.

1994—SB 283

Limited the award of noneconomic damages in wrongful death actions to $500,000, where there is one beneficiary, and $700,000, where there are two or more beneficiaries. (The legislation somewhat countered the effect of the *Streidel* decision, which held that Maryland's $350,000 limit on noneconomic damages did not apply in wrongful death actions.)

1987—SB 237

Limited the award of noneconomic damages in public entity lawsuits to $200,000 per person and $500,000 per incident.

1986—SB 558

Limited the award of noneconomic damages to $500,000.

The Court of Special Appeals of Maryland upheld the constitutionality of the noneconomic damages limit in Potomac Electric Co. v. Smith, 79 Md. App. 591, 558 A.2d 768 1989.

OHIO

2003—SB 281

Limited the award of noneconomic damages in medical malpractice cases to $350,000, with a provision to allow the cap to rise to $1 million, depending on the severity of the injuries and the number of plaintiffs involved in the suit.

1997—HB 350

Limited the award of noneconomic damages to the greater of $250,000 or three times economic damages to a maximum of $500,000, unless there is a finding that a plaintiff suffered:

1) a permanent and severe physical deformity; or

2) a permanent physical functional injury that permanently prevents her from being able to independently care for herself and perform life sustaining activities.

If a plaintiff establishes the criteria set forth above, noneconomic damages are limited to the greater of $1 million or $35,000 times the number of years remaining in the plaintiff's expected life.

Held unconstitutional by the Ohio Supreme Court in Ohio Academy of Trial Lawyers v. Sheward, August 1999.

OKLAHOMA

2003—SB 629

Limited the award of noneconomic damages to $350,000 in cases involving pregnancy (labor, delivery, and post partum period) as well as emergency care.

OREGON

1987—SB 323

Limited the award of noneconomic damages to $500,000.

The Oregon Supreme Court declared the $500,000 limit on noneconomic damages unconstitutional in the case of Larkin v. Senco Products, Inc. — P.2d. —, 1999 WL 498088 Or. July 15, 1999.

TEXAS

2003—H.J.R. 3 (PROPOSITION 12)

Constitutional amendment that provided the Texas Legislature with the authority to place limits on noneconomic damages.

2003—HB 4

Limited the award of noneconomic damages in medical malpractice cases to $250,000 against all doctors and health care practitioners and a $250,000 per-facility cap against health care facilities such as hospitals and nursing homes, with an overall cap of $500,000 against health care facilites, creating in effect an overall limit of noneconomic damages in medical malpractice cases of $750,000.

PREJUDGMENT INTEREST

In the absence of an applicable statute or rule, the courts generally applied the traditional common law rule that prejudgment interest was not available in tort actions since the claim for damages was unliquidated. In an effort to compensate tort plaintiffs for the often-considerable lag between the event giving rise to the cause of action, or filing of the lawsuit, and the actual payment of the damages, many state legislatures have enacted laws that provide for or allow prejudgment interest in particular tort actions or under particular circumstances. In addition to seeking to compensate the plaintiff fully for losses incurred, the goal of such statutes is to encourage early settlements and to reduce delay in the disposition of cases, thereby lessening congestion in the courts. Although well-intended, the practical effects of prejudgment interest statutes can be inequitable and counter-productive. Prejudgment interest laws can, for example, result in over-compensation, hold a defendant financially responsible for delay it may not have caused, and impede settlement.

At a time when policymakers are attempting to lower the cost of the liability system in an equitable and just manner, prejudgment interest laws that currently exist and new proposals should be reviewed to ensure that they are structured fairly and in a way designed to foster settlement. At a minimum, the interest rate should reflect prevailing interest rates by being indexed to the treasury bill rate at the time the claim was filed and an offer of judgment provision should be included.

Fourteen states have enacted prejudgment interest reforms.

ALASKA

1997—HB 58

Set prejudgment interest rates at the Twelfth Federal Reserve District's discount rate plus 3%.

