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 ...

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**

➢ Executive Sessions ... ES
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➢ Public Hearings ... PH
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INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

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**

➢ Hearing Records ... HR (bills and resolutions)
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➢ Miscellaneous ... Misc

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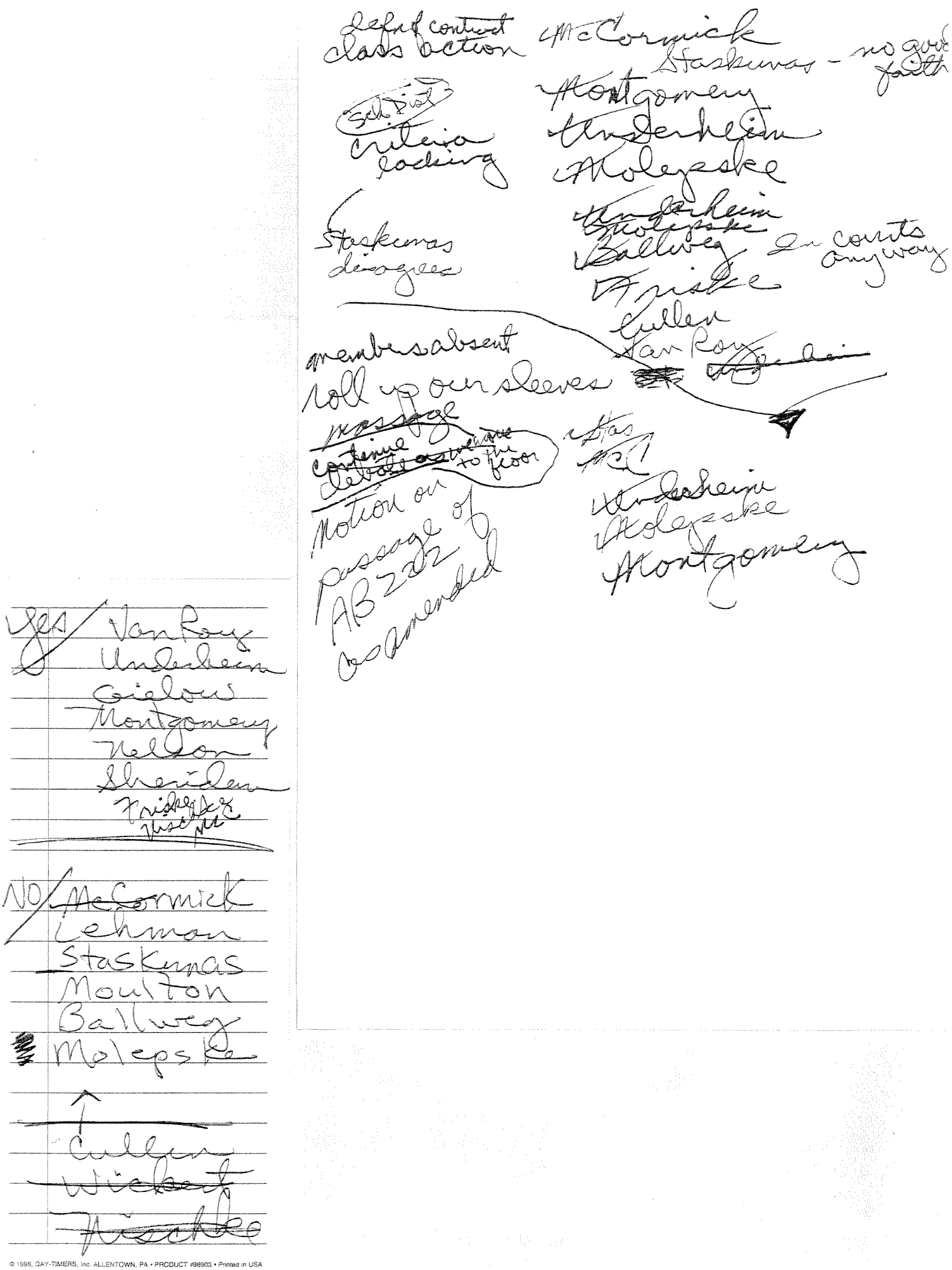
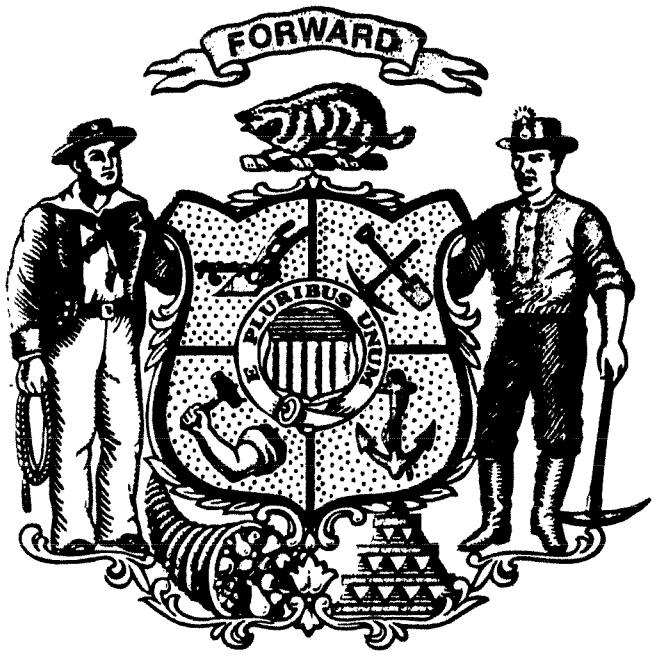
(un-dated documents)

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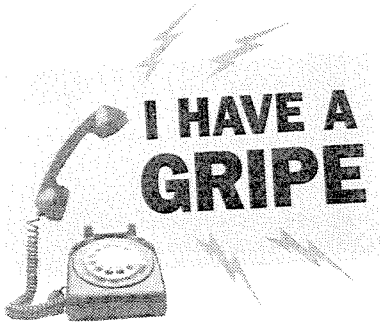


Q. This column has had several questions dealing with cleaning up the banks of the Fox River downtown. Gee whiz, what a surprise that no one's cleaned it up. My question is this: Are downtown property owners paying for cleaning up the river or does the cost to clean up the river downtown fall under a tax incremental financing district and we pay?

A. It takes a city, a state agency and volunteers to maintain the Fox River through Waukesha.

But there is no city program where property owners are assessed for cleaning up the river, said Paul Feller, Waukesha director of public works. Nor is there a TIF district set up to cover cleanup costs.

The river is a resource under the jurisdiction of the state Department of Natural Resources which runs through the city.

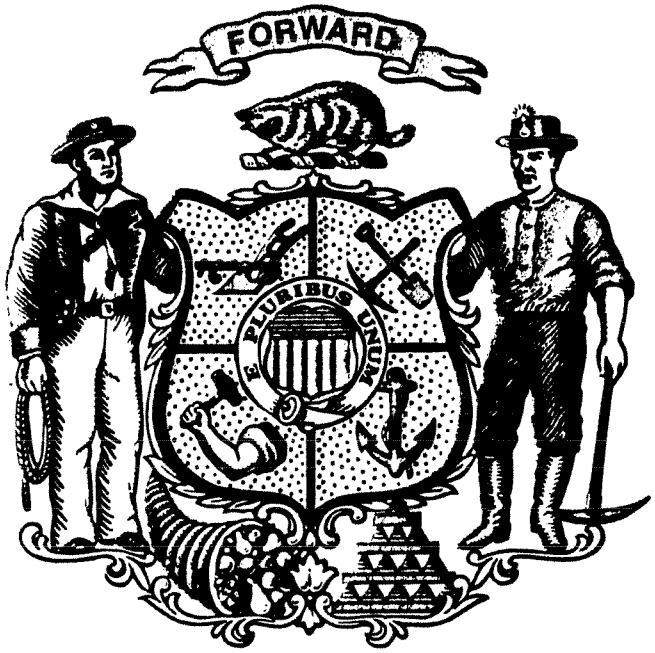
The only cleanup done on a regular basis is when a team of volunteers, including local individuals, companies and other organizations, teams up once a year to clean up the river, Feller said.

