WISCONSIN STATE LEGISLATURE
COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

(Form Updated: 11/20/2008)

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Medical Liability Reform - NOW!
March 26, 2004

American Medical Association
515 North State Street
Chicago, Illinois 60610

I. Identification of the Problem

A. Recurrence of an Old Problem?

1. The medical liability insurance system experienced a period of crisis in the early 1970s, when several private insurers left the market because of rising claims and inadequate rates.

2. This exodus of capacity resulted in an availability crisis and created an affordability issue for those physicians and hospitals lucky enough to find insurance.

3. Over the next fifteen years, various attempts were made to ease the explosion in claims costs: tort reform, increased diagnostic testing, improved peer review and increased communication between physicians and patients. Aggressive campaigns to reform state laws governing medical liability lawsuits began in the 1970s and were successful in a number of states including California, Louisiana, Indiana and New Mexico.

4. These efforts appear to have had a positive impact. The number of claims stabilized. The severity of verdicts, in the form of the dollar amount, has continued nationwide except for the states that enacted effective reforms

B. Second PLI Crisis: 1980s

1. During the 1980s, the second crisis – one of affordability -- shook the industry, as claim frequency and severity increased again and premiums rose rapidly.

2. The affordability crisis had a dramatic effect. Physicians in specialties such as obstetrics and gynecology cut back on high-risk procedures and high-risk patients to reduce their risks and hold down their premiums.

3. Some physicians closed practices in states where the risk of being sued and the costs of premiums were especially high.

C. The Current Liability Crisis: Trends in Jury Awards

1. Recent data from Jury Verdict Research reported in the 2002 edition of Current Award Trends in Personal Injury, illustrates the problem as it exists today.[1]

2. The median medical liability award in medical liability cases jumped 110% from 1994 to 2002, topping $1 million.[2]

3. The average award reached $3.9 million in 2001.[3]

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[1] JURY VERDICT RESEARCH, CURRENT AWARD TRENDS IN PERSONAL INJURY: 2002 ed. (2003), 18.
[2] *Id. See also,* JURY VERDICT RESEARCH, MED. MALPRACTICE: VERDICTS, SETTLEMENTS & STATISTICAL ANALYSIS (2002), 1.

4. *Overall, plaintiffs won just 30.5% of medical liability cases in 2002.*[4] Plaintiffs lost the majority of their cases that went to a jury. Of the 7% of claims that went to jury verdict, the defendant won 82.4% of the time.[5]

5. However, physicians who win at trial still have large fees to pay for their defenses. Defense costs averaged $91,803 per claim in cases where the defendant prevailed at trial. And in cases where the claim was dropped or dismissed, costs to defendants averaged almost $16,160. [6]

6. The frequency of very large awards is increasing.

    a. In the period 1995-1997, 36% of all verdicts that specified damages assessed awards of $1 million or more. Over the next two years, the relative frequency of these awards increased to 43%. By 2000-2001, 54% of all awards were for $1 million or more. 25% of all awards exceed $2.7 million.[7]

    b. According to a recent study by the Blue Cross/Blue Shield Association, plans in crisis states believe that inappropriately large jury verdicts are the primary factor contributing to increasing medical liability premiums. Non-crisis states attributed the increases mostly to increased patient litigiousness.[8]

D. The Current Liability Crisis: Access to Care

1. A February 2003 poll shows that 84% of Americans fear that skyrocketing medical liability costs could limit their access to care.[9]

2. 45% of hospitals reported that the professional liability crisis has resulted in the loss of physicians and/or reduced coverage in emergency departments.[10]

3. A Blue Cross/Blue Shield survey shows that rising medical liability premiums are causing access and cost problems in crisis states. Access problems are beginning to surface in the remaining states as well.[11]

4. Residents' Concerns

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[3] JURY VERDICT RESEARCH, *supra* note 1, at 18.
[4] PHYSICIAN INSURERS ASS'N OF AM., PIAA CLAIM TREND ANALYSIS: 2002 ed. (2003), exhibit 1-2.
[5] *Id.* at exhibit 6a.
[6] Lori A. Bartholomew of PIAA, Remarks to the Am. Coll. Of Radiology (May 13, 2003).
[7] JURY VERDICT RESEARCH, *supra* note 1, at 43.
[8] BLUE CROSS BLUE SHIELD ASS'N, THE MALPRACTICE INSURANCE CRISIS: THE IMPACT ON HEALTHCARE COST AND ACCESS 3 (2003).
[9] WIRTHLIN WORLDWIDE, FED. REFORM EFFORTS, *available at* http://www.hcla.org (last visited Feb. 12, 2004).
[10] AM. HOSP. ASS'N., PROF'L LIABILTY INS. SURVEY (2003).
[11] BLUECROSS BLUESHIELD ASS'N, *supra* note 8, at 4.

a. Medical residents and students report growing concerns. The future of medicine may be in jeopardy as medical residents report growing dis-satisfaction with the practice of medicine because of the medical liability crisis. 62% of medical residents reported that liability issues were their top concern in 2003—surpassing any other concern, and representing an enormous increase from 2001, when only 15% of residents said liability was a concern.[12]

b. This concern is epitomized by the story of a medical resident, who despite utilizing the best practices of evidence-based medicine (EBM), watched in horror as he was sued and the plaintiff's attorney portrayed EBM as nothing more than "a cost-saving method," and that "the few lives saved were not worth the money." Thus, despite the resident showing how he followed "conscientious, explicit, and judicious use of the current best evidence in making clinical decisions about the care of individual patients," the plaintiff's attorney used it against him. The resident was exonerated, but the residency program was found liable for $1 million.[13]

5. Students' Concerns

a. Students, too, are affected by the current crisis. In fact, half of the respondents of a recent AMA survey indicated the current medical liability environment was a factor in their specialty choice.

b. 39% said the medical liability environment was a factor in their decision about a state in which they would like to complete residency training.

c. 69% of students whose professors discussed the liability situation said the professors also discussed defensive medicine, including increasing unnecessary or excessive care.

d. 61% of students reported they are extremely concerned the current medical liability environment is decreasing physicians' ability to provide quality medical care.

e. 48% of students in their third or fourth year of medical school indicated the liability situation was a factor in their specialty choice.[14]

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[12] MERITT, HAWKINS & ASSOC., SUMMARY REPORT: 2003 SURVEY OF FINAL YEAR MED. RESIDENTS 5 (2003).
[13] Daniel Merinstein, *Winners and Losers* 291 JAMA 15, 15-6 (2004).
[14] DIV. OF MKT. RESEARCH & ANALYSIS, AM. MED. ASS'N, AMA SURVEY: MED. STUDENTS' OPINIONS OF THE CURRENT MED. LIABILITY ENV'T (2003), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/31/ms-mlrhighlights.pdf (last visited Feb. 16, 2004).

E. The Current Liability Crisis: Costs

1. Altogether, medical liability adds billions to the cost of health care each year – which means higher health insurance premiums and higher medical costs for all Americans, according to estimates in a recent U.S. Department of Health and Human Services report.[15]

2. 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.[16] The federal government reported that:

> The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of liability insurance coverage. Premiums are spiking across all specialties in 2002. When viewed alongside previous double-digit increases in 2000 and 2001, **the new information further demonstrates that the litigation system is threatening health care quality for all Americans as well as raising the costs of health care for all Americans.** (emphasis added)[17]

3. HHS also stated that excessive medical liability cost $47 billion annually to what the federal government pays for Medicare, Medicaid, the State Children's Health Insurance Program, Veterans' Administration health care, health care for federal employees, and other government programs.[18]

4. HHS issued its third report on the medical liability crisis on March 3, 2003. This report provided updated figures documenting the scope of the crisis, including a revised update on the costs borne by the federal government. This report found that reasonable limits on non-economic damages would reduce the amount of taxpayers' money the federal government spends by up to $50.6 billion per year.[19]

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[15] OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERVS., ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 11 (2003) [hereinafter ADDRESSING THE NEW HEALTH CARE CRISIS].

[16] *See* OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERVS., UPDATE ON THE MEDICAL LITIGATION CRISIS: NOT THE RESULT OF THE "INSURANCE CYCLE" (2002) [hereinafter INSURANCE CYCLE], *available at* http://heal-fl-health-care-pdf.netcomsus.com/resources_update_report.doc (last visited Feb. 3, 2004).

[17] *Id.* at 3.

[18] OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS, IMPROVING HEALTH CARE QUALITY & LOWERING COSTS BY FIXING OUR MED. LIABILITY SYS. 8 (2002) [hereinafter CONFRONTING THE NEW HEALTH CARE CRISIS], *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.pdf (last visited Feb. 3, 2004).

[19] ADDRESSING THE NEW HEALTH CARE CRISIS, *supra* note 15, at 11.

5. Evidence that the litigation system is broken is further established in a study released by Tillinghast-Towers Perrin on December 10, 2003.[20] Tillinghast reported that "U.S. tort costs grew by 13.3% in 2002, on the heels of a 14.4% increase in 2001." This growth far outpaced trends of the past decade, and the current level of costs is "equivalent to a 5% tax on wages."[21] This is the only study that tracks the cost of the U.S. tort system from 1950 to 2002 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:

   a. 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.[22]

   b. As of 2002, U.S. tort costs accounted for slightly more than 2% of GDP, reflecting the highest ratio to GDP since 1990.[23]

   c. 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.[24]

   d. **Medical liability costs have risen an average of 11.9% a year since 1975 in contrast to an average annual increase of 9.3% for overall tort costs, outpacing increases in overall U.S. tort costs.**[25]

   e. Approximately 60 cents of every dollar expended on the system is absorbed by administrative costs—with legal fees being the primary component of this expense.[26]

6. The vast majority of medical liability claims, almost 70%, do not result in any payments to patients.[27] Fewer than 1% of cases result in trial victories for plaintiffs.[28]

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[20] TILLINGHAST-TOWERS PERRIN, U.S. TORT COSTS: 2003 UPDATE: TRENDS AND FINDINGS ON THE COST OF THE U.S. TORT SYSTEM (2003) [hereinafter TILLINGHAST-TOWERS PERRIN], *available at* http://www.towersperrin.com/tillinghast/publications/reports/2003_Tort_Costs_Update/Tort_Costs_Trends_2003_Update.pdf (last visited Feb. 3, 2004).

[21] *Id.* at 1.

[22] *Id.* at 1-2.

[23] *Id.* at 19, 20.

[24] *Id.* at 1.

[25] *Id.* at 2.

[26] *Costs and Compensation Paid in Tort Litigation: Hearing Before the Subcomm. on Trade, Productivity, and Econ, Growth of the Joint Econ. Comm. of the U.S. Cong.*, 99th Cong. (1986) (statement of James Kakalik & Nicholas Pace, RAND Institute for Civil Justice).

[27] CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 18, at 8.

[28] PHYSICIAN INSURERS ASS'N OF AM., *supra* note 4, at exhibit 1-2, 6a.