Prohibited the assessment of prejudgment interest for future damages and punitive damages.

COLORADO

1995—SB 165

Limited the amount of prejudgment interest that can be assessed between accrual of the action and filing of the claim to below the $1,000,000 limit on the total amount recoverable in medical liability claims.

GEORGIA

2003—HB 792

Set prejudgment interest rates at the Federal Reserve's prime interest rate plus 3%.

IOWA

1997—HF 693

Set prejudgment interest rates at the U.S. Treasury Rate plus 2%.

1987—SF 482

Prohibited the assessment of prejudgment interest for future damages. (Other interest accrues from the date of commencement of the actions at a rate based on the U.S. Treasury Bill.)

1986—SB 488

Prohibited the assessment of prejudgment interest on punitive damages awards.

Set the prejudgment interest rate at 4% above the rate on the U.S. Treasury Bill.

RHODE ISLAND

1987—HB 5885

Set the prejudgment interest rate at the U.S. Treasury Bill rate. Provided that interest accrues from the date the lawsuit is filed.

TEXAS

2003—HB 4

Set the prejudgment interest rate to the New York Federal Reserve prime rate, with a floor of 5% and a ceiling of 15%.

1987—SB 6

Limited the period during which prejudgment interest may accrue if the defendant has made an offer to settle.

□□□

PRODUCT LIABILITY

Product liability law is meant to compensate persons injured by defective products and to deter manufacturers from marketing such products. It fails, however, when it does not send clear signals to manufacturers about how to avoid liability or holds manufacturers liable for failure to adopt a certain design or warning even if the manufacturers neither know, nor could have anticipated, the risk.

Fifteen states have enacted laws specifically to address product liability. Three states have had reforms struck down as unconstitutional and have not enacted additional reforms.

CALIFORNIA

1986—SB 241

Confirmed that under California law, products like foods high in cholesterol, alcohol, and cigarettes, which are inherently unsafe and which ordinary consumers know to be unsafe, should not be the basis for product liability lawsuits.

COLORADO

2003—SB 03-231

Provided that a product liability action could not be taken against a manufacturer or seller of a product if the product was used in a manner other than which the product was intended and which could not reasonably have been expected.

Provided for an innocent seller provision which prohibits product liability action against parties who were not the manufacturer of the product.

FLORIDA

1999—HB 775

Provided a 12-year statute of repose for products with a useful life of 10 years or less, unless the product is specifically warranted a useful life longer than 12 years.

Provided a 20-year statute of repose for airplanes or vessels in commercial activity, unless the manufacturer specifically warranted a useful life longer than 20 years.

The reform does not apply to cases involving improvements to real property, including elevators and escalators; latent injury cases; and cases where the manufacturer, acting through its officers, directors or managing agents, took affirmative steps to conceal a known defect in the product.

GEORGIA

1987—HB 1

Permitted only one award of punitive damages to be assessed against any given defendant in product liability cases.

Provided that a manufacturer of a product shall not be liable for damages proximately caused by a characteristic of the product's design, if the manufacturer proves that at the time the product left his control:

1) he did not know and, in light of then-existing reasonably available scientific and technological knowledge, could not have known of the design characteristic that caused the damage;

2) he did not know and, in light of then-existing reasonable available scientific and technological knowledge, could not have known of the alternative design identified by the plaintiff; or

3) the alternative design identified by the plaintiff was not feasible, in light of then-existing reasonably available scientific and technological knowledge or existing economic practicality.

MAINE

1996—LD 346

Provided that "subsequent remedial measures" or steps taken after an accident to repair or improve the site of injury are not admissible as evidence of negligence.

MICHIGAN

1995—SB 344

Barred application of the rule of joint and several liability in product liability cases.

Provided statutory defenses to product liability claims, including adherence to government standards, FDA standards, and sellers' defenses. Provided an absolute defense, where the plaintiff was found to be at least 50% at fault due to intoxication or a controlled substance.