"Beyond that, it's something the city employees clean up as needed," Feller said.

The city employees' salary come from city budgets, "but we don't spend a lot of time doing cleanup" because of that annual volunteer project, Feller said.

DO YOU HAVE A GRIPE?

Call Terrie Peret at 513-2664 and leave your gripe on voice mail, e-mail her at tperet@conleynet.com, or send it to "I have a gripe" c/o The Freeman, P.O. Box 7, Waukesha, WI 53187. We're looking for ideas from throughout Waukesha County.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The Crisis in Mammography: Supply and Demand

More women are getting mammograms every year. This is occurring for two reasons: an aging U.S. population and thus more women over age 40 — the recommended age for initiation of breast cancer screening — and a greater proportion of women over 40 getting screened. Ironically, as the demand for mammography is increasing, the supply appears to be dwindling. Due to a growing shortage of radiologists who specialize in reading mammograms and a shrinking pool of available mammography screening facilities, accessing mammography-screening services has become more difficult for American women.

Average waiting times for women seeking first-time mammograms in the United States have been on the rise in recent years, a sign that breast cancer screening facilities are operating at or near full capacity. Reports vary but in major metropolitan areas such as New York City, patients say they are waiting an average of more than 40 days for first-time mammograms—an increase from the 14-day average waiting period five years earlier. Women in parts of Florida and California report having to wait three-to-five months for a first-time screening. These delays are occurring where mammography centers have closed or where there is a scarcity of personnel who perform and/or interpret mammograms.

Not Keeping Pace

More than 1.2 million women become eligible for recommended mammography screening each year but the number of breast imaging subspecialists who enter the profession annually is failing to keep pace with the demand. Although there are 20,000 radiologists in the U.S. who can interpret mammograms, only about 2,000 radiologists sub-specialize in the field of breast imaging. In one recent survey, more than two-thirds of radiologists acknowledged a reluctance to devote too much of their professional time to interpreting mammograms. Their reasons included:

- Fear of lawsuits
- High stress
- Low reimbursement for long hours
- Unattractiveness of the profession

In addition to a shortage of personnel, the number of mammography facility closures is outpacing the number of openings by more than two to one. As required by law, the FDA inspects every mammography facility each year. But the number of facilities they inspect is steadily declining. From 2000 to 2003, the number dropped from 9,400 to 8,600—an 8.5 percent decrease. The decline in available screening facilities is creating access problems, impeding women from getting routine mammograms.

The Malpractice Hurdle

Amidst this growing shortage of breast imagers, there has been a rise in the number of false-positive interpretations of mammograms, leading women to undergo unnecessary and painful biopsies. Some say the increase in false positive readings is due to more radiologists practicing defensive medicine. Malpractice litigation has become a major concern for breast imagers. According to the Physicians Insurers Association of America, breast cancer leads to more malpractice claims than any other medical condition, usually due to delayed diagnosis. It is second only to neurological impairment in newborns in terms of paid claims. Radiologists account for the largest proportion of paid claims involving breast cancer, and studies show that an increasing percentage of claims related to breast cancer are being filed against radiologists who interpret mammograms. The escalating cost of malpractice insurance for radiologists who read mammograms has made it difficult to attract newcomers to the profession.

Just as there are no simple cures for the malpractice liability crisis facing physicians across the United States, there is no straightforward solution to the particular legal vulnerability of radiologists who interpret mammograms. Instead of exploring risk management strategies that might reduce a radiologist's exposure to lawsuits, this report recommends a variety of measures aimed at reducing the likelihood of a missed diagnosis.

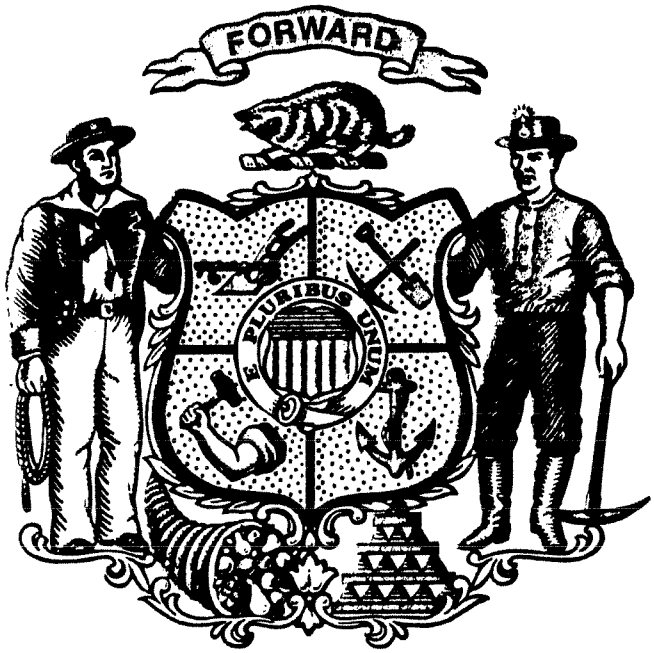
Some warn that this scarcity of breast imagers is leading to a crisis that could threaten the advancement of breast cancer detection and diagnosis. A shortage of screening personnel means not enough experts to assess and adopt promising technologies that could improve health outcomes for women. There also is a dire need for more radiologists in research to refine, test and disseminate new technologies. Right now, there is a dearth of radiological researchers to conduct trials and investigate new approaches to breast cancer detection.

What Steps Can Help Alleviate The Problem?

This crisis in capacity has prompted some health professionals to demand a major reorganization in the way the U.S. health system delivers screening services to women to increase access and improve quality. Many institutions, including the Air Force, have adopted a variety of short-term measures to meet their needs. This includes enlisting retired radiologists, relying on off-site moonlighters, or using teleradiology. But more long-term solutions are needed, especially for the supply of radiologists who specialize in breast imaging, which are in much shorter supply than general radiologists.

One idea that many embrace to alleviate shortages and reduce workloads for radiologists is to train non-physicians or physician extenders. They could be trained to pre-screen mammograms for the presence or absence of abnormalities or to double-read mammograms under the supervision of certified breast imaging specialists.

This already is being tried in other countries, such as the United Kingdom, where it appears to be effective. Preliminary studies have shown that the sensitivity, specificity, and accuracy of interpretations obtained by these non-physicians were comparable to that of a radiologist. In addition, the women who have been asked don't object to the practice.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Actuarial Memorandum

Estimating Savings Attributable to Certain Professional Liability Reform Proposals In Massachusetts

Important Limitations

Milliman's work was prepared for, and to be relied on only, by the Massachusetts Medical Society. Milliman does not intend to benefit any third party recipient of its work product. Milliman recommends any such third party be aided by its own actuary or other qualified professional when reviewing the Milliman material. This document must be distributed only in its entirety.

