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)

COMMITTEE NOTICES ...

➢ *Committee Reports* ... *CR*
**

➢ *Executive Sessions* ... *ES*
**

➢ *Public Hearings* ... *PH*
**

➢ *Record of Comm. Proceedings* ... *RCP*
**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

➢ *Appointments* ... *Appt*
**

Name:

➢ *Clearinghouse Rules* ... *CRule*
**

➢ *Hearing Records* ... *HR* *(bills and resolutions)*
**

➢ *Miscellaneous* ... *Misc*

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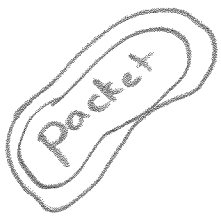
(2005 documents)

Wisconsin Association of Health Plans



WISCONSIN ASSOCIATION OF HEALTH PLANS

2005-2007 Legislative Agenda

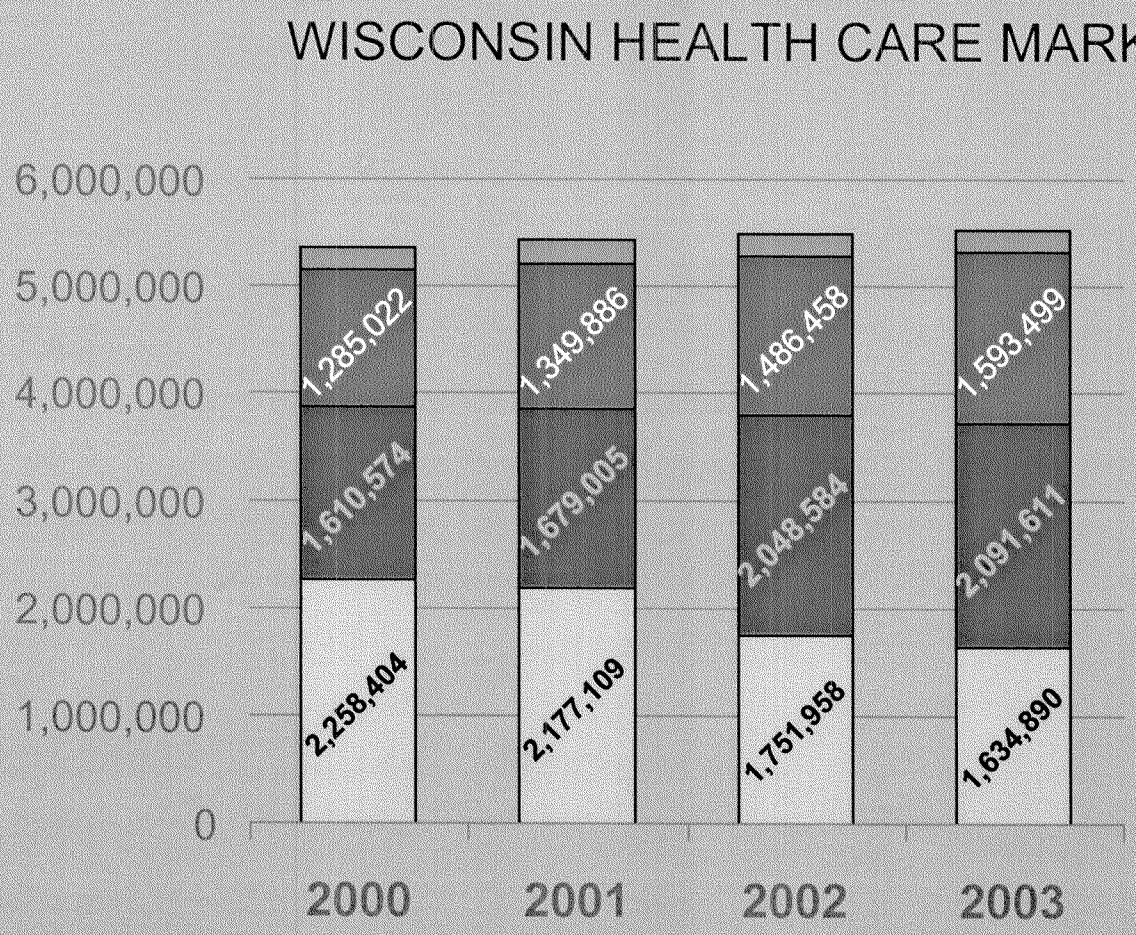
1. Relief for Wisconsin's Commercially Insured Market
   - The commercially insured market in Wisconsin has shrunk 28 percent since 2000. Groups and individuals buying health insurance in Wisconsin pay additional premium to cover the costs of 23 different state-mandated benefits and services as well as insurer assessments to fund HIRSP.
   - The self-insured market in Wisconsin, which has grown 30 percent since 2000, is not subject to state-mandated benefits or HIRSP assessments.
   - Small businesses employ more than half of Wisconsin's non-farm-sector employees, and those that can afford to provide health benefits purchase them through the insured market.
   - The Wisconsin Legislature should provide relief from the unique cost burdens placed on the commercially insured market.

2. Health Insurance Risk-Sharing Plan (HIRSP) Reform
   - Since 1999, enrollment increased 131 percent, program costs increased 162 percent and state GPR was eliminated, prompting a 333% increase in insurer assessments.
   - The hidden tax that is paid annually by each commercially insured Wisconsin citizen increased from $4.55 to $21.71 in just two years.
   - The Wisconsin Legislature should reform HIRSP through cost-containment strategies and provide assessment relief through a tax credit for insurers.

3. Actuarially Sound Rates for Medicaid HMOs
   - State and federal government savings from the Medicaid/BadgerCare Managed Care Program totaled $233 million for the period 2001-2004.
   - Nationally recognized surveys show that Wisconsin Medicaid HMOs outperform the FFS system in several key areas of access and quality and their enrollees are highly satisfied with their care.
   - Service intensity increases in 2004 HMO rates helped HMOs increase their Medicaid enrollment capacity to meet the needs of the growing Medicaid program.
   - The Wisconsin Legislature should support actuarially sound rates for Medicaid HMOs to ensure the continued success of the Medicaid/BadgerCare Managed Care Program.

10 East Doty Street • Suite 503 • Madison, WI 53703
608-255-8599 • Fax 608-255-8627 • www.wihealthplans.org

Cost Drivers: Changing Health Care Market



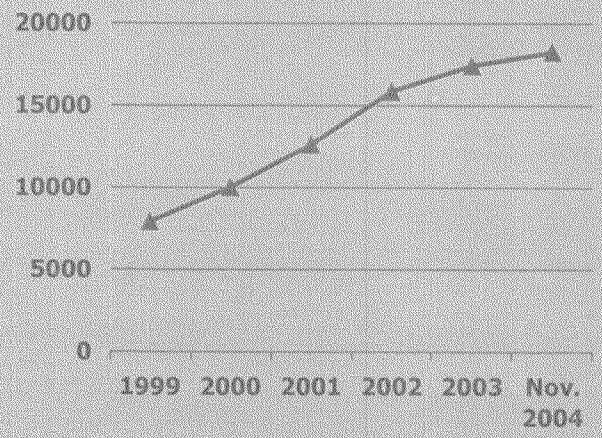
The commercially insured population in Wisconsin has declined on average 10% per year since 2000.

Office of Commissioner of Insurance; Department of Health and Family Services

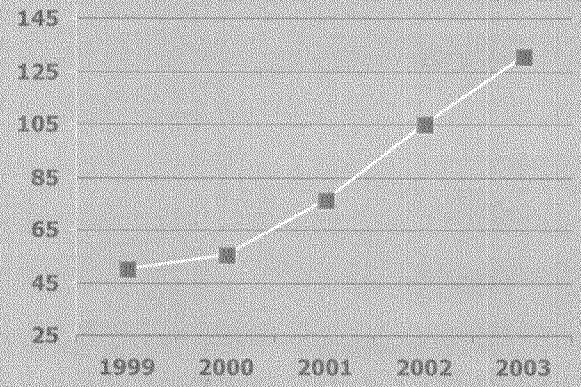
Wisconsin Association of Health Plans

Cost Drivers: Health Insurance Risk Sharing Plan

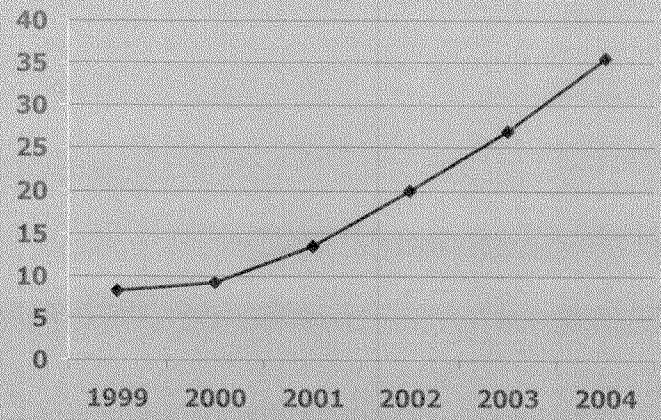
Enrollment



Program Cost ($millions)



Insurer Assessments



A GROWING BURDEN FOR PRIVATE PAYERS

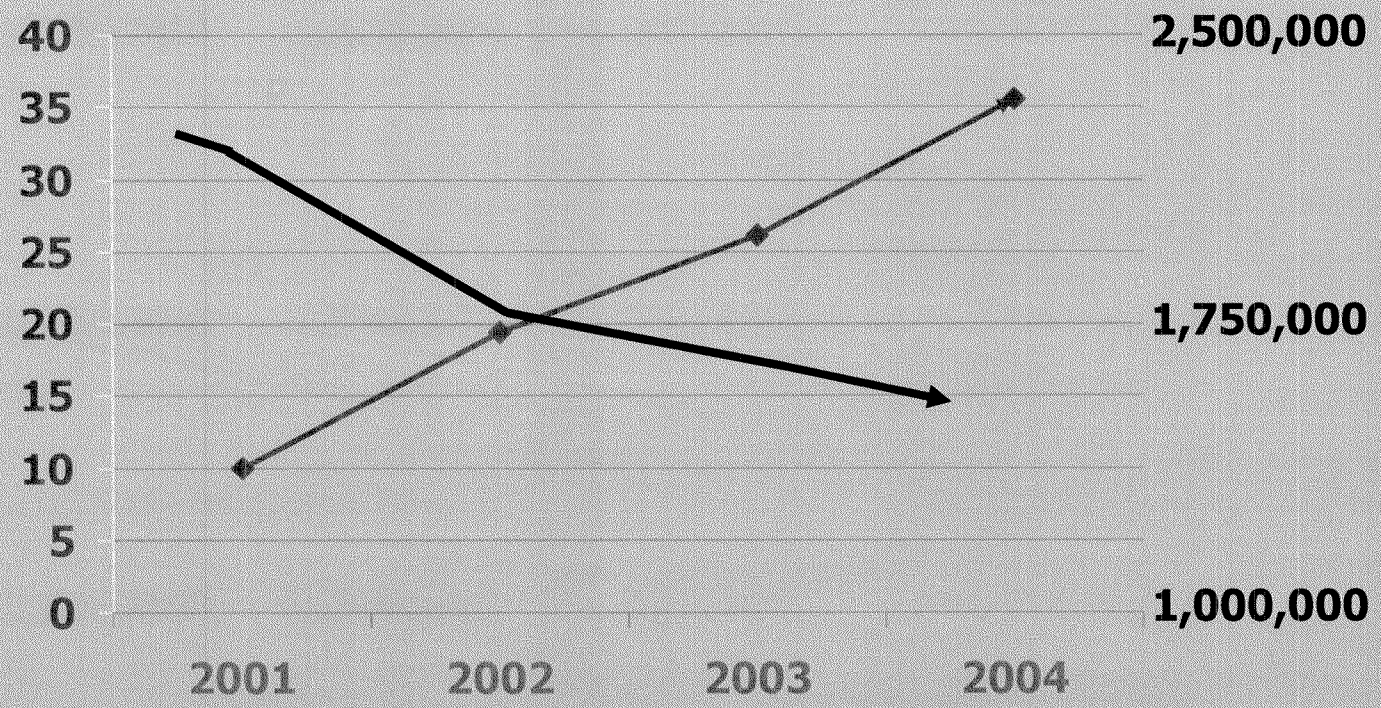
- Insurer assessments +333% since 1999
- Assessed insureds paid $35.5 million in FY 2004; $0 state general purpose revenue used

Department of Health and Family Services

Wisconsin Association of Health Plans

Health Insurance Risk Sharing Plan

The HIRSP Assessment Dilemma



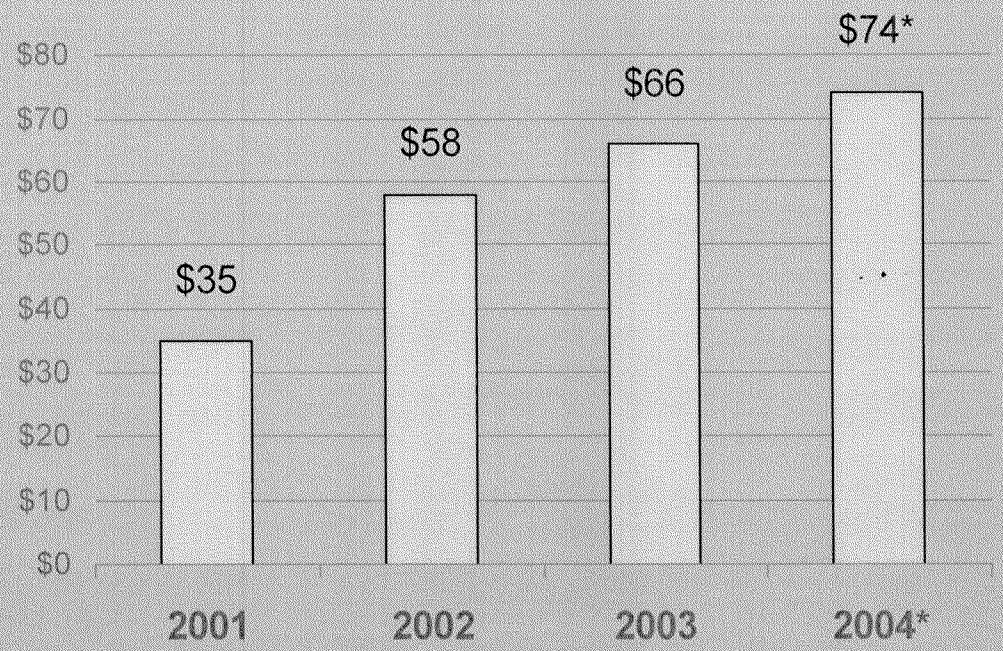
Assessments Paid ($millions) increased 260% since '01

Assessed Population declining 10% per year (average)

Wisconsin Association of Health Plans

HMOs and Medicaid

COST SAVINGS THROUGH MEDICAID/BADGERCARE MANAGED CARE PROGRAM (in millions)



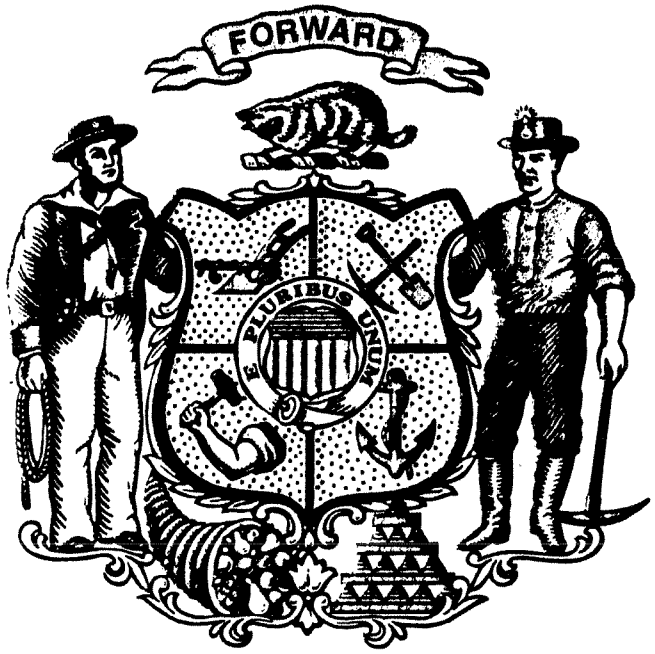
Payments to Medicaid/BadgerCare HMOs are significantly discounted from the fee-for-service amount.