Limited the award of noneconomic damages in product liability cases not involving death or loss of vital bodily function to $280,000; Limited the award of noneconomic damages in such cases to $500,000.

1995—HB 4508

Provided venue control in product liability cases.

MISSISSIPPI

1993—HB 1270

Required product liability cases to be based on a design, manufacturing or warning defect, or breach of an express warranty, which caused the product to be unreasonably dangerous.

Provided that a product that contains an inherently dangerous characteristic is not defective if the dangerous characteristic cannot be eliminated without substantially reducing the product's usefulness or desirability and the inherent characteristic is recognized by the ordinary person with ordinary knowledge common to the community.

Provided that a product's design is not defective if the harm results from an inherent characteristic of the product that is known to the ordinary person who uses or consumes it.

Provided that a manufacturer or seller is not liable for a design defect if the harm results from an *unavoidably unsafe aspect* of a product and the product was accompanied by an *adequate warning.*

Provided that the state of the art provision does not apply if the court makes all of the following determinations:

1) that the product is egregiously unsafe;

2) that the user could not be expected to have knowledge of the product's risk; and

3) that the product has little or no usefulness.

Provided that a manufacturer or seller in a warning-defect case is not liable if an *adequate warning* is given. (An adequate warning is one that a reasonably prudent person in the similar circumstances would have provided.) Established a rebuttable presumption that a government (FDA) warning is adequate.

NORTH CAROLINA

1995—HB 637

Expressly provided that there shall be no strict liability in tort for product liability actions.

Provided statutory defenses to product liability claims, including assumption of the risk.

NORTH DAKOTA

1995—HB 1369

Established a ten-year statute of repose in product liability actions.

Provided a government standards defense.

Prohibited the award of punitive damages, when a manufacturer complies with government standards.

The 10-year statute of repose was found unconstitutional in Dickie v. Farmers Union Oil Co., 2000 ND 111 (N.D. May 25, 2000).

OHIO

1996—HB 350

Amended product liability law to include additional requirements for establishing liability.

Prohibited expanding theories of liability, including enterprise liability.

Adopted a fifteen-year statute of repose in product liability cases, absent latent harm or fraud.

Held unconstitutional by the Ohio Supreme Court in Ohio Academy of Trial Lawyers v. Sheward, August 1999.

CLASS ACTION REFORM

Once considered a tool of judicial economy that aggregated many cases with similar facts, or similar complaints into a single action, class actions are now often considered a means of defendant extortion. Today, some class actions are meritless cases in which thousands, or millions, of plaintiffs are granted class status, sometimes without even notifying the defendant. In many of these cases, the victimized consumers often receive pennies, or nearly-worthless coupons, while plaintiffs' counsel receives millions in legal fees. State class action reformcan more equitably balance the interests of plaintiffs and the defendant.

Six states have reformed their laws pertaining to class actions

ALABAMA

1999—SB 72

Set procedures to certify class actions.

Codified Supreme Court rulings to ensure that a defendant receives adequate notice prior to class certification.

Provided for an immediate appeal of any order certifying a class or refusing to certify a class, and for an automatic stay of matters in the trial court pending such appeal.

COLORADO

2003—HB 03-1027

Provided for the interlocutory appeal of class action certification.

GEORGIA

2003—HB 792

Updated Georgia class action laws by providing for detailed procedures for class action cases.

Specified factors under which a court may decline to exercise jurisdiction in a cause of action of a nonresident occurring outside the state.

LOUISIANA

1997—HB 1984

Updated Louisiana class action laws by providing objective definitions of class action terms, and detailed procedures for class action cases.

OHIO

1998—HB 394

Provided for the interlocutory appeal of class action certification.