Introduction

I, William Murphy, FCAS, MAAA, was retained by the Massachusetts Medical Society to evaluate the potential savings to medical professional liability costs that might accrue as a result of proposed changes in the way medical professional liability claims are paid and adjudicated. While the proposals would not directly affect negotiated settlements, it is well understood by claims professionals that limits on recoveries and changes in the formal adjudication process are likely to affect the claim settlement process, and I have considered this potential for savings in claim settlements as well.

The purpose of this memorandum is to outline my professional conclusions and describe how I arrived at them.

Background

We have reviewed and evaluated five proposed changes, which are set forth in the Appendix. The proposals relate to the following specific medical professional liability cost issues.

- Imposing a cap of $500,000 on non-economic damages
- Changing the rate at which pre-judgment interest accrues
- Allowing future collateral sources to be considered when awards are determined
- Requiring periodic payment of certain future damages upon request of either party to the claim
- Eliminating joint and several liability

The medical professional liability costs examined in this document are those specifically related to the predominant payers of such costs, i.e., insured and self-insured physicians, surgeons and hospitals. Savings that may accrue to other health care providers have not been evaluated.

Estimates of savings are intended to apply to the total costs borne by medical care providers and their insurers, i.e., indemnification paid to claimants, together with defense and other administrative expenses. Estimated savings are in relation to costs as they would likely exist without the changes.

The relationship between estimates of medical professional liability costs and insurance prices is complex. As such, estimates of cost savings should not to be confused with predictions of future changes in insurance premiums. It is reasonable to expect, however, that if the projected savings are realized, future malpractice insurance premiums should ultimately be commensurately lower than they otherwise would have been.

These estimates are intended to apply to acts in 2003 that may give rise to medical liability actions. The estimated savings may not be realized immediately, depending on how the changes are implemented by the courts.

There is uncertainty in all actuarial projections. The uncertainty in these estimates of cost savings is increased due to the inability to anticipate how the interpretation of new legislation will differ from that of my own, and a lack of applicable data in some circumstances. The effects of these uncertainties are largely unquantifiable. Some of the more significant uncertainties that can reasonably be quantified are shown in the following sections of this memorandum.

The proposed changes will be subject to developments in case law, and some features of the proposed reforms may not ultimately be implemented as intended. The estimates contained in this memorandum assume all of the proposed changes are enacted and operate as intended after all case law is developed. The estimates incorporated Massachusetts-specific data sources where they were available, but relied on data from other states where necessary, primarily Florida and Texas. Where appropriate, these data were judgmentally adjusted to reflect Massachusetts-specific information known to me.

Summary of Findings

The following Tables summarize our best estimates of the cost savings associated with the proposed changes. While the reform proposals are believed to reduce costs associated with the payment of claims (i.e., indemnity costs), other costs, such as those of administration and claim defense, are assumed to be unaffected by the reforms, thereby resulting in a smaller savings to total costs than to indemnity costs alone.

Table 1 shows our best estimates of savings associated with each of the individual reforms.

Table 1

Proposed Reform	Estimated Savings to Indemnity Costs	Estimated Savings to Total Costs
$500,000 Non-Economic Cap	18.3%	12.7%
Pre-Judgment Interest	11.8%	8.2%
Future Collateral Sources	6.6%	4.6%
Periodic Payments	6.6%	4.6%
Joint and Several Liability	4.7%	3.3%

These best estimates are subject to uncertainty. Additional information regarding high and low savings scenarios is contained in the following sections. Estimates outside of our ranges may also be reasonable. None of our estimates should be considered the highest or lowest of possible outcomes.

The combined effect of all the proposed changes is not necessarily equal to the simple accumulation of the individual benefits, because the saving associated with a reform is dependent on whether other reforms are also enacted. Table 2 shows the estimated effects of certain combinations of reforms.

Table 2

Proposed Reforms	Estimated Savings to Total Costs
Joint & Several Liability and Pre-Judgment Interest	10.8%
Non-Economic Cap and Joint & Several Liability	14.1%
Non-Economic Cap and Pre-Judgment Interest	20.5%
J&S, Non-Economic and PJI Combined	21.5%

We believe the estimated percent savings associated with the proposed mandatory periodic payment of damages and the change to the collateral source rules are largely independent of other reforms that may be enacted. We therefore estimate the total savings from the enactment of all reforms to be approximately 25% to 30%.

We have estimated cost savings using data and reasonable assumptions. There are likely to be additional non-quantifiable cost savings that would derive from these proposals. A reduction in potential recoveries will reduce the incentive to bring marginal claims, saving defense costs and perhaps loss payments. This is particularly true regarding the proposal to limit awards for non-economic damages, the most unpredictable component of jury awards. With the incentive of obtaining a mega-award removed, claimants and their attorneys would presumably be less inclined to pursue cases of questionable liability. A $500,000 cap on non-economic damages would also moderate future cost increases, effectively producing increasing savings over time.

Further, we have assumed that no additional payments are made in excess of applicable insurance policy limits (i.e., no uninsured or "out of pocket" payments). To the extent such recoveries are currently made from individual physicians or others, our estimates of savings will be understated. No attempt has been made to quantify any of these additional benefits in this memorandum.

Sections 1 through 5 describe the methods and assumptions used to derive these estimates.

Pre-Judgment Interest

Brief Description of Change[1]

Change the rate at which pre-judgment interest accrues from 12% per annum to a rate related to the yield on 12 month Treasury bills.

Method of Analysis

While this change is strictly applicable only to claims paid by reason of a trial verdict, claims professionals believe that this change will also affect negotiated settlements. Pre-judgment interest is likely to weigh heavily in the settlement of claims where the likelihood of a successful defense is small, and may have no effect on the settlement of claims for which the likelihood of successful defense is great, or for claims settled without suit. We therefore make allowances for different categories of claims.

The average duration between the time a claim is made and the time the claim is resolved is estimated based on Massachusetts data. We do this broadly in three categories. Small, fast closing claims are assumed to be unaffected by the change in rules. Claims resulting in a trial verdict are assumed to be fully affected by the change, subject to policy limits, whereas suits that are resolved as a result of settlement negotiations are assumed to realize 50% of the potential savings.

We use Monte Carlo simulation techniques to measure the difference in interest accrued at 12% and at selected one-year Treasury bill yield rates. Individual claims are simulated according to the assumptions above, and calculated interest amounts are subject to the effects of policy limit capping. The difference between the limited outcomes using the two interest rates is equal to the estimated indemnity savings.

As yields on one-year Treasury bill rates are currently low (approximately 1%) compared to historic average yields (5%-6%), the estimated savings is likely to be less in the future than it would be today because interest rates are likely to increase. We have therefore done calculations using interest rate assumptions of 2% to 5% for our high and low savings scenarios respectively, recognizing that interest rates are unlikely to return to their long-term average any time soon. Should yields remain at their current low levels, actual savings could be greater than we have calculated. Should one-year Treasury bill rates increase to more than 5%, savings will likely be less than we have calculated.

After the savings to indemnity is estimated at various interest rates and durations of claim settlements, we adjust for those elements of a provider's costs that are not likely to be affected by this change, e.g., insurer administrative and overhead costs and the cost of

[1] See Appendix for actual proposed change.

defense. This results in a smaller percentage savings to total costs than to indemnity costs only.