7. Blue Cross/Blue Shield's health plans report that approximately half of the plans expect OB-Gyn and surgical fees to increase as a result of increased professional liability premiums. This was expected in both crisis and non-crisis states.[29]

8. Patients are aware of the impact of lawsuits on healthcare costs. Seventy-one percent (71%) agree that medical liability litigation is driving up healthcare costs.[30]

9. Health care consumers acknowledge the impact of rising insurance premiums on overall healthcare costs. An April 2002 PricewaterhouseCoopers study "The Factors Fueling Rising Healthcare Costs" concluded that litigation accounted for 7% of the increase in rising costs of health insurance premiums. "Litigation" includes the effects of defensive medicine, liability premiums, risk management and reinsurance, outsized awards and legal costs, and class action lawsuits.[31]

F. The Current Liability Crisis: Defensive Medicine

1. Defensive medicine practices include tests and treatments that are performed to help avoid lawsuits.

   a. A majority (59%) of physicians believe that the fear of liability discourages open discussion and thinking about ways to reduce health care errors.[32]

   b. Three-fourths (76%) of physicians believe that concern about medical liability litigation has negatively affected their ability to provide quality care in recent years.[33]

2. The costs of defensive medicine are estimated to be between $70-$126 billion per year. These costs could be significantly reduced by medical liability reforms.[34]

3. Defensive medicine takes many forms as physicians respond to the breakdown of access to care, including: referring patients to emergency departments, safety net hospitals and academic health centers; specialists declining to take call in the emergency department; and specialists

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[29] BLUE CROSS BLUE SHIELD ASS'N, *supra* note 8, at 2.
[30] WIRTHLIN WORLDWIDE, THE MED. LIABILITY CRISIS: A FED. PROBLEM THAT REQUIRES A FED. SOLUTION, *available at* http://www.hcla.org (Last visited Feb. 12, 2004).
[31] PRICEWATERHOUSECOOPERS, AM. ASS'N OF HEALTH PLANS, THE FACTORS FUELING RISING HEALTHCARE COSTS, 3 (2002), *available at* http://www.aahp.org/InternalLinks/PwCFinalReport.pdf (last visited Feb. 12, 2004).
[32] HARRISINTERACTIVE INC., COMMON GOOD, COMMON GOOD FEAR OF LITIGATION STUDY: THE IMPACT ON MED. 65 (2002), *available at* http://ourcommongood.com/library/download/litrprt.pdf?item_id=10032 (last visited Feb. 1q2, 2004).
[33] *Id.* at 57. *See also*, Stuart Taylor & Evan Thomas, *Civil Wars*, NEWSWEEK, Dec. 15, 2003 (detailing America's increasingly litigious culture and its repercussions in the day to day work of physicians and other professionals).
[34] Addressing the New Health Care Crisis, *supra* note 15.

declining elective referrals from emergency departments and safety net clinics, especially for uninsured patients.[35]

3. Of Blue Cross/Blue Shield plans surveyed, those in crisis states are two and a half times more likely to identify defensive medicine as "already a very serious problem" in relation to cost increases.[36] For the rest of the states, over half of the Blue Cross/Blue Shield plans feel it is an "inevitable" problem.[37]

G. Activity in the Crisis States

1. The HHS update highlights that liability insurance rates are escalating faster in states that have not established reasonable limits on unquantifiable and arbitrary non-economic damage awards. The government's report states that:

> ... 2001 premium increases in states without litigation reform ranged from 30%-75%. In 2002, the situation has deteriorated. **States without reasonable limits on non-economic damages have experienced the largest increases by far, with increases of between 36%-113% in 2002.** States with reasonable limits on non-economic damages have not experienced the same rate spiking. (emphasis added)[38]

2. The Current Liability Crisis: The Crisis States[39]

   a. The AMA has identified the following nineteen states currently experiencing a medical liability crisis: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, Nevada, West Virginia, and Wyoming.

   b. Twenty-five states and the District of Columbia are seeing the warning signs of a potential crisis.

   c. Only 6 states are considered stable; California, Colorado, New Mexico, Louisiana, Wisconsin, and Indiana.[40]

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[35] ROBERT BERENSON ET AL., CTR. FOR STUDYING HEALTH SYS. CHANGE., *Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places*, (2003), *available at* http://www.hschange.org/CONTENT/605/?words=malpractice (last visited Feb. 3, 2004).
[36] BLUECROSS BLUESHIELD ASS'N, *supra* note 8, at 3.
[37] *Id.* at 8.
[38] OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERVS., SPECIAL UPDATE ON MED. LIABILITY CRISIS (2002) *available at* http://aspe.hhs.gov/daltcp/reports/mlupd1.htm (last visited Feb. 3, 2004).
[39] *See* AM. MED. ASS'N, AM.'S MED. LIABILITY CRISIS: A NAT'L VIEW, *available* at http://www.ama-assn.org/ama1/pub/upload/mm/-1/med_liab_19stat.pdf (last visited Feb. 11, 2004).
[40] *Id.*

3. The Blue Cross/Blue Shield Association study concludes that the "medical malpractice insurance crisis is threatening healthcare affordability and access to care." (88% of plans agree.)[41]

   a. Blue Cross/Blue Shield recognizes the AMA designation of "crisis" states and acknowledges the impending problems of 30 other states.[42]

   b. The Blue Cross/Blue Shield study validates the conclusion that reduced access to care is a result of the current medical liability crisis.

      i. Fifty-six percent (56%) of Blue Cross/Blue Shield plans in crisis states respond that physicians are refusing some high risk procedures. (In non-crisis states 32% of plans report this finding.)[43]

      ii. Fifty-six percent (56%) of Blue Cross/Blue Shield plans in crisis states report that physicians are leaving practice or retiring. (The response in non-crisis states is 42%.)[44]

      iii. Almost 1/3 of the Blue Cross/Blue Shield plans in crisis states report that physicians are moving practices out of state. (In non-crisis states, 1/5 of plans report that physicians are moving out of state.)[45]

4. Selected Examples of Patients Losing Access to Care in the 19 Medical Liability Crisis States

   (The following information is derived directly from the American Medical Association's Medical Liability Crisis State Backgrounders.)

   a. **Arkansas**

      i. A 13-physician group of obstetricians at Fayetteville's FirstCare Family Doctors was forced to stop delivering babies after the group's primary insurer left the state and affordable insurance was not available. "This situation has totally disrupted the way of life we love here," said Sara McBee, MD. (Arkansas Business Jan. 13, 2003)

      ii. More than 50 percent of physicians surveyed reported they've been forced to reduce or discontinue one or more medical services in the last two years due to rising liability insurance premiums. "Surgery and other procedures" was cited as the most common service cut,

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[41] BLUECROSS BLUESHIELD ASS'N, *supra* note 8, at 2.
[42] *Id.*
[43] *Id.* at 9.
[44] *Id.*
[45] *Id.*

followed by emergency-room care, "treating patients at nursing homes," on-call duty and obstetrics. (Arkansas Medical Society)

b. **Connecticut**

i. Physicians in Connecticut are close to the breaking point because of sharply increasing premiums. Since 1999, obstetricians, neurosurgeons, radiologists and neurologists have seen their premiums increase between 118 percent or more. Obstetricians are facing premiums close to $125,000. (CMIC, 2003)

ii. A preliminary survey indicates that as of January 2003, 28 Connecticut obstetricians made the difficult decision to no longer deliver babies. On average, each obstetrician delivers about 100 babies a year, so this means that at least 2,800 mothers-to-be will have to find another obstetricians, according to the Connecticut State Medical Society. (The Hartford Courant, Feb. 3, 2003)

c. **Florida**

i. More than 1,600 doctors from across Florida gave sworn statements to a state Senate panel in August 2003 detailing how the state's medical liability crisis forced them to change their practices, including no longer providing services such as delivering babies and performing complex surgeries. (Florida Medical Association)

ii. At least seven Florida hospitals have closed their obstetrics units due to insurance concerns, and four other hospitals have reduced or limited obstetrics services. In addition, ten hospitals have eliminated, reduced or limited neurosurgical services. (Florida Hospital Association, Jan. 2, 2003)

d. **Georgia**

i. The Georgia Board for Physician Workforce in January 2003 detailed the effects of the medical liability crisis on access to care for Georgia's patients. The study showed:

1. 2,800 physicians in Georgia are expected to stop providing high-risk procedures to limit liability.
2. 1,750 physicians reported that have stopped or plan to stop providing ER coverage.
3. 630 physicians plan to quit practicing or leave the state.
4. 1 in 5 family physicians and 1 in 3 OB-GYNs reported plans to stop providing high-risk procedures, including delivering babies.
5. Almost 40% of radiologists in the state have or will stop performing high-risk procedures.

6. The number of physicians going to practice in rural areas of the state has decreased by 50% from 2002 to 2003.

e. **Illinois**

i. In February 2003, two Joliet neurosurgeons gave up brain surgery, leaving the city's only two hospitals without full-time coverage for head trauma cases. Joliet's two hospitals, Silver Cross Hospital and Provena St. Joseph Medical Center, acknowledge they will be unable to handle all emergency head trauma cases. They say they may have to stabilize and transport serious cases 45 minutes to the nearest trauma center. (Chicago Tribune, Feb. 16, 2003)

ii. Dr. Susan Hagnell grew up in Chicago's Rogers Park neighborhood, attended medical school in Illinois and delivered well over 700 babies at hospitals in the northwest suburbs. But when her liability insurance bill soared from $71,848 to $118,742 last summer, Hagnell decided to jump the border. Now she delivers Wisconsin babies. "If I knew what was going to happen, I would never have become an obstetrician/gynecologist." (Chicago Tribune, March 12, 2004)

f. **Kentucky**

i. In the past three years, Kentucky has lost 36 percent of its practicing neurosurgeons, 29 percent of its general surgeons and 25 percent of its obstetricians, according to the Kentucky Medical Association. (Associated Press, January 13, 2004)

ii. In Pikeville, three of four obstetricians who deliver babies at Pikeville Methodist Hospital have received medical liability insurance coverage cancellation notices, and the fourth said he might yet receive one. "There's no way that I could do 800 deliveries by myself," said Dr. James Pigg, the lone obstetrician in Pikeville. (Louisville Courier-Journal, Nov. 11, 2003)

g. **Mississippi**

i. Pediatric specialist Kurt Kooyer, MD, left the small town of Rolling Fork after getting fed up with a legal system that allowed lawyers to file suit against him without the patients knowledge they were suing their physician. Dr. Kooyer, the only pediatrician among three physicians in town, arrived in 1994 and was responsible for the infant mortality decreasing from an average of 10 deaths per 1,000 live births to 3.4. Dr. Kooyer now lives in North Dakota. (Clarion Ledger, Aug. 23, 2003)

ii. Mississippi is the only state in the United States the U.S. Chamber of Commerce warns businesses about doing business in. "Mississippians are losing more than 7,500 jobs a year, and the average Mississippi family pays an additional $264 a year as a direct result of the state's love affair with lawsuits," said James M. Wootton, president of the Chamber Institute for Legal Reform. (U.S. Chamber of Commerce, May 8, 2002)

iii. Rural obstetric care is in serious jeopardy. Cleveland has lost three of six Ob-gyns, Greenwood has lost two of four, and Yazoo City—with 14,550 residents, has no one practicing obstetrics. (Associated Press, Nov. 19, 2003)

h. **Missouri**

i. The trauma care network in Missouri is in jeopardy as multiple trauma centers either closed, downgraded, or faced extreme funding shortfalls due to skyrocketing insurance premiums and a loss of physicians to serve the trauma centers. St. Joseph Health Center in Kansas City, Independence Regional Health Center in Independence, DePaul Health Center in St. Louis are three examples. (Kansas City Business Journal, May 2, 2003; Kansas City Star, March 9, 2003 & April 1, 2003; St. Louis Post-Dispatch, September 22, 2003)

