

WISCONSIN STATE
LEGISLATURE
COMMITTEE HEARING
RECORDS

2005-06

(session year)

Assembly

(Assembly, Senate or Joint)

Committee on
Insurance
(AC-In)

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The Legal System and Liability Claims

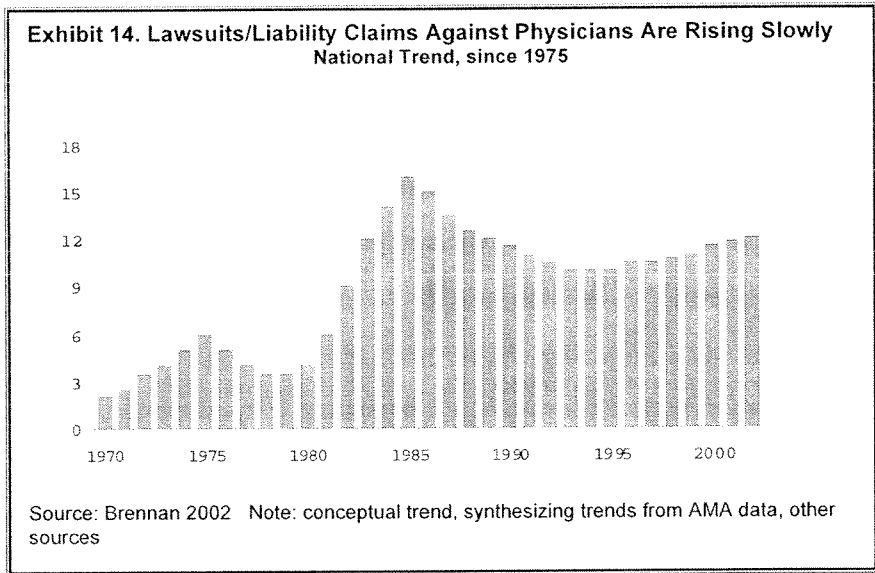
Liability claims are resolved under the rules and processes of tort law, ultimately with a trial if the parties are unable to work out an alternative. Almost all insurance claims of any consequence are associated with lawsuits, although many claims files are opened based on notice of a potential problem that proves inconsequential, and a small number are paid before a lawsuit is filed. Most lawsuits are dropped during pretrial discovery or settled through negotiation between plaintiffs' attorneys and defense counsel hired by liability insurers. Fewer than 10% go to trial. The expense of investigating and defending claims and then paying any settlements or awards constitutes the main cost of underwriting liability insurance.

This section describes the prevalence of malpractice litigation and the amount of payment handled through the legal system—what insurers call “frequency” and “severity” of claims. The legal system is intended to generate *deterrence* of substandard medical care by requiring *compensation* to patients wrongfully injured by health care providers through a dispute resolution process that offers *justice* (Bovbjerg 1986). Assessing the performance of the legal system in achieving these social goals is beyond the scope of this report.

Very little information about legal claims and subsequent outcomes, especially settlements, is available from judicial sources. Data that allow comparisons over time and across states mainly come from special surveys, from insurers' “closed claims” files, and from required reporting of paid claims involving physicians to the National Practitioner Data Bank operated by the federal government.

National Trends in Claims Frequency and Severity

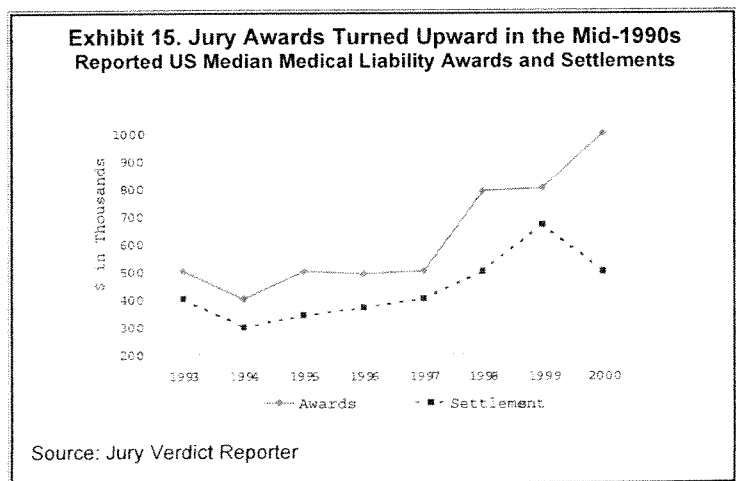
Before the 1960s, malpractice claims were rare. An AMA survey in the late 1950s found that about one in seven physicians could expect to be sued during the course of their careers. The mid-1970s and mid-1980s crises each saw run-ups in claims rates nationally



(Exhibit 14). Analysis of state-to-state variation suggested that both legal and social changes were responsible (Danzon 1985). By the mid-1980s, the average claims rate had risen to one in seven doctors *each*

year. After each of these crises, claims rates declined for a time, plausibly because of tort reforms in many states and negative publicity about lawsuits.