Important Assumptions

- The change in pre-judgment interest rules will result in a savings for all claims that result in a verdict or finding, but only partial savings will be achieved on settlements.
- The time it takes to dispose of a claim either by settlement or trial does not change significantly as a result of any of the proposed changes that may be adopted.
- Recoveries of pre-judgment interest are fully limited by insurance policy limits.

Periodic Payment of Future Damages

Brief Description of Change[1]

The change would allow either party to request that awards for future damages in excess of $50,000 be paid in periodic payments determined by the court. Payments would be discontinued on the death of the plaintiff, except where the plaintiff owed a duty of support, by law, to another individual. In that case, money damages awarded for loss of future earnings shall not be reduced or terminated.

Method of Analysis

Using publicly available data, estimate incurred loss separately by age of claimant and severity of injury. Select durations of periodic payments of 0 years, 5 years, 10, 20 and life expectancy for each age and injury category. For each duration, distribute the incurred loss in equal amounts. Make interest rate assumptions both for the accrual of interest on outstanding balances and for the present economic value of future payments. Low assumption: assume no spread between the two rates. High assumption: assume a spread of 4%.

Modify each payment stream to reflect mortality assumptions commensurate with the severity of injury, making provision for continued future earnings upon the claimant's death using life annuity calculations. Calculate the present value of each of the payment streams. Calculate the percentage difference between the originally assumed incurred loss and the present value of the hypothetical payment streams to get an estimate of savings for each of the claimant age, severity of injury and payment duration categories.

Judgmentally select weights to apply to the payment duration categories (weights for the claimant age and severity of injury categories can be estimated from publicly available data). The judgmental weighting will assume, for example, that a minor with a serious permanent injury will be more likely than most to be awarded lifetime benefits, and an older individual with a temporary injury will be more likely to be awarded a one-time payment (0 year duration). Calculate the weighted average of the indicated savings for each category to get an estimate of overall savings to future indemnity costs.

Assume no savings to past damages, defense costs and other expenses not affected by the periodic payment of future damages. Calculate the overall savings on total costs.

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[1] See Appendix for actual proposed change.

Important Assumptions

- Periodic payments will be requested and granted in most cases that involve significant future damages.
- Future damages will be paid out in equal installments over some period of time, varying by type of injury and age of claimant. We have judgmentally selected the likelihood of various payment durations.
- The sum of the court-scheduled payments will equal the original award plus accrued interest.
- Negotiated settlements will experience percentage savings similar to those experienced in court decisions.
- Mortality assumption – U.S. 1990 Population Mortality. Permanent Major and Permanent Grave claimants are assumed to have a 30% mortality deficit.
- 50% of non-economic damages are considered to be future damages.
- Economic and non-economic damages in Massachusetts are distributed similarly by severity of injury and claimant age to the proportions indicated by Florida and Texas data.

Summary Exhibit
Estimated Savings Due to
Periodic Payments of Future Damages

		Low Scenario		High Scenario	
		Effect on Indemnity	Effect on Total Cost	Effect on Indemnity	Effect on Total Cost
1)	Effect of Periodic Payment of Future Damages	2.3%	1.6%	10.9%	7.6%

Future Collateral Sources

Brief Description of Change[1]

The change would allow evidence of future recoveries from collateral sources to be introduced into evidence when determining damages in a suit.

Method of Analysis

There are two elements of damages that are most likely to benefit from collateral source recoveries -- medical and wage loss. These are analyzed separately.

We first estimate the portion of medical care that is paid for by so-called collateral sources. This includes all payers except Medicaid and out of pocket expenses. We then estimate percent of total indemnity loss attributable to medical costs, and in this case, the portion that is specifically attributable to *future* medical costs. We estimate that to be 9.7% of total indemnity (see attached exhibit).

Collateral sources related to wage loss are analyzed separately by severity of injury, and in the case of permanent injuries, by age of claimant. That is because wage loss as a function of total indemnity varies according to the severity of the injury, and collateral sources of recovery -- such as Social Security or other disability insurance -- are unlikely to be available to very young claimants. We estimate collateral source wage recoveries to approximate 2.6% of total indemnity.

Additional adjustments are needed to evaluate actual savings. We would expect a smaller degree of savings on settlements than verdicts, because future collateral sources are likely informally considered in current settlement negotiations. Secondly, as a practical matter, many state government institutions in Massachusetts subrogate against awards for damages. This will tend to reduce the savings by an amount that is probably not measurable. Finally, the statute has a provision that one year's worth of premium paid to obtain the collateral source benefit shall not be deducted from any award. All these facts tend to reduce the savings that might be obtained from the revised collateral source rule. Our estimate of the total likely savings on indemnity is 6.6%.

We then adjust the indicated savings to indemnity for those elements of a provider's costs that are not likely to be affected by this change, e.g., cost of defense, insurer administrative and overhead costs, etc. This results in an indicated saving on total costs of 4.6%.

[1] See Appendix for actual proposed change.

Important Assumptions

- Evidence as to the availability of future collateral sources of compensation will cause liability awards to be reduced by a corresponding amount.
- Subrogation by state agencies and workers compensation carriers will reduce the amount of savings ultimately realized.
- Only a portion of the percentage savings experienced by awards will be obtained in settlements.

Estimated Savings Due to Future Collateral Sources

1)	Percent of Medical Cost Payments Other than Medicaid and Self-Pay	79.0%
2)	Percent Medical Costs to Total Economic Costs	55.0%
3)	Percent Economic Costs to Total Indemnity	35.0%
4)	Percent Future Medical to Total Medical	64.0%
5)	Percent Future Medical Collateral Source Recoveries to Total Indemnity (1) x (2) x (3) x (4)	9.7%
6)	Percent Future Wage Loss Collateral Source Recoveries to Total Indemnity	2.6%
7)	Total Potential Future Collateral Source Recoveries to Total Indemnity (5) + (6)	12.4%
8)	Factor to Account for Reduced Savings on Settlements	75.0%
9)	Factor to Account for Subrogation by Collateral Source Payors	75.0%
10)	Factor to Account for One Year of Premium Exempt From Offset	95.0%
11)	Estimated Indemnity Savings Due to Consideration of Future Collateral Sources (7) x (8) x (9) x (10)	6.6%
12)	Percent Indemnity to Total Costs	70.0%
13)	Percent Saving to Total Costs Due to Future Collateral Sources (10) x (11)	4.6%

Sources

1) National Health Expenditures data
2) Florida medical malpractice database
3) Texas medical malpractice database
4), 5) Florida medical malpractice database
6) See Exhibit 2
8), 9), 10) Judgment
12) Massachusetts data and judgment

Estimated Savings Due to Future Collateral Sources -- Wage Loss

Injury	(1) Percent Distribution of Economic Loss	(2) Percent Wage Loss to Economic Loss	(3) Future Wage Loss to Total Wage Loss	(4) Estimated Collateral Recoveries on Future Wage Loss	(5) Future Collateral Wage Recoveries To Economic Loss	(6) Percent Economic to Total Loss	(7) Future Collateral Wage Recoveries To Indemnity
Temporary, Incl. Emotional Only	5.7%	19.7%	60.0%	25.0%	0.2%	20.0%	0.0%
Permanent Minor and Permanent Significant	20.2%	33.8%	70.0%	25.0%	1.2%	35.0%	0.4%
Permanent Major and Permanent Grave							
Age 19 and Over	39.3%	50.0% *	70.0%	25.0%	3.4%	40.0%	1.4%
Age 18 and Under	14.0%	50.0%	90.0%	0.0%	0.0%	40.0%	0.0%
Death	20.8%	68.7%	80.0%	20.0%	2.3%	35.0%	0.8%
	100.0%	48.9%				0.3445	2.6%

Sources

(1), (2) Florida malpractice claims database
(3), (4) Selected judgementally based on other studies
(5) = (1)*(2)*(3)*(4)
(6) Fla, Texas and judgement
(7) = (5)*(6)

Elimination of Joint and Several Liability

Brief Description of Change[1]

Currently, defendants in a medical malpractice liability action can potentially be held responsible for 100% of the amount awarded to the plaintiff if they have been found to have any liability. The change would limit a defendant's financial exposure to his/her proportionate share of the total award based on relative liability.