State and federal governments saved $233* million over the period 2001-2004.

*2004 estimate from Milliman, Inc.

Department of Health and Family Services

Wisconsin Association of Health Plans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31 Wm. Mitchell L. Rev. 1031

William Mitchell Law Review
2005

Recent Developments in Health Care Law

*1031 NOTE: CAPPING NONECONOMIC DAMAGES IN MEDICAL MALPRACTICE SUITS IS NOT THE PANACEA OF THE "MEDICAL LIABILITY CRISIS"

Melissa C. Gregory [FNd1]

I. Introduction

According to the Institute of Medicine, each year between 44,000 and 98,000 people die in hospitals as a result of medical error. [FN1] The ensuing costs of medical errors include patients' lost *1032 income, disability, and health care, all of which may add up to $29 billion annually. [FN2] As a result, some patients must live with serious injuries for the rest of their lives. For example, a health care provider's failure to adequately monitor a mother's pregnancy resulted in her son being born with permanent brain damage. [FN3] That child suffers from cerebral palsy and significant physical, cognitive, and behavioral difficulties that will endure for the rest of his life. [FN4]

Patients that are injured by physician negligence look to the legal system to recover damages for the harms committed by those physicians. [FN5] State tort law provides the legal foundation for recovery in such medical malpractice lawsuits. [FN6] The four types of recoverable damages available in most medical malpractice lawsuits are economic, [FN7] noneconomic, [FN8] punitive, [FN9] and total damages. [FN10] As compared to economic damages, noneconomic damages are *1033 difficult to quantify and may create unpredictable damage awards. [FN11] Medical malpractice insurers, physicians, and medical associations have therefore blamed unlimited noneconomic damages for the rising costs of medical malpractice liability insurance. [FN12] However, capping noneconomic damages limits the compensation available for a patient's very real injuries, [FN13] undermining the opportunity for an aggrieved person to be made whole. [FN14]

The threat of a medical malpractice insurance "crisis" continues to influence legislators, health care providers, and insurers to encourage tort reform. [FN15] In 2003 alone, forty-one states introduced legislation that either proposed or changed caps on noneconomic damages for medical malpractice awards. [FN16] The primary focus of most legislative tort reform efforts generally *1034 centers upon capping patient damages. [FN17] Capping noneconomic damages, however, has always been highly controversial. [FN18] In 2004, physicians and health insurers successfully made medical

liability reform a presidential campaign issue. [FN19] The vice-presidential candidates first debated the issue and the presidential candidates, President George W. Bush and Senator John F. Kerry, followed suit. [FN20] In fact, one survey indicated that eighty-seven percent of Americans viewed the presidential candidates' health care proposals to be influential in determining who to vote for. [FN21]

This note explores the history behind the rising costs of medical malpractice insurance rates and the responsive state legislative proposals to limit noneconomic damages. [FN22] The current state of health care liability and the recent federal proposals that include caps on noneconomic damages are then discussed. [FN23] This note analyzes the reasons why the federal government should not cap noneconomic damages, primarily because: (1) states are better able to regulate health care, (2) noneconomic damages are not the determinate cause of rising medical malpractice insurance rates, and (3) caps infringe on equal protection guarantees by limiting compensation of medical malpractice victims. [FN24] This note highlights the current state of health care liability in Minnesota and how the Minnesota legislature has dealt with rising medical ***1035** malpractice insurance costs. [FN25] Finally, this note concludes that noneconomic damage caps are not the panacea to the "medical liability crisis." States should therefore continue to regulate the health care industry through other reform measures. [FN26]

II. History

The existence of a medical liability crisis and its possible underlying causes are controversial topics. The General Accounting Office (GAO), an investigative arm of Congress, once acknowledged that "[h]ealth care providers have suffered through three medical malpractice insurance 'crises' in the past thirty years." [FN27] During the 1970s, the first crisis occurred as medical malpractice suits reached their peak. [FN28] Medical malpractice liability insurance rates climbed and resulted in some physicians being unable to obtain adequate coverage. [FN29] After a brief period of stability, medical malpractice premium rates rapidly increased again in the 1980s and later in the 1990s. [FN30] The possible causes of the medical malpractice insurance increases are always subject to debate. [FN31]

One plausible explanation is that the fear of possible medical malpractice liability causes physicians to practice "defensive medicine," which occurs when physicians perform costly additional tests or unnecessary procedures to avoid possible litigation. [FN32] "Defensive medicine" may exist, but it is difficult to measure its effect on health care costs. [FN33] Whatever the cause, rising medical malpractice insurance rates often result in physicians not performing high-risk procedures, moving to states with lower ***1036** insurance rates, or retiring. [FN34] This effect has spurred debatable concern as to the accessibility of health care, especially in rural areas. [FN35]

In response, nearly every state has passed tort reform legislation. [FN36] Reform has included varying measures: from statutes that shorten the statute of limitations to statutes that limit the damages a plaintiff can recover in medical malpractice suits. [FN37] California was one of the first states to enact legislation that specifically limited noneconomic damages. [FN38] California's Medical Injury Compensation Reform Act of 1975 (MICRA) [FN39] limited noneconomic damages to $250,000 and is still in place today, despite having never been adjusted for inflation. [FN40]

Twenty-six states followed California's initiative and enacted caps on noneconomic damages between the years 1975 and 1995. [FN41] ***1037** However, courts in seven of those states overturned the capping legislation. [FN42] A principle reason for overturning the legislation was that limiting recovery in medical malpractice lawsuits by itself is an arbitrary classification that violates plaintiffs' constitutional guarantee to equal protection. [FN43] After courts overturned the legislation, some state legislatures persisted in again passing capping legislation for a second time, but the courts once again rejected their attempts. [FN44] Consequently, by the end of 2000 only twenty states had noneconomic damages caps in place. [FN45]

In 2002, Mississippi, Nevada, and Ohio continued the legislative push and passed legislation that imposed noneconomic damage caps. [FN46] In 2003, several additional

state legislatures either introduced or changed limits on noneconomic damages in medical malpractice suits: forty-one states introduced bills, eleven of which passed the bills proposed. [FN47] For example, in June of 2003, Texas ***1038** Governor Rick Perry (R) signed legislation that imposes a $250,000 cap on noneconomic damages for health care providers and health care institutions. [FN48] On September 13, 2003, Texas voters subsequently approved an amendment to the Texas Constitution that authorizes the legislature to set limits on noneconomic damage awards. [FN49] Similarly, in August of 2003, after months of debate, Florida Governor Jeb Bush (R) signed a bill that provides tiered capping of noneconomic damages at $500,000 for physicians and $750,000 for hospitals. [FN50] In May of 2004, eight additional state legislatures continued the pursuit of tort reform measures. [FN51] As of publication, a grand total of twenty-five states have effectively passed noneconomic damage caps of varying amounts applicable to medical malpractice suits. [FN52]

III. The Current State of Health Care Liability

The American Medical Association (AMA) continually evaluates the state of health care liability in the United States by analyzing several independent sources of information. [FN53] The AMA ***1039** considers two primary factors in determining the scope and depth of "America's Liability Crisis:" (1) the magnitude of decreasing access to health care and (2) physicians ceasing certain high-risk procedures such as delivering babies and emergency care. [FN54] As of January 2005, the AMA indicated that twenty states were actually in "medical liability crisis," while twenty-four states showed "problem signs." [FN55] The AMA categorized California, along with Colorado, New Mexico, Wisconsin, Indiana, and Louisiana, as the only "OK" states in the area of medical liability. [FN56] At the federal level, during the 2003 legislative session, federal legislative proposals attempted to parallel California's cap of $250,000 and preempt state laws governing health care lawsuits. [FN57] However, these proposals ignored the fact that following the California legislature's enactment of noneconomic damage caps, California's malpractice insurance premiums continued to increase through 1988 to an "all-time high" that was 450% higher than in 1975, the year that MICRA was enacted. [FN58] California ultimately passed insurance reform in 1988, which contributed to the stabilization of medical malpractice insurance rates. [FN59] Thus, the ***1040** reasonable conclusion is that insurance reform, not noneconomic damage caps, is what caused the medical malpractice insurance rates to decline, making California an "OK" state in the area of medical liability. [FN60] The federal proposals based on California's legislation similarly ignored the fact that Massachusetts, Missouri, and West Virginia are all in "medical liability crisis" despite having noneconomic damage caps in place since 1986. [FN61]

A. Federal Proposals to Limit Noneconomic Damages in the Twenty-First Century

Passing federal legislation to cap noneconomic damages has proven to be a continual battle. In 2000, the revised Health Care Liability Reform Act of 1997 was first introduced in the House of Representatives. [FN62] The proposed legislation was intended to impose certain requirements on health care liability claims, including a $250,000 limit on noneconomic damages. [FN63] The bill was referred to the House Committee on the Judiciary but was not reintroduced back to the House. [FN64] The following year, the House of Representatives tried again and introduced the Medical Malpractice Rx Act. [FN65] This bill also proposed a $250,000 limit on noneconomic damages. [FN66] The Medical Malpractice Rx Act was referred to the subcommittee on Health and Environment but was once again not reintroduced back to the House. [FN67]

The Help Efficient, Accessible, Low Cost, Timely Health Care Act of 2002 [FN68] (HEALTH Act of 2002) was introduced in the House of Representatives on April 25, 2002. [FN69] The HEALTH Act of 2002 stated goals of improving accessibility to health care and the quality of medical care by reducing the burden of medical liability. [FN70] This ***1041** proposed legislation similarly limited noneconomic damages at $250,000, regardless of the number of defendants a plaintiff sues. [FN71] The HEALTH Act of 2002

was designed to preempt state laws concerning medical liability claims unless the applicable state law provided greater protection for health care providers. [FN72] The House of Representatives passed the HEALTH Act of 2002, but after two readings in the Senate [FN73] the Act was referred to the Judiciary Committee and never voted on. [FN74]

On March 21, 2003, The HEALTH Act of 2003 was read for the first time in the House of Representatives. [FN75] The HEALTH Act of 2003 stated the same goals of improving access to health care as well as improving medical care by reducing the burden the liability system weighs on the health care system. [FN76] Once again, the proposed cap on noneconomic damages was set at $250,000. [FN77] The Health Act of 2003 eventually passed in the House, but again was only read twice in the Senate and never voted on. [FN78]

On June 28, 2003, the Senate Republicans introduced the Patients First Act of 2003. [FN79] The Patients First Act of 2003 was intended to increase access to quality health care by reducing liability cost effects. [FN80] The bill was very similar to the HEALTH Act of 2003 in that both would have imposed a $250,000 cap on noneconomic damages in health care lawsuits. [FN81] The Patients First Act, however, hit a political impasse when on July 7, Senate Republicans attempted to bring the legislation to the floor but the Democrats objected to the motion to proceed the bill. [FN82]

***1042** Federal legislative activity on the issue continued when the House Republicans introduced the HEALTH Act of 2004 on May 5, 2004. [FN83] As before, limits on noneconomic damages were set at $250,000. [FN84] On May 12, the House successfully passed the bill by a vote of 229-197. [FN85] The bill was never voted on in the Senate, however, the HEALTH Act of 2005 has rekindled the proposed $250,000 noneconomic damage cap in any health care lawsuit. [FN86] The critical fate of capping noneconomic damages is in the hands of the 109th Congress.

Some Republicans and Democrats are able to agree that rising malpractice premiums are causing health care accessibility problems; however, they are unable to agree on a solution. [FN87] Generally, Republican lawmakers continue to focus on capping damages and other limitations on medical lawsuits, while Democrats focus on tightening rules for medical malpractice insurance carriers. [FN88] Medical liability reform legislation therefore continues to be shut down in the Senate, but the controversy of capping noneconomic damages continues.

