Addressing the New Health Care Crisis:

Reforming the Medical Litigation System to Improve the Quality of Health Care

March 3, 2003

Prepared by
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Assistant Secretary for Planning and Evaluation

TABLE OF CONTENTS

Introduction 1

I. The Crisis Affects All Americans 3
1. Access to Care is Threatened 3
2. Quality of Care is Jeopardized 7
Physicians Too Often Order Procedures for Litigation Purposes, not Medical Need 7
The Litigation System Does Not Promote Quality of Care 8
The Litigation System in Fact Impedes Efforts to Improve the Safety and Quality of Care 9
3. Health Care Costs are Increased 11

II. The Litigation System Is Responsible For The Crisis 12

III. The Litigation System Does Not Benefit the Injured Patient 15

IV. As A Result, Insurance Premiums Are Rising Rapidly 17

V. Insurers Are Leaving The Market 21

VI. States With Realistic Limits On Non-Economic Damages Are Faring Better 23

VII. The President's Framework For Improving The Medical Litigation System 27
1. Establish a Fair, Predictable, and Timely Process 27
2. Improve Health Care Quality Through Litigation Reform 29

VIII. It Is Specious To Blame Insurers For The Crisis 33

Conclusion 36

TABLE OF CONTENTS

Introduction

The Crisis Affects All Americans 3
1. Access to Care is Threatened 3
2. Quality of Care is Jeopardized 7
   Physicians Too Often Order Procedures for Litigation Purposes, not Medical Need 7
   The Litigation System Does Not Promote Quality of Care 8
   The Litigation System in Fact Impedes Efforts to Improve the Safety and Quality of Care 9
3. Health Care Costs are Increased 11

II. The Litigation System Is Responsible For The Crisis 12

III. The Litigation System Does Not Benefit the Injured Patient ... 15

IV. As A Result, Insurance Premiums Are Rising Rapidly 17

V. Insurers Are Leaving The Market 21

VI. States With Realistic Limits On Non-Economic Damages Are Faring Better 23

VII. The President's Framework For Improving The Medical Litigation System 27
1. Establish a Fair, Predictable, and Timely Process 27
2. Improve Health Care Quality Through Litigation Reform 29

VIII. It Is Specious To Blame Insurers For The Crisis .. 33

Conclusion 36

Endnotes 37

List of Exhibits

Table 1. Mega Awards In States Without Caps 13

Table 2. Medical Malpractice Liability Average Premium Increases by Specialty 17

Table 3. Highest Premium Increases for Specialists in States without Meaningful Caps 18

Table 4. Average Combined Highest Premium Increases for Specialty Providers in States Experiencing a Litigation Crisis 19

Table 5. States with High Premiums in 2002 by Specialty, Compared to California 19

Table 6. Comparison of States with Caps to States without Meaningful Non-Economic Caps 23

Table 7. Malpractice Liability Rate Ranges by Specialty by Geography as of October 2002 25

Figure 1. Premium Growth: California vs. U.S. Premiums 1976-2000 26

Table 8. Five Year Historical Asset Allocation Table for Medical Malpractice Carriers 34

ADDRESSING THE NEW HEALTH CARE CRISIS:
Reforming the Medical Litigation System to Improve the Quality of Health Care

Introduction

Americans enjoy high quality health care. But we can do better. To that end, the Administration is undertaking a number of initiatives to increase access to care, while enhancing even further the quality of care and constraining cost increases. The Administration is acting to make more information available to consumers to help them identify quality care and to choose providers that offer quality care. We are encouraging and promoting the introduction of computer technology in health care to support the efforts of health professionals and to reduce the chance of error. Reform of the litigation system is a further, critical part of our efforts to improve quality. The excesses of the litigation system raise the cost of health care for everyone, threaten Americans' access to care, and impede efforts to improve the quality of care.

Americans spend far more per person on the costs of litigation than any other country in the world. The excesses of the litigation system are an important contributor to "defensive medicine"--medical treatments provided for the purpose of avoiding litigation. Doctors' insurance premiums are increasing at a rapid rate, particularly in states that have not taken steps to make their legal systems function more predictably and effectively. Some doctors cannot obtain insurance despite having never had a single malpractice judgment or even faced a claim. As multimillion-dollar jury awards have become more common in recent years, these problems have reached crisis proportions.

This is a threat to health care quality for all Americans. Increasingly, Americans are at risk of not being able to find a doctor when they most need one. Doctors have given up their practices, limited their practices to patients who do not have health conditions that are more likely to lead to lawsuits, or have moved to states with a fairer legal system where insurance can be obtained at a lower price. In addition, excessive litigation is impeding efforts to improve quality of care. Hospitals, doctors, and nurses are reluctant to report problems and participate in joint efforts to improve care because they fear being dragged into lawsuits, even if they did nothing wrong.

This broken system of litigation also is raising the cost of health care that all Americans pay, through out-of-pocket payments, insurance premiums, and taxes.

Judgments for very large amounts of non-economic damages in a small proportion of cases and the settlements they influence are driving this litigation crisis. At the same time, most injured patients receive no compensation. The

Endnotes 37

List of Exhibits

Table 1. Mega Awards In States Without Caps 13

Table 2. Medical Malpractice Liability Average Premium Increases by Specialty 17

Table 3. Highest Premium Increases for Specialists in States without Meaningful Caps 18

Table 4. Average Combined Highest Premium Increases for Specialty Providers in States Experiencing a Litigation Crisis 19

Table 5. States with High Premiums in 2002 by Specialty, Compared to California 19

Table 6. Comparison of States with Caps to States without Meaningful Non-Economic Caps 23

Table 7. Malpractice Liability Rate Ranges by Specialty by Geography as of October 2002 25

Figure 1. Premium Growth: California vs. U.S. Premiums 1976-2000 26

Table 8. Five Year Historical Asset Allocation Table for Medical Malpractice Carriers 34

ADDRESSING THE NEW HEALTH CARE CRISIS:
Reforming the Medical Litigation System to Improve the Quality of Health Care

Introduction

Americans enjoy high quality health care. But we can do better. To that end, the Administration is undertaking a number of initiatives to increase access to care, while enhancing even further the quality of care and constraining cost increases. The Administration is acting to make more information available to consumers to help them identify quality care and to choose providers that offer quality care. We are encouraging and promoting the introduction of computer technology in health care to support the efforts of health professionals and to reduce the chance of error. Reform of the litigation system is a further, critical part of our efforts to improve quality. The excesses of the litigation system raise the cost of health care for everyone, threaten Americans' access to care, and impede efforts to improve the quality of care.

Americans spend far more per person on the costs of litigation than any other country in the world. The excesses of the litigation system are an important contributor to "defensive medicine"--medical treatments provided for the purpose of avoiding litigation. Doctors' insurance premiums are increasing at a rapid rate, particularly in states that have not taken steps to make their legal systems function more predictably and effectively. Some doctors cannot obtain insurance despite having never had a single malpractice judgment or even faced a claim. As multimillion-dollar jury awards have become more common in recent years, these problems have reached crisis proportions.

This is a threat to health care quality for all Americans. Increasingly, Americans are at risk of not being able to find a doctor when they most need one. Doctors have given up their practices, limited their practices to patients who do not have health conditions that are more likely to lead to lawsuits, or have moved to states with a fairer legal system where insurance can be obtained at a lower price. In addition, excessive litigation is impeding efforts to improve quality of care. Hospitals, doctors, and nurses are reluctant to report problems and participate in joint efforts to improve care because they fear being dragged into lawsuits, even if they did nothing wrong.

This broken system of litigation also is raising the cost of health care that all Americans pay, through out-of-pocket payments, insurance premiums, and taxes.

Judgments for very large amounts of non-economic damages in a small proportion of cases and the settlements they influence are driving this litigation crisis. At the same time, most injured patients receive no compensation. The

current litigation system hurts everyone--injured patients and Americans seeking high-quality care. The only ones who benefit are those who operate the system--particularly the trial lawyers who bring these cases and those who defend them. Some states have already taken action to squeeze the excesses out of the litigation system. But federal action, in conjunction with further action by states, is essential to help Americans get high-quality care when they need it, at a more affordable cost.

We reported on the growing access crisis in the report we issued on July 24, 2002,[1] and updated with two supplements.[2] As we predicted, the crisis has only worsened since we issued those reports. The scope and intensity of the crisis have increased. More doctors, hospitals, and nursing homes in more states are facing increasing difficulty in obtaining insurance against lawsuits, and as a result more patients in more states are facing greater difficulty in obtaining access to doctors. Premiums charged to specialists in 18 states without reasonable limits on non-economic damages increased by 39% between 2000 and 2001.[3] Premiums in these states have now gone up an additional 51%.[4] Thus, specialty premiums have almost doubled in two years in hard-hit states. This report describes the problems we currently face, the reasons these problems have arisen, and how we can fix them.

I. THE CRISIS AFFECTS ALL AMERICANS

1. Access to Care is Threatened

There are a number of obstacles that limit access to affordable health care in this country, including the difficulty many Americans have in obtaining private insurance and an outdated Medicare program. We now face another obstacle– the litigation crisis that has made insurance premiums unaffordable or even unavailable for many doctors, through no fault of their own. This is currently making it more difficult for many Americans to find care, and threatening access for many more. This crisis affects patients, physicians, hospitals, and nursing homes all across the United States.