ATTORNEY RETENTION SUNSHINE

In state recoupment litigation against the tobacco industry, most states retained plaintiffs' personal injury lawyers on a contingent fee basis to assist them with their litigation. Unfortunately, many of these contracts, inked without competitive bidding, and with little or no outside oversight, were rife with political favoritism, inside dealing, and in at least one case, amid the stench of corruption. Many of these billion-dollar fees (which bore little or no relation to the value of the work performed) are being strategically reinvested into the political process, and into still more litigation. Attorney "sunshine" legislation requires legislative approval of most large contingent fee contracts, and reasserts the legislature's oversight of "regulation through litigation."

Five states have adopted this proposal.

COLORADO

2003—SB 03-086

Required monthly reports by outside counsel to include number of hours worked, court costs incurred, and to provide such data in aggregate from the effective date of the contingent fee contract.

Required, at the conclusion of representation, outside counsel to provide the state with a statement of hours worked and fees recovered through a contract for legal services between the state and outside counsel. Provided that in no instance shall the state pay fees, even on a contingent fee basis, in excess of $1,000 per hour.

KANSAS

2000—HB 2627

Required open and competitive bidding for all contingent fee contracts for legal services between the state and outside counsel, where fees and services exceed $7,500

Required proposed contracts for legal services between the state and outside counsel in excess of $1,000,000 to be submitted to the legislative budget committee for approval.

Required, at the conclusion of representation, outside counsel to provide the state with a statement of hours worked and fees recovered through a contract for legal services between the state and outside counsel. Provided that in no instance shall the state pay fees, even on a contingent fee basis, in excess of $1,000 per hour.

NORTH DAKOTA

1999—SB 2047

Required an emergency commission of the legislature to approve the attorney general's appointment of a special assistant attorney general in a case in which the amount of the controversy exceeds $150,000.

APPEAL BOND REFORM

According to Lawyer's Weekly USA, the total amount of 1999's top ten jury verdicts was three times higher than 1998's level, and 12 times higher than the 1997 total. While many of these verdicts are overturned or reduced on appeal, defendants in many states are required to post an appeal bond sometimes equal to 150 percent of the verdict in question. In an era when billion-dollar verdicts are no longer uncommon, appealing an outrageous verdict can force a company or an industry into bankruptcy. Appeal bond waiver legislation limits the size of an appeal bond when a company is not liquidating its assets or attempting to flee from justice.

Twenty-five states have adopted this proposal.

ARKANSAS

2003 —HB 1038

Limited the amount a defendant can be required to pay to secure the right to appeal to $25 million.

CALIFORNIA

2003 — AB 1752

Limited the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal to $150 million and applies to all judgments in civil litigation regardless of legal theory.

COLORADO

2003—HB 1366

Limited the amount a defendant can be required to pay to secure the right to appeal to $25 million.

FLORIDA

2003—S 2826

Limited the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal to $100 million.

2000 —HB 1721

Limited the amount a defendant can be required to pay to secure the right to appeal punitive damages awards in class actions to the lesser of 10% of the defendants net worth or $100 million.

The reform applies in out-of-state judgments during the stay period only.

Provided that a court will rescind the limit if an appellee proves by a preponderance of the evidence that the party for whom the bond to stay execution has been limited is purposefully dissipating or diverting assets outside of the ordinary course of business for the purpose of avoiding ultimate payment of the judgment.

MINNESOTA

2003—HF 750

Limited the amount a defendant can be required to pay to secure the right to appeal to $25 million.

MISSISSIPPI

2001

The Mississippi Supreme Court, acting on its own motion, imposed a $100 million limit on the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal large punitive damages verdicts.

MISSOURI

2003—SB 242

Limited the amount a defendant can be required to pay to secure the right to appeal to $50 million.

NEVADA

2001 —AB 576

Limited the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal to $50 million.

NEW JERSEY

2003—SB 2738

Limited the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal to $50 million.

NORTH CAROLINA

2003 —SB 784

Limited the amount a defendant can be required to pay to secure the right to appeal to $25 million regardless of legal theory. Provided that foreign judgments cannot be executed in North Carolina if appeal is pending in a foreign jurisdiction or the judgment has been stayed by the court that rendered it and a bond has been posted.

