Evaluating State Approaches to the Medical Malpractice Crisis

Over the last several years, state leaders have been forced to grapple with the rising cost of medical malpractice insurance. Concerned with the effect on access to care and under pressure from medical groups, state policy-makers have plunged into the debate, seeking effective solutions to a complicated problem.

Now, two years into the crisis, states have the opportunity to evaluate their responses. What effect have state reforms had? What policies succeeded in reducing or stabilizing premiums quickly and what policies are expected to benefit states in the long-term?

In an attempt to answer these questions, The Council of State Governments hosted "Evaluating State Approaches to the Medical Malpractice Crisis" on April 7, 2004, as part of its Health Policy Monitor teleconference series. This teleconference invited experts to reflect on how the current situation compares to past crises and to evaluate the short- and long-term benefits of various state approaches. Panelists included:

- Dr. William Sage, professor of law, Columbia University
- J. Andrew Crompton, counsel to the president pro tempore, Pennsylvania Senate
- Assemblyman Bob Beers, Nevada State Assembly

The Medical Malpractice ‘Crisis’

Nationally, during the current crisis malpractice insurance premiums have increased by between 15 percent and 30 percent. While this average increase seems relatively moderate, breakdowns by state and medical specialty reveal a wildly varying market. In Pennsylvania, one of the first states the American Medical Association put on its list of states in crisis, the largest carrier increased premiums for primary coverage 40 percent in 2002 and 54 percent in 2003. Other states faced similar problems:

- A comparison of liability insurance premiums paid by obstetrician-gynecologists in Los Angeles and Las Vegas found that those in Nevada paid more than twice what those in California paid: $141,000 compared to $60,000.
- The New Jersey Hospital Association reported that between 1999 and 2002 the amount hospitals in the state paid for liability insurance increased by 203 percent.
- According to the West Virginia State Medical Association, in the last two years, about 150 doctors have either retired early or relocated to other states in response to rising premiums or difficulty obtaining coverage.

Observers blame many factors for such rapid increases. One major factor is the withdrawal of medical malpractice insurers from the market. The St. Paul Companies, a giant in the industry, exited the market in 2002, followed by several other regional insurers. Together, these groups accounted for almost 14 percent of the national market. Without the competition, remaining insurers have less incentive to keep prices down.

The poor economy also played a role. When the stock market was booming during the 1990s, insurers' investments performed so well that premium increases may not have reflected the actual costs of doing business. When investment income plummeted, significant premium increases followed.

Finally, the severity of claims (jury awards and settlements, defense and administrative costs) also contributed to premium increases. Data from the Physician Insurers Association of America show that "median malpractice awards (including both jury awards and settlements) per paid claim have doubled in real terms between 1990 and 2001." According to a recent report by the U.S. General Accounting Office "because insurers base their premium rates on their expected costs, their anticipated losses will therefore be the primary determinant of premium rates."

"I think of medical malpractice as the Rip Van Winkle issue in health care politics and policy: it wakes up every 15 or 20 years. The problem is that when Rip Van Winkle wandered down from the hills, people noticed that his clothes were tattered and that his musket didn't work, and in malpractice it seems that the issue wakes up and we start arguing in exactly the same terms... In doing so, we ignore the huge changes in the American health care system.”

Dr. William Sage, Columbia University

This publication was prepared by Jenny Sewell, senior health policy analyst for The Council of State Governments.
State Responses

As premiums increased and insurers closed up shop, affected states came under intense pressure to take action. In Pennsylvania, the pressure translated into a push to establish caps on awards for non-economic damages, something the state constitution forbids. Since it will take several years to try to pass a constitutional amendment, the state forged ahead, passing other comprehensive reforms in March 2002. These reforms cover a wide range of topics, such as the following:

- Periodic payment – Awards of more than $100,000 no longer have to be paid in a lump sum.
- Collateral source rule – Payments for lost earnings or past medical expenses paid from other sources are deducted from the total award.
- Statute of limitations – Claims must be filed within seven years of the event.
- Venue shopping – Lawsuits must be filed in the county in which the incident took place.