The crisis is affecting access to care in numerous ways in states that have not reformed their litigation systems. A few examples of the real problems we face:

Three obstetrician-gynecologists who staffed a practice responsible for delivering half of all babies in Fayette County, Pennsylvania, stopped delivering babies effective November 1 in an effort to reduce malpractice premium expense. The policy would have been $400,000 if they had continued OB services and will be under $100,000 without it.[5]

Dr. Lauren Plante, a maternal-fetal medicine specialist in Philadelphia, stopped practicing because her malpractice insurance premiums increased 60% in one year.[6]

Dr. Peter Blanc, a vascular surgeon in Wilkes-Barre, shut down his practice in August because "...increasing insurance premiums have forced him out of business." Dr. Blanc, who has never been sued, would have had to pay $51,000 to renew his medical liability coverage in October, up from $27,000 in 2000.[7]

Abington (PA) Memorial Hospital closed the only trauma center in Montgomery County at the end of 2002 because insurance carriers were not willing to offer malpractice liability insurance to doctors staffing it. Since 1999, annual hospital liability premiums have risen from $7 million to $23 million.[8]

In Tacoma, Washington, some doctors were faced with a tripling of their premiums. The Washington State Medical Association has reported a 31% increase in the number of physician members moving out of state since 1998.[9]

The Vermont Medical Society reported that malpractice premiums are rising so rapidly that doctors are being forced out of the profession.[10]

According to the president of the Massachusetts Medical Society, obstetricians in the state have seen their insurance premiums double in the past year. Insurance premiums for obstetrician-gynecologists in Massachusetts are among the highest in the country and have forced several doctors practicing in the Springfield area to stop delivering babies.[11]

The University of Nevada School of Medicine has estimated that Clark County should have between 150 and 160 obstetricians delivering babies but has only 85 in practice, due to the medical litigation crisis.[12]

The University of Nevada Medical Center closed its trauma center in Las Vegas for ten days in July 2002. Its surgeons had quit because they could no longer afford malpractice insurance.[13] Their premiums had increased sharply, some from $40,000 to $200,000. The trauma center was able to re-open only because some of the surgeons agreed to become county government employees for a limited time, which capped their liability for non-economic damages if they were sued. This is obviously only a temporary solution.

Dr. Cheryl Edwards, 41, closed her decade-old obstetrics and gynecology practice in Las Vegas because her insurance premium jumped from $37,000 to $150,000 a year. She moved her practice to West Los Angeles, leaving 30 pregnant women to find new doctors.[14]

Dr. Darren Housel, who had been practicing in Las Vegas since 1996 delivering more than 200 babies a year, saw his patients for the last time September 19. He moved to Utah, where his malpractice premiums will drop from nearly $100,000 to $39,000 annually.[15]

Dr. Frank Jordan, a vascular surgeon, in Las Vegas, closed his practice. "I did the math. If I were to stay in business for three years, it would cost me $1.2 million for insurance. I obviously can't afford that. I'd be bankrupt after the first year, and I'd just be working for the insurance company. What's the point?"[16]

A doctor in a small town in North Carolina decided to take early retirement when his premiums skyrocketed from $7,500 to $37,000 per year. His partner, unable to afford the practice expenses by himself, may now close the practice, and work at a teaching hospital.[17]

Many physicians in Ohio saw their malpractice premiums triple in 2001, and some are leaving their practice as a result. Dr. James Wilkerson, an Akron urologist, decided to retire. Had Dr. Wilkerson continued to practice, he would have spent seven months of his yearly income to cover the $84,000

premium. "I would have had to go back to working 90 hours a week and didn't want to do that..."[18]

West Virginia is also facing critical access problems for urgently needed care such as obstetrics. In rural areas, such as Putnam County and Jackson County, the sole community provider hospitals have closed their OB units because the obstetricians in those areas cannot afford malpractice insurance.[19]

Many communities in Mississippi are losing access to needed medical care Physicians, who specialize in family medicine and obstetrics/gynecology in Indianola, and in other rural areas of the state, have stopped delivering babies because of skyrocketing insurance costs.[20]

Most of the cities with populations under 20,000 in Mississippi no longer have doctors who deliver babies.[21]

Due to rising insurance costs, only one doctor with expertise in head trauma was available last July to cover all the hospitals in Gulfport, Mississippi. Tony Dyess suffered permanent brain damage as a result.[22]

One in six participants in an August 2002 survey by the Florida Medical Directors Association reported that attending physicians have stopped following patients in nursing homes in the last 12 months because of difficulty obtaining liability coverage; 27% reported that physicians in their facilities had been informed that their medical liability coverage would not be renewed or would be more costly because they attended patients in nursing homes. In 2001, Florida had one of the highest premium costs per nursing home bed in the United States ($11,000).[23]

In Georgia, the 80-bed Bacon County Hospital in Alma took out a loan to cover a premium that more than tripled.[24]

Another Georgia hospital, Memorial Hospital and Manor in Bainbridge, which operates a hospital and a nursing home, was faced with a 600% premium increase from 2001 to 2002.[25]

In New Jersey, 65% of the hospitals report that physicians are leaving because of increased premiums (over 250% over the last three years).[26]

Arizona Family Care Association, an operator of rural health clinics on the Arizona-Mexico border, saw its malpractice insurance increase from $500,000 per year with no deductible to $897,000 per year with a $50,000 deductible, and that was only if it stopped performing OB. AFCA stopped delivering babies; the closest OB services are an hour away.[27]

The Wyoming Medical Society has indicated that it is increasingly difficult for physicians to stay in business due to increasing medical liability costs--one of the two insurance carriers providing OB coverage increased rates 40% in 2002.[28] Dr. Willard Wood, an obstetrician serving three Wyoming counties, stopped delivering babies during the winter of 2003; his annual malpractice premium to provide only gynecological services was $116,000, or three times what he had paid a year earlier.[29]

Doctors who would volunteer their time to provide care in free clinics and other volunteer organizations, or who would volunteer their services to the Medical Reserve Corps, are afraid to do so because they do not have malpractice insurance. This makes it more difficult for clinics to provide care to low-income patients. The clinics must spend their precious resources to obtain their own coverage, and have less money available to provide care to people who need it. The proportion of physicians in the country providing any charity care fell from 76% to 72% between 1997 and 1999 alone, increasing the need for doctors willing to volunteer their services.[30] Health Link Medical Center opened in March 2001 in Southampton, Pennsylvania, to provide free health care to the working poor. Dr. Theodore Onifer, a retired physician, volunteered his services on the board but was unable to volunteer to provide medical care because of the fear of lawsuits and the cost of insurance.

A substantial number of nursing home chains, including Beverly Enterprises, National Healthcare Corporation, Extendicare and Health Ventures, have been forced to sell nursing homes in Florida and Arkansas because they could not obtain liability insurance coverage for these facilities.[31]

Six of the largest nursing home companies, both privately and publicly owned, have filed for bankruptcy in the past two years. A significant factor in their financial downturn is uncontrolled costs associated with medical liability premiums and tort related expenses.[32]

The American Medical Association has reported that an alarming number of physicians are unable to obtain or afford medical liability insurance in 12 states.[33] The American College of Obstetricians and Gynecologists (ACOG) has identified nine states in which access to care is compromised due to availability and affordability of malpractice insurance for obstetricians.[34] A 2002 ACOG survey of obstetrician-gynecologists found that 73% of respondents in these states have been forced to retire, relocate, or modify their practice (e.g. decrease surgical procedures, stop obstetrics, and/or decrease the amount of high-risk obstetric care).[35]

Similarly, the American Association of Neurological Surgeons has identified 25 crisis states in which neurosurgeons faced either a 50 percent increase in premiums from 2000 to 2002, or average premiums near or over $100,000 in 2002.[36]

A new study conducted by the American Hospital Association and the American Society of Hospital Risk Management demonstrates that the scope of the crisis extends beyond physicians: one-third of hospitals saw an increase of 100% or more in liability insurance premiums in 2002. Over one-fourth reported either a curtailment or complete discontinuation of one service or another as a result of growing liability premium expenses.[37]

The effect this crisis is having on patients' access to care is indicated by a recent survey conducted by the Blue Cross Blue Shield Association (BCBS).[38] A substantial number of BCBS plans predict that surgical fees and emergency room costs will increase as a result of higher medical malpractice premiums.

2. Quality of Care is Jeopardized

Physicians Too Often Order Procedures for Litigation Purposes, not Medical Need

The litigation crisis affects the quality of care available to Americans in a number of ways. Physicians are reacting to the threat of litigation by avoiding the specialties that present the greatest risk of suit. A recent survey of physicians reveals that one-third shied away from going into a particular specialty because they feared it would subject them to greater liability exposure.[39] When in practice, physicians increasingly are forced to engage in defensive medicine to protect themselves against suit. They perform tests and provide treatments that they would not otherwise perform merely to protect themselves against the risk of possible litigation. The recent survey revealed that over 76% of physicians are concerned that malpractice litigation has hurt their ability to provide quality care to patients.[40] Because of their fear of the excesses of the litigation system:

- 79% said that they had ordered more tests than they would, based only on professional judgment of what is medically needed, and 91% have noticed other physicians ordering more tests;
- 74% have referred patients to specialists more often than they believed was medically necessary;
- 51% have recommended invasive procedures such as biopsies to confirm diagnoses more often than they believed was medically necessary; and
- 41% said that they had prescribed more medications, such as antibiotics, than they would based only on their professional judgment, and 73% have noticed other doctors similarly prescribing excessive medications.

A large majority of nurses (66%) and hospital administrators (84%) who participated in the survey reported that unnecessary or excessive care is provided because of fear of litigation.[41] Every test and every treatment that is not

taken for medical reasons poses an unnecessary risk to the patient, and takes away funds that could better be used to provide health care to those who need it.

A recent survey of 1,573 physicians in three South Florida counties[42] revealed how litigation fears have influenced the way physicians practice:

- 44% recently stopped performing high-risk procedures, including some spinal surgeries and treatment of chest wounds;
- 66% are performing more tests to protect themselves from lawsuits;
- One in nine respondents no longer has malpractice coverage;
- Seven of 29 radiologists have stopped reading mammograms; and
- Almost 31% limit their practice in hospital emergency rooms.

The Litigation System Does Not Promote Quality of Care

The liability system is not an effective way of improving quality. In many cases it does not provide a useful guide to what care should be, and does not provide a guide to providers or to patients. A comprehensive study of the prevalence of medical errors found that most events for which claims were filed in fact did not constitute negligence.[43] Other studies demonstrate the same pattern of randomness.[44] Several medico-legal scholars have noted that "Evidence is growing that there is a poor correlation between injuries caused by negligent medical treatment and malpractice litigation.... [I]n a sample of 31,000 patients treated in 51 New York State hospitals, there was a poor correlation between a malpractice suit and the presence of actual malpractice."[45]

Not surprisingly, most professionals involved in health care delivery believe that the system does not accurately reflect the realities of health care or correctly identify malpractice. A 2002 survey indicated that 83% of physicians and 72% of hospital administrators do not believe the system achieves a reasonable result.[46]

Because its results are largely random and unpredictable, the litigation system often does not accurately identify negligence, deter bad conduct, or provide justice. "The evidence is growing that there is a poor correlation between injuries caused by negligent medical treatment and malpractice litigation."[47]

For example, obstetricians face more suits than any other specialty, more than two per career on average, and claims for neurologically impaired infants make up 30 percent of them, according to the American College of Obstetricians and Gynecologists. The average award by juries in such cases is about $1 million. However, a study released in January 2003 finds that doctors are often sued for brain damage that can result from oxygen deprivation during delivery, even though the vast majority of such cases actually stem from infections and causes that are beyond the control of physicians and other delivery room staff.[48] The study, which is "one of the most highly peer-reviewed reports ever,"[49] suggests that suits are being brought against doctors for brain damage and cerebral palsy that were not caused by negligent care.[50]

With this randomness, the litigation system cannot be relied upon to deter error or set meaningful standards of care. That this is in fact the case is evidenced by the Institute of Medicine's estimate that as many as 98,000 people die each year from medical error.[51] Results like these indicate that the current system is failing to ensure quality care.