B. The Federal Government Should Not Impose Caps on Noneconomic Damages

1. States Regulate Health Care

Legislators continually take sides about whether the federal government should take over traditionally state regulated health care reform. On one side of the debate, Senate Republican Conference Chairman Rick Santorum (R.-Pa.) stated that health care reform is a federal matter because rising medical malpractice ***1043** insurance premiums take a financial toll on the federal health care programs of Medicare and Medicaid. [FN89] The Patients First Act likewise stated that the health care and insurance industries are affecting interstate commerce and federal spending. [FN90] On the other side of the debate, some members of Congress disagree that health care reform is a federal issue because tort reform proposals are historically state legislative decisions that are not governed by the federal legislature. [FN91] The U.S. Supreme Court has affirmed that Congress cannot "cavalierly pre-empt state-law causes of action." [FN92]

The American Bar Association's Committee on Medical Professional Liability also contends that medical professional liability issues, including damage caps in medical malpractice cases, should remain "tort-based and state-based." [FN93] Indeed, the states have had authority over medical liability laws for over 200 years. [FN94] This is because each individual state considers unique factors in addressing issues of health care lawsuits. [FN95] Thus, the individual state is in the best position to determine which tort reform measures most clearly address the health care matters within the state.

The judiciary and legislative branches of the federal government have upheld state

regulatory powers in the area of health care. The U.S. Supreme Court has recognized states as the ***1044*** preferred authority to handle health care accountability issues because states traditionally regulate health care within their borders. [FN96] Furthermore, the Court has held that traditional state regulation in the health care field would not be preempted by federal law without a "clear manifestation of congressional purpose." [FN97] Congress has equally recognized in past federal legislation that health care organizations are subject to a state's regulatory powers. [FN98] States are separate sovereigns in the federal system and tort remedies ought to remain within their historic policing powers. [FN99]

2. Noneconomic Damage Caps Are Not the Determinant Factor

GAO determined that insurance companies' increased losses seem to be the greatest contributor to increased medical malpractice insurance rates. [FN100] However, GAO was unable to determine the effects of health care settlements, trial verdicts, and economic and noneconomic damages on medical malpractice insurance rates. [FN101] GAO concluded that there was not a comprehensive source of information on the breakdown of insurers' losses between economic and noneconomic damages. [FN102] Factors other than noneconomic damages may therefore have caused or contributed to the resultant increase in medical malpractice insurance rates. [FN103] These other factors include the presence of other tort reform measures, [FN104] state laws regulating the ***1045*** premium rate setting process, [FN105] and certain market forces [FN106] on the insurance industry. [FN107]

Analyzing and comparing data from various states is more complicated than it appears. The Department of Health and Human Services Agency for Healthcare Research and Quality reported that states with noneconomic damages caps in health care lawsuits have approximately twelve percent more physicians per capita than states without caps. [FN108] However, GAO contends that it is difficult to compare states on the basis of whether or not they have enacted caps because state tort reform and insurance reform laws are dramatically different. [FN109] GAO recommends that future data collection of frequency, severity, and cause of losses from medical malpractice suits would allow for appropriate analysis. [FN110]

However, the Department of Health and Human Services blamed the "increasingly unpredictable, costly and slow litigation system" for the high medical liability insurance premiums. [FN111] On the contrary, the litigation system is just as costly to medical malpractice insurers based on the significant expense to defend medical malpractice claims, as compared to the small number of successful claims that actually result in large jury awards. [FN112] ***1046*** Furthermore, results from a 1976 study, during a supposed "medical insurance liability crisis," indicated that only 8-13% of filed claims went to trial, with only 1.2-1.9% resulting in a decision for the plaintiff. [FN113] The Department of Health and Human Services also referred to a 1987 GAO study, which indicated that 57-70% of claims resulted in no payment to the patient. [FN114] Thus, the major expense for insurance companies is in defending non-meritorious claims, not unlimited noneconomic damages that may potentially result from the small number of successful claimants.

3. Noneconomic Damage Caps Do Not Provide Equal Protection

Almost every state constitution encompasses an equal protection clause similar to the federal constitution. [FN115] Statutes limiting noneconomic damages for medical malpractice claims violate equal protection because plaintiffs are arbitrarily distinguished from other tort victims. [FN116] Capping noneconomic damages in medical malpractice lawsuits also discriminates against low-income individuals who are unable to prove large economic damages but nonetheless suffer valid noneconomic damages. [FN117] Such noneconomic damage caps result in classifying plaintiffs based on the severity of the injury: less seriously injured patients are able to receive full compensation while more seriously injured patients are not able to receive adequate compensation. [FN118] ***1047*** Plaintiffs with valid claims are not the source of the problem; it is therefore unfair that seriously injured plaintiffs should be deprived of full compensation. [FN119] Limiting damages that compensate a patient for his or her pain and suffering would therefore

violate the basic legal premise that damages should be "sufficient in amount to indemnify the injured person for the loss suffered and thereby make him or her whole." [FN120]

Regardless, some state statutes that limit noneconomic damages have been upheld under the state constitutional guarantees of equal protection. [FN121] Some of these statutes have also been upheld under the Equal Protection Clause of the U.S. Constitution. [FN122] In doing so, most courts have employed a rational basis test [FN123] to review an equal protection challenge to statutory damage caps because the caps are economic in nature. [FN124] The ***1048** rational basis test is satisfied if there is (1) a "plausible policy reason" for the classification of plaintiffs, (2) the legislative facts on which the classification is based may be considered true by a governmental decision maker, and (3) the classification in relation to its goal is not arbitrary. [FN125]

When courts apply the rational basis test, they consistently find that statutes capping noneconomic damages are in fact rationally related to the legitimate government purposes of: (1) controlling health care costs and accessibility, [FN126] or (2) reducing malpractice insurance premiums. [FN127] However, these courts failed to conduct a proper analysis under the rational basis test because the courts did not assess the existence of a medical crisis within the state. [FN128] Based on current statistics, limiting noneconomic damage caps is not the rational response to meet the goals of reducing medical malpractice insurance rates. [FN129] Regardless, a court may revere this as judicial fact-finding, and choose not to adopt such reasoning. [FN130]

The dissenting opinion in Fein v. Permanent Medical Group agreed with applying the rational basis test, but disagreed with the level of scrutiny applied under the rational basis test by the majority. [FN131] The majority required that the legislation not only serve a conceivable legislative purpose, but also that each classification has a "fair and substantial relationship to a legitimate purpose." [FN132] The dissent, however, correctly reasoned that under ***1049** the second prong of the analysis the $250,000 damage cap should have been regarded as "grossly underinclusive" by any standard applied. [FN133] Thus there is no rational basis for classifying the most severely injured patients to pay for the monetary relief to physicians and their medical malpractice insurers. [FN134]

When courts apply an intermediate test, however, limiting noneconomic damages has been found to be in violation of some state constitutional guarantees of equal protection. [FN135] The intermediate test employs a higher degree of scrutiny than the rational basis test. [FN136] State courts that have employed an intermediate review have done so because "[a]lthough the right to recover for personal injuries is not a 'fundamental right,' it is nevertheless an important substantive right." [FN137] States are able to grant individuals more rights than the Federal Constitution requires. [FN138] To do so under the intermediate test, the court must determine (1) "whether the statute has a fair and substantial relation to this legitimate legislative objective" and (2) "whether it imposes unreasonable restrictions on private rights." [FN139] Using the intermediate test, the North Dakota Supreme Court concluded that damage caps preclude full recovery for patients with meritorious claims, do nothing toward the elimination of nonmeritorious claims, and actually encourage physicians to practice at the expense of patients with meritorious claims. [FN140] Limits on noneconomic damages should therefore not be upheld under any meaningful ***1050** level of judicial scrutiny, even the rational basis test.

The Alabama Supreme Court also correctly determined that the correlation between noneconomic damage caps and the reduction of health care costs is indirect and remote. [FN141] Even though there is evidence that noneconomic damage caps have a possible connection to the size of claims, again, they are only one of a multitude of factors. [FN142] The New Hampshire Supreme Court has similarly concluded that there is a weak relationship between the legislature's goal of insurance rate reduction and limiting noneconomic damages. [FN143] Courts, such as the Illinois and New Hampshire Supreme Courts, have reminded Congress that the power of remittitur [FN144] is always available and is the correct judicial tool that should be used in the event of an excessive

jury award. [FN145]

C. Health Care Liability in Minnesota

Minnesota does not impose noneconomic damage caps in medical malpractice suits. [FN146] Minnesota's doctors, per 100,000 ***1051** county residents, increased from 75 in 1970 to 126 in 2000, a 68% increase. [FN147] California, with a $250,000 noneconomic damage cap, however, has only had a 47.2% increase within the same time period. [FN148] The fact is that, caps or no caps, from 1975 to 1986 the incurred losses for medical malpractice insurers were on the rise in both Minnesota and California. [FN149] Incurred losses for medical malpractice insurers similarly declined drastically in 1986 for Minnesota and did the same in 1988 for California. [FN150] As previously concluded, insurance reform caused California's 1988 decline in medical malpractice insurance rates, not noneconomic damage caps. [FN151]

Minnesota's drastic decline in medical malpractice insurers' losses was caused by two significant pieces of legislation that passed in 1986. The first legislation was Minnesota Statutes section 145.682, [FN152] which was explicitly enacted in an effort to remedy rising costs of medical insurance by reducing frivolous health care lawsuits. [FN153] Section 145.682 does not limit noneconomic damages, but rather requires an affidavit from an expert demonstrating that the expert believes that the plaintiff has a valid claim. [FN154] Another affidavit listing expert witnesses must be served upon the defendant within 180 days after commencement of the suit. [FN155] The Minnesota Supreme Court continues to uphold a case dismissal if a plaintiff fails to obtain sufficient certification of expert review. [FN156] This ***1052** legislation effectively remedied the expense of defending against frivolous lawsuits and should be utilized by other states prior to jumping to noneconomic damages caps. [FN157]

A major factor assessed in the American Medical Association's determination of whether or not a state is in medical liability crisis is the magnitude of patients losing access to health care. [FN158] The second piece of significant Minnesota legislation approved in 1986 addressed this issue by establishing rural hospital financial assistance grants. [FN159] This rural health initiative required the commissioner of health, through the office of rural health, to provide financial assistance to rural hospitals that were in danger of closing without such assistance. [FN160] Unfortunately, on June 5, 2003, the Minnesota Legislature repealed the statute providing financial assistance to rural hospitals. [FN161]

Notably, Minnesota's largest insurance company's medical liability insurance rates for general surgeons only increased by 2% from 1999 to 2002, compared to a 75% increase in Florida [FN162] and a 130% increase in Pennsylvania. [FN163] Despite these favorable statistics in Minnesota, Minnesota has somehow been classified by the AMA as a state showing "problem signs" in the area of medical liability. [FN164] Even with Minnesota's success in reducing frivolous lawsuits and past assistance for hospitals in rural areas, health care reform bills were active in the 2003-04 regular session and biennial budget session. On February 20, 2003, H.F. 482 was introduced in the Minnesota House of Representatives, had a first reading, and was ***1053** referred to the Civil Law Committee. [FN165] Its companion Senate bill, S.F. 459, was also introduced, had a first reading, and was referred to the Judiciary Committee. [FN166] Both House and Senate bills proposed limits of $250,000 for noneconomic damages in an action for injury or death against a health care provider, but neither passed. [FN167] Noneconomic damages would inevitably include all non-pecuniary harm for which damages are recoverable. [FN168] In 2005, the Minnesota Legislature is considering a $250,000 cap on noneconomic damages in actions for injury or death against a health care provider. [FN169]

Even though medical malpractice insurance rates are low and the supply of physicians is increasing, the legislature may be considering tort reform because "rising health care costs and health coverage has again become a critical issue for Minnesotans." [FN170] The legislature may also be reacting to President Bush's national push on tort reform or the recent withdrawal of St. Paul Companies from the medical malpractice insurance

market. [FN171] Minnesota's St. Paul Companies, at one time the largest medical malpractice insurer in the country, stopped selling malpractice insurance nationwide in December of 2001. [FN172] The chairman and chief executive officer of St. Paul Companies blamed recent market ***1054** trends. [FN173] Even though St. Paul Companies provided insurance nationally, medical malpractice insurance rates depend on varying compositions of insurance, legal, and health care structures within a state. [FN174]

Minnesota has a history of social consciousness and leadership in health care matters. [FN175] Minnesota should not consider noneconomic damage caps in any tort reform plan because of Minnesota's current success in patient accessibility and low medical malpractice rates. However, due to the recent repeal of financial aid to rural hospitals, Minnesota should continue to monitor access to health care in rural areas.

D. Considerations for Future Legislation

Whether under the Federal or State legislative umbrella, capping noneconomic damages will not solve the medical insurance liability crisis. All legislators should seriously consider how noneconomic damage caps would affect the health care system. [FN176] Even if noneconomic damage caps would influence lower medical malpractice insurance rates for physicians, the caps may in turn increase health insurance costs for the public because they are the potential victims of medical negligence. [FN177] Any legislative solution should include (1) a process to reduce the incidence of medical malpractice by physicians, (2) assessment of insurance regulation as to how insurance rates are set, and (3) a process to reduce the number of frivolous medical malpractice cases. [FN178] ***1055** Minnesota has addressed these issues in the following ways. First, Minnesota has peer review organizations intact to reduce the incidence of medical malpractice. [FN179] The purpose of peer review is to assure that discussion of medical errors occurs without threat of medical malpractice suits. [FN180] Secondly, the Minnesota Department of Commerce regulates the insurance industry through a file and use system. [FN181] In 2001, the Department of Commerce introduced a "speed to market" filing procedure for insurance companies that meet certain requirements. [FN182] Third, Minnesota requires expert affidavits to limit frivolous lawsuits, which contributed to the drastic decline in medical liability insurers' losses in 1986. [FN183]

Even though these measures have aided in reducing medical malpractice insurance rates in Minnesota, such measures should be reassessed as compositions of insurance, legal, and health care structures change over time. Each state should make similar assessments to create the proper balance of tort and insurance reform to decrease medical malpractice insurance rates. Many tort reform alternatives are available: abolish collateral source payments, abolish "joint and several liability," restrict the statute of limitations, allow periodic payment of damages, limit attorney fees, require expert certification of claims, and provide for greater use of arbitration. [FN184]

IV. Conclusion

Legislatures have legitimate concerns about the health care delivery system, but the panacea of the "medical liability crisis" does not lie in capping noneconomic damages. The federal government should not cap noneconomic damages because: (1) states are in the best position to regulate health care, (2) statistics show that noneconomic damages are not the determinate factor in increasing medical liability insurance rates, and (3) caps do not provide equal protection by limiting compensation of medical malpractice victims. Even at the state level, noneconomic damage caps should ***1056** not be a part of tort reform legislation. A small number of severely injured victims should not have to suffer so that medical malpractice insurance rates will decrease. Other insurance and tort reform measures should be utilized to protect physicians against frivolous lawsuits and provide full compensation for those injured in rare cases of physician negligence.

