Confronting the New Health Care Crisis:

Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System

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American health care is the envy of the world, but with rapidly rising health care costs, reforms are needed to make high-quality, affordable health care more widely available. These include new approaches to making employer-provided coverage more affordable, new initiatives to help states expand Medicaid and S-CHIP coverage for lower-income persons, and new policies including health insurance credits for persons who do not have access to employer or public health insurance. A critical element for enabling all of these reforms to provide real relief, and to help all Americans get access to better and more affordable health care, is curbing excessive litigation.

Americans spend proportionately 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"--the costly use of medical treatments by a doctor for the purpose of avoiding litigation. As multimillion-dollar jury awards have become more commonplace in recent years, these problems have reached crisis proportions. Insurance premiums for malpractice are increasing at a rapid rate, particularly in states that have not taken steps to make their legal systems function more predictably and effectively. Doctors are facing much higher costs of insurance, and some cannot obtain insurance despite having never lost a single malpractice judgment or even faced a claim.

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 because the doctor has given up practice, limited the practice to patients without health conditions that would increase the litigation risk, or moved to a state with a fairer legal system where insurance can be obtained at a lower price.

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

Increasingly extreme judgments 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. 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.

Access to Care is Threatened

There are a number of obstacles that limit access to affordable health care in this country, including lack of affordable insurance and an outdated Medicare program. We now face another--the litigation crisis that has made insurance premiums unaffordable or even unavailable for many doctors, through no fault of their own. This is making it more difficult for many Americans to find care, and threatening access for many more.

- Nevada is facing unprecedented problems in assuring quick access to urgently needed care. The University of Nevada Medical Center closed its trauma center in Las Vegas for ten days earlier this month. Its surgeons had quit because they could no longer afford malpractice insurance.[1] 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. If the Las Vegas trauma center closes again, the most severely injured patients will have to be transported to the next nearest Level 1 trauma center, five hours away. Access to trauma care is only one problem Nevada faces; access to obstetrics and many other types of care is also threatened.

- Overall, more than 10% of all doctors in Las Vegas are expected to retire, or relocate their practices by this summer.[2] For example, 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.[3]

- Dr. Frank Jordan, a vascular surgeon, in Las Vegas, left 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?"[4]

- Other states are facing the same problem. 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.[5]

- Pennsylvania physicians are also leaving their practices. About 44 doctors at the height of their careers in Delaware County outside Philadelphia left the state in 2001 or stopped practicing medicine because of high malpractice insurance costs.[6]

- When Chester County (Pennsylvania) physicians were polled in January 2001, 65% said they were seriously considering moving their practice to another state. Many specialists (such as neurosurgeons) have already moved to less hostile medical-legal environments of surrounding states.[7]

- At Frankford Hospital's three facilities in Northeast Philadelphia and Bucks County, all twelve active orthopedic surgeons decided to lay down their scalpels after their malpractice rates nearly doubled to $106,000 each for 2001.[8]

- 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 I didn't want to do that..."[9]

- 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.[10]

- 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.[11] Ambur Peterson's obstetrician in Cleveland, Mississippi, stopped practicing three weeks before her due date, and she had to drive out of state, over a hundred miles, to Memphis, Tennessee, to get the care she needed.[12]

- Most of the cities with populations under 20,000 in Mississippi no longer have doctors who deliver babies.[13] Doctors in Natchez say they will relocate their practice across the Mississippi River to Louisiana because of the cost of insurance in Mississippi and runaway jury awards. They are planning a new $6 million medical office building in Vidalia, Louisiana.[14]

- In Georgia, the 80-bed Bacon County Hospital in Alma took out a loan to cover a premium that more than tripled.[15]

- Another Georgia hospital, Memorial Hospital and Manor in Bainbridge, that operates a hospital and a nursing home, was faced with a 600% increase.[16]

- In New Jersey, 65% of the hospitals report that physicians are leaving because of increased premiums (over 250% over the last three years).[17]

- In Tacoma, Washington, some doctors were faced with a tripling of their premiums. High premium rates and an inability to obtain insurance may force many physicians in the state to leave.[18]

- 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.[19]

- 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, volunteers his services on the board but is unable to volunteer to provide medical care because of the fear of lawsuits and the cost of insurance.