The Litigation System in Fact Impedes Efforts to Improve the Safety and Quality of Care

Health professionals' understandable fear of unwarranted litigation threatens patient safety in another way. It impedes efforts of physicians and researchers to improve the quality of care. Specifically, fear of liability discourages open discussion of medical errors and ways to reduce them. As medical care becomes increasingly complex, there are many opportunities for improving the quality and safety of medical care, and reducing its costs. However, because of the litigation environment, only one-fourth of physicians, nurses and hospital administrators think that their colleagues are very comfortable discussing adverse events or uncertainty about proper treatment with them. Even fewer, roughly 5%, think that their colleagues are very comfortable discussing medical errors with them.[52]

The best way to achieve these needed improvements in quality of care is to provide better opportunities for health professionals to work together to identify errors, or practices that may lead to errors, and to correct them. Experts believe these quality improvement opportunities hold the promise not only of significant improvements in patient health outcomes, but also of reductions in medical costs by as much as 30%.[53] Many problems in the health care system result not from one individual's failings, but from complex system failings. These can best be addressed by collecting information from a broad range of doctors and hospitals, and encouraging them to collaborate to identify and fix problems. Already many health care systems are beginning to make these improvements:

- Intermountain Health Care and LDS Hospital in Utah improved quality and efficiency of the intensive care unit by applying quality improvement techniques and improving collaborative efforts.

- The Pittsburgh Regional Healthcare Initiative has brought together hospitals, health plans, physicians, and purchasers of health care in a collaborative effort to identify better ways to provide care. It has reduced blood infections in intensive care units by 20% in just two years, and it is encouraging reporting to reduce medication errors.

  The Baylor Medical Center in Dallas, Texas, has recently initiated an error reporting system and integrated it into care delivery to reduce medication and other errors.[54]

Through the Northern New England Cardiovascular Disease Study Group, eight hospitals reduced mortality for cardiac bypass surgery by developing a collaborative patient registry, tracking how care is delivered and what the outcomes are, and sharing what they learn.

A proprietary drug-dispensing system developed by the Veterans' Administration that uses bar-code technology has reduced problems associated with medication errors by 74% in the five years since its introduction.[55]

However, these efforts and other efforts are impeded and discouraged by the lack of clear and comprehensive protection for collaborative quality efforts. Doctors are reluctant to collect quality-related information and work together to act on it for fear that it will be used against them or their colleagues in a lawsuit. Perhaps as many as 95% of adverse events are believed to go unreported.[56] To make quality improvements, doctors must be able to exchange information about patient care and how it can be improved--what is the effect of care not just in one particular institution or of the care provided by one doctor, but how the patient fares across all providers. These quality efforts require enhancements to information and reporting systems.

In its report, "To Err is Human," the Institute of Medicine (IOM) observed that, "[R]eporting systems are an important part of improving patient safety and should be encouraged. These voluntary reporting systems [should] periodically assess whether additional efforts are needed to address gaps in information to improve patient safety and to encourage health care organizations to participate in...reporting, and track the development of new reporting systems as they form."[57]

However, as the IOM emphasized, fear that information from these reporting systems will be used to prepare a lawsuit against them, even if they are not negligent, deters doctors and hospitals from making reports. This fear, which is understandable in the current litigation climate, impedes quality improvement efforts. According to many experts, the "#1 barrier" to more effective quality improvement systems in health care organizations is fear of creating new avenues of liability by conducting earnest analyses of how health care can be improved. Without protection, quality discussions to improve health care can be used as fodder for more litigation. Doctors are busy, and they face many pressures. They will be reluctant to engage in health care improvement efforts if they think that reports they make and recommendations they offer will be thrown back at them or others in litigation. Quality improvement efforts must be protected if we are to obtain the full benefit of doctors' experience in improving the quality of health care.

The IOM Report emphasized the importance of shifting the inquiry from individuals to the systems in which they work: "The focus must shift from blaming individuals for past errors to a focus on preventing future errors by

designing safety into the system."[58] But the litigation system impedes this progress--not only because fear of litigation deters reporting but also because the scope of the litigation system's view is restricted. The litigation system looks at the past, not the future, and focuses on the individual in an effort to assess blame rather than considering how improvements can be made in the system. "Tort law's overly emotional and individualized approach...has been a tragic failure."[59]

3. Health Care Costs are Increased

The medical litigation system attacks the wallet of every American. Money spent on malpractice premiums (and the litigation costs that largely determine those premiums) raises health care costs. A GAO study in 1994 estimated that malpractice premiums comprise 1% of total health care expenditures; given current spending, this amounts to $14 billion dollars.[60]

The litigation system also imposes large indirect costs on the health care system. Defensive medicine that is caused by unlimited and unpredictable liability awards not only increases patients' risk but it also adds costs. A leading study estimates that reasonable limits on non-economic damages, such as California has had in effect for 25 years, can reduce health care costs by 5-9% without "substantial effects on mortality or medical complications."[61] With national health care expenditures currently estimated to be $1.4 trillion, if this reform were adopted nationally, it would save $70-126 billion in health care costs per year.

The costs of the runaway litigation system are paid by all Americans, through higher premiums for health insurance (which reduces workers' take home pay if the insurance is provided by an employer), higher out-of-pocket payments when they obtain care, and higher taxes.

The Federal Government--and thus every taxpayer who pays federal income and payroll taxes--pays for health care in a number of ways. It provides direct care, for instance, to members of the armed forces, veterans, and patients served by the Indian Health Service. It provides funding for the Medicare and Medicaid programs. It funds Community Health Centers. It also provides assistance, through the tax system, for workers who obtain insurance through their employment. The Federal Government spends $33.7-$56.2 billion per year for malpractice coverage and the costs of defensive medicine.[62] Reasonable limits on non-economic damages would reduce the amount of taxpayers' money the Federal Government spends by $28.1-$50.6 billion per year.[63]

II. THE LITIGATION SYSTEM IS RESPONSIBLE FOR THE CRISIS

The crisis that we face--as consumers, taxpayers, or health care professionals--is caused by our expensive litigation system, which often finds liability on a random basis and increasingly imposes very large judgments for non-economic damages.

The insurance premiums that health professionals and hospitals must pay are largely determined by the costs that the litigation system imposes on the insurers. The malpractice insurance system and the litigation system are inexorably linked.

Although most cases do not actually go to trial, it costs a significant amount of money to defend each claim--expenses on claims settled in 2001 averaged $39,819.[64] Data from states that maintain this information demonstrate the rapid rate of increase in recent years. Between 1999 and 2001, the average expense, per defendant, in a medical litigation case in Illinois increased 30.3% (from $14,855 to $19,363).[65] In the period 1980 to 1984, the average defense cost in Missouri was $4,700; in the period 1995 and 1999, it increased to almost $19,000--an increase of more than 300% percent.[66]

And payments made on claims are increasing. In Illinois, the average payment per paid claim increased from just under $129,000 in the period 1980-1984 to almost $500,000 in the period 1995-1999.[67] Missouri reported similar increases--the average payment per defendant rose 38% between 1999 and 2001.[68]

Between 1991 and 2001, the number of payments made for malpractice claims against physicians reported to the National Practitioner Data Bank (NPDB) increased 21.6% from 13,711 to 16,676.[69] During this same period, the median payment more than doubled--from $63,750 to $135,941--while the maximum reported payment escalated from $5,300,000 to $20,700,000.[70]

Of particular concern is the rise in mega-awards and settlements. The number of payments of $1 million or more reported to the NPDB exploded in the past 7 years, not only in AMA crisis states such as New Jersey, Pennsylvania and Ohio, but nationwide. Between 1991 and 2002, the number of payments of $1 million or more that were reported to the NPDB increased from 298 to 806; payments of $1 million or more increased from 2.2% to 5.4% of total payments reported. While the NPDB represents the most comprehensive data source for medical malpractice claims payments, it may understate the extent of the crisis since it includes all doctors, and the problem is concentrated in high risk specialties.

Mega-awards for non-economic damages have occurred in states that do not have limitations on the amounts of non-economic damages that can be recovered. A number of states have experienced mega-judgments. See Table 1.

TABLE 1. Mega-Awards In States Without Caps

State	Jury Award	Year
Arizona	$3,000,000	1998
Kentucky	$13,000,000	1998
Mississippi	$100,000,000	2002
Nevada	$6,000,000	2001
	$5,400,000	2001
	$4,600,000	2001
New York	$94,500,000	2002
	$80,000,000	2002
	$91,000,000	2002
North Carolina	$23,500,000	1997
	$4,500,000	2001
	$8,100,000	2001
Ohio	$3,500,000	2002
Pennsylvania	$100,000,000	1999
	$7,000,000	2003
Texas	$4,400,000	2002
Washington	$3,790,000	1998

Source: ASPE Review of Media Reports from The Advocate, Las Vegas Review, North Carolina Lawyers Weekly, and other select sources.

A large proportion of these awards are not to compensate injured patients for their economic loss--such as wage loss, health care costs, and replacing services the injured patient can longer perform (such as child care). Much of the judgment (in some cases, particularly the largest judgments, perhaps 50% or more) is for non-economic damages. Awarded on top of compensation for the injured patient's actual economic loss, non-economic damages are meant to be compensation for intangible, non-monetary losses, such as pain and suffering, loss of consortium, hedonic (loss of the enjoyment of life) damages, and various other theories that are developed.