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States Marine Corps, 1993-1997. Special thanks extended to Shannon Gregory, Kathryn Gammelgaard, and Ginger Gammelgaard for their continual encouragement and support.

[FN1]. Agency for Healthcare Research and Quality, Health Care Costs, AHRQ Publication No. 02-P033 (2002), available at http:// www.ahrq.gov/news/costsfact.htm. "Even at the lowest number, medical errors would be the eighth leading cause of death in this country, bypassing motor vehicle accidents, breast cancer, and AIDS. About 7,000 people die from medication errors alone, which is about 16% more deaths than can be attributed to work-related injuries." Id.

[FN2]. Quality Interagency Coordination Task Force, Doing What Counts For Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact (2000), at http://www.quic.gov/report/index.htm.

[FN3]. Gourley ex rel. Gourley v. Neb. Methodist Health Sys., Inc., 663 N.W.2d 43, 55-56 (Neb. 2003).

[FN4]. Id.

[FN5]. Jason Leo, Case Note, Torts--Medical Malpractice: The Legislature's Attempt to Prevent Cases Without Merit Denies Valid Claims: Lindberg v. Health Partners, Inc., 27 Wm. Mitchell L. Rev. 1399, 1400 (2000).

[FN6]. U.S. Gen. Accounting Office, Medical Malpractice: Implications of Rising Premiums on Access to Health Care, GAO-03-0836, 2 n.1 (2003) [hereinafter Implications]. "Medical malpractice lawsuits are generally based on principles of tort law. A tort is a wrongful act or omission by an individual that causes harm to another individual. Typically, a legal claim of malpractice would be based on a claim that the negligence of a provider caused injury and the injured party would seek damages." Id.

[FN7]. Economic damages are defined as "those designed to compensate the plaintiff for his or her out-of-pocket expenses. These include any tangible economic loss, such as past and future medical expenses, costs of follow-up treatment, and lost wages." Christopher S. Kozak, A Review of Federal Malpractice Tort Reform Alternatives, 19 Seton Hall Legis. J. 599, 621 n.98 (1995).

[FN8]. Noneconomic damages are defined as "the portion of the award that compensates for 'pain and suffering."' Id. n.99. "Because there exists no basis by which to measure the mental and physical anguish of an injury in its rehabilitation, these damages tend to be the most unpredictable." Id.

[FN9]. Punitive damages are defined as a tool to "punish tortfeasers for their outrageous conduct and to deter similar future conduct." Id. n.100. Punitive damages are "rarely used in malpractice cases unless the physician is found to have acted with willful indifference to or in deliberate disregard of the patient's needs." Id.

[FN10]. Id. at 621.

[FN11]. U.S. Gen. Accounting Office, Medical Malpractice: Multiple Factors Have Contributed to Increased Premium Rates, GAO-03-702, 42 (2003) [hereinafter Multiple Factors]. Even though noneconomic damages are difficult to quantify, the Illinois Supreme Court determined that "it does not follow that the difficulty in quantifying compensatory damages for noneconomic injuries is alleviated by imposing an arbitrary limitation or cap in all cases." Best v. Taylor Mach. Works, 689 N.E.2d 1057, 1076 (Ill. 1997).

[FN12]. See Multiple Factors, supra note 11, at 8. "In response to concerns over rising premium rates, physicians, medical associations, and insurers have pushed for state and federal legislation that would, among other things, limit the amount of damages paid out on medical malpractice claims." Id.

[FN13]. Association of Trial Lawyers of America, Fact Sheet: Oppose S. 11: The Same Old Story, available at http://www.atla.org/consumermediaresources/tier3/press_room/facts/medmal/s11.aspx (last visited Jan. 14, 2004). Real injuries that are entitled to compensation include: "loss of a limb or sight, the loss of mobility, the loss of fertility, excruciating pain and permanent and severe disfigurement.... [and] the loss of a child or a spouse." Id.

[FN14]. If $250,000 noneconomic damage caps were imposed, then "victims [would] receive arbitrary compensation for the horrendous and oftentimes permanent injuries they suffer, rather than allowing a jury to determine the appropriate level of compensation in each individual case." Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong., Comments (2003).

[FN15]. See Kozak, supra note 7, at 600; see also Mitchell S. Berger, Following the Doctor's Orders --Caps on Non-Economic Damages in Medical Malpractice Cases, 22 Rutgers L.J. 173, 174 (1991). "To reduce malpractice claims payments and insurance premiums and for other reasons, some have advocated changes to tort laws, such as placing caps on the amount of damages or limits on the amount of attorney fees that may be paid under a malpractice lawsuit. These changes are collectively referred to as 'tort reforms.'" Implications, supra note 6, at 2 n.1.

[FN16]. Health Insurance Association of America, HIAA Reports on State Health Insurance Legislation (2003), available at http://www.hiaa.org/news/newsitem.cfm?ContentID=24412 (on file with author). In late 2003, HIAA merged with AAHP to form America's Health Insurance Plans (AHIP). Further information can be found at http://www.ahip.org.

[FN17]. Kozak, supra note 7, at 619.

[FN18]. Berger, supra note 15, at 183.

[FN19]. Professional Liability: GOP Senators Fall Short of Votes Needed to Start Consideration of Malpractice Bill, in BNA's Health Care Daily Report (July 10, 2003).

[FN20]. Joel B. Finkelstein, Health Care Emerges as a Major Issue in 2004 Election, amednews.com (April 12, 2004), at http://www.ama-assn.org/amednews/2004/04/12/gvsd0412.htm. Transcripts of all presidential and vice-presidential debates are available on The Washington Post website, available at www.washingtonpost.com/wp-dyn/politics/elections/2004/debates/ (last visited Dec. 2, 2004). The vice-presidential candidates were first to raise the issue of medical liability tort reform: Vice-president Dick Cheney stated, "[W]hat we need to do is cap non-economic damages." John Edwards responded, "We want to put more responsibility on the lawyers to require ... independent experts to determine if the case is serious and meritorious before it can be filed." Transcript: Vice Presidential Debate, Case Western Reserve University, Cleveland, Ohio at 42-43 (Oct. 5, 2004), available at http://www.washingtonpost.com/wp-srv/politics/debatereferee/debate_1005.html.

[FN21]. Finkelstein, supra note 20.

[FN22]. See infra Parts II, III.

[FN23]. See infra Part III.A-B.

[FN24]. See infra Part III.B.

[FN25]. See infra Part III.C.

[FN26]. See infra Part IV.

[FN27]. See Multiple Factors, supra note 11, at 46.

[FN28]. Leo, supra note 5, at 1402. "[T]here were approximately 'five medical malpractice suits filed for every 10 doctors."' Id. at 1402-03 (citations omitted).

[FN29]. Berger, supra note 15, at 175; Leo, supra note 5, at 1403.

[FN30]. Implications, supra note 6, at 1.

[FN31]. Berger, supra note 15, at 177. Physicians and insurers attributed rising costs to both the quantity of suits filed and the size of damage awards, while lawyers and consumer groups blamed excessive insurance profits and the medical profession's inability to eliminate substandard practitioners. Id. The decline in the U.S. stock market in the early 1970s also contributed to the rising costs. Id. at 177-78.

[FN32]. Leo, supra note 5, at 1403.

[FN33]. Implications, supra note 6, at 27.

[FN34]. Id. at 1; Leo, supra note 5, at 1403; Minnesota Medical Association, Issue Brief--Medical Malpractice, at http://www.mnmed.org/advocacy News/tpmedicalmalpractice.cfm (last updated Jan. 17, 2003) [hereinafter Medical Malpractice].

[FN35]. Implications, supra note 6, at 38 (explaining that the American Medical Association questioned GAO's finding that access problems were not widespread based on GAO's work in five states, which were among the most often-cited examples of "crisis states").

[FN36]. Berger, supra note 15, at 179 (explaining the results of the crisis in the 1970s and the states' response of tort reform to preserve health care access at a reasonable cost); Leo, supra note 5, at 1403-04.

[FN37]. Leo, supra note 5, at 1404.

[FN38]. Agency for Healthcare Quality, Impact on State Laws Limiting Malpractice Awards on Geographic Distribution of Physicians, Table 1A: Supply of Physicians in States With Caps on Malpractice Awards (2002) [hereinafter Table 1A], at http://www.ahrq.gov/research/tortcaps/torttab1a.htm (showing that California, Indiana, and Louisiana imposed noneconomic damage caps in medical malpractice suits during 1975).

[FN39]. Cal. Civ. Code § 3333.2 (1975). The California Supreme Court determined that the California legislature was responding to the rising cost of medical malpractice insurance that posed serious problems for California's health care system, which "threaten[ed] to curtail the availability of medical care in some parts of the state and creat[ed] the very real possibility that many doctors would practice without insurance, leaving patients who might be injured by such doctors with the prospect of uncollectible judgments." Fein v. Permanente Med. Group, 695 P.2d 665, 680 (Cal. 1985).

[FN40]. Help Efficient, Accessible, Low-cost, Timely Health Care (HEALTH) Act of 2003, H.R. 5, 108th Cong., Comments (2003) (noting that California's cap was enacted in 1975 and has never been adjusted for inflation, which, if adjusted for inflation, would be $1,500,000 in 2003).

[FN41]. Table 1A, supra note 38; Agency for Healthcare Quality, Impact on State Laws Limiting Malpractice Awards on Geographic Distribution of Physicians, Table 1B: Supply of Physicians in State Without Caps on Malpractice Awards for Noneconomic Damages (2002) [hereinafter Table 1B], at http:// www.ahrq.gov/research/tortcaps/torttab1b.htm (listing Alabama, Alaska, California, Colorado, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Montana, New Mexico, North Dakota, Ohio, Oregon, South Dakota, Texas, Utah, Virginia, West Virginia, Washington, and Wisconsin as states enacting caps between 1975 and 1995).

[FN42]. Table 1B, supra note 41 (listing Alabama, Florida, Illinois, Ohio, Oregon, Texas, and Washington as overturning caps on noneconomic damages). Florida, Ohio, and Texas have since passed legislation capping noneconomic damages. Id.

[FN43]. For example, the Illinois Supreme Court overturned a $500,000 noneconomic damage cap on constitutional grounds in 1976 and did so again in 1997. Wright v. Central DuPage Hosp. Ass'n, 347 N.E.2d 736 (Ill. 1976); Best v. Taylor Mach. Works, 689 N.E.2d 1057 (Ill. 1997). In Wright, the plaintiff successfully argued that noneconomic caps "arbitrarily classified, and unreasonably discriminated against, the most seriously injured victims of medical malpractice, but has not limited the recovery of those victims who suffer moderate or minor injuries." Wright, 347 N.E.2d at 741.

[FN44]. American Medical Association, Medical Liability Reform (2003), at http://www.ama-assn.org/ama/pub/category/7861.html [hereinafter Medical Liability Reform].

[FN45]. Table 1A, supra note 38 (listing Alaska, California, Colorado, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Montana, New Mexico, North Dakota, South Dakota, Utah, Virginia, West Virginia, and Wisconsin).

[FN46]. Table 1B, supra note 41.

[FN47]. Health Insurance Association of America, State Issues Tracking Report: Midyear Review at 4 (2003), at http:// membership.hiaa.org/pdfs/communications/030729statetrack.pdf. Medical malpractice and tort reform have emerged as high profile issues in 2003. Id. The most significant health insurance issues facing state legislatures during the first six months of 2003 were "mandated benefits, medical malpractice reform, privacy, and prescription drug coverage." Id.

[FN48]. Texas: Governor Signs a Bill, Calls it "Most Sweeping in the Nation," in BNA's Health Care Daily Report (June 20, 2003).

[FN49]. Texas: Voters Approve Constitution Change that Clears Way for Damages Caps Law, in BNA's Health Care Daily Report (Sept. 16, 2003). Kathy Walt, spokesman for Governor Rick Perry, said that the "approval of Proposition 12 also has national significance.... The governor expects President Bush and Congress will view Texas as the model for passing meaningful medical liability and general tort reform at the federal level." Id.

[FN50]. Drew Douglas, Florida: Gov. Bush Signs Malpractice Reform Bill: Trial Bar Vows

Constitutional Challenge, in BNA's Health Care Daily Report (Aug. 15, 2003). Prior to passing the bill the House pushed for a $250,000 cap while the Senate opposed caps, but later modified its stance to include cap proposals within the bill that ranged from $500,000-$750,000. Id. "The cap was probably the most contentious part of the negotiations while formulating this legislative package." Id.

[FN51]. Tanya Albert, 3 States Pass Tort Reform; Others Still Waiting (June 14, 2004), at http://www.ama-assn.org/amednews/2004/06/14/gvsa0614.htm. New Jersey, Ohio, and Oklahoma passed tort reform measures, while Alaska, Connecticut, Iowa, Missouri, and New Hampshire rejected tort reform. Id.

[FN52]. Table 1A, supra note 38; Table 1B, supra note 41; Adam D. Glassman, The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?, 37 Akron L. Rev. 417, 432- 58 (2004) (listing the individual state laws pertaining to medical liability).

[FN53]. Memorandum from Daniel Blaney-Koen, Field Communications Officer, American Medical Association (June 2002) (on file with author) (listing numerous sources analyzed, such as the U.S. Department of Health and Human Services, Agency for HealthCare Research and Quality, General Accounting Office, and the Joint Economic Commission of the U.S. Congress).

[FN54]. Id. (considering the additional factors of "[a] state's legislative, legal, and judicial climate; [a]ffordability and availability of professional liability insurance; and [t]rend[s] of jury awards and settlements").

[FN55]. American Medical Association, America's Medical Liability Crisis: A National View, at http://www.ama-assn.org/ama/noindex/category/11871.html (last updated Jan. 31, 2005) [hereinafter Medical Liability Crisis] (showing Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, and Wyoming as states in full-blown "medical liability crisis" and showing Alabama, Alaska, Arizona, Delaware, Hawaii, Idaho, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, Nebraska, Montana, New Hampshire, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, and Virginia as states showing "problem signs"). The AMA does not explicitly define "problem signs," but the inferred meaning would be those states on the verge of being in "medical liability crisis." See id.

[FN56]. Medical Liability Crisis, supra note 55.