The law also defined what it means to be an “expert” witness, requiring any individual who testifies, for example, to be a board-certified “physician engaged in active clinical practice or teaching and experienced in the care at issue.”

Finally, the legislation addressed quality issues. First, health care facilities must create a patient safety plan and notify patients in writing if an event occurs (this document cannot be used as evidence in a trial). Second, the Pennsylvania Patient Safety Authority – an independent state agency funded by hospitals – will track errors, identify trends and recommend changes in health care practices and procedures. The goal, according to Andrew Crompton, is to “remedy the situation long before litigation occurs.” More information is available at www.psa.state.pa.us.

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U.S. General Accounting Office

Policy-makers also responded by exploring the strategies that seem to be serving other states well. California, for example, passed extensive tort reform in the 1970s. Known as the Medical Injury Compensation Reform Act of 1975, or MICRA, the legislation has several components:

- Non-economic damages are capped at $250,000.
- Awards for economic damages of more than $50,000 can be paid in either a lump sum or over time.
- Disputes can be settled through binding arbitration.
- Attorneys’ fees are limited to a certain percentage of the settlement.
- Claims have to be filed within one year of the discovery of the injury or three years after the event took place.
- A written notice of intent to sue must be filed at least 90 days in advance to give the sides an opportunity to reach an out-of-court settlement.

What effect have these policies had? Data from the National Association of Insurance Commissioners show that “between 1975 and 2000, malpractice premiums grew much more slowly in California than they did in the rest of the nation (167 percent versus 305 percent),” according to a report by the Agency for Healthcare Research and Quality.

For Nevada Assemblyman Bob Beers, California’s close proximity made Nevada’s crisis all the more obvious. “MICRA is hard to argue now that it has been in place here for 25 years,” Beers said. The Nevada state Legislature held a special session in 2002 to address medical malpractice. Several reforms came out of that session, including a $350,000 cap on non-economic awards (per defendant, not per claim). In addition, damages must be reduced by the amount of any compensation the plaintiff received from other sources, and payment may be made over time instead of in a lump sum.

Additional changes may be in Nevada’s future. An initiative known as “Keep Our Doctors in Nevada” will be on the ballot in November 2004. In addition to many MICRA components, this initiative would:

- allow jurors to hear if damages or medical expenses have already been paid for by the insurance company or other party before issuing a verdict;
- award non-economic damages on a per claim basis, not per defendant, when multiple defendants are named in a claim;
- Hold doctors liable only for their percentage of fault.

According to Beers, the impact of one reform from the 2002 special session – a state-based medical malpractice insurance fund – will only be known far in the future. “Insurance is a tricky business and in these cases, much of it is based on actuarially calculating out a future cost for expected injuries,” he said. While Beers knows that the state insurance premiums were less than what the private sector was charging, the fund may not be able to withstand multiple million-dollar awards. “Ask us in 15 years … we may be giving our children the legacy of a billion dollar unfunded liability.”

Pennsylvania’s state-run malpractice fund has been similarly worrisome. According to Crompton, these funds “are great in the beginning because they don’t have to pay many claims. But as the years go on and more claims build up they become a real difficulty.” Crompton added that Pennsylvania plans to phase out its program by 2009. “We carry about a $2 billion unfunded liability associated with that fund.”

Old Tools for a New Problem?

For the most part, the solutions states have implemented or considered during this crisis are the same ones states used during problem periods in the 1970s and 1980s. According to Dr. Sage, this may present a problem. “I think of medical malpractice as the Rip Van Winkle issue in health care politics and policy: it wakes up every 15 or 20 years. The problem is that when Rip Van Winkle wandered down from the hills, people noticed that his clothes were tattered and that his musket didn’t work, and in malpractice it seems that the issue wakes up and we start arguing in exactly the same terms and debating, more or less, the same solutions. In doing so, we ignore the huge changes in the American health care system.”