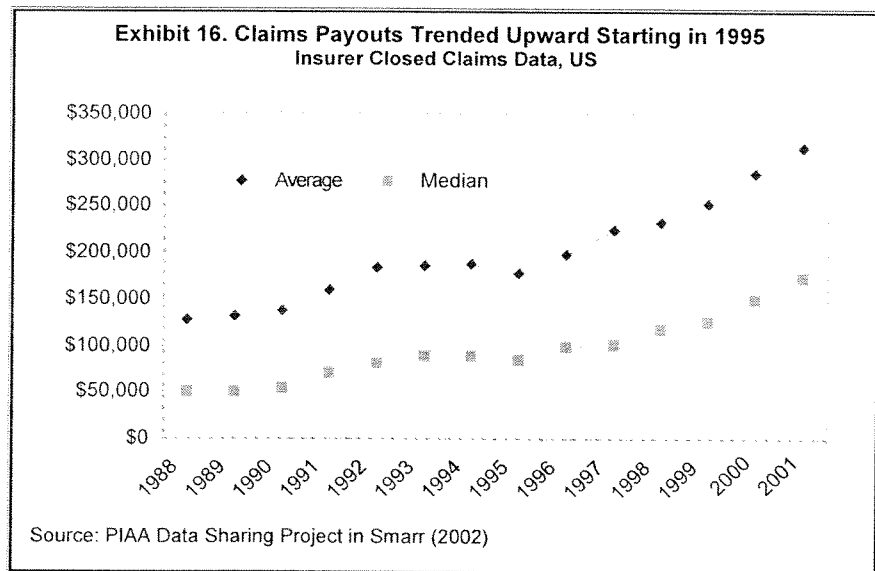
The current crisis seems different. Claims rates have risen little nationally since the mid-1990s, although some states have seen increases. Instead, insurers report that increases in payouts are the key driver of rising claims costs. National data from the *Jury Verdict Reporter* are often cited. These show that the median size of verdicts in cases taken to trial where the jury finds in favor of the patient more than doubled between 1995 and 2000 to about \$1 million per case (Exhibit 15, top line). The mean verdict was even higher. However, *JVR* relies



heavily on voluntary submission of information by trial attorneys and probably overemphasizes large cases that attorneys want to publicize. In recent years, *JVR* has sought reports of out-of-court settlements as well as verdicts, but likely includes only a small share of them (Exhibit 15, bottom line). This may partly explain the divergence in apparent trends for settlements and for verdicts.

More representative data on total payouts come from a census of closed claims reported to the trade association of physician-run insurers by its members (Exhibit 16).

Average payouts in nominal dollars nearly doubled between 1995 and 2001, a period of relatively low inflation. Particularly troubling to insurers is that high-end payouts rose the fastest. Claims payments of \$1 million and above increased



from about 3% of total paid claims in 1995 to almost 8% in 2001.

Claims Frequency and Severity Trends in Pennsylvania

Rates of litigation vary substantially by geographic location. Comparing Pennsylvania to other states, Philadelphia County and Allegheny County (Pittsburgh) ranked quite high in malpractice filings per population among 45 large counties across the country when studied by federal officials in 1992 (Exhibit 17). Pittsburgh's rate was more

**Exhibit 17. Pennsylvania Traditionally Had Medium-High Rates of Malpractice Lawsuits and Trials
Rates of Tort Filings and Trials, 1992 & 1996, by County**

County	All Torts		Auto torts			Medical Malpractice				
	Filing rate	Trial rate	Filing rate	Pct. of tort filings	Trial rate	Pct. of tort trials	Filing rate	Pct. of tort filings	Trial rate	Pct. of tort trials
National median	384	11	189.0	55.9%	5.2	48.4%	16.7	4.6%	1.0	12.2%
Allegheny, PA	407	17	229.2	56.3%	6.6	39.5%	25.7	6.3%	3.8	22.8%
Philadelphia, PA	1,178	24	706.6	60.0%	6.0	25.2%	35.5	3.0%	4.5	18.7%
Bergen, NJ	818	16	514.0	62.8%	6.7	42.9%	21.6	2.6%	3.8	24.1%
Essex, NJ	1,363	15	989.2	72.6%	8.6	57.0%	15.5	1.1%	1.9	12.3%
Middlesex, NJ	1,034	26	707.1	68.4%	11.7	44.3%	33.5	3.2%	3.4	13.0%
New York, NY	614	20	216.6	35.2%	4.4	22.4%	70.4	11.5%	3.3	16.8%
Cuyahoga, OH	679	15	415.0	61.1%	8.6	57.6%	47.1	6.9%	2.6	17.1%
Franklin, OH	398	8	219.9	55.2%	4.9	64.9%	19.3	4.8%	1.0	13.0%

Source: Bureau of Justice Statistics Bulletin, Civil Justice Survey of State Courts, "Tort Cases in Large Counties, 1992"; "Tort Trials and Verdicts in Large Counties, 1996" Notes: rates are per 100,000 population; data are from two surveys of 45 large counties, nationwide; case data from 1992, trial data from 1996

than 50% above the national median; Philadelphia's rate was just over double the national median. The Pennsylvania counties included in the sample ranked above two counterparts in New Jersey and one in Ohio, but far below New York County (Manhattan) and Cuyahoga County (Cleveland).

Similar surveys of trials in 1996 found that Pennsylvania's urban counties had about four times the rate of malpractice trials as the national median, above New York and other comparison counties in neighboring states. For all the counties studied, malpractice cases constituted a far higher share of tort trials than of tort filings. For example, in Philadelphia, malpractice accounted for only 3% of tort filings, but 18.7% of tort trials; only about one in 100 automobile accident filings went to trial, but about one in 8 malpractice filings. These ratios are not precise, as survey years differed for filings and trials. In general, the higher trial percentages for malpractice cases reflect their larger stakes and greater complexity, which make them harder to settle out of court. Lower trial percentages in other areas, particularly auto torts, are attributable to no-fault rules in certain states, the availability of small-claims court in appropriate cases, and other factors.