Recent data from the Florida Department of Insurance Closed Claims Database show that non-economic damages comprised 77% of awards.[71] In Texas, the average judgment today is $2.1 million; of that, 70% is for non-economic damages. Texas has experienced a 500% increase in the size of judgments awarded in the last 10 years.[72]

Non-economic damages are an effort to compensate a plaintiff with money for what are in reality non-monetary considerations. The theories on which these awards are made however, are entirely subjective. As one scholar has observed: "The perceived problem of pain and suffering awards is not simply the amount of money expended, but also the erratic nature of the process by which the size of the awards is determined. Juries are simply told to apply their 'enlightened conscience' in selecting a monetary figure they consider to be fair."[73]

Unless a state has adopted limitations on non-economic damages, the system essentially gives juries a blank check to award huge damages.

Even though few cases end with mega jury awards, they encourage lawyers in the hope that they can win this litigation lottery, and they influence every settlement that is entered into. Mirroring the increase in jury awards, settlement payments have steadily risen over the last two decades. The average settlement payment per paid claim increased from approximately $110,000 in 1987 to $250,000 in 1999.[74]

III. THE LITIGATION SYSTEM DOES NOT BENEFIT THE INJURED PATIENT

The litigation system is expensive, and, at the same time, it is slow and provides little benefit to patients who are injured by medical error.

Most victims of medical error do not file a claim--one comprehensive study found that only 1.53% of those who were injured by medical negligence even filed a claim.[75] When a patient does decide to go into the litigation system, only a very small number recover anything. Most claims--57-70%--result in no payment to the patient.[76, 77] One study found that only 8-13% of cases filed went to trial; and only 1.2-1.9% resulted in a decision for the plaintiff.[78]

The results are as arbitrary for patients as they are for providers. When there are recoveries, they often are based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status (educated, attractive patients recover more than others).[79]

One prominent personal injury trial lawyer explained the secret of his success: "The appearance of the plaintiff [is] number one in attempting to evaluate a lawsuit because I think that a good healthy-appearing type, one who would be likeable and one that the jury is going to want to do something for, can make your case worth double at least for what it would be otherwise and a bad-appearing plaintiff could make the case worth perhaps half..."[80]

Only a small number of claimants achieve the large judgment for non-economic losses. A winning lottery ticket in litigation, moreover, is not as attractive as it may seem at first blush. A plaintiff who wins a judgment must pay the lawyer 30-40% of it, and sometimes even more. Lawyers, therefore, have an interest in finding the most attractive case. They develop a portfolio of cases and have an incentive to gamble on a big "win." If only one case results in a huge verdict, they have had a good payday. Thus, they have incentives to pursue selected cases to the end in the hope of winning the lottery, even when their client would be satisfied by a settlement that would make them whole economically. The result of the contingency fee arrangement is that lawyers have few incentives to take on the more difficult cases or those of less attractive patients.

For most injured patients, therefore, the litigation process, while offering the remote chance of a jackpot judgment, provides little real benefit, even for those who file claims and pursue them. Even successful claimants do not recover anything on average until five years after the injury, longer if the case goes to trial.[81]

The friction generated by operating the system consumes most of the money. When doctors and hospitals buy insurance (sometimes they are required to buy coverage that provides more "protection" than the total amount of their assets), it is intended to compensate victims of malpractice for their loss. However, only 28% of what they pay for insurance coverage actually goes to patients; 72% is spent on legal, administrative, and related costs.[82]

Our current system forces injured patients to sue their doctors in order to obtain compensation and forces both patients and doctors to go through what is a traumatic process for all. Patients must wait years for recovery (if they ever win any). Doctors are subject to minute scrutiny of actions they took, often years before, and their actions are judged on the basis of hindsight and perhaps even on the basis of changed medical standards. The process consumes the time and energy of the doctor that could better be spent in patient care. It is essentially punitive in nature, yet random. Rather than helping doctors do better, it causes them to engage in defensive medicine. It is a process that benefits no one except those who must operate it--trial lawyers, both those who represent plaintiffs and those who represent defendants.

The cost of these awards for non-economic damages is paid by all other Americans through higher health care costs, higher health insurance premiums, higher taxes, reduced access to quality care, and threats to quality of care. The system permits a few plaintiffs and their lawyers to impose what is in effect a tax on the rest of the country to reward a very small number of patients--and their lawyers--who happen to win the litigation lottery. It is not a democratic process.

IV. AS A RESULT, INSURANCE PREMIUMS ARE RISING RAPIDLY

The costs imposed by the litigation system show up in the cost of insurance coverage. Premiums have increased rapidly over the past several years, particularly for doctors who practice internal medicine, general surgery, and obstetrics/gynecology (see Table 2 below). The average increases ranged from 12% to 18% in 2000, were about 10% in 2001, but accelerated rapidly in 2002. The most recent report revealed that rate increases are now averaging 20% and above.[83]

TABLE 2: Medical Malpractice Liability Average Premium Increases by Specialty (Date is When Survey Was Taken, Compared to Previous Period)

Specialty	July 2000	July 2001	July 2002
Internists	18%	10%	25%
	15%	10%	25%
Obstetrician/Gynecologists	12%	9%	20%

Source: Medical Liability Monitor. The data reflect an average for the listed specialties in all states. Averaging disguises the different experiences in states that have reformed their litigation systems and those that have not.

As seen in Table 3, which shows the highest rate increase reported for any of the three specialties, specialty physicians in states without reasonable limits on non-economic damages have experienced very significant premium increases from 2001 to 2002.

TABLE 3. Highest Premium Increases for Specialists in States without Meaningful Caps*	
State	**Premium Increase from 2001- 2002**
Arkansas	112%
Connecticut	40%
Florida+	75%
Georgia	40%
Maryland	37%
Mississippi	99%
Nebraska	36%
Nevada	50%
New Hampshire	50%
North Carolina	50%
Ohio+	60%
Oregon	80%
Pennsylvania	40%
South Carolina	42%
Tennessee	65%
Texas+	40%
Virginia	113%
Wyoming	38%

Source: Medical Liability Monitor, 2002.
*Highest increase in rates for internal medicine, general surgery or obstetrics-gynecology as reported in MLM Survey, October 2002.
+ Florida imposes a cap of $250,000-$350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate. Florida is not considered to have a meaningful cap on non-economic damages because of the confusion associated with the arbitration provision. An Ohio statute limiting non-economic damages was declared unconstitutional in 1999. The Texas statute limits damages ($1.4 million in 2002) in wrongful death cases only; application of it to all negligence actions was ruled unconstitutional in 1990.

Analyzing the data differently, the same pattern is evident in Table 4, which shows that the highest premium increases averaged among all three specialists increased substantially in 2002.

TABLE 4. Average Combined Highest Premium Increases for Specialty Providers in States Experiencing a Litigation Crisis	
State	Premium Increase from 2001-2002
Florida	61%
	29%
	66%
	31%
	42%
	50%
	38%
	30%
	22%
Source: Medical Liability Monitor, October 2002. Data represent the average of the highest premiums reported for internal medicine, general surgery and obstetrics-gynecology specialists.	

The states with the highest average premiums are states that have not reformed their litigation systems.[84] Table 5 compares the premiums in non-reform states with those charged in California, which reformed its system in 1975.

TABLE 5. States with High Premiums in 2002 by Specialty, Compared to California			
State	OB/GYNs	Surgeons	Internists
Florida	$211-$78K	$164-$55K	$56-$15K
	$142-$59K	$85-$38K	$23-$11K
	$141-$51K	$107-$43K	$46-$14K
	$115-$33K	$66-$19K	$17-$6K
	$110-$47K	$76-$29K	$32-$9K
	$117-$43K	$88-$33K	$34-$11K
	$96-$29K	$38-$24K	$11-$6K
	$95-$69K	$64-$40K	$18-$9K
	$95-$69K	$43-$37K	$14-$7K
District of Columbia	$90-$84K	$43-$38K	$13-$11K
California	$75-$28K	$49-$18K	$21-$5K
Source: Medical Liability Monitor October 2002 Report. Highest and lowest premiums reported for internal medicine, general surgery and ob-gyn physicians.			

The effect of these premiums on what patients must pay for care can be seen from an example involving obstetrical care. If an obstetrician delivers 100 babies per year (which is roughly the national average) and the malpractice premium is $200,000 annually (as it is in Florida), each mother (or the government or her employer who provides her health insurance) must pay approximately $2,000 merely to pay her share of her obstetrician's liability

insurance. If a physician delivers 50 babies per year, the cost for insurance premiums per baby is twice as high, about $4,000. It is not surprising that expectant mothers are finding their doctors have left states with litigation systems imposing these costs.

Nursing homes are a new target of the litigation system. From 1990 to 2001, the average size of claims tripled, and the number of claims increased from 3.6 to 11 per 1,000 beds.[85] Premium increases paid by nursing homes are rising rapidly because of dramatic increases in both the number of lawsuits and the size of awards. Between 1995 and 2001, the average premium increased from $240 per occupied skilled nursing bed per year to $2,360. These costs vary widely across states, again in relation to whether a state has implemented reforms that improve the predictability of the legal system. Florida ($11,000) had one of the highest per bed costs in 2001.[86] Nursing homes in Mississippi have been faced with increases in total premiums as great as 900% in the past two years.[87] Since Medicare and Medicaid pay most of the costs of nursing home care, these increased costs are borne by taxpayers, and consume resources that could otherwise be used to expand health (or other) programs.

V. INSURERS ARE LEAVING THE MARKET

The litigation crisis is affecting patients' ability to get care not only because many doctors find the increased premiums unaffordable but also because liability insurance is increasingly difficult to obtain at any price, particularly in non-reform states. Demonstrating and exacerbating the problem, several major carriers have stopped selling malpractice insurance.

- St. Paul Companies, which was the largest malpractice carrier in the United States, covering 9% of all doctors, announced in December 2001 that it would no longer offer coverage to any doctor in the country.[88]

  MIXX pulled out of every state; it has reorganized and sells only in New Jersey.