Patient Safety is Jeopardized

Because the litigation system does not accurately judge whether an error was committed in the course of medical care, physicians adjust their behavior to avoid being sued. A recent survey of physicians revealed that one-third shied away from going into a particular specialty because they feared it would subject them to greater liability exposure.[20] When in practice, they 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 survey revealed that over 76% are concerned that malpractice litigation has hurt their ability to provide quality care to patients.

Because of the resulting legal fear:

- 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.

Every test and every treatment poses a risk to the patient, and takes away funds that could better be used to provide health care to those who need it.

Physicians' understandable fear of unwarranted litigation threatens patient safety in another way. It impedes efforts of physicians and researchers to improve the quality of care. As medical care becomes increasingly complex, there are many opportunities for improving the quality and safety of medical care, and reducing its costs, through better medical practices. According to some experts, these quality improvement opportunities hold the promise of not only significant improvements in patient health outcomes, but also reductions in medical costs of as much as 30%.[21]

A broad range of experts on improving health care quality have developed strong evidence that 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 correct them. Many problems in the health care system result not from one individual's failings, but from complex system failings. These can only 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.[22]

- 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.

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.[23] 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 in the system across all providers. These quality efforts require enhancements to information and reporting systems.

In its recent 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."[24]

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 provide fodder for litigants to find ways to assert that the status quo is deficient. 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 make 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." [25] 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."[26]

Health Care Costs are Increased

The litigation and malpractice insurance problem raids the wallet of every American. Money spent on malpractice premiums (and the litigation costs that largely determine premiums) raises health care costs. Doctors alone spent $6.3 billion last year to obtain coverage.[27] Hospitals and nursing homes spent additional billions of dollars.

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. The leading study estimates that limiting unreasonable awards for non-economic damages could reduce health care costs by 5-9% without adversely affecting quality of care.[28] This would save $60-108 billion in health care costs each year. These savings would lower the cost of health insurance and permit an additional 2.4-4.3 million Americans to obtain insurance.[29]

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--also 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 direct cost of malpractice coverage and the indirect cost of defensive medicine increases the amount the Federal Government must pay through these various channels, it is estimated, by $28.6-47.5 billion per year.[30] If reasonable limits were placed on non-economic damages to reduce defensive medicine, it would reduce the amount of taxpayers' money the Federal Government spends by $25.3-44.3 billion per year.[31] This is a very significant amount. It would more than fund a prescription drug benefit for Medicare beneficiaries and help uninsured Americans obtain coverage through a refundable health credit.[32]

The Increasingly Unpredictable, Costly, and Slow Litigation System is Responsible

Insurance premiums are largely determined by the expensive litigation system. The malpractice insurance system and the litigation system are inexorably linked. The litigation system is expensive, but, at the same time, it is slow and provides little benefit to patients who are injured by medical error. Its application is unpredictable, largely random, and standardless. It is traumatic for all involved.

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.[33] Most claims--57-70%--result in no payment to the patient.[34, 35] When a patient does decide to go into the litigation system, only a very small number recover anything. 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.[36]

Although most cases do not actually go to trial, it costs a significant amount of money to defend each claim--an average of $24,669.[37] The most dramatic cost, however, is the cost of the few cases that result in huge jury awards. Even though few cases result in these awards, they encourage lawyers and plaintiffs in the hope that they can win this litigation lottery, and they influence every settlement that is entered into.

A large proportion of these awards is 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). Instead, 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 said to be compensation for intangible losses, such as pain and suffering, loss of consortium, hedonic (loss of the enjoyment of life) damages, and various other theories that are imaginatively created by lawyers to increase the amount awarded.

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 and without any standards. 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."[38]

Unless a state has adopted limitations on non-economic damages, the system gives juries a blank check to award huge damages based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status (educated, attractive patients recover more than others).[39]

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 who happen to win the litigation lottery. It is not a democratic process.