[FN57]. Help Efficient, Accessible, Low-cost Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong., Comments (2003).

[FN58]. Glassman, supra note 52, at 459 (quoting The Foundation of Taxpayer and Consumer Rights, How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California: and How Malpractice Caps Fail, (March 7, 2003), available at http://www.consumerwatchdog.com).

[FN59]. Id.; see also Association of Trial Lawyers of America, The Truth About Caps-They Don't Work, at http:// www.atla.org/ConsumerMediaResources/Tier3/press_room/FACTS/medmal/capsfactsheet.aspx (last visited Dec. 2, 2004). The California Proposition 103 required prior approval of insurance rates and also required the Commissioner of Insurance to request a public hearing if a commercial carrier requests a rate increase of greater than 15%. Multiple Factors, supra note 11, at 59.

[FN60]. See Glassman, supra note 52, at 459.

[FN61]. Table 1B, supra note 41.

[FN62]. H.R. 1091, 105th Cong. (2000).

[FN63]. Id.

[FN64]. Id.

[FN65]. H.R. 2242, 106th Cong. (2001).

[FN66]. Id.

[FN67]. Id.

[FN68]. H.R. 4600, 107th Cong. (2002).

[FN69]. Melissa A. Wojtylak et al., Recent Developments in Medicine and Law, 38 Tort Trial & Ins. Pract. L.J. 549, 551 (2003).

[FN70]. Id. The purposes of the proposed legislation are listed as improving availability of health care where health care liability claims have contributed to decreasing availability of services, reducing health care liability insurance costs, ensuring adequate compensation for patients with meritorious injury claims, and improving fairness and cost efficiency of the alternative dispute resolution system by reducing uncertainty of damage awards. Id.

[FN71]. Id. at 552.

[FN72]. Id.

[FN73]. S. 2793, 107th Cong. (2002).

[FN74]. H.R. 4600, 107th Cong. (2002); S. 2793, 107th Cong. (2002).

[FN75]. H.R. 5, 108th Cong. (2003).

[FN76]. Id.

[FN77]. Id.

[FN78]. S. 607, 108th Cong. (2003).

[FN79]. S. 11, 108th Cong. (2003).

[FN80]. Id.

[FN81]. Elizabeth White, Professional Liability: No Senate Action on Malpractice, as Republicans, Democrats Trade Blame, in BNA's Health Care Daily Rep. (July 9, 2003).

[FN82]. Elizabeth White, Professional Liability: Senate Democrats Object to GOP Bringing Damage Caps Bill to the Floor, in BNA's Health Care Daily Rep. (July 8, 2003) [hereinafter White]. Senators voted along party lines except two Republicans who voted with the Democrats: Lindsey O. Graham (S.C.) and Richard A. Selby (Ala.). Id. Three Democratic Senators were missing for the vote. Id.

[FN83]. H.R. 4280, 108th Cong. (2004).

[FN84]. Id.

[FN85]. Id. On May 13, the bill was laid on the table and its text was appended to H.R. 4279. Id.

[FN86]. H.R. 4279, 108th Cong. (2004). This bill was received in the Senate on May 17, 2004, read twice, placed on the Senate Legislative Calendar, and never voted on. Id. New capping legislation was introduced on February 2, 2005 and has been referred to the Committee on the Judiciary and the Committee on Energy and Commerce. H.R. 534, 109th Cong. (2005). Related bills have also been introduced in the Senate. S. 366, 367, & 354, 109th Cong. (2005).

[FN87]. White, supra note 82.

[FN88]. Id.

[FN89]. Id.

[FN90]. S. 11, 108th Cong. (2003). The Patients First Act of 2003 stated that the health care and insurance industries affect interstate commerce by "contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers." Id. § 2(a)(2). Congress also found that health care liability systems throughout the states have a "significant effect on the amount, distribution, and use of Federal funds because of the large number of individuals who receive health care benefits under programs operated or financed by the Federal government." Id. § 2(a)(3).

[FN91]. H.R. Rep. No. 108-32, pt. 2 at 39 (2003).

[FN92]. Medtronic, Inc. v. Lohr, 518 U.S. 470, 485 (1996).

[FN93]. Douglas, supra note 50.

[FN94]. Letter from Robert D. Evans, American Bar Association, to the United States House of Representatives, 108th Cong. (Mar. 10, 2003), at http://www.abanet.org/poladv/letters/108th/mpl031003.html [hereinafter Evans]. The letter explained that the system of allowing states to regulate the resolution of cases within their borders is the "hallmark of our American Justice System." Id. This is "[b]ecause of the role they have played, the states are the repositories of experience and expertise in these matters." Id.

[FN95]. Joyce E. Butler, Medicare: State Lawmakers' Group Urges Congress to Adopt Medicare Prescription Drug Benefit, in BNA's Health Care Daily Rep. (July 29, 2003) (referring to the Law and Criminal Justice Committee's resolution opposing the federal government's preemption of existing state law in medical malpractice suits).

[FN96]. Evans, supra note 94. Robert D. Evans, in his letter to the United States House of Representatives, cited both Pegram v. Herdrich, 530 U.S. 211, 237 (2000) (holding that state law applies to mixed eligibility decisions by physicians and are not fiduciary decisions under the federal Employee Retirement Income Security Act (ERISA)) and Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 357 (2002) (holding that the ERISA statute does not preempt the Illinois Health Maintenance Organization Act).

[FN97]. Pegram, 530 U.S. at 237; see also Medtronic, 518 U.S. at 484.

[FN98]. See Rush, 536 U.S. at 356-67 (emphasizing that Congress recognized HMOs as being subject to state regulation).

[FN99]. Geier v. Am. Honda Motor Co., 529 U.S. 861, 894 (2000).

[FN100]. Multiple Factors, supra note 11, at 4.

[FN101]. Professional Liability: GAO Sees Claims Losses as Main Driver of Long-Term Rise in Malpractice Premiums, in BNA's Health Care Daily Rep. (July 29, 2003); see also Multiple Factors, supra note 11, at 42-43 (concluding that the impact of "various measures" and lack of data makes it impossible to "quantify the impact of a cap on noneconomic damages on insurers' losses").

[FN102]. Multiple Factors, supra note 11, at 43.

[FN103]. Id. at 4.

[FN104]. See Implications, supra note 6, at 11-12. GAO named other sorts of tort reform provisions, which include abolishing collateral source payments, abolishing "joint and several liability," restricting the statute of limitations, allowing periodic payment of damages, limiting attorney fees, requiring expert certification of claims, and providing for greater use of arbitration. Id.

[FN105]. Multiple Factors, supra note 11, at 56-57 (explaining that statutory requirements vary by state, but generally provide that "insurance rates be adequate, not excessive, and not unfairly discriminatory").

[FN106]. Id. at 4. From 1998 through 2001, interest rates fell on bonds that made up about 80% of insurers' investment portfolios. Id. "[A] decrease in investment income meant that income from insurance premiums had to cover a large share of insurers' costs." Id. Competition also encouraged offering low rates during times of high investment returns, which did not completely cover their ultimate losses for some insurers. Id.

[FN107]. Implications, supra note 6, at 7.

[FN108]. White, supra note 82.

[FN109]. Multiple Factors, supra note 11, at 43 (explaining that damage caps can vary in amount, type of damages covered, and how the limitations apply).

[FN110]. Id. at 46. "Such data would serve the interests of state and federal governments and allow both to better understand the causes of recurring crises in the medical malpractice insurance market and formulate the most appropriate and effective solutions." Id.

[FN111]. Health and Human Services, Confronting the New Health Care Crisis: Improving Health Care Quality And Lowering Costs By Fixing Our Medical Liability System (July 25, 2002), available at http:// aspe.hhs.gov/daltcp/reports/litrefm.htm.

[FN112]. Id. (noting that in 2000 the average cost to defend a medical malpractice claim was $24,669).

[FN113]. Id. (citing Jeffrey O'Connell, An Alternative to Abandoning Tort Liability, 60 Minnesota: 501-506-509 (1976)).

[FN114]. Id. (citing U.S. General Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984, GAO/HRD-87-55, 18 (Apr. 1987)).

[FN115]. Anthony Viorst & Jim Leventhal, Constitutional Challenges to Damage-Cap Statutes, in ATLA Winter Convention Reference Materials, ATLA-CLE 515 (Winter 2004). "Equal protection of the laws requires the government to treat similarly situated persons in a similar matter." Id.

[FN116]. Carol Crocca, Annotation, Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims, 26 A.L.R. 5th 245 (1995).

[FN117]. See Association of Trial Lawyers of America, supra note 13 (classifying low income individuals as "children, the elderly, the disabled, and others who may not have substantial earnings to establish lost wages"); see also American Political Network, Statelines Malpractice: AHL Features Developments in Five States, American Health Line (Aug. 22, 2003). In Texas, consumer advocacy groups and seniors argued that capping noneconomic damages in medical malpractice lawsuits would discriminate against low-income individuals because they are unable to prove large economic damages. Id.

[FN118]. See Association of Trial Lawyers of America, supra note 13.

[FN119]. Berger, supra note 15, at 184 (explaining that some individuals will be harmed by noneconomic damage caps). The New Hampshire Supreme Court has consistently decided that noneconomic damage caps violate the state's equal protection clause by distinguishing between classes of tortfeasors. See, e.g., Brannigan v. Usitalo, 587 A.2d 1232, 1236 (N.H. 1991) (focusing on the distinction "between malpractice victims with noneconomic losses that exceed [ed] $250,000 and those with less egregious non-economic losses"); Carson v. Maurer, 424 A.2d 825, 837 (N.H. 1980).

[FN120]. 25 C.J.S. Damages § 21 (2004). "There is universal agreement that the compensatory goal of tort law requires that an injured plaintiff be made whole." Best v. Taylor Mach. Works, 689 N.E.2d 1057 (Ill. 1997).

[FN121]. Crocca, supra note 116 (citing cases that uphold the validity of statutes that limit noneconomic damages in medical malpractice actions); see, e.g., Fein v. Permanente Med. Group, 695 P.2d 665 (Cal. 1985); Mizrahi v. N. Miami Med. Ctr., Ltd., 761 So. 2d 1040 (Fla. 2000); Adams v. Children's Mercy Hosp., 832 S.W.2d 898 (Mo. 1992); Vincent v. Johnson, 833 S.W.2d 859 (Mo. 1992); Robinson v. Charleston Area Med. Ctr., Inc., 414 S.E.2d 877 (W. Va. 1991); Zdrojewski v. Murphy, 657 N.W.2d 721 (Mich. Ct. App. 2002).

[FN122]. Hoffman v. United States, 767 F.2d 1431, 1437 (9th Cir. 1985); Mizrahi, 761 So. 2d at 1040.

[FN123]. See Berger, supra note 15, at 194 (explaining that the courts agree that the rational basis test should be used to determine if statutes limiting noneconomic damage caps have a "real and substantial relationship" to a legitimate state interest).

[FN124]. See Hoffman, 767 F.2d at 1435; Fein, 695 P.2d at 679-80; Mizrahi, 761 So. 2d at 1043; Zdrojewski, 657 N.W.2d at 738; Robinson, 414 S.E.2d at 883. "Most legislative classifications, including those which involve economic rights, are subject to a minimal level of scrutiny, the traditional equal protection concept that the legislative classification will be upheld if it is reasonably related to the achievement of a legitimate state purpose." Robinson, 414 S.E.2d at 883; see also Gourley ex rel. Gourley v. Neb. Methodist Health Sys., Inc., 663 N.W.2d 43, 71 (Neb. 2003). But see Evans ex rel. Kutch

v. State, 56 P.3d 1046, 1052 (Alaska 2002) (applying a three part "sliding scale" to analyze the right of equal protection under the Alaska Constitution).

[FN125]. Gourley, 663 N.W.2d at 71.

[FN126]. Mizrahi, 761 N.W.2d at 1043; Zdrojewski, 657 N.W.2d at 739.

[FN127]. Hoffman, 767 F.2d at 1437; Fein, 695 P.2d at 680.

[FN128]. See Arneson v. Olson, 270 N.W.2d 125, 136 (N.D. 1978) ("When we examine the legislative purpose of the Act, we find that the incidence of malpractice claims in North Dakota is far lower than average in the United States."); see also Mizrahi, 761 N.W.2d at 1043 (Pariente, J., dissenting) ("There is no indication that the past medical malpractice crisis continues into the present.... Indeed, it is a 'settled principle of constitutional law' that although a statue is constitutionally valid when enacted, that statute may become constitutionally invalid due to the changes in the conditions to which the statute applies.").

[FN129]. See Moore v. Mobile Infirmary Ass'n, 592 So. 2d 156, 167 (Ala. 1991) (citing a GAO study suggesting that "the connection between damage caps and the total cost of health care "is remote, pointing out that, despite statutory reform, including damage caps, in place for nearly ten years in some states, total medical malpractice costs for physicians and hospitals rose by more than either the consumer price index or the medical care index in that period."); see also supra Part III.B.2.

[FN130]. Gourley ex rel. Gourley v. Neb. Methodist Health Sys., Inc., 663 N.W.2d 43, 55-56 (Neb. 2003).

[FN131]. 695 P.2d 665, 691 (Cal. 1985) (Bird, C.J., dissenting).

[FN132]. Id. at 692.

[FN133]. Id. "Although the Legislature normally enjoys wide latitude in distributing the burdens of personal injuries, the singling out of such a miniscule and vulnerable group violates even the most undemanding standard of underinclusiveness." Id.

[FN134]. Id.

[FN135]. Crocca, supra note 116 (citing cases that do not uphold the validity of statutes limiting noneconomic damages in medical malpractice actions); see, e.g., Moore v. Mobile Infirmary Ass'n, 592 So. 2d 156, 169 (Ala. 1991) (concluding that the legislative goal of lowering insurance costs would not be supported through noneconomic damage caps because "paid-out damage awards constitute only a small part of total insurance premium costs"); Carson v. Maurer, 424 A.2d 825, 834 (N.H. 1980) (holding that the statute precluded full recovery for severely injured plaintiffs, creating classifications among medical malpractice plaintiffs that unfairly denied such plaintiffs equal protection of the laws).

[FN136]. Berger, supra note 15, at 194.

[FN137]. Brannigan v. Usitalo, 587 A.2d 1232, 1234 (N.H. 1991) (quoting Carson, 424 A.2d at 830).