  PHICO and Frontier Insurance Group have also left the medical malpractice market.[89, 90]

  Doctors Insurance Reciprocal stopped writing group specialty coverage at the beginning 2002.[91]

Fifteen insurers have left the Mississippi market in the past five years.[92] The number of medical liability insurance companies active in Florida dropped from 66 in the late 1990s to only 12 in 2002.[93] These remaining companies have limited capacity to write new policies for providers whose carriers have departed the market.[94]

According to the Missouri Insurance Commissioner's office, of the 32 companies writing medical malpractice coverage in the state in 2001, only 8 are still writing policies for doctors.[95] The companies that are still in business are charging more and offering fewer discounts. Five specialties in Missouri are facing particular problems in getting coverage: obstetrics-gynecology, orthopedics, neurosurgery, radiology and trauma. Similarly, the two major carriers of professional liability coverage for doctors in Iowa, MMIC and PIC Wisconsin, have reached near capacity (which limits their ability to write new or additional coverage).[96]

The National Association of Insurance Commissioners (NAIC) has examined the increasing unwillingness of insurers to sell malpractice insurance and explains the reasons for this crisis:

> "The reason insurers are not writing, or are pulling back from medial malpractice insurance, is because there are many other lines of insurance that offer more opportunities for profit at a lower risk. The uncertainties and historical return in this line of business

lead many commercial insurers to commit capital in other lines of commercial insurance. It is our experience this market will remain volatile in some states until such time as claims costs stabilize."[97]

VI. STATES WITH REALISTIC LIMITS ON NON-ECONOMIC DAMAGES ARE FARING BETTER

The insurance crisis is acute in states that have not reformed their litigation systems. Over the last two years, states with limits of $250,000 or $350,000 on non-economic damages have seen average combined highest premium increases of 18%, but states without reasonable limits on non-economic damages (in states representing almost half of the entire United States population) have seen average increases of 45%, as shown in Table 6.

TABLE 6: Comparison of States with Caps to States without Meaningful Non-Economic Caps
(Average Highest Premium Increase)

States with Caps < $250,000				States without Caps			
	2001	2002	Avg.		2001	2002	Avg.
California	20%	20%		Arkansas	18%	104%	
		55%		Connecticut	50%	28%	
		35%		Florida+	47%	59%	
	5%	35%		Georgia	32%	37%	
	16%	36%		Illinois	52%	72%	
years			26%	Mississippi	0%	66%	
States with Caps < $350,000				Nevada	35%	50%	
	2001	2002		New Jersey	24%	13%	
California	20%	20%		North Carolina	0%	50%	
	0%	5%		Ohio+	60%	60%	
	16%	55%		Oregon	56%	80%	
Michigan	39%	13%		Pennsylvania	77%	62%	
Montana	21%	35%		Rhode Island	60%	9%	
New Mexico	12%	42%		Tennessee	17%	49%	
North Dakota	0%	15%		Texas+	32%	45%	
	0%	20%		Virginia	37%	74%	
	5%	35%		Washington	55%	6%	
	5%	5%		West Virginia	44%	46%	
	13%	24%		AVERAGE	39%	51%	
AVERAGE over 2 years			18%	AVERAGE over 2 years			45%

SOURCE: Medical Liability Monitor, October 2001 and October 2002. Percentages represent the combined average of the highest premium increases for OB/GYNs, Internists, and General Surgeons among select states, 2002. Average highest premium increase is derived from the highest potential premium increase among internal medicine, general surgery or obstetrics/gynecology specialists in that state during 2002. These combined averages are not weighted.

+ Florida imposes a cap of $250,000-$350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate. Florida is not considered to have a meaningful cap on non-economic damages because of the confusion associated with the arbitration provision. An Ohio statute limiting non-economic damages was declared unconstitutional in 1999. The Texas statute limits damages ($1.4 million in 2002) in wrongful death cases only; the statute had applied to all negligence actions but was ruled unconstitutional in 1990.

As Table 7 below shows, there is a substantial difference in the level of medical malpractice premiums in states with meaningful caps and states without meaningful caps. For example, internists in Los Angeles are charged less than one-half of the premium charged internists in Ft. Lauderdale and Miami. General surgeons and obstetrician-gynecologists in Florida are charged three to four times as much as their peers in California.

In each instance, the premiums in California are less than those charged to specialists in non-reform states. The success of California, and other states that have taken similar actions to rein in the excesses of the litigation system, is not accidental. It is a result of a willingness to confront the problem and enact reforms. In the early 1970s California faced an access crisis like that facing many states now. With bi-partisan support, including leadership from Jerry Brown, then Governor, and from Henry Waxman, then chairman of the Assembly's Select Committee on Medical Malpractice, California enacted comprehensive changes to make its medical liability system more predictable and rational. The Medical Injury Compensation Reform Act of 1975 (MICRA) made a number of reforms, in particular:

Placing a $250,000 limit on non-economic damages while continuing unlimited compensation for economic damages.

Shortening the time in which lawsuits could be brought to three years (thus ensuring that memories would still be fresh and providing some assurance to doctors that they would not be sued years after an event that they may well have forgotten).

Providing for periodic payment of damages to ensure the money is available to the patient in the future.

California has more than 25 years of experience with this reform. It has been a success. Doctors are not leaving California. Insurance premiums have risen much more slowly than in the rest of the country without any effect on the quality of care received by residents of California. Insurance premiums in California have risen by 167% over this period while those in the rest of the country have increased 505%.[98]

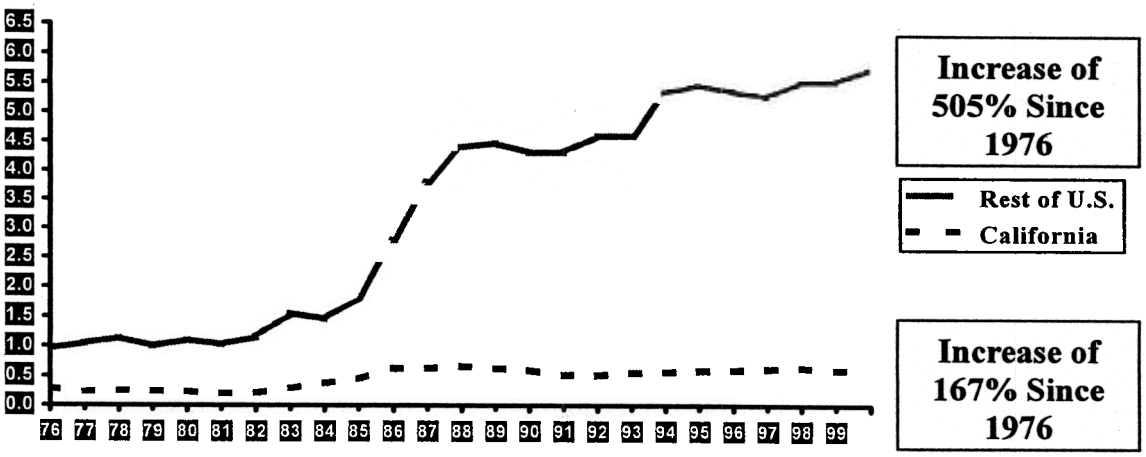
States that do not have the benefit of reforms like California's will continue to experience larger payments for non-economic losses, larger settlements, higher premiums, and reduced access to care. The National Association of Insurance Commissioners--the organization of the state insurance regulators--is concerned about the premiums charged by medical malpractice insurers--concerned that they are too low. Referring to the amounts paid out on claims and defense costs, the NAIC recently warned, "Because of extremely high loss ratios in many states, regulators concerns have been with rate inadequacy, and not excessiveness or unfair discrimination."[99]

TABLE 7: Malpractice Liability Rate Ranges by Specialty by Geography as of October 2002			
	Cap on Non-Economic Damages	Low	High
INTERNISTS			
State Wide Data			
Wisconsin	$350,000	$4,500	$6,000
Montana	$250,000	7,000	7,900
Utah	$250,000	7,900	10,600
Hawaii	$350,000	7,100	7,100
Connecticut	No cap	7,400	13,800
Washington	No cap	6,700	9,800
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$8,800	$21,200
Pennsylvania (Urban Philadelphia area)	No cap	11,000	12,000
Nevada (Las Vegas area)	No cap	17,400	23,600
Illinois (Chicago area)	No cap	19,900	31,700
Florida (Miami and Ft. Lauderdale areas)*	No cap	26,800	56,100
GENERAL SURGEONS			
State Wide Data			
Wisconsin (state wide)	$350,000	$16,000	$19,300
Montana (state wide	$250,000	21,900	31,400
Utah (state wide)	$250,000	35,500	39,100
Hawaii (state wide)	$350,000	25,800	25,800
Connecticut (state wide)	No cap	36,900	43,400
Washington (state wide)	No cap	20,100	35,200
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$30,700	$49,400
Pennsylvania (Urban Philadelphia area)	No cap	50,100	104,400
Nevada (Las Vegas area)	No cap	59,800	85,100
Illinois (Chicago area)	No cap	63,600	75,600
Florida (Miami and Ft. Lauderdale areas)*	No cap	95,500	174,300
OBSTETRICIANS/GYNECOLOGISTS			
State Wide Data			
Wisconsin (state wide)	$350,000	$21,500	$27,800
Montana (state wide	$250,000	33,900	52,200
Hawaii (state wide)	$350,000	42,900	42,900
Utah (state wide)	$250,000	46,900	60,000
Connecticut (state wide)	No cap	69,500	95,000
Washington (state wide)	No cap	30,900	51,900
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$54,600	$65,400
Pennsylvania (Urban Philadelphia area)	No cap	64,300	116,400
Nevada (Las Vegas area)	No cap	93,200	141,800
Illinois (Chicago area)	No cap	102,400	110,100
Florida (Miami and Ft. Lauderdale areas)*	No cap	136,200	210,600

Source: Medical Liability Monitor, October 2002: Shook, Hardy, Bacon, L.L.P., October 9, 2001.
* Florida imposes caps of $250,000-350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate. Florida is not considered to have a meaningful cap on non-economic damages because of the confusion associated with the arbitration provision.

The litigation system must be reformed to protect Americans' access to high quality health care.

FIGURE 1. Premium Growth: California vs. U.S. Premiums 1976-2000
(Billions of dollars)



SOURCE: NAIC Profitability Study, 2000.

VII. THE PRESIDENT'S FRAMEWORK FOR IMPROVING THE MEDICAL LITIGATION SYSTEM

Federal and state action is needed to address the impact of the medical litigation crisis on health care costs and the quality of care.