The number of mega-verdicts is increasing rapidly. The average award rose 76% from 1996-1999.[40] The median award in 1999 was $800,000, a 6.7% increase over the 1998 figure of $750,000; and between 1999 and 2000, median malpractice awards increased nearly 43%.[41] Specific physician specialties have seen disproportionate increases, especially those who deliver babies. In the small proportion of cases where damages were awarded, the median award in cases involving obstetricians and gynecologists jumped 43% in one year, from $700,000 in 1999 to $1,000,000 in 2000.[42]

The number of million dollar plus awards has increased dramatically in recent years. In the period 1994-1996, 34% of all verdicts that specified damages assessed awards of $1 million or more. This increased by 50% in four years; in 1999-2000, 52% of all awards were in excess of $1 million.[43] There have been 21 verdicts of $9 million or more in Mississippi since 1995--one of $100,000,000.[44] Before 1995 there had been no awards in excess of $9,000,000.[45]

These mega-awards for non-economic damages have occurred (as would be expected) in states that do not have limitations on the amounts that can be recovered, as shown in 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
North Carolina	$ 23,500,000	1997
	4,500,000	2001
	8,100,000	2001
Pennsylvania	$100,000,000	1999
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.		

Mirroring the increase in jury awards, settlement payments have steadily risen over the last two decades. The average payment per paid claim increased from approximately $110,000 in 1987 to $250,000 in 1999.[46] Defense expenses per paid claim increased by $24,000 over the same period.[47]

The winning lottery ticket in litigation, however, 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 results in a huge verdict, they have had a good payday. Thus, they have incentives to pursue 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.

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…"[48]

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.[49]

The friction generated by operating the system takes 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.[50] Less than half of the money that does go back to injured patients is used to compensate the patient for economic loss that is not compensated from other sources--the purpose of a compensation system.[51] More than half of the amount the plaintiff receives duplicates other sources of compensation the patient may have (such as health insurance) and goes for subjective, non-economic damages (a large part of which, moreover, actually goes to the plaintiff's lawyer).

The malpractice system does not accurately identify negligence, deter bad conduct, or provide justice. The results it obtains are unpredictable, even random. The same study that found that only 1.53% of patients who were injured by medical error filed a claim also found, on the flip side, that most events for which claims were filed did not constitute negligence.[52] Other studies show the same random results.[53] "The evidence is growing that there is a poor correlation between injuries caused by negligent medical treatment and malpractice litigation."[54]

Not surprisingly, most people involved in health care delivery on a day-to-day basis believe that the system does not accurately reflect the realities of health care or correctly identify malpractice. A recent survey indicated that 83% of physicians and 72% of hospital administrators do not believe the system achieves a reasonable result.[55]

With this randomness, the litigation system cannot be expected to deter error or set meaningful standards of care. That this is, in fact, the case is evidenced by the IOM's estimate that as many as 98,000 people die each year from medical error.[56] If so, the system is failing not only to compensate patients fairly, but even more importantly to ensure quality care.

Yet 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 live off it--trial lawyers, both those who represent plaintiffs and those who represent defendants.

Insurance Premiums are Rising Rapidly

The cost of the excesses of the litigation system shows up in the cost of malpractice insurance coverage. Premiums have increased rapidly over the past several years. Experts believe we are seeing just the tip of what will happen this year and next. Rates have escalated rapidly for doctors who practice internal medicine, general surgery, and obstetrics/gynecology (see Table 2 below). The average increases ranged from 11% to 17% in 2000, were about 10% in 2001, but are accelerating rapidly this year. A recent special report revealed that rate increases are averaging 20%.[57]

TABLE 2. Medical Malpractice Liability Average Premium Increases by Specialty, 2000-2001

	July 2000	July 2001	December 2001
Internists	17%	10%	22%
General Surgeons	14%	10%	21%
Obstetricians/ Gynecologists	12%	9%	19%
SOURCE: Medical Liability Monitor, 2001			

However, these increases have varied widely across states, and some states have experienced increases of 30-75%, although there is no evidence that patient care had worsened. As seen in Table 3, a major contributing factor to the most enormous increases in liability premiums has been rapidly growing awards for non-economic damages in states that have not reformed their litigation system to put reasonable standards on these awards.

TABLE 3. Premium Increases in Non-Reform States Between 2000-2001 or 2001-2002

State	Premium Increase
Nevada	30%
Mississippi	30-40%
North Carolina	50%
Pennsylvania	40%
Virginia	75%
Florida	30%
Ohio	30%
Illinois	Over 30%
Source: Survey of PIAA companies, July 2002 and ASPE Review of Articles, 2000-2002.	