ii. Julie Wood, MD, grew up in Macon, Mo., and loved practicing medicine there, as well as delivering babies. Yet, she was forced to close her practice and become part of a teaching hospital in Kansas City because of skyrocketing insurance rates. The town's two other family practitioners also decided to stop delivering babies and the nearest obstetrical care now is at least one hour away. (Springfield News Leader, May 10, 2003)

i. **North Carolina**

i. Dr. David Pagnanelli, a neurosurgeon, said he moved to Hendersonville, North Carolina in 2002 because liability costs were too high in Pennsylvania. But they shot up here too -- to close to $190,000 a year -- even though there've been no successful claims against him, he said. Following his insurance carrier's advice, Pagnanelli stopped seeing trauma cases. But neurosurgeons are in short supply in Hendersonville, so his decision means patients with life-threatening head injuries have been shipped to other hospitals, Pagnanelli said. Next month he's moving to Oklahoma, where his liability costs will be lower, he said. (Charlotte Observer, February 11, 2004)

ii. Obstetricians and trauma surgeons in Western North Carolina are seeing increases in their professional liability insurance rates as high as 50-100 percent, according to Dr. Hal Lawrence, director of the Mountain Area Health Education Center's Women's Health Center. (Ashville Citizen-Times, Feb. 8, 2003)

j. **Nevada**

i. Las Vegas' only trauma center, which treated more than 11,000 patients in 2001, and is the only Level I center within 400 miles of Las Vegas, closed for 10 days in July 2002 because it did not have enough surgeons to staff the center. Lawsuit abuse continues in Las Vegas as orthopedic surgeons and Ob-gyns have more closed claims against them than any other specialty. (Medical Dental Screening Panel data 1986-2002)

ii. Mary Rasar's father died in Las Vegas after the only Level 1 trauma center was forced to close due to skyrocketing medical liability costs. Jim Lawson was injured July 4 in a traffic accident and rather than being rushed to the Level 1 trauma center at nearby University Medical Center, which had been forced to close, Lawson was taken to a hospital that did not have the resources necessary to save his life. He died while physicians tried to stabilize him for airlift to Salt Lake City. (PR Newswire, April 21, 2003)

iii. Physicians at the Nevada School of Medicine say that for the first time, the majority of obstetrical residents haven't remained in Las Vegas because of the skyrocketing liability premiums. "We've always had three out of the three residents stay in Las Vegas the past 20 years," said Dr. Joe Rojas Sr., who has been training Nevada obstetricians for more than 30 years. "Now only one of the residents finishing this year might stay here to practice. People used to call me looking for jobs in private practice all the time. Now, nobody ever calls me anymore." (Las Vegas Review-Journal, January 10, 2003)

k. **New Jersey**

i. An eight-physician ophthalmology practice, which treats premature babies born with retinopathy—a condition that can lead to blindness—will no longer offer the procedure due to the high-risk and liability exposure. (Medical Society of New Jersey)

ii. In January 2002, there were 85 practicing neurosurgeons in the state. A little more than a year later, an estimated 20 have stopped practicing. Warren County residents,

including its 200-bed hospital, saw its only two neurosurgeons leave in September 2002. The closest neurosurgery center is more than one hour away. (Medical Society of New Jersey)

l. **New York**

i. Sixteen percent of New York Ob-gyns have stopped practicing obstetrics because of the state's medical liability crisis, 40 percent of the state's counties have fewer than 5 practicing Ob-gyns, and seven counties, with as many as 300 births per year, currently have no obstetrician. (ACOG 2002 survey)

ii. Forty-five percent of Ob-gyn residents who graduated in New York in 2002 left the state. (Long Island Business News, March 28, 2003)

m. **Ohio**

i. "My wife and I are both physicians and just arrived in Wausau [Wisconsin] in March. We fled the crisis in Ohio after spending our whole careers in that state," said Christopher J. Magiera, a gastroenterologist. Magiera and his wife, Pamela G. Galloway, a general surgeon, gave up their 15-year-old practice when their medical liability premiums that were projected to reach $100,000 apiece. In Wisconsin, they pay a fraction of that. (Journal Sentinel, April 20, 2003)

ii. Dr. Rebecca Glaser, a popular breast cancer specialist, will retire from surgery on April 1 because of high liability insurance premiums. "I think it's horrifying when we lose a physician who has literally a one-of-a-kind practice," said Donna Buchheit, one of Glaser's breast cancer patients. She continues, "It is literally a life and death issue. The legislature needs to understand that. It is not melodramatic to say that there will be women who die this year because of this. I certainly hope I won't become one of them." (Dayton Daily News, February 28, 2004)

iii. Insurance premiums got so high for Dr. Brian Bachelder of Mount Gilead that he stopped delivering babies in 2003. Because he was the only obstetrician in Morrow County, women there now travel at least a half-hour to Marion. (Columbus Dispatch, February 16, 2004)

n. **Oregon**

i. Rural patients in Oregon are being particularly hard hit. Roseburg Women's Healthcare, which delivered 80% of the babies for the area, closed its doors in May 2002 because its liability insurance was canceled after a

single, $8.5 million lawsuit. The closest other providers are 60-90 minutes away. "We consider this a medical crisis for the community," Mercy Medical CEO Vic Fresolone told the Associated Press. (Associated Press, Jun. 26, 2002)

ii. Dr. Katherine Merrill delivered as many as 40 babies a year in Astoria, a job she loved. In August 2003, Merrill stopped delivering babies - a decision prompted by the steeply rising costs of medical liability insurance. Merrill said something needs to be done to keep physicians from leaving the state or quitting high-risk specialties. "Otherwise there will be no doctors in your town to deliver babies or to do brain surgery when you've been in a car accident," she said. (The Associated Press, January 24, 2004)

o. **Pennsylvania**

i. Physicians are leaving Pennsylvania because of skyrocketing medical liability insurance rates and the out-of-control legal climate:

General surgeon drop: 1,600 to just over 1,000 (1997-2002)
Orthopedic surgeon drop: 890 to 745 (1997-2002)
Neurosurgeon drop: 215 to 180 (1995-2002)
Philadelphia lost approximately 450 physicians (1997-2002)
(Source: Pennsylvania Medical Society)

ii. Medical students are less likely to seek residencies in Philadelphia, and residents are less likely to stay and practice in the area because of "prohibitively high" medical liability insurance rates, according to Jefferson Medical College professor Stephen L. Schwartz, MD. (Associated Press, Oct. 4, 2002)

p. **Texas**

i. In the past two years, 62 percent of Texas physicians have begun denying or referring high-risk cases in the past two years, and 52 percent have stopped providing certain services to their patients in the past two years. Nearly two-thirds of physicians say the climate for practicing medicine and the fear of malpractice lawsuits have forced them to deny or refer high-risk cases to other doctors (Texas Medical Association, April 2003)

ii. A pregnant woman showed up in Dr. Lloyd Van Winkle's Castroville office in South Texas, less than 10 minutes from delivery. Her family doctor in Uvalde had recently stopped delivering babies, citing malpractice concerns, and the woman was trying to drive 80 miles to her San Antonio doctor and hospital. (Fort Worth Star-Telegram, January 26, 2003)

q. **Washington**

i. Delivering babies finally got too expensive for Mount Vernon doctor Bob Pringle. Like physicians throughout Washington, he has abandoned obstetrics. "Patients who find themselves in high-risk pregnancies are going to have a problem," he said of the trend. Pringle, who recently cut his practice to part-time gynecology, said delivering babies would cost him $79,000 a year in liability insurance, nearly twice what it did a few years ago. Two years ago there were nine full-time obstetricians in central Skagit County. Today there are four, he said. (Seattle Post-Intelligencer, March 3, 2004)

ii. Facing escalating liability insurance rates, Valley Women's Healthcare, one of the larger obstetric and gynecology clinics in south King County, is reducing services. Swedish Physicians, which operates out of 11 clinics including Pine Lake and Factoria, has cut the number of family physicians delivering babies from 21 to 7. (King County Journal, January 25, 2004)

iii. When rural doctors decide to drop obstetrics insurance coverage and stop delivering babies because of liability insurance premiums -- as they have in Odessa, Republic and Davenport -- they're also prohibited by their insurance companies from offering prenatal care. That means more pregnant women who've never had a prenatal check-up are showing up at Spokane hospitals to deliver babies. "That is Third-World medicine," said Tom Corley, president of Holy Family Hospital. "That's what you'd expect in the middle of Africa." Other rural women are making long drives into Spokane for prenatal care. (The Spokesman-Review, March 2, 2004)

r. **West Virginia**

i. After thoracic surgeon, Saad Mossallati was sued in a wrongful death case involving a patient he'd never seen, he spent four years defending the lawsuit that was ultimately dropped. The surgeon's defense cost $81,000, and his premium was raised as a result. Then Mossallati countersued and won an undisclosed, but "very substantial" settlement against the Wheeling, WV, attorney who'd brought the suit. (Medical Economics, April 11, 2003)

ii. In August 2002, the Charleston Area Medical Center (CAMC) trauma center was downgraded from a Level I to a Level III facility, with the closest Level I trauma center more than 150 miles away. CAMC's trauma center has since been reinstated to Level I. The one part-

time and three full-time surgeons were paying $800,000 in liability premiums before receiving help from the state and hospital. Trauma centers in Wheeling and southern West Virginia also are dangerously short-staffed. (Charleston Gazette, Apr. 25, 2002 and Charleston Daily Mail, August 24, 2002.)

s. **Wyoming**

i. Jim Derrisaw, MD, a Riverton anesthesiologist, moved his young family to Ft. Collins, Colorado to practice. Dr. Derrisaw grew up in Cheyenne, graduated from the University of Wyoming, married a native of Encampment, and returned to Wyoming to raise his family and "practice medicine in the state I love." Student loan debt for medical school of more than $100,000, coupled with insurance premiums that had escalated to $52,000 per year, created a burden that his deep Wyoming roots could not overcome. His insurance coverage in Colorado, a state with caps on non-economic damages and other key liability reform measures, has been quoted at a cost of $8,200. (Wyoming Medical Society)

ii. The loss of even one physician can have dire consequences for Wyoming patients, yet the unchecked liability crisis has forced the loss of obstetricians in Wheatland, Cheyenne and Newcastle. Surgeons have disappeared from Casper and Gillette, and more may leave Jackson. And all remaining Fremont County anesthesiologists have left their practice. (Wyoming Medical Society)

II. Solutions

A. Studies and Expert Opinions Confirm that Certain Types of Reform Lower Costs and Improve Access

1. In a study on the effect of reforms, Stanford University researchers Kessler and McClellan concluded that direct reforms, including caps on non-economic damages, reduced the likelihood that a physician will be sued by 2.1%. Within three years, premiums in direct reform states declined by 8.4%.[46]

2. Another study by Stephen Zuckerman *et al.* looked at several types of reforms and concluded that capping medical liability awards reduced premiums for general surgeons by 13% in the year following enactment of

[46] Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS., 81-106 (1997).

that reform and by 34% over the long term. Premiums for general practitioners and OB/GYNs were impacted similarly.[47]

3. In fact, not only do reforms lower physicians' premiums, they also lower medical expenditures, in general.

   In a different study by Kessler and McClellan, those researchers found "that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications."[48]

4. Agency for Healthcare Research and Quality demonstrates a cap on non-economic damages helps protect patients' access to care.

   a. The July 3, 2003 study from the Agency for Healthcare Research and Quality[49] looked at the distribution of physicians across states with and without caps on non-economic damages since 1970. After adjusting for multiple factors, AHRQ found that by 2000, states with damage caps averaged 12 percent more physicians per capita than states without damage caps. (emphasis added)

   b. Additional key findings include: caps are effective in improving the supply of physicians and patients' access to care; and the lower the cap, the greater its effectiveness in ensuring patients' access to care.