Method of Analysis

With joint and several liability, where multiple defendants share liability, there are greater resources available from which to seek recovery, i.e., recovery can be made from the total pool of all resources possessed by defendants with non-zero liability. If joint and several liability is eliminated, recoveries can be made only against individual defendants, up to their proportionate share of the total award.

To measure the difference in potential recoveries, we did a Monte Carlo simulation of 20,000 claims closed with payment. Based on available data, we were able to profile the number of defendants in a case. For example, we estimate that more than 40% of the time, there is exactly one doctor defendant, whereas nearly 10% of the time, there are exactly two doctor and one hospital defendants. We were also able to profile the distribution of policy limits separately for doctors and hospitals, and the distribution of percent liability separately for doctors and hospitals. Further, we were able to estimate the distribution of losses by size for an individual claimant, when all defendants are combined.

We randomly selected from these distributions according to their probabilities, first selecting a claimant's total loss, and then selecting the type and number of defendants, their policy limits and their respective liabilities.

Based on the outcomes of those simulations, we compared each individual insured's policy limits to his/her equitable portion of the total loss. This represented the non-joint and several outcome. We also compared the total loss to the sum of the policy limits available to all defendants with non-zero liability. This represented the joint and several liability outcome. The difference between the two was the indicated savings to the system for indemnity costs.

We adjust the indicated savings to indemnity for those elements of a provider's costs that are not likely to be affected by this change, e.g., cost of defense, insurer administrative

[1] See Appendix for actual proposed change.

and overhead costs, etc. This results in a smaller percentage savings to total costs than to indemnity costs only.

Important Assumptions

- The distributions of number of defendants and their respective liabilities derived from Texas data reasonably represent the patterns found in Massachusetts after judgmentally adjusting to reflect the likely impact of charitable immunity on Massachusetts hospital liabilities.
- The total recovery for a claimant from all defendants is roughly 50% greater, on average, than a recovery from an individual physician defendant.
- It is assumed that exhaustion of available policy limits will limit recoveries, and that uninsured losses to health care providers will not increase.
- The size of a claimant's award is independent of the number of defendants.

$500,000 Cap on Non-Economic Damages

Brief Description of Change[1]

This change would eliminate the waiver provision on the current cap under Massachusetts law and limit the maximum recovery per plaintiff for the non-economic portion of medical malpractice awards to $500,000 at all times, regardless of the number of defendants.

Method of Analysis

We simulated 20,000 claimant awards based on Massachusetts size of loss data. For each claimant award, we simulated the non-economic portion. This simulation was based on an analysis of Texas and other data that separately identifies the economic and non-economic portion of loss, adjusted to reflect our judgment that the proportion of non-economic loss to total loss is less in Massachusetts than it is in Texas. The non-economic portion of loss was limited to $500,000.

We then simulated a number of defendants for each claim, together with policy limits and proportionate share of liability for each defendant. The total loss, including the capped non-economic portion, was allocated among the defendants in proportion to their simulated respective liabilities, and policy limits were applied. The resulting sum of the losses was compared to the result of a similar calculation that did not cap the non-economic portion of the loss, to determine the savings on indemnity costs.

We then adjust the indicated savings to indemnity for those elements of a provider's costs that are not likely to be affected by this change, e.g., cost of defense, insurer administrative and overhead costs, etc. This results in a smaller percentage savings to total costs than to indemnity costs only.

This change will produce a one-time reduction in costs, but it will also decrease the rate at which future costs will increase. In effect, the savings from this change can be expected to increase over time if the cap is maintained at $500,000.

To the extent that potential recoveries are reduced, this may tend to discourage plaintiffs and their attorneys from bringing less meritorious claims, resulting in cost savings beyond that which we have projected. This is particularly true with respect to the limitation of non-economic damages because it removes the potential for very large awards that are not based on quantifiable measures, as are economic losses. A cap of this nature is likely to make the outcome of litigation more predictable for all parties.

[1] See Appendix for actual proposed change.

We have not quantified the savings that will likely accrue from these additional effects of the proposed changes.

Important Assumptions

- The proportion of non-economic to total loss is between 50% and 65% in Massachusetts.
- The effect of the cap on verdicts and judgments will translate into a similar percentage savings on settlements.
- The $500,000 limitation on non-economic loss applies to the entire judgment regardless of the number of defendants involved in the case.
- Awards for economic damages will not increase as a result of capping non-economic loss.
- Savings will be achieved on settlements and claims resolved by trial.
- The distributions of number of defendants and their respective liabilities derived from Texas data reasonably represent the patterns found in Massachusetts after judgmentally adjusting to reflect the likely impact of charitable immunity on Massachusetts hospital liabilities.
- The total recovery for a claimant from all defendants is roughly 50% greater, on average, than a recovery from an individual physician defendant.
- The current partial limitation on non-economic loss does not effectively reduce awards.
- The size of a claimant's award is independent of the number of defendants.

Summary Exhibit -- Savings Due to Capping Non-Economic Damages, Reducing Pre-Judgment Interest and Eliminating Joint and Several Liability

		Low Scenario		High Scenario	
		Effect on Indemnity	Effect on Total Cost	Effect on Indemnity	Effect on Total Cost
1)	Effect of Eliminating Joint and Several Liability	4.7%	3.3%	4.7%	3.3%
2)	Effect of Capping Non-Economic Damages at $500,000	14.8%	10.3%	21.7%	15.2%
3)	Effect of Changing Rate Used for Pre-Judgement Interest	9.7%	6.8%	13.8%	9.6%
4)	Combined Effect of 1), 2), and 3)	27.7%	19.4%	33.7%	23.6%

Proposed Change to Pre-Judgment Interest

Chapter 231 of the General Laws, as appearing in the 1994 Official Edition, is hereby amended by adding the following:

Section 60 M. In any action for malpractice, negligence, error, omission, mistake or unauthorized rendering of professional services, other than actions brought under section two of chapter two hundred twenty-nine, against a provider of health care, in which a verdict is rendered or a finding made or an order for judgment made for pecuniary damages for personal injuries to the plaintiff or for consequential damages, there shall be added by the clerk of the court to the amount of damages interest thereon, at a rate to be determined as set forth below rather than the rate specified in section 6B of chapter two hundred thirty-one, from the date of the commencement of the action even though such interest brings the amount of the verdict or finding beyond the maximum liability imposed by law. The rate of interest to be applied by the clerk shall be at a rate equal to the coupon issue yield equivalent, as determined by the secretary of the treasury, of the average accepted auction price for the last auction of fifty-two week United States treasury bills settled immediately prior to the date on which the verdict is rendered or finding made or order made.

Change to Effect Periodic Payment of Future Damages

Chapter 231 of the General Laws is hereby amended by adding after section 60K, the following new section:

Section 60L. In every action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider of health care where the court shall, at the request of either party, (a) Enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages. In entering a judgment ordering of the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages, the court shall require the defendant who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the defendant.
(b)(1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.