These changes include advances in treatment and in what constitutes success and failure. Dr. Sage offered an example of a lawsuit over a child born very prematurely who allegedly received negligent care in the neonatal intensive care unit. “This is a case that couldn’t possibly have arisen 20 or 25 years ago because a child this premature wouldn’t have survived,” and the treatments at issue wouldn’t have been performed. Another point this case illustrates is that in settling the case, the life expectancy of the child was 53 years. Because future cost of treatment is part of any settlement, modern medicine’s ability to keep people alive longer is a factor in increased awards.

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### Sample of State Legislation and Statutes

#### Certificate of Merit
- **Arizona:** HB 2362 (1999) Requires claimants, in certain suits against licensed professionals, to provide a preliminary expert opinion if the claimant, or the court upon the defendant's motion, determines expert testimony will be necessary to prove the licensed professional's standard of care of liability.
- **Delaware:** HB 310 (2003) An Affidavit of Merit signed by an expert witness must be obtained before a healthcare negligence lawsuit can be filed. W If an illness qualification requirement is set.

#### Collateral Source Legislation
- **Florida:** State Statutes XLV 768.76 (2003) Directs the court to reduce awards by the same amount the plaintiff has been compensated by other sources for the same loss.
- **Pennsylvania:** Act 13 (2002) A plaintiff cannot recover for past medical expenses or past lost earnings that were covered by any public or private benefit received (a collateral source) prior to the trial.

#### Damage Caps
- **Florida:** §766.209, §766.118 (2003) If a plaintiff refuses to arbitrate a medical malpractice case, non-economic damages would be subject to a $500,000 cap for charges against individual physicians and a $1 million cap for charges against multiple physicians.
- **North Dakota:** §32-42-02 (1995) Awards for non-economic damages are capped at $500,000 regardless of the number of people who sue and the number of people being sued.

#### Joint and Several Liability
- **Colorado:** Colorado Statutes 13-21-115 Personal injury, property damage, or wrongful death, each defendant is liable only for the amount of damages they are proportionately responsible for.
- **Florida:** Florida Statutes, Title XLV, Chapter 768.81 Establishes a multi-tiered limitation on the rule of joint and several liability based on whether a plaintiff is or is without fault.

#### Limitation on Attorney Fees
- **California:** Cal. Bus. & Prof. Code § 6146 California limits the amount attorneys in a medical malpractice case can collect pursuant to a contingent fee arrangement to 40 percent of the first $50,000, 33 1/3 percent of the next $50,000, 25 percent of the next $500,000, and 15 percent of any amount that exceeds $600,000. This limit applies regardless of whether the recovery is by settlement, arbitration, or judgment.
- **Delaware:** Del. Code Ann. tit. 18, §6865 (1989) Delaware limits the amount attorneys may collect as a contingency fee in medical malpractice cases to 35 percent of the first $100,000 in damages, 25 percent of the next $100,000, and 10 percent of any award above $200,000.

#### Patient Safety
- **New Jersey:** S-557 (2004) Known as the "Patient Safety Act," this act will require hospitals to report to the state medical errors resulting in injury or death. Facilities must also inform patients or their relatives when an event occurs. This information will not be admissible in court.
- **Washington:** Senate Bill 6210 (2004) Directs hospitals to share information and documents, including complaints and incident reports, so that different institutions can work together to identify problem doctors and nurses, improve safety, and reduce medical errors.

#### Periodic Payment of Damages
- **Pennsylvania:** Act 13 (2002) For awards that are expected to exceed $100,000, payments must be made overtime. A defendant may discharge this obligation by purchasing an annuity from an approved carrier. When the plaintiff dies, the obligation to pay future medical expenses ceases.
- **South Dakota:** S.D. Codified Laws Ann. §§ 21-3A-1 to 21-3A-12 (1987 & 1997) If all parties agree and if future damages are likely to exceed $200,000, any party to a medical malpractice action may, within 120 days after service of the complaint, elect to pay or receive a judgment in periodic payments.