5. Joint Economic Committee study supports caps on non-economic damages.

   a. In a study released in May 2003, the Joint Economic Committee of the U.S. Congress stated: "Some of the key reforms proposed at the federal level, including the cap on pain and suffering damages, have proven successful at producing savings when implemented."[50]

   b. The study points to California, which under MICRA has a $250,000 cap on non-economic damages, allows for binding arbitration agreements, collateral source offsets, limits on contingency fees, advance notice of liability claims, statute of limitations, and periodic payment of damages. The Joint Economic Committee praises California as "perhaps the most successful example of reform at the state level," noting its slower

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[47] Stephen Zuckerman, Randall R. Bovbjerg & Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167-182 (1990).
[48] DANIEL P. KESSLER & MARK B. MCCLELLAN, NAT'L BUR. OF ECON. ANALYSIS, DO DOCTORS PRACTICE DEFENSIVE MEDICINE?, 2 (1996), *available at* http://www.nber.org/papers/w5466.pdf .(last visited Feb. 3, 2004.
[49] FRED HELLINGER & WILLIAM ENCINOSA, U.S. DEP'T OF HEALTH AND HUMAN SERVS., THE IMPACT OF STATE LAWS LIMITING MALPRACTICE AWARDS ON THE GEOGRAPHIC DISTRIBUTION OF PHYSICIANS (2003).
[50] JOINT ECON. COMM., 108TH CONG., LIABILITY FOR MED. MALPRACTICE: ISSUES & EVIDENCE 19 (2003).

rate of growth in medical liability premiums (167% versus 505% in the rest of the country from the period 1976 to 2000).[51]

c. After observing the failure of our current system to achieve either of its central goals, *i.e.*, to compensate those who are truly negligently injured and to deter negligent behavior, the study concludes: "This indictment of the tort system serves as the basis for medical liability reform...If adopted, the federal reform discussed here could yield budgetary savings of more than $19 billion per year, reduce the number of Americans without health coverage by up to 3.9 million, and lead to an environment that is significantly more receptive to efforts to improve patient safety and reduce medical errors."[52]

d. The study offers evidence suggesting that "reduced liability expenditures will have a noticeable direct impact on premium payments as well as large indirect savings attributable to improved economic (structural) efficiency. Indeed the structural effects can be much more important than the direct premium effects."[53]

6. Tillinghast-Towers Perrin confirmed for the Medical Society of New Jersey that savings could be expected with a $250,000 cap on non-economic damages. The study further states that a cap of $500,000 is likely to be of very little benefit to physicians.[54]

B. State Efforts to Enact Caps on Non-Economic Damages

1. Twenty-two states have enacted a cap on non-economic damages, while six states have a cap on total damages. Colorado places a cap on total damages and non-economic damages.

a. States with a cap on non-economic damages – Alaska, California, Colorado, Florida, Hawaii, Idaho, Kansas, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, North Dakota, Ohio, Oklahoma, South Dakota, Texas, Utah, West Virginia, and Wisconsin. Maryland also has a $500,000 cap on non-economic damages in wrongful death actions.

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[51] *Id.* Note: the updated figures according to NAIC data , through 2001, are 182% and 569%, respectively. *See* NAT'L ASS'N OF INS. COMM'RS, PROFITABILITY BY LINE BY STATE IN 2001 (National Association of Insurance Commissioners Insurance Products & Services Division 2003).

[52] JOINT ECON. COMM., *supra* note 50, at 24.

[53] HEALTH SERVICES. RESEARCH INST., PENN. MED. SOC'Y, PENNSYLVANIA'S MED. LIABILITY CRISIS & MED. MARKETPLACE ISSUES (2003).

[54] Letter from James D. Hurley & Gail E. Tverberg, Tillinghast-Towers Perrin, to Ray Cantor, Med. Soc'y of N.J., 4 (Jan. 7, 2003) (on file with the Am. Med. Ass'n).

b. States with a cap on total damages – Colorado, Indiana, Louisiana, Nebraska, New Mexico, and Virginia.

2. It is important when looking at the effectiveness of caps on non-economic damages to make the comparison on equal terms, *i.e.*, apples to apples.

a. For example, a fixed cap, like the $250,000 cap found in California's MICRA, is not comparable to the cap provided in the Missouri law.[55] The Missouri cap increases with inflation. Originally set at $350,000 in 1986, the cap on non-economic damages in Missouri was $557,000 as of February 1, 2003. In addition, the Missouri law applies the cap individually to each defendant and each plaintiff. Missouri's cap was considerably weakened by the courts in a 2002 decision, *Scott v. SSM Healthcare*, in which the court held that the cap can be applied separately for each act of malpractice. Therefore, if there are two separate and distinct "occurrences" of malpractice that contribute to a single injury the court can apply a separate cap for each occurrence even if they are applied to a single defendant.[56]

b. A cap on non-economic damages that is subject to numerous exceptions is not as effective as a hard cap like California. For example, Florida's cap on non-economic damages is subject to several exceptions decreasing the effectiveness of the cap.

c. A cap on non-economic damages that is set too high will also not be as effective as a $250,000 hard cap like California. For example, prior to enacting legislation in 2003, West Virginia had a $1 million cap on non-economic damages. At this high level the cap was ineffective.

3. Recent State Legislation Enacting Caps on Non-Economic Damages

a. Florida

i. After four special sessions, Florida's legislature enacted S.B. 2-D, which was signed into law by Governor Bush on August, 14, 2003. In its final form, the bill does not provide the level of reforms advocated by Governor Bush's task force or by the Florida Medical Association (FMA). In particular, the language on non-economic damages and exceptions to the cap added during late stages of negotiations are troublesome. In fact, this clause prohibited FMA from supporting the legislation in its final form.[57]

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[55] MO. REV. STAT. § 538.210 (2002).
[56] Scott v. SSM Healthcare, 70 S.W.3d 560, 569, 571 (Mo. Ct. App. 2002).
[57] FLA. STAT. ch. 766.118 (2003).

ii. S.B.2-D provides a separate cap on non-economic damages for practitioners and non-practitioners. For practitioners the cap is $500,000 per claimant regardless of the number of defendants. For non-practitioners the cap is $750,000 per claimant regardless of the number of defendants. The cap can increase to $1 million for practitioners and $1.5 million for non-practitioners if the negligence resulted in death or a permanent vegetative state, or if the court finds a manifest injustice would occur if the cap was not increased because the non-economic harm sustained by the patient was particularly severe and the defendant's negligence caused a catastrophic injury to the patient.

b. Idaho

i. On March 26, 2003, Governor Kempthorne signed into law H.B. 92 which included a $250,000 cap on non-economic damages (Idaho previously had a $400,000 cap on non-economic damages which adjusted annually for inflation since 1988). The new cap also adjusts annually for inflation based on the average annual wage beginning July 1, 2004. The cap does not apply to causes of action arising out of willful or reckless misconduct, or felonious actions.[58]

c. Mississippi

i. On October 8, 2003, Mississippi's Governor Musgrove signed into law H.B. 2. Among other provisions, H.B. 2 establishes a $500,000 cap on non-economic damages for any action for injury based on malpractice or breach of standard of care. The cap will increase to $750,000 for claims for causes of action filed on or after July 1, 2011 but before July 1, 2017. The cap will be adjusted again on July 1, 2017 to $1,000,000. The limit does not apply to damages for disfigurement. The limit also does not apply if the judge determines that a jury may impose punitive damages, which may be awarded if the claimant proves by clear and convincing evidence that the defendant acted with actual malice, gross negligence which evidences a willful, wanton or reckless disregard for the safety of others, or committed actual fraud.[59]

d. Nevada

i. Cap on non-economic damages. In Nevada, legislation enacted in 2002 included a cap on non-economic

[58] ID. REV. STAT. § 6-1603 (2004).
[59] MISS. CODE ANN § 11-1-60 (2004)..

damages. Unfortunately, the cap is applied per physician, per claimant and not per incident. Thus, multiple caps can be allowed in a single event. In addition, the cap does not apply if the defendant's conduct constitutes gross malpractice, or the court determines by clear and convincing evidence that a higher award is justified because of exceptional circumstances.[60]

ii. Cap on trauma care. Nevada's new law also establishes a $50,000 cap on civil damages for claims arising from care necessitated by a traumatic event demanding immediate attention that is rendered in good faith to a patient who enters the hospital through the emergency room or trauma center. This limit does not apply to any act or omission in rendering care or assistance that occurs after the patient is stabilized (unless surgery is required within a reasonable time after the patient is stabilized) or that is unrelated to the original traumatic injury.

In cases where the physician or dentist provides follow-up care to the patient they treated in the above circumstances and the patient files a malpractice claim based on a medical condition that arises during follow-up care, a rebuttable presumption exists that the medical condition was the result of the original traumatic injury and the $50,000 limit applies.

This limit does not apply in cases amounting to gross negligence or reckless, willful or wanton conduct.[61]

e. Ohio

i. On January 10, 2003 Ohio Governor Taft signed into law S.B. 281, a medical liability reform bill to address the growing crisis in Ohio. Among other provisions, the bill establishes a sliding cap on non-economic damages. The cap shall not exceed the greater of $250,000 or three times the plaintiff's economic loss up to a maximum of $350,000 for each plaintiff or $500,000 per occurrence. The maximum cap will increase to $500,000 per plaintiff or $1,000,000 per occurrence for a claim based on either (A) a permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or (B) a permanent physical functional injury that permanently prevents the injured person from being able to

[60] NEV. REV. STAT. § 41.A.031 (2002).
[61] NEV. REV. STAT. § 41.503(2002).

independently care for oneself and perform life sustaining activities.[62]

f. Oklahoma

i. On June 4, 2003, Oklahoma's Governor Henry signed into law S.B. 629. Among other provisions, S.B. 629 includes a $300,000 cap on non-economic damages for cases involving pregnancy, labor and delivery, or care provided immediately post-partum. The cap also applies in cases involving emergency-room care or medical services provided as a follow up to such care. The bill allows a judge to lift the cap if the judge makes a finding that there is clear and convincing evidence of negligence. The cap applies regardless of the number of parties against whom the medical negligence action is brought. The $300,000 damage limit does not apply in wrongful death cases. The cap provision is scheduled to sunset in 5 years.[63]

g. Pennsylvania

i. In December 2003, Pennsylvania's legislature enacted H.B. 44, which establishes the Health Care Provider Retention Program. H.B. 44 provides physicians a full or partial abatement of their MCARE assessments for 2003 and 2004. A health care provider can receive a full abatement of the assessment if he/she meets one of the following criteria: is assessed as a member of one of the four highest rate classes of the prevailing primary premium, is an emergency physician, routinely provides obstetrical services in a rural area, or is a certified nurse midwife. All other health care providers who qualify under the act will receive a 50% abatement of their assessment. As a condition of accepting the abatement, providers must agree to practice in the state for at least one full year following the year for which the abatement was received.[64]

h. Texas

i. On June 11, 2003 Governor Perry signed H.B. 4 into law. H.B. 4 contains sweeping tort reforms, many of which exclusively address malpractice litigation against physicians. Of these reforms, perhaps the most important is the hard cap of $250,000 on non-economic damages per claimant in any judgment against a