(2) In the event that the court finds that the defendant has exhibited a continuing pattern of failing to make the payments, as specified in paragraph (1), the court shall find the defendant in contempt of court and, in addition to the required periodic payments, shall order the defendant to pay the plaintiff all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.
(c) However, money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the plaintiff, but shall be paid to persons to whom the plaintiff owed a duty of support, as provided by law, immediately prior to his death. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.
(d) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the defendant to make future payments shall cease and any security given, pursuant to section (a) shall revert to the defendant.

Proposed Change to Collateral Source Rule

Section 60G of Chapter 231 of the General Laws as appearing in 2000 official addition is amended by striking in lines 10 and 11 the following: "prior to the judgment" and adding in lines 12 and 27 after the word "compensated" the following: replaceable, compensable or indemnifiable.

Proposal to Eliminate Joint and Several Liability

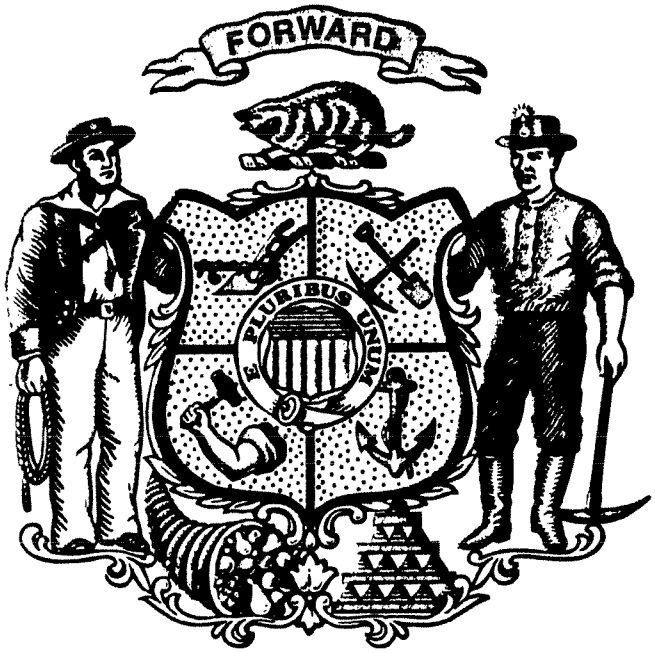
Chapter 231 of the General Laws is hereby amended by adding the following section:

Section 60N. In any action for malpractice, error, omission, mistake or the unauthorized rendering of professional services against a provider of health care, the liability of each defendant for damages shall be several only and shall not be joint. Each defendant shall be liable only for the amount of damages allocated to that defendant in direct proportion to that defendant's percentage of fault, and a separate judgment shall be rendered against that defendant for that amount.

Proposed Limitation on Non-Economic Damages

Chapter 231 of the General law amended by striking section 60H in its entirety and replacing it as follows:

In no action for malpractice, negligence, error, omission, mistake, or the unauthorized rendering of professional services, including without limitation sections under chapter 229, section 2, against a provider of health care, shall the amount of damages for pain and suffering, loss of companionship, embarrassment and other items of general damages exceed five hundred thousand dollars ($500,000). If two of more plaintiffs have received verdicts or findings of such damages in a total amount, for all plaintiffs claiming damages from a single occurrence, transaction, act of malpractice injury, or death which exceeds five hundred thousand dollars ($500,000), the amount of such damages recoverable by each plaintiff will be reduced to a percentage of five hundred thousand dollars ($500,000) proportionate to that plaintiff's share of the total amount of such damages for all plaintiffs. Such limit shall apply regardless of the number of persons liable jointly and/or severally for the said damages.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Effects of a Malpractice Crisis on Specialist Supply and Patient Access to Care

Michelle M. Mello, J.D., Ph.D.

David M. Studdert, LL.B., Sc.D.

Catherine M. DesRoches, Dr.P.H.

Jordon Peugh, M.A.

Kinga Zapert, Ph.D.

Troyen A. Brennan, M.D., J.D.

William M. Sage, M.D., J.D.

The lead:

During "malpractice crises," concerns are expressed that liability costs drive high-risk specialist physicians from practice, creating access-to-care problems. A mail survey of 824 surgical and other specialists in Pennsylvania found that the liability environment is having demonstrable effects on the supply of specialists and their willingness to perform high-risk procedures.

The survey, part of the Project on Medical Liability in Pennsylvania funded by The Pew Charitable Trusts, was published this month in *Annals of Surgery*.

Objective. To investigate specialist physicians' practice decisions in response to liability concerns and their perceptions of the impact of the malpractice environment on patient access to care.

Summary background data. A perennial concern during "malpractice crises" is that liability costs will drive physicians in high-risk specialties out of practice, creating specialist shortages and access-to-care problems.

Methods. Mail survey of 824 Pennsylvania physicians in general surgery, neurosurgery, orthopedic surgery, obstetrics/gynecology, emergency medicine, and radiology eliciting information on practice decisions made in response to rising liability costs.

Results. Strong majorities of specialists reported increases over the last 3 years in patients' driving distances (58%) and waiting times (83%) for specialist care or surgery, waiting times for

emergency department care (82%), and the number of patients forced to switch physicians (89%). Professional liability costs and managed care were both considered important contributing factors. Small proportions of specialists reported that they would definitely retire (7%) or relocate their practice out of state (4%) within the next 2 years; another third (32% and 29%, respectively) said they would likely do so. Forty-two percent of specialists have reduced or eliminated high-risk aspects of their practice and 50% are likely to do so over the next 2 years. **Conclusions.** Our data suggest that claims of a "physician exodus" from Pennsylvania due to rising liability costs are overstated, but the malpractice situation is having demonstrable effects on the supply of specialist physicians in affected areas and their scope of practice, which likely impinges upon patients' access to care.

INTRODUCTION

A recurrent theme in policy debates over medical malpractice "crises" is the effect of rising liability costs on patient access to care. Providers argue that the liability environment is not just a professional problem for doctors and hospitals, but also a grave public health problem, because liability costs drive physician specialists to leave practice or stop providing high-risk services (3). The Bush Administration has recently taken up this theme, reporting a "growing access crisis" in which "increasingly, Americans are at risk of not being able to find a doctor when they most need one (4)." Surgeons are at the leading edge of this debate because they are among those at highest risk for malpractice claims and most affected by rising insurance premiums.

In the current crisis as well as previous crises, empirical evidence offered in support of the "physician exodus" hypothesis has been scarce. The policy debate has been dominated by anecdotes and claims by medical professional societies (4,5). The General Accounting Office (GAO) recently investigated these reports in five "crisis" states and was unable to corroborate some of the claimed physician withdrawals and access problems (6).

To obtain additional data, we conducted a survey of Pennsylvania surgeons and other specialists in which we inquired about the extent to which liability pressures were causing respondents to exit the state, stop practicing, restrict the services they offer, or limit the types of patients they see. We also examined specialists' perceptions of changes in patient access to specialist care. We hypothesized that most specialists would report being heavily burdened by liability costs, but few would be committed to specific measures to reduce their costs or legal exposure; and to the extent that measures were taken, they would be concentrated among physicians in solo practice and physicians in the 5-county area around Philadelphia, where liability costs were highest.