[FN138]. Carson, 424 A.2d at 831.

[FN139]. Brannigan, 587 A.2d at 1234 (quoting Carson, 424 A.2d at 832); see also

Moore, 592 So. 2d at 165-66.

[FN140]. Arneson v. Olson, 270 N.W.2d 125, 135-36 (N.D. 1978).

[FN141]. Moore, 592 So. 2d at 168.

[FN142]. Id. at 168-69.

[FN143]. See Brannigan, 587 A.2d at 1236; Carson, 424 A.2d at 836.

[FN144]. Remittitur is the "process by which a court reduces or proposes to reduce the damages awarded in a jury verdict." Black's Law Dictionary 1298 (7th ed. 1999).

[FN145]. See Brannigan, 587 A.2d at 1236; Carson, 424 A.2d at 837. If the federal government enacts legislation to preempt state laws in medical malpractice suits, then the law may also be challenged on constitutional separation-of-power grounds. Evans, supra note 94; see also Best v. Taylor Mach. Works, 689 N.E.2d 1057 (Ill. 1997). The American Bar Association advises that courts should use their powers of remittitur to set aside excessive verdicts, instead of limiting damages that would not ensure adequate compensation. Evans, supra note 94; see also Carson, 424 A.2d at 837. Recently, the Illinois Supreme Court concluded that the $500,000 noneconomic damage cap violated the state's separation of powers clause by invading the judiciary's power of remittitur. Best, 689 N.E.2d at 1080.
The courts are constitutionally empowered, and indeed obligated, to reduce excessive verdicts where appropriate in light of the evidence adduced in a particular case. Section 2-1115.1, however, reduces damages by operation of law, without regard to the specific circumstances of individual jury awards. Although legislative limits upon certain types of damages may be permitted, such as damages recoverable in statutory causes of action, we hold that the cap in section 2-1115.1 violates the separation of powers clause of the Illinois Constitution.
Id. at 1081. For further discussion of the constitutionality of noneconomic damages see Kevin J. Gfell, Note, The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions, 37 Ind. L. Rev. 773 (2004) and Viorst & Leventhal, supra note 115.

[FN146]. Table 1B, supra note 41; see also Medical Liability Reform, supra note 44.

[FN147]. Table 1B, supra note 41.

[FN148]. Table 1A, supra note 38.

[FN149]. Multiple Factors, supra note 11, at 21 (Figure 6: Inflation-Adjusted Incurred Losses for Medical Malpractice Insurers in Seven Selected States, 1975-2001).

[FN150]. Id.

[FN151]. See supra notes 57-59 and accompanying text.

[FN152]. Minn. Stat. § 145.682 (2002).

[FN153]. Leo, supra note 5, at 1404-05.

[FN154]. Minn. Stat. § 145.682, subd. 2. "At a minimum, a 'meaningful disclosure' is required [for] setting forth the standard of care, the act or omissions violating that standard, and the chain of causation." Teffeteller v. Univ. of Minn., 645 N.W.2d 420, 430 (Minn. 2002).

[FN155]. Minn. Stat. § 145.682, subd. 4 (2002). The statute requires an affidavit listing the expert witnesses whom the plaintiff may call to testify as to issues of malpractice causation, the substance of their testimony, and a summary of the grounds for each witness' opinion. Id. The attorney and each expert witness must sign the affidavit. Id.

[FN156]. See Teffeteller, 645 N.W.2d at 431. The Minnesota Supreme Court upheld the trial court's holding that the physician's affidavit failed to meet the statutory requirements and dismissal with prejudice was appropriate. Id. The court has also upheld a district court holding that "respondent failed to file a sufficient affidavit within the 180-day deadline and that failure to comply results in mandatory dismissal upon motion." Lindberg v. Health Partners, Inc., 599 N.W.2d 572, 577 (Minn. 1999). When the plaintiff fails to comply with the 180-day requirement, each cause of action for which expert testimony is required must be dismissed upon defendant's motion. Stroud v. Hennepin County Med. Ctr., 556 N.W.2d 552, 555 (Minn. 1996).

[FN157]. See Dan Oberdorfer, State Taking the Steps to Limit Excessive Jury Awards, Star Tribune (Minneapolis-St. Paul), Apr. 21, 1986, at 1A. "[T]he Minnesota Medical Association found that 60% of all malpractice claims are closed with no money paid out." Id.

[FN158]. Blaney-Koen, supra note 53.

[FN159]. Minn. Stat. § 144.1484 (1986) (repealed 2003).

[FN160]. Minn. Stat. § 144.1483 (1986) (repealed subd. 3, 2003).

[FN161]. 2003 Minn. Laws, ch. 13, art. 7, § 89.

[FN162]. Multiple Factors, supra note 11, at 3. "The resulting 2002 premium rate quoted by the Florida insurer was $174,300 a year, more than seventeen times the $10,140 premium rate quoted by the insurer in Minnesota." Id.

[FN163]. Implications, supra note 6, at 9.

[FN164]. Medical Liability Reform, supra note 44.

[FN165]. H.R. 452, 83rd Leg. (Minn. 2003). H.F. 452 was authored by Minnesota House Representatives Lipman, Kohls, DeLaforest, Gerlach, Holberg, et al.

[FN166]. S.F. 459, 83rd Leg. (Minn. 2003). S.F. 459 was authored by Minnesota Senators Michel, LeClair, and Kiscaden.

[FN167]. H.R. 452, § 4, subd. 2; S.F. 459, § 4 subd. 2.

[FN168]. H.R. 452, § 4, subd. 1; S.F. 459, § 4, subd. 1 (defining noneconomic loss as "all non pecuniary harm for which damages are recoverable, including but not limited to pain, disability, disfigurement, embarrassment, emotional distress, and loss of consortium").

[FN169]. H.F. No. 2, 84th Leg. (Minn. 2005) (introduced, had a first reading, and referred to the Health Policy & Finance Committee on January 6, 2005); S.F. No. 0376, 84th Leg. (Minn. 2005) (introduced, had a first reading, and referred to the Health and Security Family Committee on January 19, 2005). In addition, the Minnesota Legislature is considering a resolution to support President Bush's policy on medical liability tort reform. See H.F. No. 1029, 84th Leg. (Minn. 2005) (introduced, had a first reading, and referred to the Civil Law and Elections Committee on February 14, 2005); S.F. No. 1107, 84th

Leg. (Minn. 2005) (introduced, had a first reading, and referred to the Judiciary Committee on February 21, 2005).

[FN170]. Minnesota Department of Public Health, The Joint Task Force on Health Costs and Quality, at http:// www.health.state.mn.us/divs/hpsc/hep/JTF/jtfintro.htm (last updated June 24, 2004).

[FN171]. Minnesota Medical Association, Bush Proposes Medical Malpractice Reform (2003), at http://www.mnmed.org/News/fullstory.cfm?recNum=2596.

[FN172]. Id.; see also Medical Malpractice, supra note 34.

[FN173]. Minnesota Medical Association, St. Paul Cos. To Drop Medical Malpractice Business, at http://www.mmaonline.net/News/fullstory.cfm? recNum=2197 (last visited Jan. 19, 2005).

[FN174]. Multiple Factors, supra note 11, at 46. GAO concluded, and the National Association of Insurance Commissioner's Director of Research concurred, that "medical malpractice markets are not national in nature, but vary widely with regard to their insurance markets, regulatory framework, legal environment, and health care structures" within the states. Id.

[FN175]. Keith Halleland & Deanna Mills, Beyond Band-Aids, Star Tribune (Minneapolis-St. Paul), Oct. 7, 2002, at D3.

[FN176]. Center For Studying Health System Change, Medical Malpractice Insurance Fallout Varies Across Communities (2003), at http:// www.hschange.com/CONTENT/606/.

[FN177]. Carson v. Mauer, 424 A.2d 825, 835 (N.H. 1980).

[FN178]. Martha Kessler, Connecticut: Governor Calls For Lawmakers to Adopt Cap on Noneconomic Malpractice Awards, in BNA's Health Care Daily Report (Sept. 17, 2003).

[FN179]. Minn. Stat. §§ 145.61-67 (2003). The review organizations "share information for the purpose of identifying and analyzing trends in medical error and iatrogenic injury." Minn. Stat. § 145.61 (g).

[FN180]. In re Fairview Univ. Med. Ctr., 590 N.W.2d 150, 153 (Minn. Ct. App. 1999).

[FN181]. Multiple Factors, supra note 11, at 61.

[FN182]. Id.

[FN183]. See supra Part III.C.

[FN184]. See Implications, supra note 6, at 11-12.

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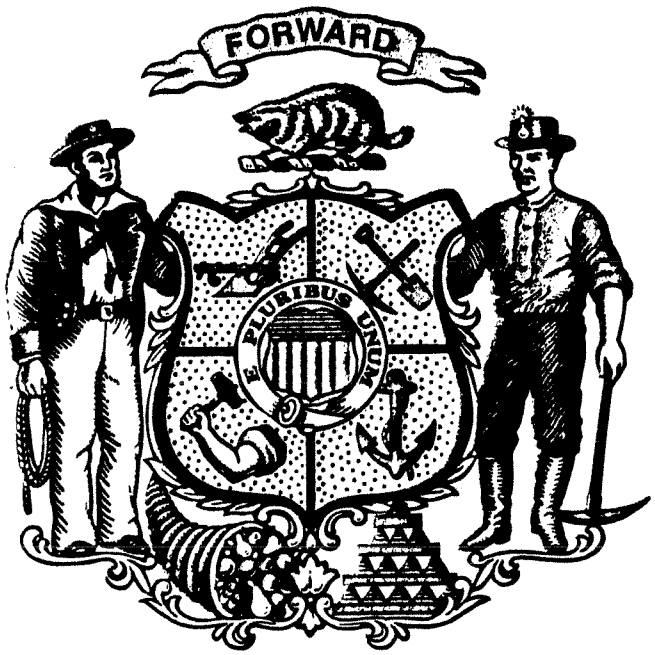
FORWARD
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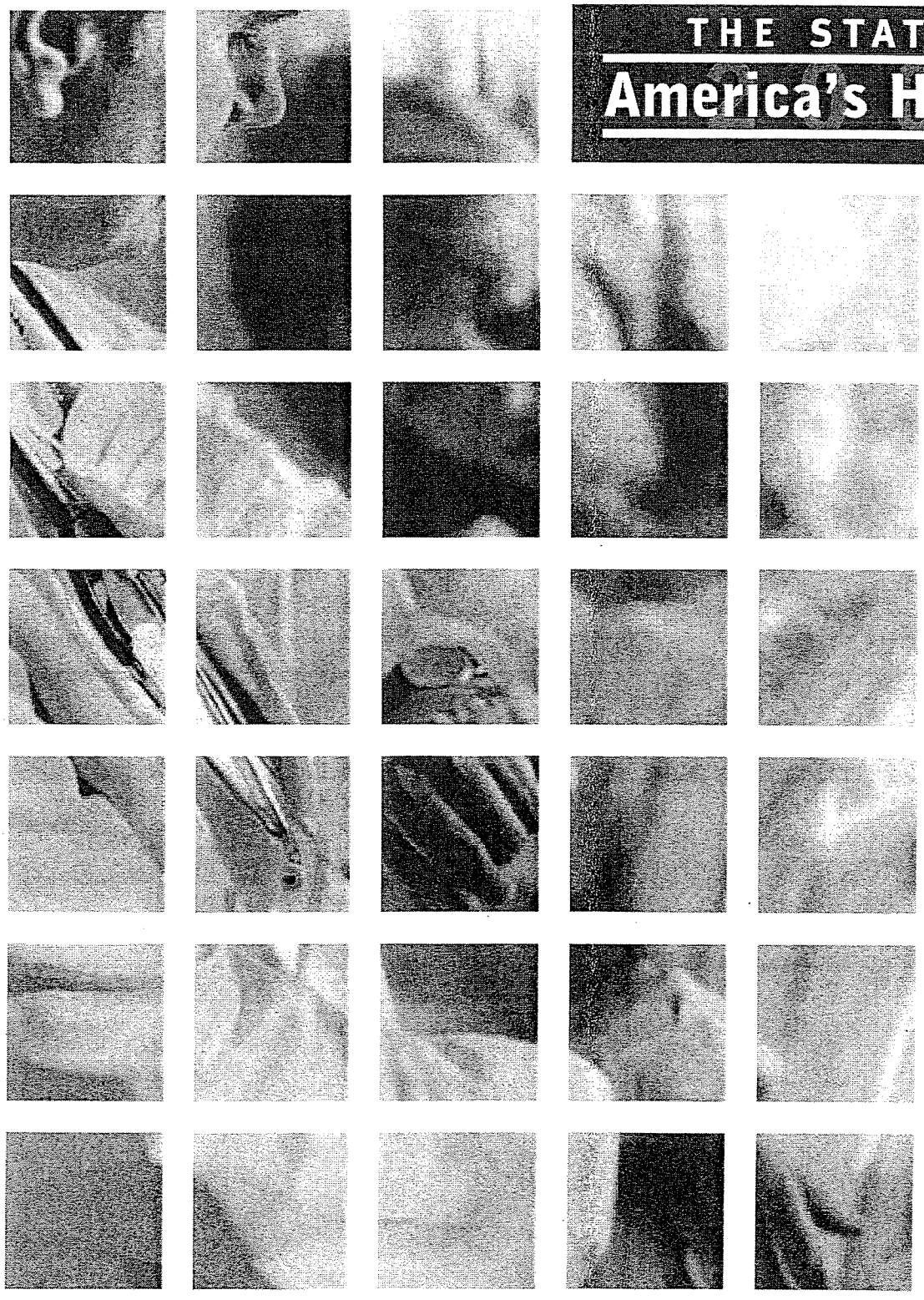
Taking the Pulse

2005

THE STATE OF America's Hospitals



American Hospital Association

Executive Summary

Every day hospitals confront many challenges that make it harder to keep the promise of caring and curing. The continually changing environment for hospitals at the local, state and federal levels makes it critically important to continuously assess the ability of hospitals to meet the health care needs of their communities.

The State of America's Hospitals: Taking the Pulse, a survey of our nation's community hospitals, illustrates hospitals' daily challenges:

- Continued high vacancy rates for health care professionals are affecting patient access to services. Hospitals reported that it has become even more difficult in the past year to recruit nurses (40%), pharmacists (38%), imaging (33%) and lab (31%) technicians.