[62] Ohio Rev. Code § 2323.43 (2004).
[63] OK CODE §63-1-1708.1F (2003).
[64] PA H.B. 44 (2004) (enacted)

physician or health care provider, regardless of any applicable theories of vicarious liability, the number of defendants involved, or the number of causes of action asserted as part of the claimant's case against the physician. H.B. 4 also places a hard cap of $250,000 on non-economic damages per claimant in any judgment against a health care institution in a medical liability cause of action. A judgment against two health care institutions shall not exceed $500,000 in non-economic damages with each institution not liable for more than $250,000 in non-economic damages.[65] All persons claiming to have sustained damages as a result of the bodily injury or death of a single person are considered a single claimant.

ii. The new law states the cap on non-economic damages applies per "claimant." This terminology may create some confusion about the scope of the cap. Fortunately, however, the new law defines "claimant" as "a person, including a decedent's estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as a result of the bodily injury or death of a single person are considered a single claimant." Therefore, all persons claiming to have sustained damages as a result of injury or death sustained by a single person are considered a single claimant. The new law also states the cap applies regardless of the number of defendants or causes of action asserted. Therefore, the maximum amount a claimant (including all persons that claim damages as a result of injury or death of a single person) can recover in non-economic damages, even if multiple physician defendants are involved and the claimant asserts multiple causes of action, is $250,000. There is also a separate cap for health care institutions whereby a claimant can recover up to an additional $250,000 for one institution and up to $500,000 if more than one institution is involved. Again this cap applies regardless of the number of causes of action asserted, or persons who claim to have damages from the injury or death of a single person.

iii. The caps provision states as follows: "(a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages of the physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious

[65] TEX. CIV. PRAC. & REM. § 74.301(2004).

liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based. (b) in an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant. (c) In an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution is, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000 for each claimant."

iv. On September 13, 2003, the people of Texas approved Proposition 12, a ballot initiative to amend the state constitution to specifically allow the legislature to enact laws that place limits on non-economic damages in medical and health liability cases. This vote validates the legislature's work in enacting HB 4. The final vote was 51.12% in favor of Proposition 12 and 48.88% against. Thus a decrease in liability insurance premiums can occur immediately rather than a possible 10 year wait for the state supreme court to decide whether caps are allowed under the state constitution. The constitutional change clearly states that the legislature can set a cap on non-economic damages in medical and health care liability cases.[66]

i. West Virginia

i. Cap on non-economic damages. On March 11, 2003, West Virginia's Governor Bob Wise signed into law H.B. 2122. As enacted, the bill contains a number of reforms including a $250,000 cap on non-economic

[66] A tribute to the effectiveness of Proposition 12 came soon after its passing when personal injury trial attorney and member of the Oklahoma legislature Stratton Taylor sent a letter to his ATLA colleagues in Texas to offer the services of his firm to any Texas attorney wishing to forum-shop and file suit in Oklahoma—where there are still no caps. Editorial, *Oklahoma!*, THE WALL ST. J., Dec. 19, 2003.

damages applied per occurrence regardless of the number of defendants or plaintiffs. The cap increases to $500,000 per occurrence for cases involving a permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system, or permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities. The cap will be adjusted annually for inflation up to $375,000 per occurrence or $750,000 for injuries that fall within the exception.[67]

ii. Cap on trauma care. The bill also includes a $500,000 cap on civil damages for any injury to or death of a patient as a result of health care services rendered in good faith and necessitated by an emergency condition for which the patient enters a health care facility designated as a trauma center. This limit also applies in the following circumstances: (1) to health care services rendered by a licensed EMS agency or employee of a licensed EMS agency. (2) any act or omission of a health care provider in rendering continued care or assistance in the event that surgery is required as a result of the patient's emergency condition.

This limit does not apply if the care is rendered in willful and wanton or reckless disregard of a risk of harm to the patient or in clear violation of established written protocols for triage and emergency health care procedures developed by the office of emergency medical services. Likewise, the limit does not apply to any act or omission in rendering care that occurs after the patient has been stabilized and is considered a non-emergency patient, or care that is unrelated to the original emergency condition.

If the physician who provided care to the patient when the patient was presented with an emergency condition provides follow-up care to the same patient and a medical condition arises during the course of this follow-up care that is directly related to the original emergency condition, there is a rebuttable presumption that the medical condition was the result of the original emergency condition, and, therefore, the cap applies. There is also a rebuttable presumption that a medical condition that arises in the course of follow-up care provided by a health care provider in the trauma center is directly related to the original emergency condition,

[67] W. VA. CODE § 55-7B-8 (2003).

where the follow-up care is provided within a reasonable time after the patient's admission to the trauma center.[68]

4. Judicial Activity

   a. The courts in the following states upheld legislation for caps on non-economic damages: Alaska, California, Colorado, Idaho, Kansas, Maryland, Michigan, Minnesota, Missouri, Nebraska, Virginia, West Virginia and Wisconsin. (Of them, Missouri, North Carolina, and West Virginia are considered crisis states.)[69]

   b. Courts in Indiana, Louisiana and New Mexico upheld caps that encompass both economic and non-economic damages.[70] Louisiana's cap, akin to New Mexico, does not include medical expenses, which are paid as incurred.[71]

   c. Courts in the following states struck down caps on non-economic damages: Alabama, Georgia, Illinois, Kansas, New Hampshire, North Dakota, Ohio, Oregon, Washington[72]

   d. In Florida and Texas, caps were upheld, but with some restrictions.[73]

5. Favorable State Case Law Establishes Rationale for Supporting Legislative Reforms - Failed Legal Challenges Brought Against Caps on Non-economic Damages[74]

   a. Equal Protection Clause

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[68] W. VA. CODE § 55-7B-9C (2003).

[69] *See* Evans v. State, 56 P.3d 1046 (Alaska 2002); Hoffman v. U.S., 767 F.2d 1431 (9th Cir. 1985); Scholz v. Metro. Pathologists P.C., 851 P.2d 901 (Colo. 1993); Kirkland v. Blaine County Med. Ctr., 4 P.3d 1115 (Idaho 2002); Samsel v. Wheeler Transp. Serv., Inc. 246 Kan. 336 (Kan. 1990); Murphy v. Edmunds, 601 A.2d 102 (Md. 1992); Zdrojewski v. Murphy, 657 N.W.2d 721 (Mich. Ct. App. 2002); Adams v. Children's Mercy Hosp., 848 S.W.2d 535 (Mo. Ct. App. 1993); Linder v. Smith, 629 P.2d 1187 (Mont. 1981); Prendergast v. Nelson, 256 N.W.2d 657 (Neb. 1977); Gourley ex. rel. Gourley v. Neb. Methodist Health Sys., 633 N.W.2d 43 (Neb. 2003); Etheridge, et. al. v. Med. Ctr. Hosp., 367 S.E.2d 525 (Va. 1989); Robinson v. Charleston Area Med. Ctr., 186 W.Va. 720 (W. Va. 1991); Verba v. Ghaphery, 552 S.E.2d (W. Va. 2001); Guzman v. St. Francis Hosp., 623 N.W.2d 776 (Wis. Ct. App. 2000).

[70] Johnson v. St. Vincent Hosp., 404 N.E.2d 585 (Ind. 1980); Butler v. Flint Goodrich Hosp., 607 So.2d 517 (La. 1992), Fed. Express Corp. v. U.S., 228 F. Supp. 2d 1267 (N.M. 2002).

[71] LA. REV. STAT. § 40:1299.42(B)(1) (2003).

[72] *See* Moore v. Mobile Infirmary Ass'n, 592 So.2d 156 (Ala. 1991); Denton v. Con-Way S. Express, Inc., 402 S.E. 2d 269 (Ga. 1991); Best v. Taylor Mach. Works, 689 N.E.2d 1057 (Ill. 1997); Kan. Malpractice Victims Coalition v. Bell, 757 P.2d 251 (Kan. 1988) (new law enacted in 1988); Carson v. Mauer, 424 A.2d 825 (N.H. 1980); Arneson v. Olson, 270 N.W.2d (N.D. 1978); State ex rel. Ohio Academy of Trial Lawyers v. Sheward, 715 N.E. 2d 1062 (Oh. 1999); Lakin v. Senco Products, Inc., 987 P.2d 463 (Or. 1999); Sofie v. Fibreboard Corp., 771 P.2d 711 (Wash. 1989).

[73] *See* Univ. of Miami v. Echarte, 618 So.2d 189 (Fla. 1993); Lucas v. U.S., 757 S.W.2d 687 (Tex. 1988); Rose v. Doctors Hosp., 801 S.W.2d 841 (Tex. 1990).

[74] *See* cases cited *supra*, note 68.

i. Under the "deferential rational relationship" test, a number of courts have upheld damages caps as a permissive and rational means of achieving the legitimate state goal of reducing insurance premiums paid by physicians.

ii. Other societal goals supporting the implementation of caps that have been upheld by the court include; (i) ensuring the availability of physicians in the state, (ii) the continued existence of state compensation funds, (iii) the continued existence of insurance for physicians in the state, and (iv) assurance of medical related payments to all claimants.

iii. Courts have held it constitutional for damage caps to differentiate between medical liability tort claimants who have suffered injuries valued at a level below the damages cap, and those who have suffered damages valued above the damages cap amount based upon the legitimate purpose of the legislature.

b. Due Process Clause

Court analysis of due process challenges has also proceeded under the rational relationship test, where damages caps have been found to be neither arbitrary nor irrational legislative goals.

c. Right to Trial by Jury

i. After a plaintiff is awarded damages up to the amount of the statutory cap, the determination of damages is removed from consideration by the jury and given to the court. This is not a denial of the right to trial by jury, since the jury has already completed its fact-finding mission, determining that the plaintiff is owed compensation. Deciding how much a patient will recover is a question of law for the court. The court implements the policy decision of the legislature.

ii. Reviewing courts have also held that it is within the legislature's power to modify common law and statutory rights and remedies, as was done with the caps.

d. Open Court Challenge

The courts have struck down the argument that a damage cap impermissibly allows the legislature to intrude on the judicial process. Instead of being an impermissible barrier to the courts, the cap is merely a limit on recoveries.

e. Intrusion on the Rulemaking Power of the Judicial Branch

i. The courts did not find that caps allow the legislature to overstep its constitutional powers. Instead, the courts found that the legislature has full purview over questions of policy, as opposed to procedural questions. Damage caps are questions of policy, properly within the legislature's scope of power.

6. California's Solution: MICRA

a. California enacted the Medical Injury Compensation Reform Act of 1975 (MICRA) which largely eliminates the lottery aspect of medical liability litigation in that state.[75]

b. Now, in California, claims are settled in one-third less time than in states without caps on non-economic damages.[76] This not only decreases the cost of litigation, it also means injured patients are indemnified much faster in California.

c. California's experience with MICRA shows that tort reform works. MICRA has been held up as "the gold standard" of tort reform, and a model for repeated attempts at Federal reform legislation.

d. According to Phil Hinderberger of Norcal Mutual, before MICRA was passed, "California physicians paid almost 25% of all medical liability premiums paid in the [U.S.] at a time when they represented only about 10% of all practicing physicians in the [U.S.]. Today, California physicians pay about [10]% of all medical liability premiums paid in the [U.S.] which represents a fair share."[77]

e. According to the National Association of Insurance Commissioners, while total premiums in the rest of the U.S. have risen 569%, California premiums have risen only 182% since 1976.[78]

f. Since 1975, The Doctors Company, one of the 45 carriers that comprise the Physician Insurers Association of America (PIAA), has lowered its medical liability premium rates in California by 40% in constant dollars.[79]

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[75] CAL. CIV. CODE § 3333.2 (2003).