Study Design

Researchers at the Harvard School of Public Health and Columbia Law School partnered with a professional survey organization, Harris Interactive, Inc., to design and conduct the survey. The design of the sample and survey questionnaire were informed by findings from a series of 41 in-depth key informant interviews conducted with representatives from medical specialty societies, county medical societies, hospitals, insurers, and government agencies in Pennsylvania in fall 2002.

Sample

Key informants identified 6 specialties (general surgery, neurosurgery, orthopedic surgery, obstetrics/gynecology, emergency medicine, and radiology) as being especially affected by the current liability crisis. A stratified random sample of 1,333 physicians in these specialties was drawn from the American Medical Association Physician Masterfile; one primary stratum consisted of 5 counties in southeast Pennsylvania which key informants identified as most affected by the crisis and the other consisted of all other counties. Within each stratum, specialists who were active in direct patient care at least 50% time according to Physician

Masterfile data were sampled. Sampling was proportionate by specialty except that neurosurgeons were oversampled to ensure adequate representation.

Survey Questionnaire

We developed a 6-page questionnaire using topics and response categories suggested by the key informant interviews. The questionnaire was pretested on 10 Pennsylvania physicians in the targeted specialties who were debriefed in cognitive interviews focusing on comprehension and appropriateness of question topics, wording, response options, and layout. After revision, the questionnaire contained 41 questions, including queries regarding perceptions of specialist supply and patient access to specialist care; likelihood of deciding to relocate, leave, or restrict their practice in response to liability concerns; insurance and malpractice claims experience; and demographic information.

Specialists' Personal Decisions to Leave or Modify Practice

Only a small proportion (less than 4%) of specialists indicated that would definitely relocate part or all of their practice time out of state within the next 2 years because of the cost of professional liability insurance; much larger proportions reported that they were very likely (12%) or somewhat likely (17%) to relocate (Table 2). Surgeons (general surgeons, neurosurgeons, and orthopedic surgeons) were significantly more likely than other specialists to report plans to relocate (F=4.28, p=0.002). Solo practitioners were most inclined to relocate and hospital-based physicians were least inclined (F=3.64, p=0.0004).

One third of specialists were at least somewhat likely to retire early or cease direct patient care in response to liability costs within the next 2 years, with 7 percent indicating that they would definitely do so (Table 2). Surgeons were more inclined to retire early than other specialists (F=3.72, p=0.01). The "solo practitioner" effect was again significant (F=7.01, p<0.0001), perhaps owing to the higher mean age of solo practitioners (54 years) relative to specialists in other settings (49 years) (t=-5.72, p<0.0001).

A very substantial proportion of specialists reported restricting the scope of their clinical practice because of liability concerns. Forty-three percent had already personally reduced or eliminated high-risk aspects of their practice and 50% said they would likely (continue to) do so over the next 2 years (12% definitely will, 19% very likely, and 19% somewhat likely). Surgeons were significantly more likely than other specialists to have already restricted their practice (56% vs. 34%, $P<0.0001$) and to be planning future restrictions ($F=6.27$, $p=0.0003$). Solo practitioners were significantly more likely (62%) than specialists based at hospitals (32%) or group practices (42%) to have already restricted their practice ($F=15.68$, $p<0.0001$), as well to be planning future restrictions ($F=5.59$, $p<0.0001$). Specialists who had been sued within the last 3 years were also more likely than those who had not been recently sued to be planning future restrictions ($F=3.18$, $p=0.02$).

Physician Reports of Steps Likely to Be Taken by Hospitals and Physician Practices

We asked specialists to identify, if known to them, steps that their practice or hospital would likely take in response to liability costs. Nearly two thirds of respondents reported at least some likelihood that their practice or hospital would reduce or eliminate high-risk services such as delivering babies and performing back surgery within the next 2 years (14% definitely will and 24% very likely) (Table 3). Thirty-six percent reported that their practice or hospital would definitely or very likely avoid "high-risk patients" such as obese persons and women with high-risk pregnancies, with another 24% reporting that they were somewhat likely to do so. The solo practitioner effect was again strong ($F=10.5$, $p<0.0001$ for high-risk services and $F=11.8$, $p<0.0001$ for high-risk patients). Over half of all solo practitioners indicated they definitely would or were very likely to reduce or eliminate both high-risk services and high-risk patients. In contrast, less than a quarter of hospital-based physicians reported that their hospitals planned to do so.

Many specialists also reported that their practices or hospitals would attempt to meet liability costs by making special efforts to increase revenue. Fifty-three percent of respondents said that their practice or hospital was at least somewhat likely to decline to treat new patients whose health insurance offered relatively low reimbursement rates (30% definitely will or very likely), and 55% said their practice would attempt to increase the number of patients with relatively generous insurance reimbursement (27% definitely will or very likely). Solo and group practitioners were significantly more likely than hospital-based physicians to report that their practices planned to turn away patients with undesirable insurance (F=4.59, p<0.0001). Fifty-two percent of specialists reported that their practice or hospital was at least somewhat likely to reduce the amount of charity work (10% definitely will and 17% very likely). Again, the proclivity was much stronger among physician practices than among hospitals (F=2.96, p=0.007).

Supply of Specialists

Eighty percent of respondents reported that the supply of medical and surgical specialists in their area had greatly or somewhat decreased in the past 3 years (Table 4). Specialists in high-risk counties were significantly more likely than those in lower-risk areas to report a decrease (F=16.71, p<0.0001). Liability insurance costs were identified as the primary reason for the decrease (75%); low reimbursement was a distant second (21%). Surgeons were significantly more likely than other specialists to name liability costs as the primary reason (58% vs. 47%, p=0.04).

Patient Access-to-Care Problems

We inquired about four measures directly related to patient access to care: driving distances to see a specialist (in any specialty) or get a surgical procedure, waiting times for appointments with specialists or surgical procedures, waiting times in the emergency room, and patients having to switch physicians. A strong majority of specialists reported perceived

increases across all four indicators over the past 3 years for patients whom they treated (Table 5). For the two waiting time measures and the physician switching measure, approximately one third of respondents reported great increases and more than 80% reported at least some increase. Increased waiting times for specialist and surgical appointments were a bigger perceived problem in high-risk counties than low-risk counties, despite the presumably higher baseline supply of specialists in the greater Philadelphia area. There were also notable differences by specialty, with neurosurgeons most likely to report large increases in driving distances and waiting times and obstetrician/gynecologists and orthopedists most likely to report more patients having to switch doctors.

We probed the relative contributions of liability costs and other potential contributors to access problems by asking respondents to identify what they believe to be the primary reason for each type of reported access problem, from among the following choices: managed care restrictions / health insurance issues; reimbursement levels; professional liability insurance costs; or something else. Their responses indicate that causation is multifactorial, but for increased driving distances and waiting times for specialist and surgical care, professional liability costs are the strongest driver (Table 5). Managed care was reported to be the strongest driver for patients having to switch physicians (61%), but in high-risk counties, liability costs were more frequently cited (53%) as the primary cause than managed care (43%). Surgeons were significantly more likely than other specialists to indicate that liability costs were the primary reason for increased driving distances (p=0.04), waiting times for specialist and surgical care (p=0.002), and waiting times in the emergency room (p=0.002).

DISCUSSION

The results of this survey suggest that the supply of surgical and other specialists in Pennsylvania is likely to decrease, perhaps substantially in some areas, over the next 2 years; that this decrease is attributable primarily to the cost of professional liability insurance; and that it may be contributing to decrements in some measures of patient access to care. Reimbursement

and managed care arrangements are contributing to access restrictions, but liability is perceived to be the strongest driver.