More recent data are available on frequencies of malpractice settlements and awards made on behalf of physicians, which federal law requires to be reported to the National Practitioner Data Bank. NPDB data show that Pennsylvania had 8.5 payments per 100,000 population in 2001 (Exhibit 18). This represents a significant increase over time; the average frequency for the period 1990-2001 was 6.9 (these years constitute the entire history of the Bank). Pennsylvania exceeded the national average both for the whole

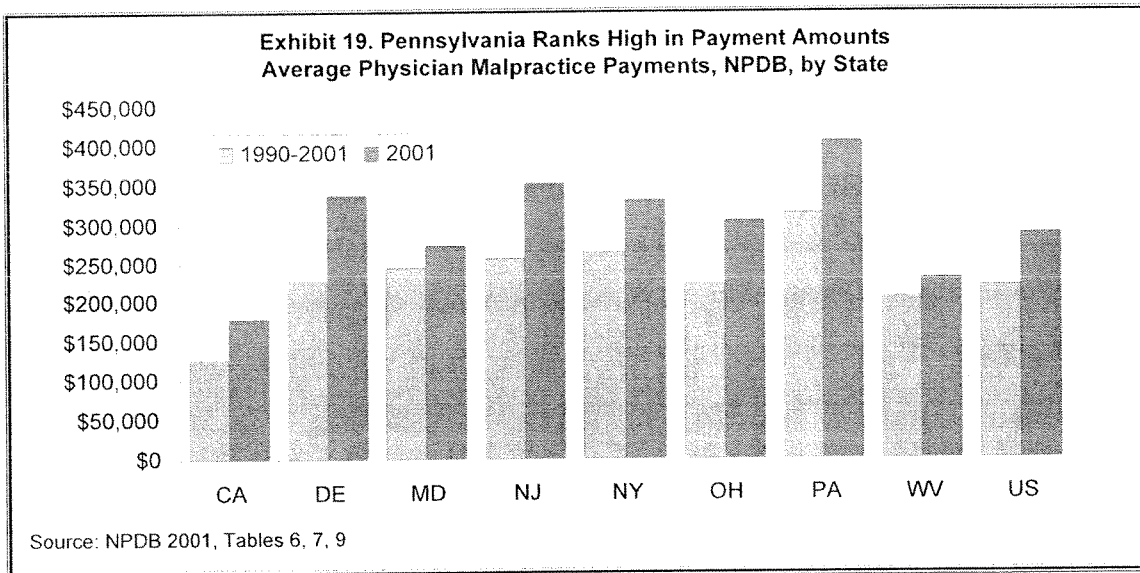
Exhibit 18. Pennsylvania Ranks High in Frequency of Paid Physician Claims

Number of Payments Reported to National Practitioner Data Bank, by Year

State	1990-2001		calendar 2001	
	total payments	rate per 100,000 pop'n (1995)	total payments	rate per 100,000 pop'n (2001)
Pennsylvania	9,993	6.91	1,049	8.53
Neighboring States				
Delaware	382	4.43	52	6.53
Maryland	2,554	4.24	283	5.25
New Jersey	6,496	6.80	940	11.04
New York	21,437	9.84	2,085	10.93
Ohio	7,526	5.62	677	5.94
West Virginia	1,640	7.51	207	11.49
California	17,834	4.72	1,459	4.22
United States	157,720	5.00	15,771	5.53

Sources: NPDB 2001 Annual Report, Tables 6 & 7; U.S. Census Bureau, State Population Estimates: Table ST-99-3, July 1, 1990 to July 1, 1999, Table ST-EST2002-01, April 1, 2000 to July 1, 2002

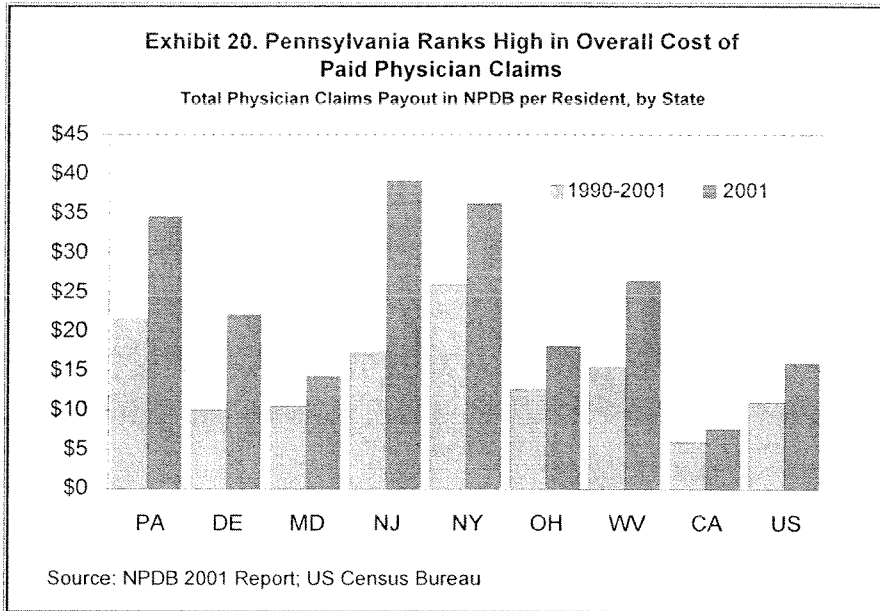
period and for 2001 alone—and its rate of increase was above average as well. Compared with its neighbors, however, Pennsylvania ranks in the middle: West Virginia, New York and New Jersey were more than two percentage points higher, while Delaware, Ohio, and Maryland were more than two percentage points lower. California ranks slightly below the national average over the entire period, and somewhat lower for 2001 cases alone. A caveat with respect to NPDB data is that states differ in physician employment patterns – when a physician works for a hospital or other institution, the institution may settle claims in its name only and therefore not report the physician.



Pennsylvania also ranks higher in payments per paid case, a calculation that combines payouts from primary coverage with those from the CAT Fund. Payouts averaged about \$400,000 in 2001, and averaged just over \$300,000 for the entire period 1990-2001 (Exhibit 19). Pennsylvania payouts were higher than in any neighboring state, and were almost a third above the national average. In contrast, California was more than a third below the national average.

Combining rates with amounts yields total physician payouts per state resident (Exhibit 20). In 2001, Pennsylvania trailed New Jersey and New York by small amounts on total payouts, but all three were more than double the national average. California was about half the national average.

A complaint often made about the legal system is that it resolves cases slowly—more so for malpractice than for other types of injury cases. The NPDB tracks the average time elapsed from incident to payment for malpractice claims against physicians (Exhibit 21). Pennsylvania takes a mean of 5.7 years to deliver payments to claimants



(median 5.2) — over a year slower than in the nation at large. New York was about 10% slower still, New Jersey very similar to Pennsylvania, and other neighbors were faster. California took only about half as long to make payments as Pennsylvania.