[76] *Harming Patient Access to Care: The Impact of Excessive Litigation: Hearing Before the Subcomm. on Health of the Comm. on Energy and Commerce*, 107th Cong. 88 (2002) [hereinafter Anderson statement] (statement of Richard E. Anderson, Chairman of the Doctors' Co. for the Physician Ins. Ass'n of Am.).

[77] Posting of Phil Hinderberger, phil-hinderberger@norcalmutual.org, to asmac-l@unity.ama-assn.org (Jan. 20, 2003) (copy on file with author).

[78] *See e.g.*, NAT'L ASS'N OF INS. COMM'RS, *supra* note 51 . Statistics presented in *MLR – Now!* have been derived from this and previous versions of the report dating back to 1975.

[79] Anderson statement, *supra* note 76.

g. According to HHS, the number of large jury awards has been declining in California, although the total number of claims has not.[80] "The percentage of claims resolved through settlement and arbitration has increased in California, saving money for injured patients."[81] "Premiums for specialists in Los Angeles are substantially less than for specialists in metropolitan areas in states without reforms such as Florida, Illinois, and Nevada."[82]

C. Federal Legislation

1. Although some states are attempting to address the medical liability crisis at the state level, a federal solution is also needed. Many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions that limit reforms.

2. The existing crisis is not confined within state lines. Many patients are losing access to their physicians, forcing them to travel to neighboring states for their health care.

3. All patients pay the escalating costs generated by our nation's dysfunctional medical liability system. These costs are especially grave for the Federal government, given that one-third of the total health care spending in our country is paid by the Medicare and Medicaid Programs.

4. Activities in the U.S. House of Representatives

a. On February 5, 2003, Representative James C. Greenwood (R-PA), introduced H.R. 5, the HEALTH Act (Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2003), which is modeled after the successful MICRA statute.

b. H.R. 5 includes provisions that would –

i. Ensure that patients receive 100 percent compensation for their economic losses, including medical expenses, rehabilitation costs, child care, lost wages, and other quantifiable costs, if harmed by a physician's negligence;

ii. Establish periodic payments of future damages;

iii. Maximize the amount of money juries award for patients – not trial lawyers; and

iv. Place a $250,000 cap on non-economic damages (*e.g.*, pain and suffering, mental anguish, physical impairment,

[80] INSURANCE CYCLE, *supra* note 16, at 4.
[81] *Id.*
[82] *Id.*

etc.) and allow states the flexibility to establish different caps whether higher or lower than those provided for in H.R. 5.

c. On March 13, 2003, the House of Representatives passed H.R. 5, the HEALTH Act, by a vote of 229-196. The vote was largely along party lines: 213 Republicans and 16 Democrats supported the bill; 9 Republicans, 186 Democrats and 1 Independent opposed the bill; 1 Republican voted "present"; and 8 members did not vote.

d. H.R. 5 would safeguard patients' access to care by enacting common sense reforms that provide a $250,000 cap on non-economic damages, thus reasonably limiting damages without preempting existing state law.

e. The Supremacy Clause, principles of preemption, and the language of H.R. 5 would protect states with existing caps and provide a federal standard for a non-economic cap, even if such caps are barred by a state constitution.

f. A 2003 Congressional Budget Office (CBO) study on H.R. 5 (108th Congress) indicates that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical liability insurance. Consequently, CBO estimates that, in states that currently do not have controls on medical liability torts, H.R. 5 would significantly lower premiums for medical liability insurance from what they would otherwise be under current law.[83]

5. Activities in the U.S. Senate

a. On June 26, 2003, Senator John Ensign (R-NV), Senate Majority Leader Bill Frist (R-TN), and Senate Majority Whip Mitch McConnell (R-KY) introduced S. 11, the "Patients First Act of 2003." S. 11 is similar to H.R. 5 as introduced in the U.S. House of Representatives, except that it includes a provision to reform expert witness requirements. Like H.R. 5, the AMA strongly supported this bill.

b. Despite the strong backing by the Senate Republican Leadership, on July 9, 2003, S. 11 failed to acquire the sixty votes needed to overcome a Democratic filibuster, thereby preventing the Senate from proceeding to a full debate. Forty-nine Senators voted in favor of breaking the filibuster, while forty-eight voted against –

[83] CONG. BUDGET OFFICE, H. R. 5 HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2003 (2003), *available at* http://www.cbo.gov/showdoc.cfm?index=4091&sequence=0 (last visited Feb. 10, 2004).

despite support from President Bush, the House of Representatives, and 72% of the American public.

c. Shortly after the July 2003 vote, the Senate Republican Leadership again expressed its strong commitment to federal medical liability reform by announcing their intent to bring numerous medical liability reform bills to the floor of the Senate throughout 2004.

d. On February 24, 2004, the Senate had a cloture vote on S. 2061, the "Healthy Mothers and Healthy Babies Access to Care Act of 2003," which was introduced by Senate HELP Committee Chairman Judd Gregg (R-NH) and Senator John Ensign (R-NV). If enacted, the legislation would apply certain MICRA-type reforms to physicians who provide obstetrical and gynecological services related to childbirth. The AMA expressed concerns that language in S. 2061 relating to collateral source/subrogation and ERISA scope of preemption (as included in previously introduced legislation, S. 607) could disadvantage patients and physicians. However, the AMA urged a "yes" vote on the motion to invoke cloture as a step to advance Senate legislation on medical liability reform. Supporters of S. 2061 failed to overcome a Democrat filibuster by a vote of 48-45 (60 votes needed).

e. Additional legislation (S. 2207) that would apply certain MICRA-like reforms to physicians who provide trauma/emergency services and OB/GYN services is expected to be considered in early April 2004. Like S. 2061, this legislation was introduced by Senators Gregg and Ensign and contains the same language regarding collateral source/subrogation and ERISA scope of preemption. The AMA again expressed concerns, but is urging a "yes" vote on the motion to invoke cloture as a step to advance Senate legislation on medical liability reform.

f. The AMA remains strongly committed to enacting federal legislation that will provide comprehensive medical liability reform for all physicians.

6. Public Support for Federal Legislation

a. President Bush and the American public continue to be strong advocates for medical liability reform.

b. Seventy-six percent (76%) of those surveyed in a Wirthlin Worldwide poll favor a law that would guarantee an injured patient full payment for lost wages and medical costs and place reasonable limits on awards for "pain and suffering" in medical

liability cases.[84] A recent Gallup poll confirms this public opinion. The poll results, released February 4, 2003, show that 72% of Americans support limiting the amount patients can be awarded for "pain and suffering."

III. Responding to Other Arguments

A. Public Citizen and Other Anti-Tort Reform Groups' Concerns

1. Claim: Physicians are victims of insurance companies that made bad business decisions and are now trying to make up their losses.[85]

Fact: Figures reported by A.M. Best representing 76% of the industry show that 80% of investments by PIAA companies between 1995 and 2001 were in high-grade bonds, with the remainder divided among stocks, mortgages, real estate and working cash.[86] Increased losses on claims are the primary contributor to higher medical liability premium rates. Insurers are not charging and profiting from excessively high premium rates. In fact, according to the Physician Insurers Association of America, 60% of all physicians in private practice are insured by physician-owned and/or operated insurance companies. Further, none of the insurance companies studied by a recent GAO report experienced a net loss on investments.[87]

2. Claim: Insurance companies raise rates when they are seeking ways to make up for declining interest rates and market-based investment losses.[88]

Fact: Annual Statement data summarized in Best's Aggregates & Averages, Property-Casualty, 2003 edition, showed that the Investment Yields of medical liability insurers have been stable and positive since 1998. Those returns have ranged from 4.5%-5.4%, and include income from interest, dividends, and real estate income. Medical liability insurers have approximately 80% of their investments in the bond market. Therefore, their total returns on invested assets are strongly influenced by bond market performance, and less so by stock market performance. Best's Aggregates and Averages indicates that insurers' total returns on invested assets has fallen by only 5.1 percentage points over that period. The facts simply don't justify anyone trying to place blame on the

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[84] WIRTHLIN WORLDWIDE, AMERICAN'S BELIEVE ACCESS TO HEALTH CARE THREATENED BY MED. LIABILITY CRISIS (2003), *available at* http://www.hcla.org (last visited Feb. 12, 2004).

[85] *See e.g.*, PUB. CITIZEN, BACKGROUNDER ON THE MED. MALPRACTICE ISSUE, *available at* http://www.citizen.org/congress/civjus/medmal/articles.cfm?ID=8306 (last visited Feb. 12, 2004).

[86] *Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care?: Hearing Before the Subcomm. on Commercial and Admin. Law of the Comm. on the Judiciary*, 107th Cong. 64 (2002) (statement of Lawrence E. Smarr, Pres. of Physician Ins. Ass'n of Am.) *citing to* Tillinghast - Towers Perrin, *Medical Malpractice - Market Review and Update*, (Mar. 2002).

[87] U.S. GEN. ACCOUNTING OFFICE, MED. MALPRACTICE INS.: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 15, 32, 25 (2003), *available at* http://www.gao.gov/new.items/d03702.pdf (last visited Feb. 3, 2004).

[88] *See e.g.*, AMERICANS FOR INS. REFORM, MED. MALPRACTICE INS.: STABLE LOSSES/UNSTABLE RATES 7 (2002), *available at* http://www.insurance-reform.org/StableLosses.pdf (last visited Feb. 12, 2004).

insurance industry for an out-of-control legal system.[89]

According to the Ohio Department of Insurance, the vast majority of invested assets are fixed-income instruments such as treasury, municipal, and corporate bonds whose losses have been minimal.[90]

The Ohio Department of Insurance also refutes this misconception by stating that there is no provision in its regulations that allows insurance companies to increase their rates in order to recoup past costs resulting from pricing mistakes, larger than expected claims, adverse court decisions, or other unexpected costs.[91]

Brown Brothers Harriman & Co. (BBH) completed a study ("Did Investments Affect Medical Malpractice Premiums?") that analyzed the impact of insurers' asset allocation and investment income on the premiums they charge. BBH concluded that there is no correlation between the premiums charged by the medical liability insurance industry, on the one hand, and the industry's investment yield, the performance of the U.S. economy, or interest rates, on the other hand.[92]

In addition, BBH conducted a follow-up study that analyzed National Association of Insurance Commissioners (NAIC) data to determine whether investment gains by medical liability insurance companies declined in the recent bear market. BBH asked the question: "Did medical malpractice companies raise premiums because they had come to expect a certain percentage gain that was not achieved due to market conditions?" BBH determined that the decline in equities (which are a small percentage of insurance company investments) was more than offset by the capital gains by bonds (which make up a substantial part of insurance company investments) due to a decline in interest rates. BBH concluded that "investments did not precipitate the current crisis."[93]

3. Claim: The crisis was created by the "insurance cycle." Reform should focus on preventing such insurers investment practices, not restricting claimants' rights.[94]

Fact: It is not the underwriting cycle that drives the problem, but the growing size of jury awards. The U.S. Department of Health and Human Services argues that if the insurance cycle were the cause of the current crisis, "then all states would be equally experiencing a crisis."[95] Insurers