Among the states with the highest average medical malpractice insurance premiums are Florida, Illinois, Ohio, Nevada, New York, and West Virginia.[58] These states have not reformed their litigation systems as others have. (Florida's caps apply only in limited circumstances. New York has prevented insurers from raising rates, and accordingly it is expected that substantial increases will be needed in 2003.) The comparison of the rates in these states

with those in California, which has reformed its litigation system, is shown in Table 4 below.

TABLE 4. States with High Annual Premiums in 2001 by Specialty Compared to California			
	OB/GYN	**Surgeon**	**Internists**
Florida	$143K-203K	$63K-159K	$27K-51K
Michigan	$87K-124K	$67K-94K	$18K-40K
Illinois	$89K-110K	$50K-70K	$16K-28K
Ohio	$58K-95K	$33K-60K	$11K-16K
Nevada	$60K-95K	$32K-57K	$9K-$16K
New York	$34K-115K	$19K-63K	$6K-22K
West Virginia	$63K-85K	$44K-56K	$8K-16K
California	**$23K-72K**	**$14K-42K**	**$4K-15K**
Source: Medical Liability Monitor's "Trends in 2001 Rates for Physicians' Medical Professional Liability Insurance," Vol. 25, No. 10, October 2001.			

The effect of these premiums on what patients must pay for care can be seen from an example involving obstetrical care. The vast majority of awards against obstetricians involve poor outcomes at childbirth. As a result, payouts for poor infant outcomes account for the bulk of obstetricians' insurance costs. 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 malpractice premiums per baby is twice as high, about $4,000. It is not surprising that expectant mothers are finding their doctors have left states that support litigation systems imposing these costs.

In addition to premium increases for physicians, nursing home malpractice costs are rising rapidly because of dramatic increases in both the number of lawsuits and the size of awards. Nursing homes are a new target of the litigation system. Between 1995 and 2001, the national average of insurance costs increased from $240 per occupied skilled nursing bed per year to $2,360. 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.[59]

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.[60] Nursing homes in Mississippi have been faced with increases as great as 900% in the past two years.[61] It has been recently reported that "nearly all companies that used to write nursing home liability [insurance] are getting out of the business."[62] Since the costs of nursing home care are mainly paid by Medicaid and Medicare, these increased costs are borne by taxpayers, and consume resources that could otherwise be used to expand health (or other) programs.

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 doctors, announced in December 2001 that it would no longer offer coverage to any doctor in the country.[63]

- MIXX pulled out of every state; it will reorganize and sell only in New Jersey.

- PHICO and Frontier Insurance Group have also left the medical malpractice market.[64, 65]

- Doctors Insurance Reciprocal stopped writing group specialty coverage at the beginning 2002.[66]

States that had not enacted meaningful reforms (such as Nevada, Georgia, Oregon, Mississippi, Ohio, Pennsylvania, and Washington) were particularly affected.[67] Fifteen insurers have left the Mississippi market in the past five years.[68]

States with Realistic Limits on Non-Economic Damages Are Faring Better

The insurance crisis is less acute in states that have reformed their litigation systems. States with limits of $250,000 or $350,000 on non-economic damages have average combined highest premium increases of 12-15%, compared to 44% in states without caps on non-economic damages, as shown in Table 5.

TABLE 5. Comparison of States with Caps to States without Meaningful Non-Economic Caps (Average Premium Increase)			
States with Caps ≤ $250,000		**States without Caps**	
California	20%	Arkansas	18%
Indiana	15%	Connecticut	50%
Montana	21%	Georgia	32%
Utah	5%	Nevada	35%
		New Jersey	24%
		Oregon	56%
		Pennsylvania	77%
		Washington	55%
		Ohio	60%
		West Virginia	30%
AVERAGE	**15%**	**AVERAGE**	**44%**
States with Caps ≤ $350,000		**States without Caps**	
California	20%	Arkansas	18%
Hawaii	0%	Connecticut	50%
Indiana	15%	Georgia	32%
Michigan	39%	Nevada	35%
Montana	21%	New Jersey	24%
New Mexico	13%	Oregon	56%
North Dakota	0%	Pennsylvania	77%
South Dakota	0%	Washington	55%
Utah	5%	Ohio	60%
Wisconsin	5%	West Virginia	30%
AVERAGE	**12%**	**AVERAGE**	**44%**

SOURCE: Medical Liability Monitor, 2001. Percentages represent the combined average of the highest premium increases for OB/GYNs, Internists, and General Surgeons among select states, 2000-2001. 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 2001. These combined averages are not weighted.