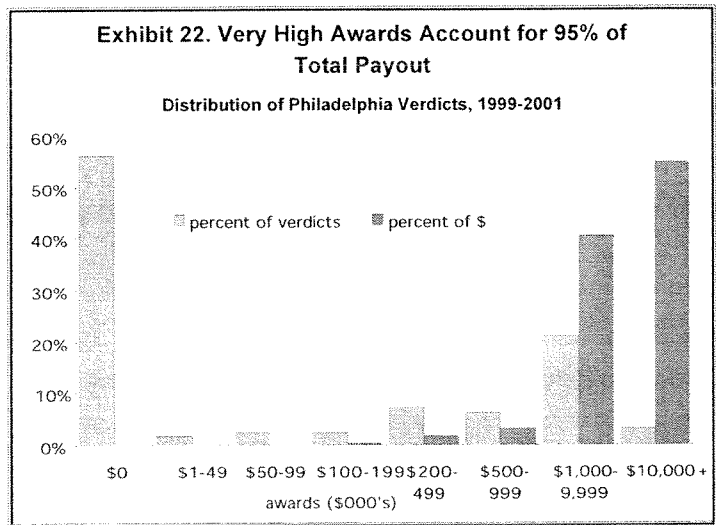
Exhibit 21. Pennsylvania Pays Physician Claims More Slowly than the National Average
Years from Incident to Payment, National Practitioner Data Bank

	2001 calendar year		1990 through 2001	
	mean	median	mean	median
Pennsylvania	5.70	5.22	5.96	5.57
Neighboring States				
Delaware	4.00	3.82	4.48	4.03
Maryland	4.48	4.08	4.71	4.27
New Jersey	5.76	5.24	6.17	5.09
New York	6.22	5.67	6.98	6.08
Ohio	4.39	3.73	4.49	3.56
West Virginia	4.60	4.15	5.54	4.24
California	3.02	2.59	3.39	2.82
United States -Total	4.63	4.08	4.81	4.02

Source: NPDB 2001 Annual Report, Table 9
Note: PA times may be overstated because NPDB receives additional reports from state "CAT Fund" when it pays upper layer of large claims, and such large claims take longer than average

The Special Case of Philadelphia

Philadelphia is generally believed to have very high jury awards. This reputation is confirmed by available information for 1999-2001 for the Court of Common Pleas, which handles almost all malpractice cases in the county. Most verdicts favored defendants, with no money being awarded in 56% of cases taken all the way to jury verdict (Exhibit 22, left-hand bars). Of the cases decided in favor of plaintiffs, more than half generated awards of over \$1 million. The over \$1 million categories accounted for nearly all the dollars awarded, with



55% deriving from a small number of cases with damages exceeding \$10 million (right-hand bars). Comparable official court statistics are not available for the rest of Pennsylvania.

The plaintiff “win” rate of 44% may not seem high, but it is roughly double the national average. Only about 20% of U.S. jury verdicts in 2000 awarded money to plaintiffs, according to closed-claim information from physician insurers (Smarr 2002). In Philadelphia, 24% of verdicts awarded amounts in excess of \$1 million. Indeed, from 1999 through 2001 the number of verdicts over \$1 million in Philadelphia (87) approached the number of verdicts plus settlements of this magnitude in all of California (101, Neupauer 2002). Win rates in Philadelphia were not constant from year to year: above 50% in 1999 and 2000 but 40% in 2001. Nor were the number of verdicts, which were higher in 1999

than in 2000 and 2001. The Philadelphia tracking effort ended in 2001, without gathering sufficient data to establish a long-term trend in number of verdicts or amount of plaintiff awards.

Philadelphia court data do not present a complete picture. They fail to reveal what types of cases go to trial, or whether jury awards are reduced by judges or settled for lesser amounts to avoid lengthy appeals. It is also possible that 1999-2001 were not typical years. Qualitatively, interviewees reported that Philadelphia courts in the late 1990s were catching up on an accumulated backlog of cases, including some that were unusually large. At least one media account has suggested that verdicts have declined since 2001.

Pennsylvania's Health Care System

The ability to assure access to affordably priced, high-quality health care is an important element in Pennsylvania's relative attractiveness to residents and businesses. The health care system is therefore vital to the state's economic and social well-being, as well as the physical health of its inhabitants. Among other things, teaching hospitals help anchor the state's health care system, producing physicians for a national market as well as health services locally. The state itself is one of the largest purchasers of medical services, a fact reflected in Medicaid's share of Pennsylvania's state budget. The medical malpractice crisis and potential reforms must be assessed in light of these public policy issues. The following data provide background on access to health care in Pennsylvania, its quality, and its cost. As yet, however, there is little information directly connecting malpractice liability to medical performance. Possibly the most urgent question is the extent to which current problems of availability and affordability of liability insurance affect patients' access to care.

Access to and Cost of Health Coverage

Pennsylvania's twelve million residents closely resemble their counterparts across the U.S. (Exhibit 23). Pennsylvanians are slightly older; 14% are age 65 and above, two percentage points above the national average. The state has under half the proportion of non-whites as the U.S. generally (14% versus 30%). Pennsylvania residents are slightly more likely to live in metropolitan areas (85% versus 81%). They enjoy slightly higher than average family incomes (about 4% above the national average) as well as slightly lower rates of poverty and unemployment.