1. Establish a Fair, Predictable, and Timely Process

As years of experience in many states have proven, reasonable limits on the amount of non-economic damages that are awarded significantly restrain increases in the cost of insurance premiums. These reforms improve the predictability of the medical litigation system, reducing incentives for filing frivolous suits and for prolonged litigation. Greater predictability and more timely resolution of cases means patients who are injured can get fair compensation more quickly. They also reduce health care costs, enabling Americans to get more from their health care spending and enabling federal health programs to provide more relief. They improve access to care, by making insurance more affordable and available. They also improve the quality of health care, by reducing defensive medicine and enabling doctors to spend significantly more time focusing on patient care. President Bush has, on several occasions, urged Congress to give all Americans the benefit of these reforms, eliminate the excesses of the litigation system, and protect patients' ability to get quality care.

The President supports federal reforms in medical liability law that would implement these proven steps for improving our health care system:

- Improve the ability of all patients who are injured by negligence to get quicker, unlimited compensation for their "economic losses," including the loss of the ability to provide valuable unpaid services like care for children or a parent.

- Ensure that recoveries for non-economic damages could not exceed a reasonable amount ($250,000).

- Reserve punitive damages for cases that justify them--where there is clear and convincing proof that the defendant acted with malicious intent or deliberately failed to avoid unnecessary injury to the patient--and avoid unreasonable awards (anything in excess of the greater of two times economic damages or $250,000).

- Provide for payment of a judgment over time rather than in one lump sum--and thus ensure that the money is there for the injured patient when needed.

- Ensure that old cases cannot be brought years after an event when medical standards may have changed or witnesses' memories have faded, by providing that a case may not be brought more than three years following the date or injury or one year after the claimant discovers or, with reasonable diligence, should have discovered the injury.

  Informing the jury if a plaintiff also has another source of payment for the injury, such as health insurance.

- Provide that defendants pay any judgment in proportion to their fault, not on the basis of how deep their pockets are.

The success of the states that have adopted reforms like these shows that malpractice premiums could be reduced by 34%.[100] The savings to the Federal Government resulting from reduced malpractice premiums could be $4.8 billion.[101]

In October 2002, the House of Representatives passed H.R. 4600--a bill introduced by Congressman Jim Greenwood with almost 100 bipartisan cosponsors. The Senate did not act. The bill was reintroduced in the House in February 2003, as H.R. 5. Enactment of similar legislation, with improvements to ensure that its meaningful standards will apply nationally, will be a significant step toward the goals of affordable, high-quality health care for all Americans, and a fair and predictable liability system for compensating injured patients.

In addition, there are other promising approaches for compensating patients injured by negligence fairly and without requiring them to go through full-scale, time-consuming, and expensive litigation. States should also adopt and evaluate alternatives to litigation.

Early Offers is one innovative approach.[102] This would provide a new set of balanced incentives to encourage doctors to make offers, quickly after an injury, to compensate the patient for economic loss, and for patients to accept. It would make it possible for injured patients to receive fair compensation quickly, and over time if any further losses are incurred, without having to enter into the litigation fray. Because doctors and hospitals would have an incentive to discover adverse events quickly in order to make a qualifying offer, it would lead to prompt identification of quality problems. The money that otherwise would be spent in conducting litigation would be recycled so that more patients get additional recovery, more quickly, with savings left over to the benefit of all Americans. It may also be possible to implement an administrative form of Early Offers as an option for patients who are injured in the course of receiving care under certain federal health programs.

A second innovative approach involves strengthening medical review boards to reduce claims of malpractice. Boards with special expertise in the technical intricacies of health care can streamline the fact gathering and hearing process, make decisions more accurately, and provide compensation more quickly and predictably than the current litigation process. Physicians must have confidence that the "legal system will get the facts right in the first place".[103] As with Early Offers, incentives are necessary for patients and health care providers to submit cases to the boards and to accept their decisions.

The Administration intends to work with states on developing and implementing these alternatives to litigation, so that injured patients can be fairly compensated quickly and without the trauma and expense that litigation entails.

2. Improve Health Care Quality Through Litigation Reform

Medical professionals, not lawyers, are the key to quality care. High quality care that achieves the best possible patient outcomes makes litigation unnecessary. The Administration is already taking many steps to improve quality of care.

The ability of Americans to work with their doctors to choose and control their own health care is an important ingredient of quality. The people who are most affected by the quality of care--patients and their families--should be the ones deciding how and from whom they obtain their health care. To do so, they need helpful information.

The Administration is undertaking a number of activities to promote quality by increasing and improving the information available to patients, and taking other steps to make the system safer and more effective. Some specific activities include:

Providing quality information about nursing homes on the Internet to enable families to make comparisons and informed judgments.

- Promoting the use of information technology to provide better real-time information for doctors, to include all the relevant information in the patient's record and to make it accessible no matter where the patient is.

Promoting the introduction and use of bar coding for dispensing prescription drugs to reduce errors. This action alone stands to dramatically reduce the number of medication errors in hospitals, and reduce the costs to society of preventable drug adverse events--recently estimated total direct and indirect costs to society to be a staggering $177 billion yearly.

Adopting comprehensive standards necessary to make the creation of an electronic health care record possible. This would make a patient's medical records available across different care sites, and to the patient.

- Encouraging disease management programs that can improve the quality of care for people with asthma and diabetes.

Promoting computer software that hospitals can use to identify quality problems, assisting in quality improvement activities.

The Administration will work to expand these efforts, to give patients and their doctors the information they need to make informed and appropriate medical decisions, while protecting the confidentiality of sensitive information from inappropriate uses.

One of the key ingredients to reducing errors is optimizing doctors' to improve patients' health care. We must encourage them and other experts to identify problems before they result in injury and to develop better ways of providing care.

Researchers have found that most errors are system failures, rather than individual faults. Doctors could do their job correctly, and most errors would still occur. In addition, since human error inevitably occurs, built-in systems should automatically prevent, detect and/or correct errors before they occur. Continuous quality improvement processes, which have been effective in many other "high-risk" sectors, focus on finding ways to design work processes so that better results and fewer errors can be achieved. This requires measurement and analysis of the ways health care is provided, and the results of care for patients. By encouraging the experts to work both inside their own organization and with outside groups to share information on how medical errors or "near misses" occur and ways to prevent them, health care organizations have begun to develop tools to prevent injury and increase knowledge of how errors occur.

Success in improving health care practices to prevent errors and deliver high-quality care, however, requires a legal environment that encourages health care professionals and organizations to work together to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients.

A principal obstacle to taking these steps is the fear by doctors, hospitals, and nurses that reports on adverse events and efforts to improve care will be subject to discovery in lawsuits. As several distinguished physicians recently wrote, "for reasons that include liability issues and a medical culture that has discouraged open discussion of mistakes, the power of individual case presentation, so important in the physician's clinical medicine education, has not been harnessed to educate providers about medical errors."[104]

A number of states have enacted peer review statutes that protect the confidentiality of information within hospitals and other health care entities.

Confidentiality protections provided by law for specific activities also have proven successful in identifying problems and reducing medical errors:

The National Nosocomial Infections Surveillance System, operated by the Centers for Disease Control, receives voluntary reports from hospitals on hospital-acquired infections. It has reduced these infections by 34%. The system works because federal law assures participating hospitals that information supplied by them will be kept confidential.

MedWatch is a voluntary Medical Products Reporting System operated by the Food and Drug Administration. Adverse events concerning medical devices and drugs may be reported to it to identify problem areas. Names of the reporting doctors and hospitals, and the name of patients involved, are not releasable under the Federal Freedom of Information Act.

The Department of Veterans Affairs maintains a Patient Safety Reporting System to learn about issues related to patient safety. To encourage reporting, federal law provides that reports relating to new safety ideas, close calls, or unexpected serious injury are confidential and privileged. This is based on the successful system operated by the National Aeronautics and Space Administration for aviation safety reporting.

New York State operates the New York Patient Occurrence Reporting and Tracking System. Adverse events are reported to it. New York State law prevents disclosure of reports under the state's freedom of information law.

The IOM report "To Err is Human" noted that while many of the legal protections developed by states have promise, many current state peer review statutes do not go far enough. For example, these laws typically provide legal protection for communications within individual institutions, and usually only for certain committees. These laws do not reflect the systemic nature of health care as it is now provided. They do not provide a way to obtain data from various providers at one time and to compare results. Many states, moreover, do not have any peer review statutes at all. The IOM, therefore, recommended legislation to ensure that peer review proceedings and reports remain confidential.[105]

The President believes that new, good faith efforts to improve the quality and safety of health care should be protected and encouraged, not penalized by new lawsuits. President Bush has on several occasions urged Congress to address this problem by enacting legislation that will give health professionals the confidence necessary to expand their reporting of problems in the health care system.

Following the President's request, and with assistance from the Administration, legislation was introduced in both Houses of Congress last year that would provide confidentiality and other protections for information reported to Patient Safety Organizations and for their collaborative efforts to improve care. A tri-partisan Bill that reflects the President's goals, sponsored by Senators Jeffords, Breaux, Frist, and Gregg, was introduced in the Senate last year (S. 2590). The House Energy and Commerce Committee and the Ways and Means Committee recently reported similar bills (H.R. 663 and H.R. 877 respectively). Passage of this kind of legislation will ensure that patient safety and quality reports are given the protection they deserve.

The assurance of confidentiality is a proven approach to increase reporting by doctors, nurses, and other health care providers. With more information, quality experts will be better able to identify problems and recommend improvements in a proactive way. Rather than reacting to an avoidable injury or quality problem after it occurs, without benefit of careful and systematic review, medical professionals will be able to find system weaknesses and fix them before a patient is injured. Passage of the legislation will improve the quality of health care.

VIII. IT IS SPECIOUS TO BLAME INSURERS FOR THE CRISIS

Trial lawyers, and interest groups associated with them, do not dispute the fact that there is an insurance crisis. They argue, however, that the fault lies with the insurance companies themselves--not the litigation system--and that the cure is not to impose a reasonable limit on the amount of non-economic damages, but instead for doctors to form their own insurance companies.

The trial lawyers' advice to doctors to organize their own insurance companies overlooked the fact that doctors have already done this. Physician-owned companies currently insure more than 60% of doctors.[106] A number of doctor-owned companies were created in the 1970s, when many doctors were unable to obtain coverage. Not surprisingly, however, these companies have suffered the same increases in claim costs as the commercial companies.[107] The reason is that the overriding cost element--the litigation the excesses of the litigation system--affects all insurers regardless of their form of ownership.