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[89] AM BEST, BEST'S AGGREGATES & AVERAGES - PROPERTY/CASUALTY, QUANTITATIVE ANALYSIS REPORT, MED. MALPRACTICE PREDOMINATING: 2003 ed. (2003), 18.
[90] Holly Saelens of OH Dep't of Ins., Remarks entitled "Med. Malpractice Ins.", at 19.
[91] *Id.* at 18.
[92] Raghu Ramachandran, *Did Investments Affect Medical Malpractice Premiums?,* Jan. 21, 2003, *available at* http://salsa.bbh.com/news/Articles/MedMal.html (last visited Feb. 3, 2004).
[93] Raghu Ramachandran, *A Note on Investment Income of Medical Malpractice Companies,* Feb. 4, 2003, *available at* http://salsa.bbh.com/news/Articles/medmal2.html (last visited Feb. 3, 2004).
[94] *See e.g.*, Meg Green, *Consumer Groups Blame Premium Hikes on Regulatory Inaction*, BESTWIRE, Aug. 1, 2002, *available at* http://www.consumerwatchdog.org/insurance/nw/nw002586.php3 (last visited Feb. 3, 2004)
[95] INSURANCE CYCLE, *supra* note 16, at 1.

are not leaving other lines of insurance markets. They are leaving the medical liability insurance market because of the risk of unbounded payouts in that sector, particularly in non-reform states.[96] As a case in point, "St. Paul Companies, which was the largest medical liability carrier in the U.S. (covering 9% of physicians), announced in December of 2001 that it would no longer offer coverage to any doctor in the country."[97]

4. Claim: The insurance cycle is evidence of the breakdown in the state regulatory system. Regulators need to keep rates from being both excessive and inadequate.[98]

   Fact: The American Association of Health Plans finds that "all state insurance departments and other state governmental agencies heavily regulate and monitor the solvency of medical malpractice carriers...and require extensive reporting."[99] These regulators place strict limits on the types and riskiness of investments insurers can purchase. Also, the insurers are required to report annually on the status of their investments. The AAHP also reasoned that if the stock market were to blame, the crisis would resonate across the country to all medical liability insurers. This is not the case, as evidenced by the fact that it is mostly physicians that practice in states without meaningful medical liability reform who are significantly affected.[100]

B. Proposition 103 Myth: "Proposition 103, not MICRA, is responsible for lowering medical liability premiums in California."

   (The information in this section is derived from the American Medical Association's Proposition 103 Myth document).

   1. Fact: Proposition 103 is not responsible for keeping California's medical liability premiums down. Rather, MICRA has been the force behind California's success.

      a. In 1975, California's legislature enacted MICRA, the "Medical Injury Compensation Reform Act" — thirteen years before the passage of Proposition 103 in 1988.

      b. MICRA reformed the state's medical liability system and included a $250,000 cap on non-economic damages. A recent report by the U.S. General Accounting Office (GAO) and other studies have shown that states with caps on non-economic

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[96] *Id.* at 3.
[97] *Id.*
[98] *See e.g.,* AMERICANS FOR INS. REFORM, AMERICANS FOR INS. REFORM LAUNCHED TO FIGHT INSURANCE INDUSTRY MISMGMT. & PRICE GOUGING 1 (2002), *available at* http://www.insurance-reform.org/pr/AIRRelease.pdf (last visited Feb. 12, 2004).
[99] AM. ASS'N OF HEALTH PLANS, "LAWSUIT LOTTERY" CAUSES MED. MALPRACTICE CRISIS—SUGGESTIONS THAT POOR INVESTMENTS LED TO CRISIS DON'T PASS SMELL TEST 1, *available at* http://www.americanbenefitscouncil.org/documents/refutingstockmarketargument.pdf (last visited Feb. 12, 2004).
[100] *Id.*

damages have experienced slower premium rate increases than states with more limited reforms.

c. MICRA has been the driving force that has kept premiums one-half to one-third below those premiums in states without caps on non-economic damages and similar reforms.

d. According to National Association of Insurance Commissioners data, California's medical liability premiums have increased 182% since MICRA's enactment in 1975, while the nation's premiums have increased 569%.

2. Fact: Proposition 103 does not cover all entities that offer insurance.

a. Only about one-half of medical providers in California are insured by entities that are subject to Proposition 103.

b. The remaining half of medical providers are covered by a combination of risk retention groups and self-insured institutions, both public and private, that are not subject to Proposition 103.

3. Fact: Proposition 103 did not have any substantial effect on liability premiums until the early 1990's.

a. Like MICRA, Proposition 103's actual impact on premiums was delayed for many years due to numerous court challenges and California's regulatory process.

b. At the time of Proposition 103's passage in 1988, MICRA had been declared constitutional, and liability premiums in California had already begun to stabilize due to insurers' confidence that the courts were beginning to uniformly apply MICRA.

4. Fact: Proposition 103 does not prohibit increases in premiums, it only requires that the increases are justified and are not "excessive, inadequate, or unfairly discriminatory."

b. Under Proposition 103, the California Department of Insurance must grant a hearing for a challenge to any increase above 15 percent for commercial lines of insurance.

c. The California Department of Insurance has denied only one medical liability rate increase since Proposition 103 was enacted. [*In 2003, SCPIE requested a 15.6% increase, which was challenged and subsequently reduced to 9.9%. The order reducing the rate increase was effective September 22, 2003.*]

C. Myths Raised by the Trial Bar in Relation to H.R. 5

(The information in this section is derived from the American Medical Association's H.R. 5 Myth document).

1. Myth: Capping non-economic damages prevents patients from adequately recovering for their injuries.

   Fact: The HEALTH Act does not limit the amount a patient can receive for economic injuries. An injured patient can recover all of her medical costs, lost wages, future lost wages, rehabilitation costs, and any other economic out of pocket loss suffered as a result of a health injury.

2. Myth: Caps on non-economic damages will not address the problem of affordability and availability of coverage.

   Fact: The HEALTH Act is modeled after California's 1975 Medical Injury Compensation Reform Act, which has enabled health care professionals to focus on providing high-quality care. Research has demonstrated that direct medical care litigation reforms—like the HEALTH Act which includes limitations on non-economic damage awards—reduce medical liability claims rates and insurance premiums, and other stresses on doctors that may impair the quality of medical care. California now has some of the lowest liability premiums in the country.

3. Myth: Adjusting the statute of limitations means patients will not have enough time to seek redress.

   Fact: The HEALTH Act limits the number of years a plaintiff has to file a health care liability action, ensuring that claims are brought before evidence is destroyed, while witness are available and memories are fresh. It guarantees that health care lawsuits will be filed no later than 3 years after the date of injury. In some circumstances, however, it is important to guarantee patients additional time to file a claim. Accordingly, the Act extends the statute of limitations for minors injured before age 6.

4. Myth: The bill disproportionately affects women and children.

   Fact: Obstetricians are being forced to stop delivering babies, reduce the number they do deliver, and further cut back, or eliminate, care for high-risk patients, the uninsured, and the underinsured. Without federal medical liability reform legislation, women will receive less prenatal care and less preventive health care.

5. Myth: Abolishing joint liability is unfair to patients.

   Fact: The HEALTH Act abolishes joint liability because the archaic rule unfairly puts full responsibility on those who may have been only marginally at fault. Instead of making a party responsible for another's negligence, the Act ensures that a party will only be liable for her own share. Under the current system, defendants who are only 1% at fault may be held liable for 100% of the damages. This provision eliminates the

incentive for plaintiffs' attorneys to search for "deep pockets" with the hope of getting rich from the injury to one client.

6. Myth: It is unfair to restrict attorneys' fees. Contingency fees are a built-in incentive which encourage plaintiffs' attorneys to take only meritorious cases.

   Fact: The HEALTH Act empowers courts to maximize patients' awards by ensuring that an unjust portion of the patient's recovery is not misdirected to her attorney. Trial lawyers that link their payment to awards have an inherent incentive to generate as much litigation as possible and drag out proceedings as long as possible. Legislation like this helps expedite medical liability claims. This provision will help discourage baseless lawsuits by limiting the incentive to pursue meritless claims. Without this limitation, attorneys could continue to routinely pocket large percentages of an injured patient's award, leaving patients without the money they need for their medical care.

7. Myth: Plaintiffs are required to prove an impossibly heightened standard of clear and convincing evidence for punitive damages.

   Fact: The HEALTH Act places reasonable guidelines on punitive damages to make the punishment fit the offense. It appropriately raises the burden of proof for the award of quasi-criminal penalties to clear and convincing evidence to show either malicious intent to injure or deliberate failure to act to avoid injury. The bill does not cap punitive damages. Rather, it delineates a guideline, allowing for punitive damages to be as much as $250,000 or two times the amount of economic damages awarded, whichever is greater.

8. Myth: Periodic payments of all future damages punish meritorious plaintiffs.

   Fact: The HEALTH Act allows the money for future medical expenses to be paid periodically rather than in one lump sum. The bill does not reduce the amount a patient will receive. In fact, it protects the delivery of future health care because past and current expenses will continue to be paid at the time of judgment or settlement while future damages can be funded over time. This ensures that a plaintiff will receive all of the damages to which she is entitled in a timely fashion without risking the bankruptcy of the defendant.

9. Myth: It's the insurance companies' fault that liability insurance rates have skyrocketed. Insurers lost a lot of money in the stock market – and now they're making it up in premiums

   Fact: Insurance companies are required by law to make very conservative investments. They typically place about 80 percent of their investments in the bond market – not the stock market. According to A.M. Best, the investment yields of medical liability insurers have been stable and positive for the last five years. In addition, insurers can not raise premiums to

recover past losses. Medical liability premiums are strictly tied to estimates of future paid losses. There is no possible way to raise rates in order to cover losses – whether in the stock market or anywhere.

10. Myth: Insurance reform in California – specifically Proposition 103 – stabilized medical liability premiums in California, not MICRA.

Fact: 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.

11. Myth: Repealing McCarran-Ferguson — the federal law which provides a limited federal antitrust exemption for the business of insurance, subject to state regulation and oversight — would be more effective in lowering medical liability premiums.

Fact: The McCarran-Ferguson Act is the federal law authorizing state regulation of insurance. State regulators are required by law to reject rates that are excessive, inadequate or unfairly discriminatory. The exemption does not insulate insurers from the enforcement of state or federal antitrust laws in the context of anti-competitive business practices such as boycott, coercion or other intimidation in the marketplace. Repealing McCarran-Ferguson would do absolutely nothing to change the underlying reason for the rise in medical liability premiums – namely the explosion of meritless litigation and skyrocketing jury awards.

D. Additional Trial Bar Myths

1. Myth: Tort reforms unfairly penalize patients and are ineffective in holding down premiums for physicians and hospitals.[101]

Fact: Awards of non-economic damages that are out of scale with equity or need are not fair to anyone, given that economic damages are unlimited. Thus, legislators must consider the needs of the greater public welfare to ensure access to care for all. Tort reforms reduce unfair penalties to patients by improving the fairness of awards and ensuring that more of it goes to patients than lawyers. Consider that only fifty percent (50%) of total medical liability costs are returned to patients.[102]

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[101] *See e.g.,* ASS'N OF TRIAL LAWYERS OF AM., MED. MALPRACTICE FIBS & FACTS, *available at* http://www.atla.org/ConsumerMediaResources/Tier3/press_room/FACTS/medmal/medmalfibsfacts.aspx (last visited Feb. 12, 2004).