The state's population is heavily concentrated in and around the two biggest cities, Philadelphia and Pittsburgh, in the southeast and southwest (Exhibit 24). Although Pennsylvania is highly metropolitan in percentage terms, it has the nation's largest rural

Exhibit 23. Demographically, Pennsylvania Resembles the US at Large
Recent Population Data

Characteristic	PA	US
Residents, 1999-2000 (millions)	11.8	275.7
Children 18 and under (%)	26	28
Age 65 and above (%)	14	12
Metropolitan residents (%)	85	81
Race/ethnicity (%)		
White	86	70
Black	9	13
Hispanic	3	12
Other	2	5
Economics		
Median Family Income, 1998-2000	\$29,000	\$27,830
Under Federal Poverty Level, 1999-2000 (%)	13	15
Unemployment Rate (Seasonally Adjusted)		
Oct. 2002 (%)	5.3	5.7
Oct. 2001 (%)	5.0	5.4

Source: Kaiser Family Foundation, State Health Facts <<http://www.statehealthfacts.kff.org>>

population because of the state's overall size and its many well settled farming communities (Pennsylvania Economy League 2002).

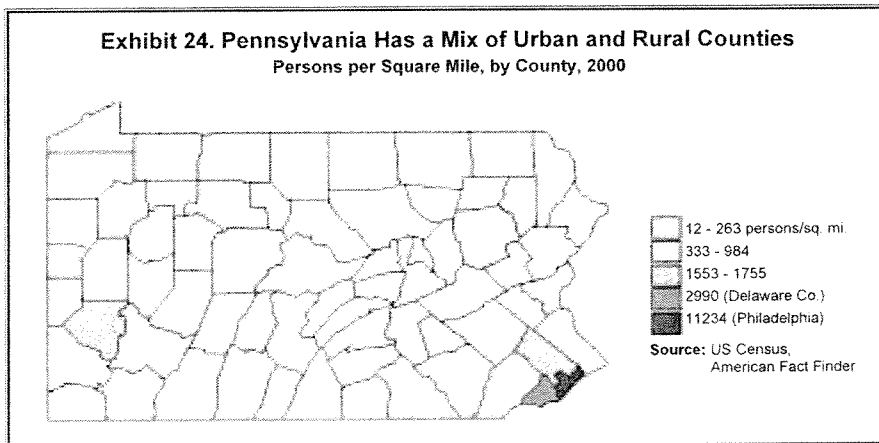
Pennsylvania has high rates of health insurance coverage (Exhibit 25). Only 9% of residents are uninsured, about one third less than the national average

and even below the well-insured neighboring states. Pennsylvania's advantage mainly comes from employer-sponsored insurance (ESI) — private coverage provided as an employee benefit.

The state's rates of private insurance coverage are about 3% above the national average both for workers (own ESI) and for depend-

ents (other ESI). Slightly more Pennsylvanians are covered by Medicare because of the state's relatively elderly population. Medicaid covers slightly less than the national average—not because eligibility standards are low but because fewer people qualify, a result

Exhibit 24. Pennsylvania Has a Mix of Urban and Rural Counties
Persons per Square Mile, by County, 2000



Source: US Census, American Fact Finder

**Exhibit 25. A High Share of Pennsylvanians Have Health Insurance
Coverage Comparisons with Neighboring States, US (average, 2000 & 2001)**

type of insurance	US	PA	MD	NJ	NY	OH
ESI--own	30.4%	32.9%	33.4%	33.4%	28.5%	31.9%
ESI--other	29.0%	32.3%	34.6%	31.5%	27.4%	32.5%
Private Non-Group	4.6%	4.2%	3.8%	2.4%	3.5%	3.9%
Medicaid and Other State	8.1%	7.1%	4.2%	5.3%	11.3%	6.8%
Medicare and other Federal	13.5%	14.5%	12.7%	14.7%	13.4%	13.7%
Uninsured	14.5%	9.0%	11.4%	12.7%	15.9%	11.2%

Source: Urban Institute, 2002. Notes: "ESI" is employer-sponsored insurance; two years of CPS data were used to assure sufficient sample size

of the state's relatively low poverty rate. A relatively high proportion of Pennsylvanians' health insurance coverage is arranged through HMOs, according to national statistics (Exhibit 26). Fully one third of Pennsylvanians are enrolled in HMOs, including Medicare and Medicaid enrollees. Starting from a low baseline, Pennsylvania HMO growth greatly outpaced that of the nation as a whole during the 1980s. By 1990, Pennsylvania had almost reached the national average. HMO enrollment continued to grow at rates one-third higher than the national average until peaking in 1998. HMO enrollment in Pennsylvania and nationally has declined since that time. HMO penetration is higher in urban areas. In 1998,

**Exhibit 26. Pennsylvania Ranks High in HMO Coverage
Percentages of population enrolled**

State	1980	1985	1990	2000	2001	ave. ann. pct. chg.	
						1980-90	1990-2001
United States	4.0	7.9	13.5	30.0	27.9	12.9%	7.5%
New York	5.5	8.0	15.1	35.8	35.0	10.6%	8.8%
New Jersey	2.0	5.6	12.3	30.9	31.7	19.9%	9.9%
Pennsylvania	1.2	5.0	12.5	33.9	33.4	26.4%	10.3%
Ohio	2.2	6.7	13.3	25.1	23.4	19.7%	5.8%
Delaware	--	3.9	17.5	22.0	22.8	--	2.7%
Maryland	2.0	4.8	14.2	43.9	38.4	21.7%	10.5%
West Virginia	0.7	1.7	3.9	10.3	10.9	18.7%	10.8%

Source: CDC, Health, United States, 2002, Table 146

<<http://www.cdc.gov/nchs/products/pubs/pubd/hus/listables.pdf>>

Note: Includes Medicare & Medicaid HMOs, full population

for example, HMO penetration was more than twice as high in metropolitan Philadelphia as in the Harrisburg-Lebanon-Carlisle metropolitan area (McDonnell and Fronstin 1999).

A few health insurers dominate the market in many communities in Pennsylvania. One late-1990s study found that the top insurer in the six-county Pittsburgh metropolitan statistical area had a 69% market share (Guadagnino 2000). The next three firms accounted for nearly all the remainder. For the nine-county Philadelphia metropolitan area, the top insurer had a 57% market share, the next largest 19%, and no other firm more than 3.5%.