The trial lawyers assert, however, that the problem is not the increase in the amounts insurers pay out but the insurers' management practices. They argue that insurers are making up for bad investments in the stock market; they point out that interest rates have declined; and they complain that the premiums the insurers charged in the 1990s were too low. From these statements they somehow seek to persuade us that the litigation system is not causing the crisis.

If the factors alleged by the trial lawyers explained the problem, insurers in every state would be forced to increase their premiums to the same extent. But the fact is that the insurers are being forced to increase their premiums more rapidly and more steeply in the non-reform states than in states that have placed reasonable limits on non-economic damages.

The difference in premiums among the different states cannot be explained by management practices. When St. Paul Companies pulled out of the malpractice insurance market in 2002, they continued to offer other lines of insurance. The difference is the litigation climate in which the different lines of insurance are required to operate.

The argument that the problem is caused by bad investments is similarly specious. In fact, investments by medical malpractice companies have been conservative. Most states have laws that specifically limit the percentage of assets an insurance company can put in stocks. Over the last five years, the industry wide allocation of assets into equities has been relatively constant. Medical malpractice insurers' investments in equities as a percentage of total assets, as shown below, has been 11% or less.

TABLE 8. Five Year Historical Asset Allocation Table for Medical Malpractice Carriers							
	Asset Class						
	Cash	Corp	Equity	Govt	Muni	Other	Pref
	%	%	%	%	%	%	%
1997	4.98	27.61	8.87	21.12	34.19	1.27	1.96
1998	5.83	26.51	8.93	18.77	36.44	1.89	1.64
1999	5.39	28.52	10.78	15.54	36.89	1.37	1.51
2000	6.48	30.89	9.72	14.90	35.03	1.40	1.57
2001	7.74	34.84	9.03	13.73	31.41	1.53	1.73
Brown Brothers Harriman & Co., 2002.							

Insurers' returns on bonds have decreased. Interest rates have declined in the country and the world. The amounts earned on investments help pay claims. But the investment climate is a fact, beyond the control of the insurance companies. Their need to raise premiums can best be reduced by controlling increases in the amounts they must pay out--particularly for unreasonable amounts of non-economic damages. Neither asset allocation nor investment income correlates to, much less causes, the current medical malpractice crisis. Specifically, Brown Brothers Harriman & Company analyzed the relationship between premiums and the change in investment yields among malpractice insurers. The results showed that the performance of the economy and interest rates do not determine medical malpractice premiums.[108]

While the trial lawyers' argue that insurers' premiums were too low in prior years, premiums are affected by the competitive climate, in the context of costs that all participants must bear. If premiums were "too low" in previous years, this just means that physicians were charged less then than the trial lawyers believe they should have been. It does not change the costs the insurers are forced to pay or the total amount of premiums that would have to be collected; even under the trial lawyers' theory of how the insurers should price their product, some undetermined amount of the premiums being charged currently should have been collected in previous years. It would not change the total revenue needs of the insurers (which are determined by the amount they must pay out).

The trial lawyers' argument that the root of the crisis lies in the organizational form or management practices of the insurers thus has no validity.

Trial lawyers also attempt to shift the blame to insurers by asserting that they have engaged in anti-competitive practices. The NAIC has reviewed this assertion and reported that "insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation."[109] Rather, the NAIC also says, "the preliminary evidences points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice [insurance] prices."[110]

Consistent with their failure to focus on the costs the insurers must bear, the trial lawyers argue, finally, that California's MICRA legislation, placing reasonable limits on non-economic compensation, is not the cause of California's success in avoiding the increase in premiums that non-reform states have experienced. They point, instead, to a change in the law of California in 1988 that imposed rate review on the premiums of insurance companies. Regulation, however, cannot avoid the need for insurers to receive a premium sufficient to pay their expenses and make a fair profit. Nor does California's regulation of premiums differentiate it from the rest of the country. As the NAIC explains, "Almost all states have rating laws for property and casualty insurers, including medical malpractice. These rating laws require that insurance rates not be excessive, inadequate or unfairly discriminatory."[111] California's adoption of increased regulation in 1988 therefore does not explain its ability to avoid the rapid increase in premiums and access problems that states without reasonable caps have experienced.

In fact, premiums in the rest of the country already were increasing more rapidly than in California before 1988, as shown in Figure 1. What makes the difference is the litigation system, not insurance reforms.

CONCLUSION

Americans' access to high quality care is threatened by the excesses of the litigation system. Higher costs for defending claims, larger judgments, particularly for subjective non-economic damages in states that have not introduced reasonable limits on non-economic damages, and settlements that reflect the trend of jury awards are raising insurers' costs. Insurers must raise premiums to pay claims. Patients are paying the price in reduced access to care as doctors increasingly leave the states with the highest costs, retire, or restrict their practice. Patients are being injured. The crisis is going to get worse if we do not act; the insurance regulators believe premiums in many states are currently too low. States like California that have placed reasonable limits on the amount of non-economic damages are not suffering the same high premiums and reductions of access to care as the states that do not have such limits. The Administration supports legislation that will ensure that all states have the benefit of reasonable limits, which will stabilize their insurance markets and encourage doctors to continue to practice there.

In addition, legislation is necessary to protect efforts by hospitals, doctors, and other experts to improve quality by encouraging reporting of needed information and collaborative use of it. Reports about safety problems and "close calls" in the course of health care are essential to improving quality, but the litigation system now discourages reporting and impedes the exchange of information and collaboration necessary to improve quality. The efforts of health professionals to improve quality will be enhanced if the information developed for these purposes is protected from use in the litigation system. Quality of care can best be protected, and improved, by health care experts, not by lawyers.

Enactment of these two reforms will improve the litigation system, increase access to health care, reduce the cost of health care, and improve quality. It will do so while ensuring that injured patients have the same access to information about their care as they do now, and that they can recover all their actual losses and a reasonable amount of non-economic damages as well.

[1] US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System, July 25, 2002.

[2] Website http://aspe.hhs.gov/daltcp/home.shtml.

[3] See Table 6. These rates reflect average highest premium increases among internal medicine, general surgery and obstetrics-gynecology specialists.

[4] See Table 6. These rates reflect average highest premium increases among internal medicine, general surgery and obstetrics-gynecology specialists.

[5] Philadelphia Inquirer, August 30, 2002.

[6] ASPE/HHS Communication, September 25, 2002.

The Times Leader, August 10, 2002.

[8] Rep. Ellen Bard, ASPE/HHS Communication, December 13, 2002.

[9] The Impact of Medical Malpractice Insurance and Tort Reform on Washington's Health Care Delivery System, Washington State Medical-Education and Research Foundation, September 2002.

[10] Robin Palmer, "Doctors, Lawyers Square off in malpractice insurance debate", Rutland Herald, 1/11/2003.

[11] Website http://massmed.org, Massachusetts Medical Society, December 3, 2002.

[12] Las Vegas Journal Review, August 29, 2002.

[13] Washington Post, July 4, 2002.

[14] Los Angeles Times, March 4, 2002.

[15] Las Vegas Journal Review, August 29, 2002.

[16] Los Angeles Times, March 4, 2002.

[17] Senn, Dunn, Marsh, Roland Insurers, Personal Correspondence, July 2002.

[18] Akron Beacon Journal, January 2002.

[19] Advancing Health in America, June 12, 2002, Statement before the House Judiciary Subcommittee on Commercial and Administrative Law.

[20] Los Angeles Times, "Mississippi Doctors Give Up Obstetrics," November 19, 2001

[21] Fox News, "Lawsuits Fueling Health Care Crisis," May 14, 2002.

[22] Testimony of Leanne Dyess before the Senate Judiciary and HELP Committees, February 11, 2002.

[23] Website http://www.fmda.org/progressreport.html#contfrm1.

[24] Bryant, Julie, "Malpractice Rates Sicken Hospitals," Atlanta Business Chronicle, March 25, 2002.

[25] Bryant, Julie, "Malpractice Rates Sicken Hospitals," Atlanta Business Chronicle, March 25, 2002.

[26] American College of Obstetricians and Gynecologists, "The Hot States," Red Alert Facts: The Professional Liability Insurance Crisis, May 2002.

[27] Rural Health News, Vol. 9, No. 1, Spring-Summer 2002.

[28] Rural Health News, Vol. 9, No. 1, Spring-Summer 2002.

[29] Washington Post, February 3, 2003.

[30] Center for Health Systems Change, "An Update on the Community Tracking Study, A Focus on the Changing Health System," Issue Brief No. 18, February 1999.

[31] Linda Keegan, ASPE/HHS Personal Communication, February 24, 2003.

[32] Linda Keegan, ASPE/HHS Personal Communication, February 24, 2003.

[33] The AMA has identified Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia as crisis states.

[34] American College of Obstetricians and Gynecologists, "The Hot States," Red Alert Facts: The Professional Liability Insurance Crisis, May 2002. ACOG has identified Florida, Mississippi, Nevada, New Jersey, New York, Pennsylvania, Texas, Washington, West Virginia as Red Alert states.

[35] American College of Obstetrics and Gynecologists, Department of Liability & Risk Management, November 2002.

[36] Neurosurgery in a State of Crisis: Report on the State of Professional Liability Rates and the Impact on Neurosurgeons and their Patients, American Association of Neurological Surgeons, September 25, 2002.

[37] Hospitals Face a Challenging Operating Environment, Statement of the American Hospital Association before the Federal Trade Commission, Health Care Competition Law and Policy Workshop, September 9-10, 2002.

[38] The Malpractice Insurance Crisis: The Impact on Healthcare Cost and Access, Blue Cross and Blue Shield Association, January 15, 2003.

[39] "Fear of Litigation Study," conducted by Harris Interactive, Final Report, April 11, 2002.

[40] "Fear of Litigation Study," conducted by Harris Interactive, Final Report, April 11, 2002.

[41] "Fear of Litigation Study," conducted by Harris Interactive, Final Report, April 11, 2002.

[42] Ft. Lauderdale Sun-Sentinel, January 2, 2003.

[43] Localio, A.R.; Lawthers, A.G.; et.al., "Relation between malpractice claims and adverse events due to negligence. Results of the Harvard Medical Practice Study III," New England Journal of Medicine, Volume 325:245-251, July 25, 1991.