[102] Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms,* HEALTH AFFAIRS, Jan. 21, 2004, at 25, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1.pdf (last visited Feb. 3, 2004), *citing to* Kakalik and Pace, *supra* note 26.

Tort reforms hold down premiums. Compare California's premiums with those of the other large states. For example, 2002 manual rates for general surgeons in Los Angeles ranged from $26,600 to $58,830 while rates in Miami ranged from $108,473 to $226,542.[103]

Furthermore, Prof. Kenneth E. Thorpe of Emory University concluded that, "[t]he empirical results indicate that the caps on awards adopted by several states were associated with lower loss ratios and lower premiums. ... Loss ratios in states capping awards were 11.7 percent lower than in states without caps....Premiums in states with a cap on awards were 17.1 percent lower than in states without such caps."[104] He concluded, "Stopgap reforms (caps on rewards) of our current liability system would ultimately result in lower premiums (relative to their levels without the caps)."[105]

2. Myth: Rather than tort reform, more efforts should be directed at removing incompetent physicians and improving quality of care.

Fact: Removing "incompetent" physicians based on how many times they have been sued or have been found liable for negligence would be an extreme and ineffective method of trying to resolve the crisis because of the randomness of the litigation system. The vast majority of claims—almost 70 percent—have no merit.

Also, according to HHS, researchers have found that most errors are system failures, rather than failures of individual physicians. That is to say, even though physicians perform their jobs correctly, most errors would still occur.

A better approach to fixing the problem of system errors would be to dispel the fear by physicians, hospitals and nurses that open discussion on adverse events would be discoverable in lawsuits. This could be accomplished through state peer review statutes that protect confidentiality of such discussions.[106] A federal statute that allows confidential peer review, with expedited systems for correction including dissemination of de-identified information, is a model that works for the Aviation Safety Reporting System and should be replicated for health care.

The AMA supports bipartisan efforts in the House and Senate to advance legislation that would establish the statutory framework to create a "culture of safety" whereby information on health care errors could be reported in a confidential and legally protected manner. In the 108th Congress, the House passed a patient safety bill (H.R. 663) and a key Senate committee has cleared legislation (S. 720) for a full Senate vote. The two bills are

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[103] Med. Liability Monitor, 28 (2003).
[104] Thorpe, *supra* note 102, at 26. *See also*, CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MED. MALPRACTICE, (2004) (Reporting that, "[o]n average, premiums for all physicians nationwide rose by 15 percent between 2000 and 2002" (*Id.* at 1)), *available at* ftp://ftp.cbo.gov/49xx/doc4968/01-08-MedicalMalpractice.pdf (last visited Feb. 3, 2004).
[105] Thorpe, *supra* note 102, at 28.
[106] CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 18, at 22.

similar in many respects, and after the Senate votes on its patient safety bill a conference committee will meet to reconcile the differences.

3. Myth: Tort reform will only benefit insurance companies and physicians.

   Fact: Tort reform, including placing a reasonable cap on unquantifiable non-economic damages, would lower insurance premiums as well as costs borne by the entire health care system. If physicians' liability exposure is reduced, they are less likely to practice defensive medicine or limit the procedures they perform. The true beneficiaries of tort reform will be tax payers and patients who need access to critical medical care.[107]

4. Additional Reflections of the Insurance Industry

   Myth: Insurers can somehow remain financially viable without increasing revenue, or, in other words, raising rates.

   Fact: Insurance is not magic. Large underwriting losses are not sustainable over the long term, and will merely result in less competition. The medical liability combined ratio, a measure of profitability, reached 154.2% in 2001,[108] compared with 115.9% for all lines combined.[109] That means, for every $1 insurers received in premiums, they paid out $1.54. In 2002, the loss ratio remained high at 141.6% compared with only 107.4% for all lines combined as incurred, and indemnity payouts soared from less than $7.4 billion in 2001 to more than $8.0 billion in 2002.[110] Rate regulation simply reduces the availability of insurance, and ultimately cannot prevent the rate increases required to fund indemnity and expense payments.

E. GAO Reports

1. A report released July 28, 2003 by the U.S. General Accounting Office confirmed that medical liability premiums have skyrocketed in some states and specialties -- and increased losses on claims are the primary contributor. The report also put to rest two main trial lawyer smokescreens: that insurance company gouging and/or stock market losses have caused the medical liability crisis. This report made clear that bonds make up 80 percent of insurers' investments and that 'no medical malpractice insurers experienced a net loss on their investment portfolios.' The GAO report also stated that insurer 'profits are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates.' It also noted that insurance regulators in most states have the authority to deny excessive premium rates. [111]

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[107] BLUE CROSS BLUE SHIELD ASS'N, *supra* note 8, at 2.
[108] AM BEST, *supra* note 89, at 356. *See also*, Saelens *supra* note 91.
[109] AM BEST, *supra* note 89, at 350.
[110] *Id* .at 350, 364.
[111] U.S. GEN. ACCOUNTING OFFICE, *supra* note 87, at 15.

2. While verifying that the liability crisis has affected access to health care services, the GAO made several determinations in its August 2003[112] report that the AMA believes do not accurately reflect the severity of the current crisis in real time. Numerous changes to the GAO methodology would strengthen the basic findings of this report. Among the data sources, measures, or analytical methods that could be improved are the following:

   a. *Examination of all crisis states.* The GAO only examined five of the 19 crisis states. The current medical liability crisis is far more widespread, extending to the additional 14 states as well.

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

   c. *More accurate counts of physicians by specialties and local markets.* Physician/population ratios that aggregate physicians across local markets and specialties obscure the significant market-specific or specialty-specific changes in the supply of physicians and availability of critically important medical services.

   d. *Use of multi-payor data to accurately measure access to health care services that Medicare data alone do not capture.* Utilization statistics based exclusively on data from a single payor (Medicare) exclude data for obstetric and emergency care, and fail to capture the impairment of access among other vulnerable populations, such as Medicaid patients.

   e. *Use of current source of data to capture the magnitude of the access problem in real time.* The GAO accorded no weight to current sources of data which reflect the magnitude of impairment of patient access today.[113]

IV. Patient Safety Efforts

A. Quality of care declines when patients are denied access to physicians.

B. A culture of safety requires a legal environment that encourages professionals and organizations to work together to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients.

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[112] U.S. GEN. ACCOUNTING OFFICE, MED. MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE (2003), *available at* http://www.gao.gov/new.items/d03836.pdf (last visited Feb. 3, 2004).

[113] *See e.g.*, HEALTH SERVICES RESEARCH INST., *supra* note 53 (Concluding that the GAO's misleading and inadequate evidentiary survey contributed to the report's failure to identify an ongoing and worsening access problem).

C. A recent New England Journal of Medicine report declares that, "... in spite of the mission of malpractice law to improve the quality of care through deterrence—indeed, perhaps because of it--the fear of litigation obstructs progress in ensuring patient safety."[114]

D. The current litigation system does not encourage a culture of safety by:

1. Encouraging defensive medicine.

2. Creating a lottery mentality throughout the nation's court system.

3. Enriching certain trial lawyers at the expense of patients and physicians.

E. The Harvard Medical Practice Study used New York State hospital and medical professional liability claim data to estimate the incidence of adverse events among hospitalized patients and characterize the relationship between adverse events and malpractice claims. The study found that "a substantial majority of malpractice claims filed are not based on actual provider carelessness."[115] In fact, the authors found that negligence had occurred in only one-sixth of the filed claims.[116] Finally, they conclude that "in its initial filing stage the tort system is even more error-prone than the medical care system"[117]

One of the authors of the Harvard Study, Troyen A. Brennan and two colleagues, conducted a follow-up in 1996.[118] They found that the only significant predictor of payment to medical liability plaintiffs in the form of a jury verdict or a settlement was disability, and *not* the presence of an adverse event due to negligence. In other words, the severity of a patient's disability.[119]

The Institute of Medicine report "To Err is Human" (the "IOM Report") used information from the Harvard Study to speculate that up to 98,000 deaths per year are due to preventable medical errors. While there are many reasons to take issue with the way that particular estimate was derived[120], the principal finding of the report was that the vast majority of

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[114] David Studdert, Michelle Mello & Troyen Brennan, *Medical Malpractice,* 350 NEW ENG. J. MED., 283, 287 (2004).

[115] PAUL C. WIELER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION & PATIENT COMPENSATION 140 (Harvard University Press 1993).

[116] *Id.* at 139.

[117] *Id.* at 140.

[118] Troyen A. Brennan, Colin M. Sox & Helen R. Burstin, *Relation between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 N. ENG. J. MED. 1963 (1996).

[119] *Id.* at 1965.

[120] For example, McDonald et al. find that the underlying studies of the IOM report were "observational," not intended "to describe causal relationships." The authors state "The Harvard study includes no information about the baseline risk of death in these patients or information about deaths in any comparison group. Therefore, it cannot be determined whether adverse events are correlated with, let alone whether they cause, death." The authors comment that "reliance on studies without controls to make headline claims about huge numbers of preventable deaths was

patient injuries are due to defects in the systems of medical care delivery, and not due to negligence on the part of providers. True advocates of patient safety, such as the AMA and the IOM, are fighting to replace the fault-based, adversarial medical liability system, which gives all parties strong incentives to conceal errors and system defects, with a system that encourages all parties to promote patient safety by reporting errors and system defects. However, trial lawyers stand in firm opposition to changing our broken liability system, because today's needlessly injured patients are tomorrow's multimillion dollar clients.

F. AMA policy is to be part of the solution, not the problem. The AMA believes that one preventable error is one error too many. In fact, the AMA helped launch the National Patient Safety Foundation in 1996, well before publication of the IOM report. The Foundation's approach is to create a culture of cooperative learning and mutual improvement, as opposed to a culture of shame and blame. The AMA has contributed $7.3 million to the National Patient Safety Foundation.

G. The AMA supports bipartisan efforts in the House and Senate to advance legislation that would establish the statutory framework to create a "culture of safety" whereby information on health care errors could be reported in a confidential and legally protected manner.

H. In the Senate, Senators Jeffords (I-VT), Breaux (D-LA), Frist, MD (R-TN), and Gregg (R-NH) introduced S. 720, the "Patient Safety and Quality Improvement Act of 2003." On July 23, 2003, the Senate Committee on Health, Education, Labor, and Pensions (HELP) approved S. 720 by a unanimous vote. This clears the way for the bill to be debated and voted on by the full Senate.

I. S. 720 would create a confidential, voluntary reporting system in which physicians and other health care providers could report information on errors to entities to be known as Patient Safety Organizations (PSOs). The PSOs would collect and analyze unique "patient safety data" that would be confidential and legally protected.

J. Similar legislation (H.R. 663) passed the U.S. House of Representatives on March 12, 2003, by a vote of 418-6.

K. In conjunction with the observance of National Patient Safety Awareness Week in March 2004, the AMA sent a letter to the U.S. Senate strongly urging Senators to pass S. 720 immediately and move forward to conference with the House legislation, H.R. 663.

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one error it did not catch." *See* Clement J. McDonald et al., *Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report*, 284 JAMA 93, 93 (2000).

Note: The most current version of this document can be accessed electronically by visiting the AMA Web site: http://www.ama-assn.org/go/mlrnow

Additional background and data can be found on the AMA Web site at http://www.ama-assn.org/go/liabilityreform