- Sixty-nine percent of urban hospitals and 33 percent of rural hospitals report that emergency departments (EDs) are "at" or "over" capacity.

- A majority of urban hospitals (70%) and teaching hospitals (74%) experienced periods of ED diversion in the past year. Nearly one in six urban hospitals responding experienced diversion more than 20 percent of the time.

- The number one reason cited for ED diversion was lack of critical care capacity (44%) followed by ED overcrowding (23%) and lack of general acute care beds (13%).

- Forty-one percent of hospitals report that they have lost specialty coverage for a period of time in the last 24 months, and cite uncompensated care and liability concerns as their top reasons.

- The professional liability insurance crisis continues — 30 percent of hospitals in the American Medical Association-designated crisis states reported increases in liability insurance costs of 50 percent or more.

- Hospitals experienced double-digit increases in expenses for pharmaceutical products, and a seven to nine percent increase for medical supplies and devices.

- Of responding hospitals, 30 percent reported physician-owned limited-service hospitals operating in their area.

These and other problems facing hospitals must be addressed now to protect access to health care for future generations.

Background and Survey Methodology

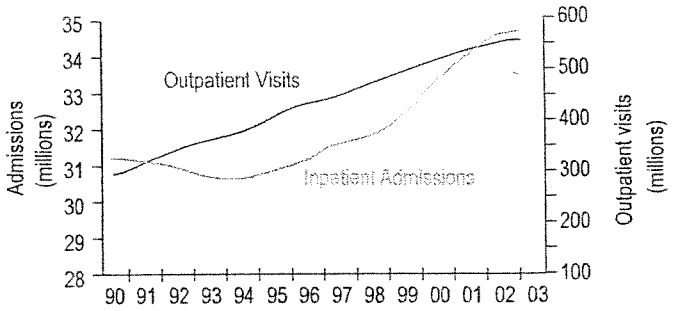
Background

Hospitals are the cornerstone of our health care system – a system that has contributed to longer and better lives for Americans. Studies show that a person born in 2000 can expect to live more than three years longer than one born in 1980. But these advances have increased the demand for hospital care and the costs to provide that care.

Since the Balanced Budget Act of 1997, the financial status of hospitals has declined. In 2003, nearly one-third of hospitals lost money overall and nearly 60 percent lost money caring for Medicare and Medicaid patients. With more than 45 million Americans lacking health insurance coverage, hospitals provided nearly $25 billion of uncompensated care in 2003. Hospitals and other health care providers, however, remain a prime target for policy-makers looking for ways to cut the federal deficit, projected at $331 billion in 2005.[1] And Medicare and Medicaid already pay substantially less than the cost of caring for patients they cover, and the shortfall is growing.

The demand for hospital care is rising.

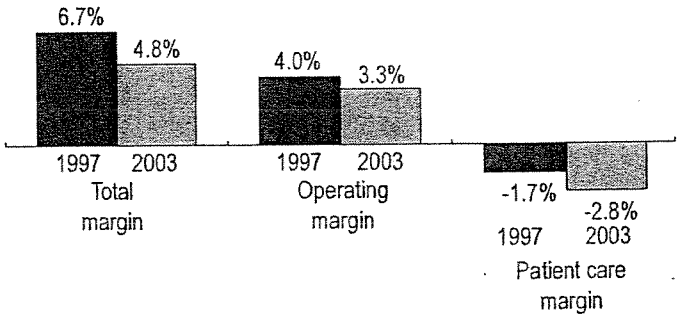
Inpatient admissions and outpatient visits, 1990 - 2003



Source: 2003 AHA Annual Survey

Hospital total margins are down 34 percent from pre-Balanced Budget Act levels.

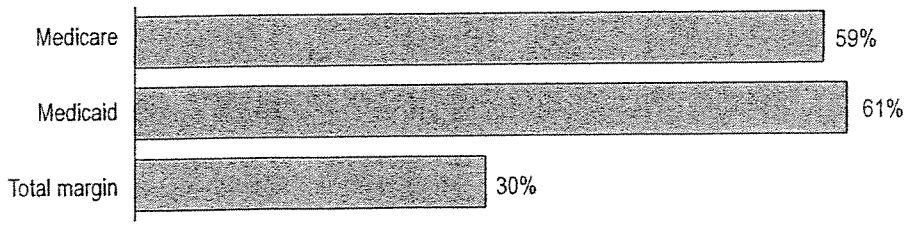
Total, operating and patient care margins,1997 (pre-BBA) vs. 2003



Source: 2003 AHA Annual Survey

The majority of hospitals lose money serving Medicare and Medicaid patients, while nearly a third lose money overall.

Percent of hospitals losing money, 2003



Source: 2003 AHA Annual Survey

But rising demand and fragile finances are only part of the picture. The following report documents other challenges that go much deeper:

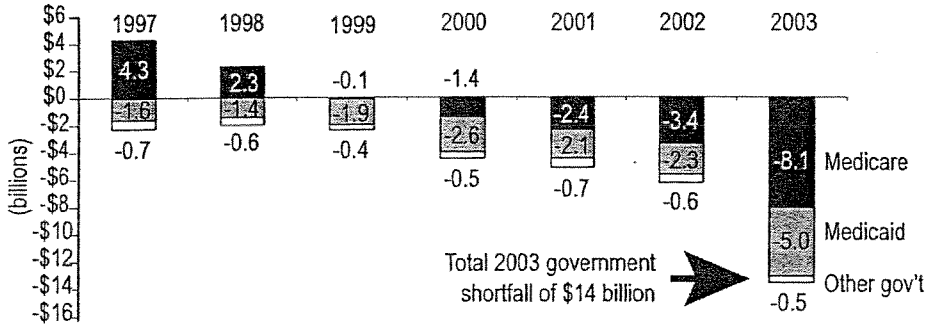
- Hospitals face workforce shortages that are projected to reach crisis proportions in the coming decades.
- Our nation's overcrowded EDs provide evidence that rising demand comes at a time of constrained capacity.
- Specialty coverage in hospital EDs is a growing concern as physicians face reimbursement pressures and have increased opportunities to practice in other settings, without the responsibilities of ED on-call duty.
- The costs to hospitals for professional liability insurance, pharmaceuticals and other supplies continue to skyrocket.
- Physician-owned limited-service hospitals raise conflict of interest concerns and threaten the stability of the health care system.

Survey Methodology

This report is based on Telling the Hospital Story, a 2005 Survey of Hospital Leaders sent to approximately 4,800 community hospital CEOs via e-mail and fax in February 2005. Unless otherwise specified, data is reflective of this time period. 700 responses were received.

Growing government shortfalls put the financial health of hospitals at risk.

Hospital payment shortfall relative to costs,
Medicare, Medicaid, and other government programs, 1997 - 2003



Source: 2003 AHA Annual Survey

SURVEY FINDINGS

I. Workforce

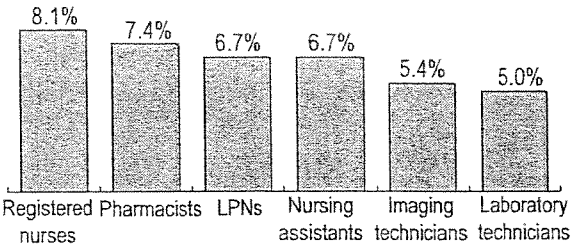
Health care is about people taking care of people. But the supply of hospital caregivers and other workers is not keeping pace with the demand for hospital care. As of January 2005, hospitals had an estimated 109,000 vacant positions for registered nurses (RN).[2] That is, 8.1 percent of RN positions, both full-time and part time, were vacant in December 2004 (Chart 1). Many hospitals report that it has become even more difficult in the past year to recruit nurses (40%), pharmacists (38%), imaging (33%) and lab (31%) technicians (Chart 2). Staff shortages can have a negative impact on access to health care services (Chart 3).

Rising unemployment in other sectors has led some to return to hospitals for employment, temporarily easing the shortage for some types of workers. But those re-entering the hospital workforce tend to be older and closer to retirement, making the long-term projections still look grim.

The health care workforce – particularly the RN population – is aging and retiring. Enrollment in health education programs has been declining as people – especially women – face an expanded range of employment options. The Health Resources and Services Administration now projects a shortage of one million RNs by 2020. This suggests that only 64 percent of the projected demand will be met.[3]

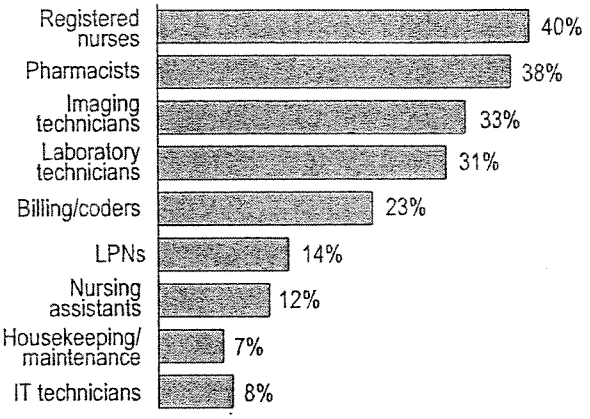
Hospitals face workforce shortages in key caregiving professions...

Chart 1: Vacancy rates for selected hospital personnel, December 2004



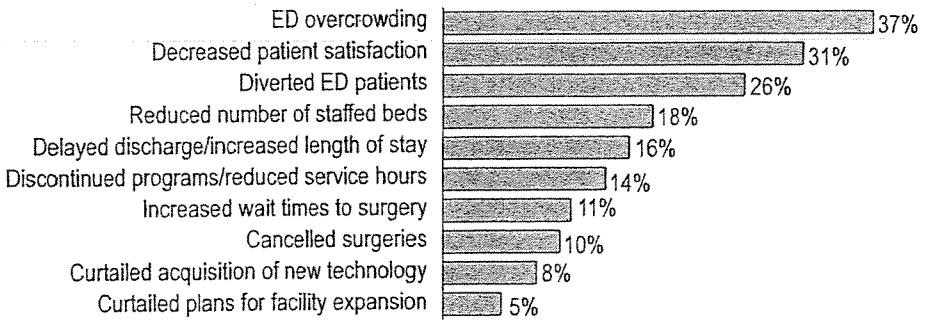
... and recruitment efforts are increasingly difficult.

Chart 2: Percent of hospitals reporting recruitment more difficult in 2004 vs. 2003



Staffing shortages are affecting patient care.

Chart 3: Percent of hospitals reporting service impacts of workforce shortage, 2004



SURVEY FINDINGS

II. Hospital Emergency Department Diversions and Physician Specialty Coverage

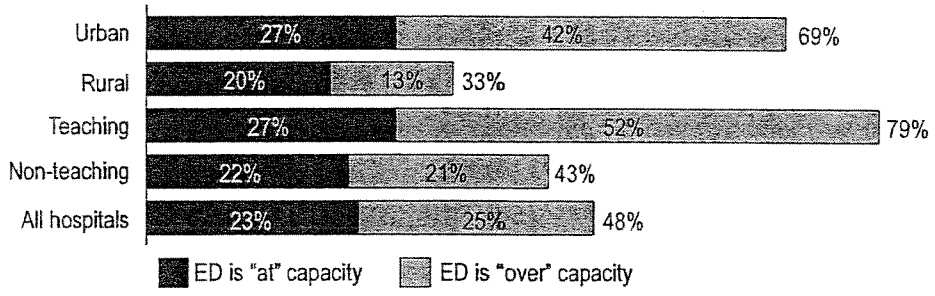
The hospital ED is the entry point for care not only for those with more immediate acute conditions like heart attacks, strokes and injury, but also for those with nowhere else to turn for any level of care – from ear infections to major trauma. In 2003, community hospitals responded to more than 111 million ED visits.[4]

From 1993 to 2003 demand for ED care rose by 20 percent, while the number of EDs declined by 9 percent.[5] This trend led to a 31 percent increase in visits per ED.[6] In 2005 nearly half of hospitals reported that they were "at" or "over" capacity (Chart 4).

The problem of ED overcrowding and diversion is most evident in our nation's urban and teaching hospitals (Chart 5). Diversion, however, is not an option for many rural hospitals that may be the only access point for care in their communities.

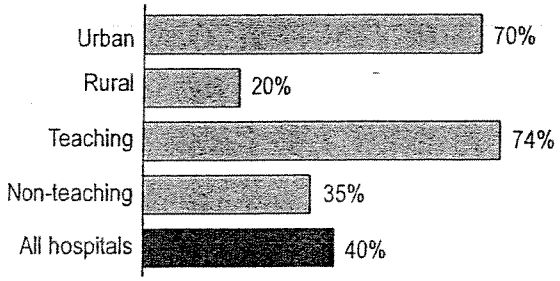
Most EDs are "at" or "over" capacity...

Chart 4: Percent of hospitals reporting ED capacity issues by type of hospital



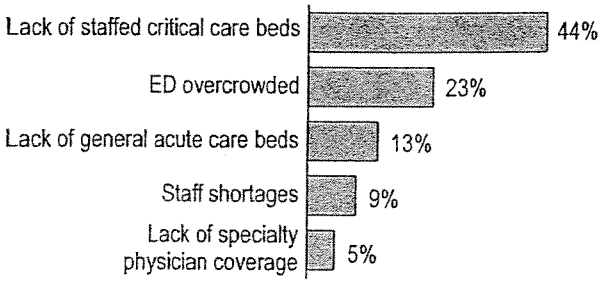
... and a majority of urban and teaching hospitals experience time on ED diversion...

Chart 5: Percent of hospitals reporting periods of ED diversion in last 12 months



... most often caused by a lack of staffed critical care beds.

Chart 6: Percent of hospitals citing factor as number one reason for ambulance diversion, January 2005



Lack of critical and acute care beds, ED overcrowding and staff shortages are most often cited as the number one reason for ambulance diversion (Chart 6).

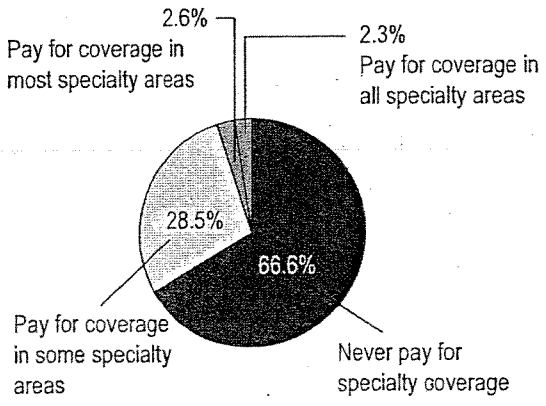
In January 2005, nine percent of urban hospitals reported being on diversion more than 20 percent of the time, and for 46 percent of hospitals the problem has deteriorated since 2002 (Chart 7).