#### Premium Assistance
- **New Jersey:** A 50 (2004) The bill establishes a temporary $78.3 million premium assistance fund to subsidize malpractice insurance premiums for physicians in high-risk specialties. The money will come from an annual employer tax of $3 per employee and a $75 licensure fee for physicians, lawyers, chiropractors and dentists.
- **West Virginia:** HB 2122 (2003) Provides for an annual tax credit equal to 21 percent of physicians' adjusted medical liability insurance premiums.

#### Rate Increase Oversight
- **California:** Proposition 103 (1988) Insurance companies must get prior approval from the California Department of Insurance before they can raise medical malpractice insurance rates.

#### Review Boards and Dispute Resolution
- **Delaware:** HB 310 (2003) Allows for up to ninety days to investigate a potential negligence claim. It is expected that this grace period will give plaintiffs an opportunity to determine whether a potential claim has merit and will result in some lawsuits that might otherwise be filed not being filed.
- **Nebraska:** Rev. Stat. §§ 44-2840 to 44-2847 (1993 & Supp. 1996) Under Nebraska law, a medical review panel must review all malpractice claims before being filed. The review board determines if the evidence supports the claim of malpractice. The panels decision is non-binding but can be admitted into evidence.

#### State-Run Insurance Funds
- **Ohio:** House Bill 282 (2003) This bill allows the director of the Ohio Department of Insurance to form by regulation a Medical Liability Underwriting Association that would issue medical liability insurance policies to eligible providers who had been declined by two admitted carriers.

#### Venue Shopping
- **Pennsylvania:** Act 13 (2002) Under this new law, a malpractice case must be heard in the county where the alleged incident occurred.
Alternative Models

Once premiums begin to stabilize, it may be time to look at other approaches beyond tort reform. One solution would be to move toward a system similar to that used for workers' compensation – “an administrative, non-litigation based system that not only reduces financial exposure and stabilizes insurance, but ends up improving medical care and providing compensation to a much larger percentage of injured patients than is the case with the tort system,” according to Dr. Sage.

He believes this system would have two important benefits. First, it would speed up the process for settling claims, which would not only help patients but would allow for faster integration of feedback about safety and quality concerns. Second, it would shift liability from the individual to the institution. “The best institutions, whether they are medical practices or hospitals, earn their way into it … and really show that they provide quality medical care,” Dr. Sage said.

Currently, Florida and Virginia operate compensation funds for children who receive brain or spinal injuries at birth. The Virginia Birth-Related Neurological Injury Compensation Program is the payer of last resort for services including medical and hospital expenses, rehabilitation services, nursing home care, etc. The program, which is administered by the Virginia Workers’ Compensation Commission, is funded by fees paid by participating doctors and hospitals, assessments on non-participating doctors, and assessments on liability insurers. More information is available at www.vabirthinjury.com. Florida’s Birth-Related Neurological Injury Compensation Association is very similar to Virginia’s program, although it includes a one-time $100,000 cash payment to parents and a $10,000 death benefit. For more information, visit http://nicaofficial.org/.

Conclusion

States have responded to the current malpractice crisis using tools from previous crises with some success: premium rates in some of the worst hit states are not growing as fast as they were and state-sponsored plans are, at a minimum, ensuring access to coverage.

But is it enough? To head off another crisis in the next decade, states may need to consider alternative methods of compensation. One solution could be an administrative system modeled after either the Florida or Virginia Birth-Related Neurological Injury Compensation Fund. The feasibility of creating a broader fund that would compensate all medical malpractice victims, however, remains to be seen. If successful, it could bring stability to an industry regularly plagued with crisis.

Footnotes

4. ibid.

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