Access to Health Care Practitioners and Institutions

One determinant of access to health care is adequacy of insurance coverage. For Pennsylvania, this is quite good, as noted above. Also vital is adequate supply and distribution of providers, notably hospitals and physicians.

Pennsylvania ranks relatively high in measures of hospital supply and usage (Lewin Group 2001). Hospital beds per population declined from 1980-1997—by 29% nationally, but by 21% in Pennsylvania (HRSA 2000). In 1999, Pennsylvania had almost 20% more beds per thousand people than the nation at large and ranked 18th highest among states (Exhibit 27). Usage of hospitals was even higher; inpatient days per thousand were 25% above the national average and ranked 9th among states. This helped hospitals maintain a higher than average occupancy rate.

Pennsylvania has about 10% more doctors of medicine (MDs) per population than the nation at large (Exhibit 28). Pennsylvania and its surrounding states also exceed national averages for other health professionals

	PA	US ave.	PA rank
Hospital beds/1,000 pop'n	3.59	3.04	18
Admissions/1,000	146.3	118.7	6
Average length of stay	6.1	5.9	19
Inpatient days/1,000	888.2	703.7	9
Occupancy rate	67.9%	63.4%	11

Source: Lewin Group (2001) using Am. Hosp. Ass'n data; Note: rank is among 50 states and DC; thus, 17 jurisdictions had more beds/pop'n

per population. Nurse practitioners are the main exception; the state has only about half the national average (HRSA 2000.) The “additional” Pennsylvania physicians relative to the national average are specialists. The state’s supply of primary-care physicians is almost exactly average, about 6 per 10,000 in 1998 (HRSA 2000). In addition, however, the state has substantially more osteopathic physicians (DOs) than most other states.

From 1975-1995, Pennsylvania gained physicians in active patient care, both absolutely and relative to the national average (Exhibit 28). The state’s edge declined marginally during 1995-2000, as growth in physicians per population slowed. That

**Exhibit 28. Pennsylvania Ranks High in Physician-Population Ratio
But Its Rate of Growth Has Slowed in Recent Years**

	Physician-Population Ratio, PA & US, 1975-2000				Ann. Pct. Chg.	
	1975	1985	1995	2000	1975-1995	1995-2000
PA	13.9	19.2	24.6	25.4	2.8%	0.6%
US	13.5	18.0	21.3	22.7	2.2%	1.3%

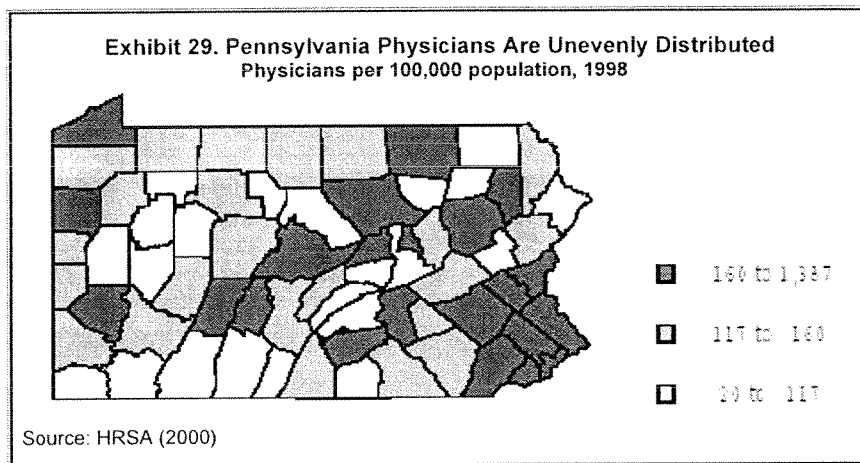
Source: CDC 2002 , Table 100 <<http://www.cdc.gov/nchs/products/pubs/pubd/hus/listables.pdf>>
Note: ratios are doctors of medicine in patient care per 10,000 civilian population

period was also marked by consolidation among health insurers and hospital systems. Furthermore, hospitals affiliated with or acquired physician practices, with related growth in employed physicians.

Physicians are not spread evenly across Pennsylvania. Philadelphia has by far the heaviest concentration of physicians (Exhibit 29). A caveat about mapping physicians’ principal locations is that it does not necessarily reflect their service areas. Patients may see providers in different offices, and physicians may practice in more than one location.

Pennsylvania physicians are slightly younger than average. Of physicians in the state in 1998, 28% were 55 years of age or older, compared to 31% of physicians nationwide. The state’s academic centers produce a substantial portion of the nation’s new physicians. Medical schools in Pennsylvania graduated 1,008 new allopathic and 259 new osteopathic physicians in 1997, ranking second among the 46 states with medical schools.

On a per capita basis, Pennsylvania graduated more new physicians per 100,000 population (10.5) than the national average (6.6), and ranked 6th. Pennsylvania produces a high share of its physicians in its own medical schools: Among active allopathic patient care physicians in Pennsylvania in 1998, 43% graduated from in-state medical schools, compared with a national average of 32% (HRSA 2000).



Quality of Health Care

Evidence on the overall quality of U.S. medical care is limited. State-specific measures of how well doctors and hospitals perform are even less readily available. General health system performance is partially reflected in state rankings of population health status. These suggest that Pennsylvania is typical of the U.S. at large. One leading compilation of state public health measures ranked Pennsylvania 23rd overall among states in 2002 (Exhibit 30), little changed from 1990. Pennsylvania scored well on extent of insurance coverage as already noted and spending for public health and Medicaid, as discussed below. It scored worse on success in reducing tobacco use, adequacy of prenatal care, and total mortality rates, as well as death rates from specific causes.