As Table 6 below shows, there is a substantial difference in the level of medical malpractice premiums in states with meaningful caps, such as California, Wisconsin, Montana, Utah and Hawaii, and states without meaningful caps.

TABLE 6. Malpractice Liability Rate Ranges by Specialty by Geography as of July 2001			
	Cap in Non-Economic Damages	**Low**	**High**
INTERNISTS			
State Wide Data			
Wisconsin	$350,000	$5,000	$6,000
Montana	$250,000	5,300	7,000
Utah	$250,000	5,900	5,900
Hawaii	$350,000	6,800	6,800
Connecticut	No cap	6,200	15,800
Washington	No cap	7,100	9,000
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$7,900	$13,000
Pennsylvania (Urban Philadelphia area)	No cap	10,700	11,800
Nevada (Las Vegas area)	No cap	11,600	15,800
Illinois (Chicagoland area)	No cap	16,500	28,100
Florida (Miami and Ft. Lauderdale areas)*	No cap	17,600	50,700
GENERAL SURGEONS			
State Wide Data			
Wisconsin (state wide)	$350,000	$16,000	$17,500
Montana (state wide	$250,000	23,300	27,000
Utah (state wide)	$250,000	26,200	26,200
Hawaii (state wide)	$350,000	24,500	24,500
Connecticut (state wide)	No cap	26,200	45,800
Washington (state wide)	No cap	20,100	32,600
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$23,700	$42,200
Pennsylvania (Urban Philadelphia area)	No cap	31,500	35,800
Nevada (Las Vegas area)	No cap	40,300	56,900
Illinois (Chicagoland area)	No cap	50,000	70,200
Florida (Miami and Ft. Lauderdale areas)*	No cap	63,200	126,600
OBSTETRICIANS/GYNECOLOGISTS			
State Wide Data			
Wisconsin (state wide)	$350,000	$23,800	$27,500
Montana (state wide	$250,000	36,000	38,600
Hawaii (state wide)	$350,000	40,900	40,900
Utah (state wide)	$250,000	44,300	44,300
Connecticut (state wide)	No cap	45,400	64,800
Washington (state wide)	No cap	34,100	59,300
Metropolitan Area Data			
California (Los Angeles area)	$250,000	$46,900	$57,700
Pennsylvania (Urban Philadelphia area)	No cap	45,900	66,300
Nevada (Las Vegas area)	No cap	71,100	94,800
Illinois (Chicagoland area)	No cap	72,500	110,100
Florida (Miami and Ft. Lauderdale areas)*	No cap	108,000	208,900

Source: Medical Liability Monitor, Vol. 26, No. 10, October 2001: 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.

In the early 1970s, California faced an access crisis like that facing many states now and threatening others. With bi-partisan support, including leadership from then Governor Jerry Brown and now Congressman 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, including:

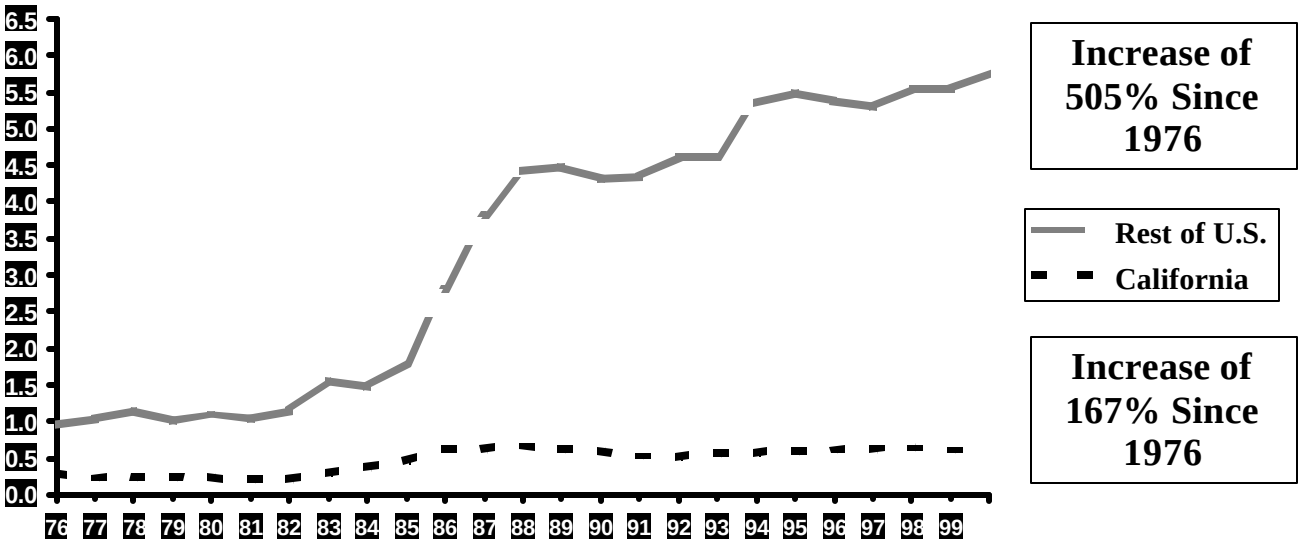
- Placing a $250,000 limit on non-economic damages while continuing unlimited compensation for economic damages.

- 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%.[69] This has saved California residents billions of dollars in health care costs and saved federal taxpayers billions of dollars in the Medicare and Medicaid programs.

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



SOURCE: NAIC Profitability Study, 2000.

The President's Framework for Improving the Medical Liability System

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

Achieving a Fair, Predictable, and Timely Medical Liability 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 malpractice premiums. These reforms improve the predictability of the medical liability 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 avoiding unnecessary "defensive" treatments and enabling doctors to spend significantly more time focusing on patient care. Congress needs to enact

legislation that would give all Americans the benefit of these reforms, eliminate the excesses of the litigation system, and protect patients' ability to get 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% by adopting these reforms.[70] The savings to the Federal Government resulting from reduced malpractice premiums would be $1.68 billion.[71]

Legislation such as H.R. 4600--a bill introduced by Congressman Jim Greenwood with almost 100 bipartisan cosponsors--is now pending in Congress. Enactment of this 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. Just as states like California have demonstrated the effectiveness of litigation reforms, they should also adopt and evaluate the impact of alternatives to litigation.

Early Offers is one innovative approach.[72] 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 care provided under federal health programs.

A second innovative approach involves strengthening medical review boards. 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. 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.

Encouraging Improvements in Health Care Quality and Patient Safety Through Litigation Reform

The best protection for patients can be provided by medical professionals, not lawyers. 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 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 better. Some specific activities include:

- Developing the Consumer Assessment of Health Plans Survey (CAHPS) that provides information on consumers' descriptive ratings of health plans as well as evaluative ratings of care.

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

- Examining how information technology, such as decision support systems embedded in clinicians' personal digital assistants (PDAs), can improve safe patient care.

- Promoting the introduction and use of bar coding for dispensing prescription drugs to reduce errors.

- Developing voluntary 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.

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

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

- Developing a program called "Put Prevention into Practice" in order to assure that evidence-based recommendations for clinical prevention are actually translated into improved delivery of services.

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' inherent ethical imperative to improve patients' health care. We must do a better

job of helping 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."[73]

A number of states have enacted peer review statutes that protect the confidentiality of information reported to hospitals and other health care entities. States that have such laws have found that they improve reporting of adverse events, thereby facilitating efforts to identify problems and improve quality. These protections do not take away from the ability of plaintiffs to succeed in lawsuits: all of the medical information currently available to pursue a lawsuit is still available.

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 apply only to a single institution and 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.[74]

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. In his speech in Milwaukee on February 11, President Bush urged Congress to do something about 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 that would provide protection from discovery in lawsuits for reports made 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, has been introduced in the Senate (S. 2590). Chairwoman Johnson and others have introduced a similar Bill in the House (H.R. 4889). Enactment of this legislation will ensure that patient safety and quality reports are given the protection they deserve. Information developed or used as part of Patient Safety Organizations' activities would be protected, and would not be available for trial lawyers to exploit in order to find new opportunities for litigation.

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.

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