2000 —SB 2

Limited the amount a defendant can be required to pay to secure the right to appeal to $25 million.

Provided that limits on bond appeals for out-of-state judgments apply during the stay period only.

WEST VIRGINIA

2001—SB 661

Limited the amount a signatory to the Master Settlement Agreement can be required to pay to secure the right to appeal to $200 million.

Provided that an appeal bond may not exceed $100 million for compensatory damages and $100 million in punitive damages.

WISCONSIN

2003—AB 548

Limited the amount a defendant can be required to pay to secure the right to appeal to $100 million.

□□□

JURY SERVICE REFORM

The right to a trial by a jury of one's peers is one most Americans support and take for granted. Recently, however, our juries are becoming less and less representative of the community. Some studies indicate that up to 20% of those summoned for jury duty do not respond and some jurisdictions have an even higher no-show rate. Occupational exemptions, flimsy hardship excuses, lack of meaningful compensation, long terms of service and inflexible scheduling results in a jury pool that makes it difficult for working Americans to serve on a jury and disproportionately excludes the perspectives of many people who understand the complexity of issues at play during trial. ATRA supports legislation to improve the jury system so that defendants and plaintiffs alike receive a fair trial.

- Eliminating occupational exemptions that give allow members of certain professions to opt-out from jury service.
- Ensuring that only those who experience true hardship are excused from jury service.
- Providing jurors flexibility in scheduling their service and guaranteeing potential jurors they will not spend more than one day at the courthouse unless they are selected to serve on a jury panel.
- Protecting employees from any adverse action in the workplace due to their responding to a juror summons.
- Establishing a lengthy trial fund, financed by a nominal court filing fee, to pay jurors who serve on long civil trials.

Three states have enacted reform.

ARIZONA

2003—H.B. 2520

Required all people to serve on juries unless they experience undue or extreme physical or financial hardship.

Established a lengthy trial fund from a modest filing fee to compensate jurors a minimum of $40 and a maximum of $300 per juror, per day for trials lasting more than 10 days, starting on the eleventh day of trial. In such circumstances, jurors would also be eligible to retroactively collect at least $40 but not more than $100 per day from the fourth day to the tenth day of service.

Provided for employee protection by prohibiting an employer to require an employee to use annual or sick leave for the time spent in the jury service process. In addition, it prohibited employers to dismiss or in any other way penalize employees for responding to a jury service summons.

Provided for protection of small business owners by requiring the court to postpone the service of an employee if another employee of that business is already serving on a jury.

Allowed for one automatic postponement from service.

American Medical Association
Physicians dedicated to the health of America

1101 Vermont Avenue, NW
Washington, DC 20005

Statement

to the

Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

RE: Assessing the Need to Enact Medical Liability Reform

Presented by: Donald J. Palmisano, MD, JD

February 27, 2003

Division of Legislative Counsel
202 789-7426

Statement

of the

American Medical Association

to the

Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives

RE: Assessing the Need to Enact Medical Liability Reform

Presented by: Donald J. Palmisano, MD, JD

February 27, 2003

On behalf of the physician members of the American Medical Association (AMA), I appreciate the opportunity to testify before you today regarding an issue that is seriously threatening the availability of and access to quality health care for patients. I would especially like to express our gratitude to you, Mr. Chair, and Representatives Jim Greenwood (R-PA), Chris Cox (R-CA), Billy Tauzin (R-LA), and other cosponsors of H.R. 5 for providing a much needed focus for action at the national level.

I am Donald Palmisano, MD, JD, President-elect of the AMA and a general and vascular surgeon from New Orleans, LA. The policy of the AMA is decided through its democratic policy-making process in the AMA House of Delegates, which meets twice a year. Our House is comprised of physician delegates representing every state, nearly 100 national medical specialty societies, federal service agencies (including the Surgeon General of the United States), and six sections representing hospital and clinic staffs, resident physicians, medical students, young physicians, medical schools, and international medical graduates. AMA policy dictates support for national medical liability reform. In particular, the AMA supports H.R. 5, the HEALTH Act.