Such population-based measures are somewhat distant from the allegations of substandard individual performance contained in medical malpractice claims. Service

**Exhibit 30. Pennsylvania Ranks Near Average in Population Health Status
Specific Public Health Measures, 1990 & 2002**

Health Measure	1990		2002	
	Rate	Rank	Rate	Rank
Prevalence of Smoking (% of pop'n)	29.3	23	24.5	34
Adequacy of Prenatal Care (% of pregnant women)	71.5	21	73.9	31
Lack of Health Insurance (% without health insurance)	7.7	4	9.2	6
Support for Public Health Care (Ratio to nat'l ave.)	0.75	18	2.07	7
Heart Disease (Deaths per 100,000 pop'n)	346.2	43	289.7	36
Cancer Deaths (Deaths per 100,000 pop'n)	212.4	43	220.0	37
Total Mortality (Deaths per 100,000 pop'n)	929.1	43	913.3	35
Infant Mortality (Deaths per 1,000 live births)	10.3	30	7.2	29
Overall		20		23

Source: United Health Foundation

quality is more directly relevant. One very recent analysis tracked national and state-level changes in performance on 22 quality indicators for Medicare services. It ranked Pennsylvania 16th in 1998-99 and 31st in 2000-2001 (Jencks et al. 2003). By comparison, New Jersey ranked 43rd, New York ranked 24th, and Ohio ranked 38th in 2000-2001. The scores were based on process-of-care measures such as prevention and treatment of acute myocardial infarction, breast cancer, diabetes mellitus, heart failure, pneumonia, and stroke. The analysis was performed by the federal Centers for Medicare and Medicaid Services and covered only care delivered to fee-for-service Medicare beneficiaries.

Quality varies by medical provider and by service. Pennsylvania and some other states have measured and publicly reported outcomes of certain hospitals procedures, notably coronary bypass surgery, whose outcomes vary widely by hospital (PHC4 2001). The goal is to effect institutional improvements through performance feedback, which was successful in New York's pioneering program (Chassin 2002). Whether medical liability, which changes from place to place within states, contributes to local practice variation has not been established. Finally, it is worth observing that some Pennsylvania hospitals rank very high nationally in qualitative surveys such as the *US News & World Report* rankings.

Health Care Spending

Spending on medical services is high in Pennsylvania by many measures. Overall, Pennsylvania's per capita personal health care expenditures in 1998 were 11% above the national average, 7th highest among states (Exhibit 31) and totaling some 14% of gross state product compared with a national average of 12% (KFF 2003). The entire

**Exhibit 31. Pennsylvania Ranks High in Medical Spending
Per Capita Personal Health Care Spending by State, 1991-1998**

State	1991	1998	rank, 1998	As % of US Ave	Ave. Ann. % Growth
US Average	\$2,685	\$3,759	--	100.0%	4.9%
New York	3,288	4,706	2	125.2%	5.3%
Delaware	2,878	4,258	5	113.3%	5.8%
New Jersey	2,966	4,197	6	111.7%	5.1%
Pennsylvania	2,988	4,168	7	110.9%	4.9%
West Virginia	2,568	4,044	9	107.6%	6.7%
Maryland	2,796	3,848	13	102.4%	4.7%
Ohio	2,709	3,747	21	99.7%	4.7%

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, 1998 State Estimates -- per Capita Personal Health Care
<<http://cms.hhs.gov/statistics/nhe/state-estimates-residence/us-per-capita10.asp>>
Note: The highest state is Massachusetts, just above NY at 128%; the lowest is Utah, at 73%; DC excluded because distorted by border-crossing

region has high costs for medical care; among neighboring states, only Ohio is near the national average. During 1991-1998, medical spending in Pennsylvania grew at the same rate as in the nation as a whole.

The distribution of personal health care spending in Pennsylvania is simi-

lar to that of the U.S. overall (Exhibit 32). However, the share of spending for physicians is about 10% below the national average. Correspondingly, the institutional share of spending is higher in Pennsylvania, especially for nursing homes.

Nonetheless, in 2000, the average annual cost of employment-based health insurance in Pennsylvania was almost identical to the US average. Individual and family coverage averaged \$2,467.06 and \$6,721.41 in Pennsylvania versus \$2,654.67 and \$6,772.47 nationally (KFF 2003).

Medicare payments per enrollee are high in Pennsylvania (8.6% above the nation

Exhibit 32. Pennsylvania Medical Spending Patterns Resemble Those of the US
Distribution of Personal Health Care Spending by Service, 1998

Personal Health Care Spending by Type of Service

Service	PA (%)	US (%)
Hospital Care	38.3	37.4
Nursing Home Care	11.7	8.6
Physician & Other Professional	26.5	29.1
Drugs & Other Medical Nondurables	12.3	12.0
Dental Services	4.3	5.3
Home Health Care	2.2	2.9
Medical Durables	1.4	1.5
Other Personal Health Care	3.2	3.1

Source: Kaiser Family Foundation

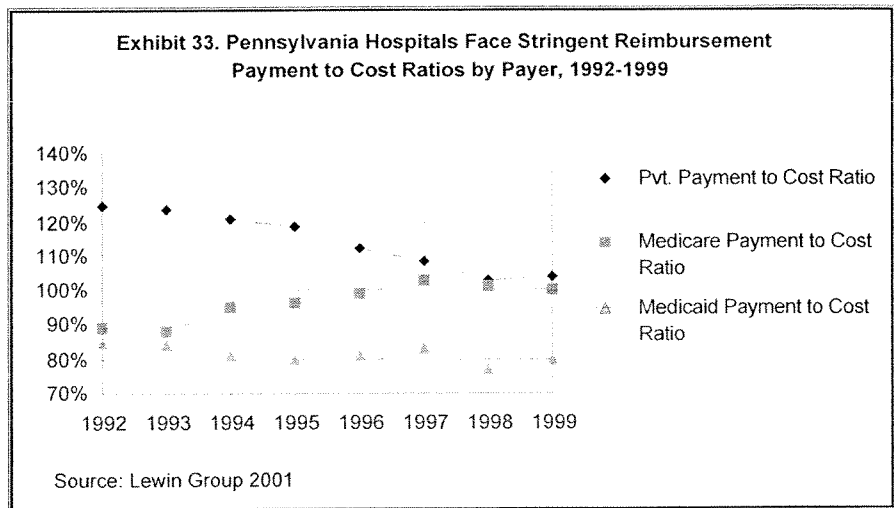
as a whole in 1999), although they grew at only half the national rate from 1994-1999. A marked increase in the managed care share of Medicare may have helped curb spending growth. Between 1994 and 1999, Pennsylvania rose from 3.3% to 27.5% (national average increase=17.8%) (CDC 2002). Medicare is the biggest payer for hospi-