In addition to overcrowding and ambulance diversion, hospitals are experiencing difficulties in obtaining specialty coverage for the ED. Forty-one percent of hospitals reported that they lost specialty coverage for a period of time over the last two years. For hospitals that lost specialty coverage, the most often cited reasons were uncompensated care, liability concerns, and physicians who retired or left the community (Chart 8).

To retain ED coverage, hospitals increasingly must pay specialists to be on-call. Thirty-three percent of hospitals reported that they are paying for "some" to "all" specialty coverage (Chart 9).

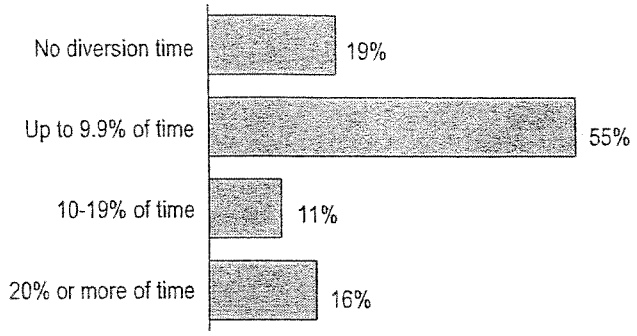
Nearly a third of hospitals now pay some physicians for specialty coverage.

Chart 9: Frequency of paying for specialty coverage in ED



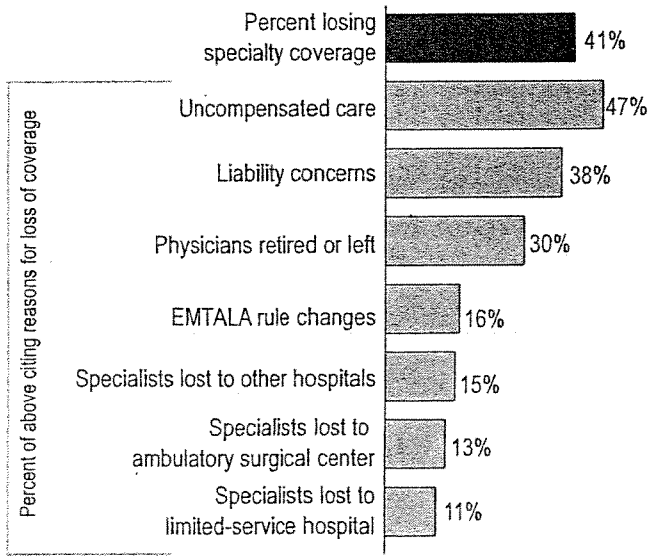
Nearly one in six urban hospitals experienced diversion more than 20 percent of the time.

Chart 7: Percent of time on diversion, urban hospitals in Janurary 2005



41 percent of community hospitals have lost specialty coverage in the emergency department for a period of time.

Chart 8: Percent of hospitals losing specialty coverage for any period of time in the last 24 months and reasons cited



SURVEY FINDINGS

III. Professional Liability Coverage

Finding affordable professional liability coverage is a growing concern for health care providers. Hospitals in American Medical Association-designated "crisis" states are seeing the largest increases in premiums for liability insurance. Nineteen percent of hospitals responding from crisis states reported increases between 50 and 99 percent in the last two years while more than 11 percent said they have seen an increase of double or more (Chart 10).

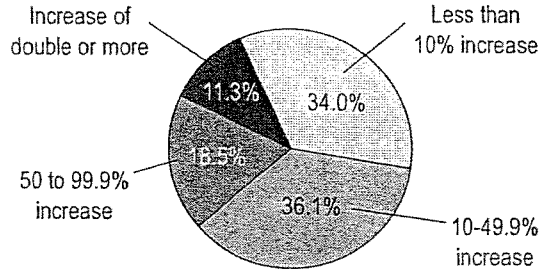
Physicians in high-risk specialties like obstetrics/gynecology and neurosurgery are most affected. In response to rising premiums for liability insurance, some physicians are curtailing services (e.g. not providing emergency call coverage or no longer delivering babies), while others are retiring early, moving to states with professional liability reform or simply abandoning their practices all together (Chart 11).

For hospitals, this can have a negative impact on their ability to provide health care services to patients. Survey respondents cited obstetrics (57%), neurosurgery (35%), and emergency care (32%) as the services most at risk (Chart 12).

In addition, efforts to reduce professional liability insurance costs have led nearly all hospitals in crisis states to take on more risk in the form of higher deductibles, reduced coverage, self-insurance, or, in rare cases, "going bare."

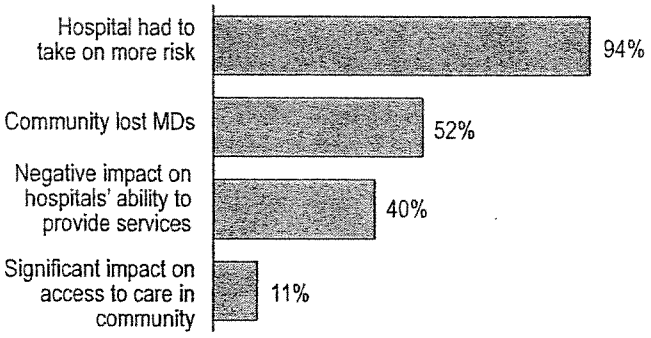
Hospitals face skyrocketing costs for medical liablilty coverage...

Chart 10: Percent of hospitals in crisis states* by rate of growth in professional liability expense over past two years



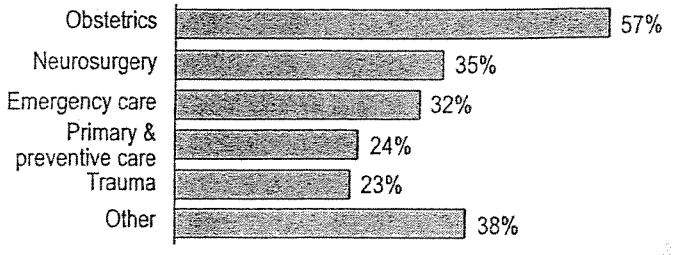
... affecting hospitals and the patients they serve...

Chart 11: Percent of hospitals in crisis states* reporting specific effects of increased professional liability expenses



... with the greatest impact on care delivery for obstetrics, neurosurgery and emergency services.

Chart 12: Percent of hospitals in crisis states* reporting negative impact on ability to provide specific services



* Crisis states identified by the American Medical Association as of March 2004 include: PA, WV, NV, MS, WA, OR, AR, MO, GA, FL, IL, NC, KY, CT, NJ, WY. Some of these states recently passed legislative reforms that have not been tested in the courts.

SURVEY FINDINGS

IV. Pharmaceutical and Supply Costs

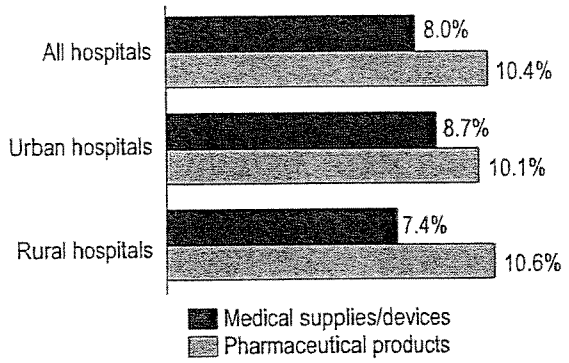
America's health care system continually offers new possibilities to meet the health care needs of our aging patients and growing population. But the rapid pace of innovation is accompanied by rising costs for pharmaceuticals, medical devices and other supplies.

Each year, newly introduced products add billions to the cost of caring. U.S. sales of Boston Scientific's Taxus Drug Eluting Stent – one new technology – are expected to hit $1.9 billion in 2005. The projected annual costs of implantable cardiac defibrillators for prophylactic use, just approved by Medicare for coverage this year, are $1 to $3 billion for the Medicare program alone.[7]

The substitution of new and more expensive products, rising prices for existing products, and more per patient use of drugs and supplies all have contributed to double-digit increases in costs to hospitals for pharmaceuticals and an increase of seven to nine percent for medical supplies and devices (Charts 13 and 14).

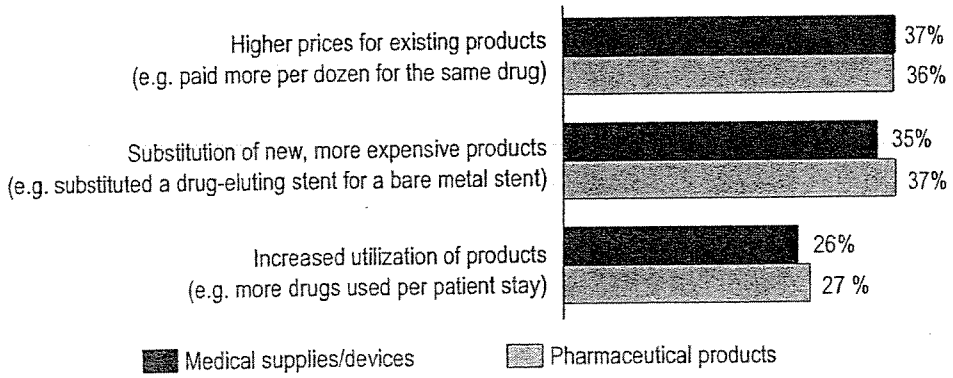
Hospitals face significant increases in the costs of pharmaceuticals and medical supplies...

Chart 13: Percent change in hospital expenses for pharmaceuticals and medical supplies/devices, 2003 to 2004



... with new products and rising prices being more important drivers than increased utilization.

Chart 14: Percent of hospitals reporting their number one reason for increases in costs for pharmaceutical products and medical supplies/devices



SURVEY FINDINGS

V. Physician-owned Limited-service Hospitals

Physician-owned limited-service hospitals are a growing trend, raising concerns about conflict of interest and the impact that these facilities have on the health care system as a whole. Thirty percent of hospital leaders reported the presence of a physician-owned limited-service hospital in their area. In addition, nearly 20 percent noted that at least one was currently in development in their area (Chart 15).

Research has shown that the economic incentives created by self-referral influence physician behavior. These behaviors include:

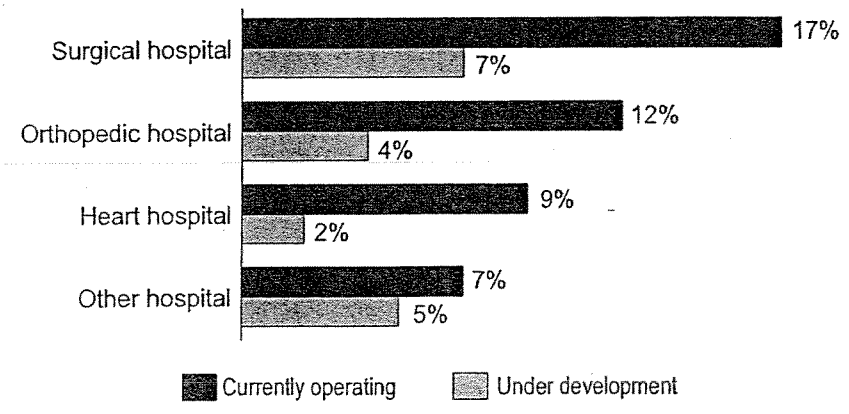
- Steering patients to the hospital in which the physician has an ownership interest;
- Cherry-picking well-paid services, better reimbursed patients, and less sick patients; and
- Increasing the number of referrals and driving up health care costs.

The hope that "competition" from these facilities would lead to greater efficiency and better quality has not been supported by the research. In fact, the Medicare Payment Advisory Commission found that physician-owned limited-service hospitals actually had higher costs.

Meanwhile, these facilities have drained critical resources from community hospitals, leading to cutbacks in patient services. In some communities, physician-owners have reduced or eliminated on-call coverage at the community hospital. Since the majority of physician-owned limited-service hospitals do not offer emergency services, this practice has jeopardized access to care for affected specialties for the community at large.

Many hospital leaders report that physician-owned limited-service hospitals are currently operating in their area and more are under development.

Chart 15: Percent of hospitals reporting limited-service hospitals operating or under development in their area



Source: 2005 AHA Survey of Hospital Leaders

Conclusion

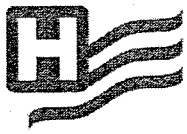
The state of America's hospitals is fragile. They face rising demand, constrained capacity and pressures from inadequate reimbursement. Our nation's health care system provides great promise to those who can access it, but current pressures put that promise at risk.

- **Worker shortages** will reach crisis proportions in the coming decades without action now.
- **Rising demand and constrained capacity** are causing emergency department overcrowding and ambulance diversion.
- **A medical liability crisis** threatens access to specialty care, especially in our nation's emergency departments.
- **Rapidly rising costs and payment shortfalls** threaten the financial stability of hospitals.
- **The tactics of physician-owned limited-service hospitals** strip critical resources from full-service hospitals and threaten access to care for the community at large.
- **Growing numbers of uninsured people** lack access to timely and appropriate care and strain the financial resources of the hospitals and others that care for them.
- **Payment shortfalls for Medicare and Medicaid** – government programs that support half of the care hospitals provide but pay less than the costs of caring – threaten financial stability.

These challenges must be addressed now to protect access to hospital care for future generations.

Endnotes

1 Congressional Budget Office, *Monthly Budget Review*, August 4, 2005.
2 AHA estimate based on total number of full and part-time RNs and current vacancy rate.
3 Biviano M., Fritz M., Spencer W., What is behind HRSA's projected supply, demand and shortage of registered nurses?, National Center for Health Workforce Analysis, Bureau of Health Professions, HRSA and Dall T. The Lewin Group. September 2004.
4 AHA 2005 Hospital Statistics
5 AHA Trendwatch Chartbook 2005. www.aha.org
6 Ibid.
7 Neumann PJ. Medicare National Coverage Decisions: How is CMS Doing? Presented at National Health Policy Conference. February 2005.



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