Mr. Chair, you know that our health care system is facing a crisis when patients have to leave their state to receive urgent surgical care. You know that our health care system is facing a crisis when pregnant women cannot find an OB/GYN to monitor their pregnancy and deliver their baby. You know that our health care system is facing a crisis when community health centers have to reduce their services or close their doors because of liability insurance concerns. You know that our health care system is facing a crisis when dedicated professionals, who have trained for years, want to give up the work of a lifetime and retire. You know that our health care system is facing a crisis when physicians and other health care professionals believe they work in a culture of fear, rather than a culture of safety. You know that our health care system is facing a crisis when efforts to improve patient safety and quality

We must bring common sense back to our courtrooms so that patients have access to their emergency rooms, delivery rooms, operating rooms, and physicians' offices.

THE LITIGATION SYSTEM IS CAUSING THE CRISIS

The primary cause of the growing liability crisis is the unrestrained escalation in jury awards that are a part of a legal system that in many states is simply out of control. While there have been several articles published since the mid-1990s indicating that increases in jury awards lead to higher liability premiums, in the last year a growing number of government and private sector reports show that increasing medical liability premiums are being driven primarily by increases in lawsuit awards and litigation expenses.

In his State of the Union Address last month, President Bush stressed that we all are threatened by a legal system that is out of control. The President stated that "Because of excessive litigation, everybody pays more for health care and many parts of America are losing fine doctors." The President's remarks are substantiated in several recent government and private sector reports—reports making clear that the medical liability litigation system in the United States has evolved into a "lawsuit lottery," where a few patients and their lawyers receive astronomical awards and the rest of society pays the price as access to health care professionals and services are reduced.

RECENT FEDERAL GOVERNMENT REPORTS

In a July 2002 report released by the U.S. Department of Health and Human Services (HHS), the federal government concluded that the excesses of the litigation system are threatening patients' access to health care. This federal government report states that insurance premiums are largely determined by the litigation system, and that the litigation system is inherently costly, unpredictable, and slow to resolve claims. **Just to defend a claim now costs on average over $24,000. Further, the fact that about 70 percent of claims end with no payment to the patient indicates the degree to which substantial economic resources are being squandered on fruitless legal wrangling**—resources that could be used to reduce health costs so that more Americans could find health insurance.

Even when there is a large award in favor of an injured patient, a large percentage of the award never reaches the patient. Attorney contingent fees, added with court costs, expert witness costs, and other "overhead" costs, can consume 40-50 percent of the compensation meant to help the patient.

On September 25, 2002, HHS issued an update on the medical liability crisis. This update reported on the results of a survey conducted by Medical Liability Monitor (MLM), an independent reporting service that tracks medical professional liability trends and issues. According to MLM, the survey determined that the crisis identified in HHS's July report had become worse. The federal government reported that:

> The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of malpractice insurance coverage. Premiums are spiking across all specialties in 2002.

medical liability insurance rates. The Task Force ultimately concluded that "the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages."

RECENT PRIVATE SECTOR REPORTS

Evidence that the litigation system is broken, and that the medical liability crisis is growing, is further established in a study released by Tillinghast-Towers Perrin on February 11, 2003. Tillinghast reported that "The cost of the U.S. tort system grew by 14.3% in 2001, the highest single-year percentage increase since 1986," which is "equivalent to a 5% tax on wages." This is the only study that tracks the cost of the U.S. tort system from 1950 to 2001 and compares the growth of tort costs with increases in various U.S. economic indicators. Some of the key findings of this study are stunning:

- The U.S. tort system is a highly inefficient method of compensating injured parties, returning less than 50 cents on the dollar to people it is designed to help and returning only 22 cents to compensate for actual economic loss.