tals, and has reduced payment growth since the Balanced Budget Act of 1997. Large teaching hospitals have been the hardest hit, which has a significant impact on Pennsylvania because of its many academic medical centers. Medicare also reduced physicians' fees, including a roughly 5% reduction for 2003. Similar cuts are scheduled for the next three years, but Congress may modify the timetable for implementing them.

The Pennsylvania Medical Assistance Program is the fourth largest Medicaid program in the nation. Spending for services and administration increased by 50% from \$6.4 billion in 1994 to \$9.6 billion in 1999. The state spends 27.4% of its budget on Medicaid, half again as much as the national average of 19.6%. Medicaid spending is more moderate on a per enrollee basis; in 1998, Pennsylvania ranked 18th in the nation (36th if long-term care is excluded) (Lewin Group 2001).

Private health insurers seem able to hold down physician fees; the largest insurer in Philadelphia unilaterally cut payment rates in 1998 (Guadagnino 1998). According to news accounts, however, this same plan increased physician payments in 2002 and plans to do so again in light of increased malpractice premium burdens on physicians (NEPA News 2002). For hospitals, one analysis suggests that the prices

paid by Pennsylvania health plans declined in the late 1990s and are lower relative to hospital costs than national norms (Lewin Group 2001) (Exhibit 33). Whereas Medicaid payments in 1999 were only 4% below hospital costs nationally, Medicaid payments were 20% below hospital costs in Pennsylvania (ninth lowest among states). Conversely, whereas private payment levels were about 15% above costs nationally, they were only 4% above costs in Pennsylvania



(fourth lowest among states). Medicare payment levels were almost the same in Pennsylvania and the nation at large. According to this analysis, the low payment-to-cost ratios are attributable to low payments, not high costs. Hospital officials assert that Pennsylvania’s hospitals are highly efficient because for a decade they have successfully cut costs, partly in response to constrained payments.

An implication of the Lewin analysis is that hospitals have very limited ability to respond to fiscal shocks—either payer-imposed price cuts or higher costs like those for malpractice coverage. According to Pennsylvania-only data compiled by the Pennsylvania Health Care Cost Containment Council (PHC4 2003), the operating margins of the state’s hospitals dropped in 1998 and 1999, with hospitals in the latter year losing one quarter of a cent on each dollar of patient revenue. Subsequent years have seen a recovery, but only to about a 2% margin, which is lower than national averages.

Conclusion

This report provides policy-makers with necessary context for generating and evaluating options for insurance and legal reform. Health care constitutes a major industrial sector in Pennsylvania. Preventing serious effects on medical services therefore is important to the state's economic health as well as its physical health. Health care providers in Pennsylvania have encountered steep increases in the cost of liability insurance since 2000, as many liability insurers have withdrawn from the market and premiums have risen for available coverage. While the medical malpractice insurance crisis is national in scope, Pennsylvania has been especially hard hit. As a result, Pennsylvania – traditionally in the middle of the pack – is now a high-cost state.

General economic trends explain part of Pennsylvania's situation, but other factors are state-specific. Pennsylvania physicians and hospitals are uniquely burdened by high assessments for the state's catastrophic loss fund. While cyclical changes within the insurance industry are clearly a factor affecting the affordability of liability coverage in Pennsylvania and elsewhere, the largest component is the rising cost of legal claims. Pennsylvania exceeds national averages for legal costs because of high claims rates and payouts. This is particularly the case in Philadelphia, where plaintiffs are twice as likely to win jury trials as in the rest of the country, and where a substantial percentage of cases result in verdicts greater than \$1 million.

No clear evidence yet exists as to the effects of the malpractice crisis on Pennsylvania's health care system. The state's supply of medical providers was little changed by the first medical liability crisis in 1975, and provider-to-population ratios for both hospitals and physicians rose relative to the nation through the mid-1980s liability insurance crisis and well into the 1990s. However, the current crisis presents greater reason for concern. Providers, particularly hospitals, are under greater financial strain now than in past crises. It may be that access problems pertain only to certain regions of the

state (e.g., rural areas, inner cities), certain patient subgroups (e.g., Medicaid patients, the uninsured), or certain medical subspecialties (e.g., obstetrics, orthopedics, neurosurgery).

Because the problems afflicting Pennsylvania's malpractice system have developed over time, they will take time to resolve. The overhang of unresolved claims and various features of the state's liability insurance market make it very difficult to reduce costs in the short term. Therefore, subsidies that allow health care providers to maintain coverage would seem to be the only practical approach to alleviating the current crisis. In the longer term, a wider range of strategies exists to control costs, improve predictability, and attract insurers to the Pennsylvania market. In addition to conventional tort and insurance reforms, lawmakers should consider systematic changes to the way that injuries caused by medical care are identified, compensated, and prevented. Although much is known about the malpractice system, much remains to be learned. The difficult public policy decisions that must be made should be based on detailed, current, and objective information.

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About the Project

The Project on Medical Liability in Pennsylvania (www.medliabilitypa.org) is a two-year program of research, consultation, and communication funded by The Pew Charitable Trusts that seeks to provide decision-makers with objective information about the ways in which medical, legal, and insurance-related issues affect the medical liability system, to broaden participation in the debate to include new constituencies and perspectives, and to focus attention on the relationship between medical liability and the overall health and prosperity of the Commonwealth.

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