Physicians' most prevalent response to liability concerns has been to restrict the scope of practice or decrease the number of practitioners in a group practice who provide high-risk services. A majority of specialists also believe that their practice or hospital will likely avoid caring for high-risk and lower-paying patients. On the basis of these reports, actual and potential access problems appear greatest for patients in need of high-risk services, uninsured patients, and patients whose insurance reimburses specialists relatively meagerly.

Our estimates of the proportions of specialists who have made or are planning to make changes to their practice are generally lower than those of several physician surveys conducted in Pennsylvania by medical professional societies. A national survey of obstetrician/gynecologists found that more than a third of respondents in Pennsylvania had either retired, moved their practices out of state, or restricted their practice to exclude obstetrical services (7). A survey of Pennsylvania orthopedic surgery practices reported that 17% of the state's orthopedic surgeons had left the state or reduced their surgical services in 2001-2002 (reasons for these decisions were not elicited) (8). Surveys conducted by provider organizations have been called into question because some have very low response rates and suffer from limited scope, lack of specificity, and other problems (6).

Our findings have several implications for health care delivery and health policy. First, our results suggest that liability pressures may be leading to greater consolidation of high-risk specialty care services in a smaller number of providers. This is likely to be particularly true for high-technology services that, prior to the onset of this malpractice crisis, had been dispersing out from the academic medical centers to community hospitals. Academic medical centers are relatively well positioned to absorb additional liability expenses and, due to higher prevalence of self-insurance, more secure than community hospitals and community-based physicians in the availability of insurance coverage (20). Whether it is desirable for teaching hospitals to reassume

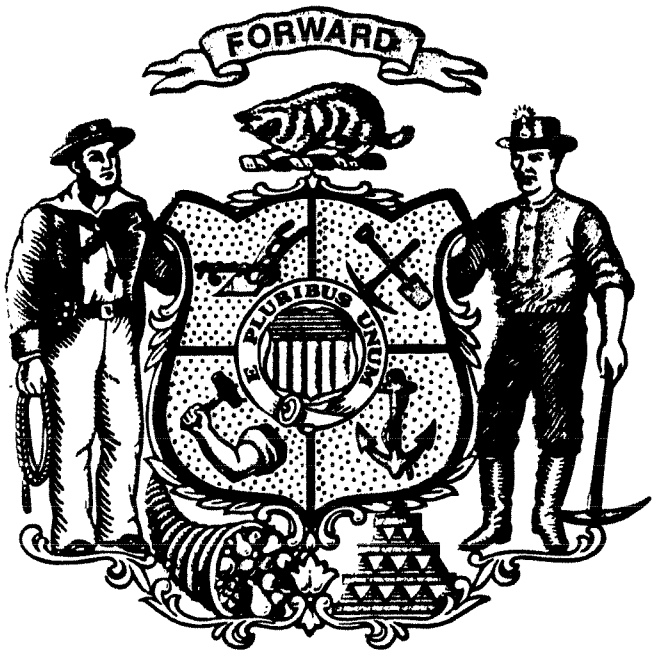
a greater volume of high-risk services is an interesting question. The well-established relationship between surgical volume and outcome (21,22,23) is an argument in favor of this trend, but a key question is whether patients residing in areas distant from teaching hospitals will find services available in their community. The increase in driving distances for specialist services reported in our study suggests that this consolidation may already be resulting in decreased availability in some areas.

Second, we found that solo practitioners were especially likely to be taking steps to reduce their liability risk and change their patient mix to boost revenue. Solo practitioners perceive their liability insurance premiums to be a greater burden than do physicians in other settings, and may encounter more difficulty securing coverage than specialists whose policies are arranged by their hospital. As we have discussed elsewhere (20), the need to find lower-cost insurance may push physicians in solo and small-group practices towards closer relationships with hospitals.

Third, the link between liability insurance costs and supply of specialists points to the need for greater risk pooling across specialties. Pricing malpractice insurance according to the legal risk associated with particular specialties, but experience-rating physicians only minimally (if at all) within specialties, is a byproduct of combining an imprecise litigation system with a fragmented health care delivery system. When insurance markets tighten, high-risk specialists suffer disproportionately. Maintaining a socially optimal supply of such specialists may require greater cross-subsidization of premiums within institutions and insurers.

Fourth, our findings suggest that policy interventions may be needed to retain high-risk specialists in states that are experiencing large and rapid rises in malpractice premiums and are not oversupplied with such specialists. This need is particularly acute in markets in which the major health care payers are not likely to be amenable to upward adjustments in reimbursement to reflect physicians' increased overhead costs. Among the policy alternatives discussed to date are

insurance subsidies, stricter insurance regulation, and reforms to the tort liability system (24,25,26).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FAIR CLAIMS ACT

Myth vs. Fact

The insurance industry and its lobbying groups have circulated materials with many misleading statements about the Fair Claims Act and what it does to keep from having to fulfill the insurance industry's responsibility to pay.

MYTH	FACT
The Fair Claims Act is an unconstitutional effort by polluters to try and rewrite pre-existing contracts for their benefit.	To the contrary, the Fair Claims Act merely codifies what many courts have stated to be the plain meaning of the insurance industry's standard-form policies. The contract clause of the federal constitution has not been an issue in states that have adopted the "Fair Claims" approach, either by legislation or through the courts. The proposed environmental insurance allocation legislation does not render the provisions of an insurance policy invalid, nor does it release policyholders from their obligations. State and federal officials urged paper companies to produce more paper with recycled fiber. As a result, carbonless paper was manufactured using PCB coating in accord with laws in effect at the time.
The Fair Claims Act will stall cleanup operations because of the many constitutional challenges, lawsuits and countersuits by lawyers for paper companies and insurance companies.	The legislation's intent is to minimize incentives for delay and costly, unnecessary litigation clogging Wisconsin's courts. The insurance industry however, has vowed to fight the Fair Claims Act if it ever passes the Legislature. Local governments have been threatened with lawsuits and may be forced to contribute to cleanup costs if insurers refuse to pay their fair share in the Lower Fox River cleanup effort.
The Fair Claims approach is unfair to Wisconsin consumers, because insurance companies would end up passing along the cost of higher insurance premiums.	A very small number of insurance companies and insurance policies will be affected. The Fair Claims Act only applies to (1) Comprehensive General Liability policies; (2) those CGL policies issued before 1986; (3) pre-1986 CGL policy claims involving environmental matters. Fair Claims will assure fair treatment of policyholders and allow paper companies to focus their resources on running their businesses rather than litigating with insurers.
The Fair Claims Act is without legal or legislative precedent in the United States.	Eight states (WA, CA, IL, IN, OH, PA, DE and MA) have required the "all sums" allocation of environmental claims through state Supreme Court action. One state, Oregon, has required the "all sums" allocation method by statute. In Wisconsin, insurers are refusing to pay environmental claims because the issue has not been addressed by Wisconsin's Supreme Court or by Wisconsin statutes.
The total price tag for the cleanup is estimated to be hundreds of millions of dollars and the paper companies are trying to avoid their responsibility to pay.	The paper companies have already invested $130 million in the cleanup effort. The paper companies are requesting that the insurers honor their obligations under the insurance policies purchased by the paper companies to cover some of the costs. The issue really is about insurance companies not wanting to pay what they owe for claims against policies they issue. The insurance companies are contractually obligated to indemnify the paper companies under the terms of the Comprehensive General Liability policies in effect with the pollution damage occurred.