- As of 2001, U.S. tort costs accounted for slightly more than 2% of GDP, signaling an increase after a 13-year decline in the ratio of tort costs to GDP.

- While the cost of the U.S. tort system has increased one hundred fold over the last fifty years, GDP has grown by a factor of only 34.

- **Medical malpractice costs have risen an average of 11.6% a year since 1975 in contrast to an average annual increase of 9.4% for overall tort costs, outpacing increases in overall U.S. tort costs.**

The study also adds that "These trends continued in 2002, with no sign of abatement in the near future." In a press release accompanying this study, a Tillinghast principal stated that, "Absent sweeping tort reform measures, we expect most of these trends to continue in 2003 and beyond."

In a 2001 report by Jury Verdict Research, data show that in just a one year period (between 1999 and 2000) the median jury award increased 43 percent. Further, median jury awards for medical liability claims grew at 7 times the rate of inflation, while settlement payouts grew at nearly 3 times the rate of inflation. Even more telling, however, is that **the proportion of jury awards topping $1 million increased from 34 percent in 1996 to 52 percent in 2000. More than half of all jury awards today top $1 million, and the average jury award has increased to about $3.5 million.**

These are just a few examples of growing evidence that reveal that out-of-control jury awards are inexorably linked to the severe increases in medical liability insurance premiums. It is clear that corrective action through federal legislation is urgently needed.

conclusions about how state-specific changes in premiums may be related to state-specific changes in payouts. **Conclusions about what has or has not caused recent premium escalation without accounting for the state-level factors listed above are unsupportable.**

In addition to claiming that the current medical liability crisis is an insurance issue, there have been attempts to argue that medical liability insurance premium rates in California have remained stable because of Proposition 103, not because of the successful medical liability reforms (known as MICRA—discussed later) that have been in place in California since 1975. Such claims are misguided. Proposition 103, also known as the Insurance Rate Reduction and Reform Act, applies to all lines of insurance, not just medical liability insurance. It was passed as an initiative by the voters in 1988 (thirteen years after MICRA), yet did not take effect until 1989. This is when the state's high court struck down its rate rollback provisions while maintaining the remainder of the law.

Proposition 103 implemented a basic standard that "no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter." However, Proposition 103 provides that "every insurer which desires to change any rate shall file a complete rate application with the commissioner." Proposition 103 also requires that the Department of Insurance grant a hearing for a challenge to any increase above 15 percent for commercial lines of insurance.

According to Californians Allied for Patient Protection, "Insurers have regularly applied for and obtained significant rate increases in all lines of insurance, except medical liability where MICRA has kept the rates from rising astronomically. Between September and the end of October, 2002, for instance, the Insurance Department approved more than 75 applications for double-digit increases in insurance rates." **None of these approved increases included medical liability insurance.** This illustrates that Proposition 103 is not responsible for keeping medical liability premiums down. Rather, as we discuss later, it is MICRA that has been the force behind California's success.

Such misdirected claims as discussed above are a disservice to patients who are losing access to health care services, and an affront to the physicians and other health care professionals who dedicate their lives to healing and caring for the sick and working to find ways to improve the quality of care. America's medical liability crisis is too serious and the consequences of inaction too grave for the public and Congress to use anything but the facts to make decisions about reform. In short, these claims are counterproductive to the debate on resolving the medical liability crisis.

FEDERAL SOLUTION

The medical liability crisis is a growing national problem that requires a national solution. If the crisis was just a matter of physicians obtaining or affording medical liability insurance in one state, we might agree that a national approach would not necessarily be required. However, the problem goes far beyond physicians and other health care professionals and institutions. The medical liability crisis has become a serious problem for patients and their

provide quality care in recent years, and nearly all physicians and hospital administrators feel that unnecessary or excessive care is provided because of litigation fears. It also shows that an overwhelming majority of physicians (83%) and hospital administrators (72%) do not trust the current system of justice to achieve a reasonable result to a lawsuit.