[44] O'Connell, Jeffrey; Pohl, Christopher, "How Reliable is Medical Malpractice Law?," 359 Journal of Law and Health,1998. A Review of Vidmar, Neil, "Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards," University of Michigan Press, 1995.

[45] O'Connell, Jeffrey; Pohl, Christopher, "How Reliable is Medical Malpractice Law?," 359 Journal of Law and Health,1998. Brennan, T.A, Sox, C.M. and Burstin, H.R., "Relation between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation", New England Journal of Medicine, 355(26): 1963-1967, December 26, 1996.

[46] "Fear of Litigation Study," conducted by Harris Interactive, Final Report, April 11, 2002.

[47] O'Connell, Jeffrey; Pohl, Christopher, "How Reliable is Medical Malpractice Law?," 359 Journal of Law and Health,1998. A Review of Vidmar, Neil, "Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards," University of Michigan Press, 1995.

[48] Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology, report of the Task Force on Neonatal Encephalopathy and Cerebral Palsy, January 31, 2003.

[49] Quote by Dr. Gary Hankin, Chair of Task Force on Neonatal Encephalopathy and Cerebral Palsy, as cited in Walter Olson, "Delivering Justice," Wall Street Journal Opinion, February 27, 2003.

[50] Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology, report of the Task Force on Neonatal Encephalopathy and Cerebral Palsy, January 31, 2003. Walter Olson, "Delivering Justice," Wall Street Journal Opinion, February 27, 2003.

[51] IOM Report, "To Err is Human: Building a Safer Health System," 2000.

[52] "Fear of Litigation Study," conducted by Harris Interactive, Final Report, April 11, 2002.

[53] Berwick, Donald M., "As Good As It Should Get: Making Healthcare Better in the New Millennium," National Coalition for Healthcare, 1998.

[54] Maulik, Joshi; Anderson, John; et al., "A Systems Approach to Improving Error Reporting," Journal of Healthcare Information Management, Vol. 16, No. 1.

[55] Website http://www.wired.com/news/medtech/0,1286,57311,00.html.

[56] Maulik, Joshi; Anderson, John; et.al. "A Systems Approach to Improving Error Reporting," Journal of Health Care Information Management, Vol. 16, No. 1.

[57] Committee for Quality Health Care in America/Institute of Medicine, "To Err is Human: Building a Safer Health System," 2000.

[58] IOM Report, "To Err is Human: Building a Safer Health System," 2000.

[59] O'Connell, Jeffrey; Baldwin, Joseph, "Tort Law as Melodrama--Or Is It Farce?", 50 UCLA Law Review, at 425 (December 2002).

[60] Office of the Assistant Secretary for Planning and Evaluation using Council of Economic Advisors' Estimates, February 2003.

[61] Kessler, D. & McClellan, M, "Do Doctors Practice Defensive Medicine," Quarterly Journal of Economics, 111(2): 353-390, 1996.

[62] This amount includes $28.1-$50.6 billion for the cost of defensive medicine; $4.29 billion in liability insurance paid to Medicare, Medicaid, Veterans' Affairs, and other federal programs; $263 million in liability insurance paid through health benefits for its employees and retired employees; and $1 billion in lost tax revenue from self-employed and employer-sponsored health insurance premiums that are excluded from income.

[63] Total Federal health care expenditures in 2002 were estimated to be $562 billion. Estimates show that medical liability reforms would lead to a decline in medical expenses from defensive medicine amounting to 5% to 9% of total medical costs (See Kessler, D. and McClellan, M, 1996). Our estimate of the savings to the Federal Government from reduced defensive medicine would range from $28.1 billion (5% of $561.837 billion) to $50.6 billion (9% of $561.837 billion).

[64] PIAA Claim Trend Analysis, January 3, 2003.

[65] Illinois Department of Insurance, Casualty Actuarial Section, Medical Malpractice Claims Study, 2001.

[66] Missouri Department of Insurance, Statistics Section, 2001 Missouri Medical Malpractice Insurance Report, September 2002.

[67] Illinois Department of Insurance, Casualty Actuarial Section, Medical Malpractice Claims Study, 2001.

[68] Missouri Department of Insurance, Statistics Section, 2001 Missouri Medical Malpractice Insurance Report (physicians and surgeons), September 2002.

[69] US Department of Health and Human Services, National Practitioner Data Bank, January 28, 2003 data run.

[70] US Department of Health and Human Services, Health Resources and Services Agency, National Practitioner Data Bank, January 28, 2003 data run.

[71] Report of the Governor's Task Force on Healthcare Professional Liability Insurance, January 29, 2003.

[72] John Thomas, General Counsel of Baylor Health System and President of the Council for Affordable and Reliable Health Care (CARH), Presentation at Health Policy Summit, Jacksonville, FL, December 17, 2002.

[73] Weiler, Paul, "Medical Malpractice on Trial," Boston: Harvard University Press. 1991

[74] Physician Insurers Association of America (PIAA), Trend Analysis of Claims by Close Year, 2000.

[75] Localio, A.R.; Lawthers, A.G.; et.al., "Relation between malpractice claims and adverse events due to negligence. Results of the Harvard Medical Practice Study III," New England Journal of Medicine, Volume 325:245-251, July 25, 1991.

[76] GAO, "Medical Malpractice: Characteristics of Claims Closed in 1984," GAO/HRD-87-55, April 1987, p. 18; Physicans' Insurers Association of America.

[77] Subcommittee on Commercial and Administrative Law before the House Judiciary Committee, testimony presented by PIAA, June 12, 2002.

[78] O'Connell, Jeffrey, "An Alternative to Abandoning Tort Liability," 60 Minnesota Law Review: 501-506-509, 1976.

[79] O'Connell, Jeffrey; Kelly, Brian, "The Blame Game," p.125; Dodd, Christopher, "A Proposal for Making Product Liability Fair, Efficient, and Predictable," p.139; Statement of George Priest, "Punitive Damages: Tort Reform and FDA Defenses," Hearings before the Committee on the Judiciary of the United States Senate, Serial No. J-104016, April 4, 1995, p. 85. (dealing with product liability litigation generally).

[80] Quoted in Keeton, Robert; O'Connell, Jeffrey, "Basic Protection for the Traffic Victim," Little Brown, 1965.

[81] Subcommittee on Commercial and Administrative Law before the House Judiciary Committee, testimony presented by PIAA, June 12, 2002.

[82] O'Connell, Jeffrey, "An Alternative to Abandoning Tort Liability," 60 Minnesota Law Review: 501-506-509, 1976.

[83] Medical Liability Monitor, Vol. 27, No. 1, August 2002.

[84] American Tort Reform Association, December 2001--Non-Economic Damage Reform; Shook, Hardy & Bacon L.L.P, Liability Reform Laws, October 2001.

[85] Aon Risk Consultants, Inc., "Long Term Care General Liability: Professional Liability Actuarial Analysis," February 28, 2002.

[86] Aon Risk Consultants, Inc., "Long Term Care General Liability: Professional Liability Actuarial Analysis," February 28, 2002.

[87] Information supplied By Rep. Chip Pickering.

[88] Modern Healthcare, January 7, 2002; "Medical Malpractice III, Insurance Issues Update," March 2002.

[89] The Record (New Jersey), December 23, 2001.

[90] The New York Times, "Doctors Face a Big Jump in Insurance," March 22, 2002.

[91] The Clarion-Ledger, "Lloyd's of London Agrees to Insure Mississippi Doctors But 25-Member Group Will Pay Rates 400% Higher," December 22, 2001.

[92] Best's Insurance News, "Mississippi Looks for Answers to Lack of Med-Mal Coverage," December 28, 2001.

[93] The Governor's Select Task Force on Healthcare Professional Liability Insurance, January 29, 2003.

[94] The Governor's Select Task Force on Healthcare Professional Liability Insurance, January 29, 2003.

[95] Randy McConnell, ASPE/HHS Communication, December 20, 2002.

[96] Medical Malpractice Insurance--A Crisis Waiting to Happen in Iowa, Jeanine Freeman, JD Statement Before the Iowa Insurance Division, June 24, 2002.

[97] Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.

[98] NAIC Profitability by Line by State, 2001, presented before House Judiciary Committee by PIAA June, 2002.

[99] Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.

[100] Zuckerman, Stephen, Bovbjerg, Randall R., and Sloan, Frank, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," Inquiry 27: 167-182, Summer 1990.

[101] Analysis from the Council of Economic Advisors, July 2002.

[102] O'Connell, Jeffrey, "Offers that Can't be Refused," 1977 Northwestern University Law Review 589 (1982); Moore, Henson; O'Connell, Jeffrey, "Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss," 44 Louisiana Law Review 1267 (1984); Moore, Henson; Hoff, John, "H.R. 3084: A More Rational Compensation System for Medical Malpractice," 49 Law and Contemporary Problems 117 (Spring 1986). A Statement by the Committee for Economic Development, "Breaking the Litigation Habit," 2000. A Bill to implement this approach was first introduced by Rep. Henson Moore and Rep. Richard Gephardt in 1987, H.R. 5400, 98th Congress.

[103] Walter Olson, "Delivering Justice," Wall Street Journal Opinion, February 27, 2003.

[104] "Learning from our Mistakes: Quality Grand Rounds, a New Case-Based Series on Medical Errors and Patient Safety," Annuals of Internal Medicine, Volume 136, Number 11, June 4, 2002.

[105] IOM Report, "To Err is Human: Building a Safer Health System," 2000.

[106] Statement of the Physician Insurers Association of America before a joint hearing of the US Senate Judiciary Committee and Health, Education, Labor and Pensions Committee, February 11, 2003.

[107] The current President of PIAA, Lawrence Smarr, reported in a presentation at the Health Policy Summit in Jacksonville, FL on December 17, 2002, that he himself once thought that physician-owned malpractice insurance companies would be able to restrain costs more effectively than commercial companies. He left employment with a commercial company to work for a physician-owned one. He described, however, that experience taught him otherwise. Physician owned and commercial carriers face the same challenges--the escalating losses that are generated by the litigation system.

[108] Ramacachandran, Raghu, "Did Investments Affect Medical Malpractice Premiums?," Brown Brothers Harriman & Company, January 21, 2003.

[109] Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.

[110] Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.

[111] Mike Pickens, President of the National Association Of Insurance Commissioners, in a letter to Senator Judd Gregg, Chair, U.S. Senate Committee on Health, Education, Labor, and Pensions, February 7, 2003.