The Harris study found that a majority (59%) of physicians believe ("a lot") that the fear of liability discourages open discussion and thinking about ways to reduce health care errors. The AMA has long believed that health professionals and organizations should be encouraged to report and evaluate health care errors and to share their experiences with others in order to prevent similar occurrences. However, this "culture of fear" caused by our over-litigious society suppresses such information.

The AMA strongly supports the principle underlying the 1999 Institute of Medicine (IOM) report entitled, *To Err is Human: Building a Safer Health System*, that the health care system needs to transform the existing culture of blame and punishment, which suppresses information about errors, into a "culture of safety" that focuses on openness and information-sharing to improve health care and prevent adverse outcomes. The AMA also supports the IOM's focus on the need for a system-wide approach to eliminating adverse outcomes and improving safety and quality, instead of focusing on individual components of the health system in an isolated or punitive way.

Toward this end, the AMA supports H.R. 663, the "Patient Safety and Quality Improvement Act," which was favorably reported by the House Energy & Commerce Committee on February 12, 2003. H.R. 663 would provide a framework to create a "culture of safety" by establishing a confidential, non-punitive, and evidence-based system for reporting health care errors. There is a very broad and strong consensus of agreement on this legislative approach within the health care community. By implementing this approach, errors can be identified and analyzed to improve patient safety by preventing future errors.

In addition to patient safety and quality improvement, the fear of litigation stifles the advancement of new medical treatments and medications, encourages physicians to practice defensive medicine, overwhelms the health care system with paperwork—leaving less time for patient care, and discourages qualified candidates from pursuing a career in medicine or from moving to a state with a bad liability climate.

THE PRACTICAL SOLUTION

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as devastating or worse to patients and their families than injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation.

This compensation should include, first and foremost, full payment of all out of pocket "economic" losses. The AMA also believes that patients should receive reasonable

MICRA-type reforms are effective, especially at controlling non-economic damages. Several economic studies substantiate this point. One study looked at several types of reforms and concluded that capping non-economic damages reduced premiums for general surgeons by 13% in the year following enactment, and by 34% over the long term. Similar results were shown for premiums paid by general practitioners and OB/GYNs. It was also shown that caps on non-economic damages decrease claims severity (i.e., amount of the claim) (Zuckerman et al. 1990).

Another study published in the *Journal of Health Politics, Policy and Law* concluded that caps on non-economic damages reduced insurer payouts by 31%. Caps on total damages reduced payouts by 38% (Sloan, et al. 1989). Another study concluded that states adopting direct reforms experienced reductions in hospital expenditures of 5% to 9% within three to five years. If these figures are extrapolated to all medical spending, a $50 billion reduction in national health spending could be achieved through such reforms (Kessler and McClellan, *Quarterly Journal of Economics*, 1997).

Further, as discussed above, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress) asserts caps on non-economic damages have been extremely effective in reducing the severity of claims and medical liability premiums. Conversely, a 1996 American Academy of Actuaries study shows that medical liability costs rose sharply in Ohio after the Ohio Supreme Court overturned a liability reform law in the 1990s that set limits on non-economic damages. (Ohio recently enacted a new liability reform law.)

Furthermore, a Gallup poll released on February 5, 2003, show that 72% of those polled favor a limit on the amount patients can be awarded for pain and suffering. This Gallup poll is consistent with a 2002 survey conducted by Wirthlin Worldwide showing that three-quarters of Americans understand the detrimental effect that excess litigation has on our health care system. The Wirthlin survey shows that the vast majority of Americans agree we need common sense medical liability reform. In addition to the 78 percent discussed above who said that they are concerned about access to care, the survey found that:

- 71 percent of Americans agree that a main reason health care costs are rising is because of medical liability lawsuits.
- 73 percent support reasonable limits on awards for "pain and suffering" in medical liability lawsuits.
- More than 76 percent favor a law limiting the percentage of contingent fees paid by the patient.

CONCLUSION

Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an