



# National Conference of State Legislatures

## STATE HEALTH LAWMAKERS' DIGEST

POLICY, RESEARCH AND PRACTICES TO INFORM THE DECISION-MAKING PROCESS

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Just as it seemed our nation had broken a suspected 10-year cycle, malpractice premiums began to inch upward in 2000, reminiscent of the 1970s and mid-1980s crises. By 2002, a new crisis had begun and now, a year later, analysts still are wondering what went wrong. There is consensus that dangerously low medical malpractice premiums during the mid-1990s provoked sudden rate hikes when the economy slowed and investment income no longer was available to offset insurers' underwriting losses. Still, insurers and doctors continue to blame frivolous lawsuits and out-of-control jury awards for exploding insurance premiums. Consumer groups accuse insurance companies of reckless investments, price gouging and failing to pass on savings to physicians. Simultaneously, plaintiffs' attorneys condemn a system plagued by medical errors that discourages reporting and promotes costly defensive practices.

The debate over remedies is equally contentious. States typically consider packages of tort reforms aimed at reducing the number of suits and limiting damage awards, pinpointing a single responsible factor is difficult. Recently, even the effectiveness of noneconomic damage caps, the centerpiece of many malpractice reforms, has been challenged. An independent study released in June 2003 by Weiss Ratings Inc. found that, between 1991 and 2002, median annual premiums for standard malpractice coverage rose 36 percent in states without caps on noneconomic damages, but rose 48 percent in states with caps. Median 2002 premiums were found to be about equal in states with and without caps.

Often, discussion of tort reforms neglects alternatives to litigation. For example, dispute resolution programs, such as arbitration, have been used effectively to resolve medical malpractice claims outside of the court system. Proponents believe arbitration leads to more predictable and equitable results. Its informal nature promotes open dialogue between patients and providers, addressing what went wrong and what can be done to prevent future problems. Critics fear its nonpublic nature, which can protect those at fault, and its exclusion of attorneys.

Other alternatives aim to reform the current environment of distrust and improve patient safety. Doctors are increasingly protecting themselves against possible lawsuits by ordering unnecessary tests, a costly practice known as defensive medicine. In 1998, the General Accounting Office estimated that the federal government would save more than \$10 billion if legislation were enacted that reduced defensive medical practice. President Bush recently estimated the cost of defensive medicine to be as much as \$28 billion per year.

The no-fault compensation model allows patients with medical injuries to be compensated without having to prove negligence. They promote a positive relationship between patients and providers and are better equipped to promote safety than negligence-based litigation since they encourage open reporting of errors. Although patient compensation usually is limited to economic damages, studies have shown that administrative costs are lower, more people are compensated, and patients receive a larger share of the total than under the current system. Critics fear that by eliminating liability, incentives to deliver quality care are diluted. Doubts also have been raised about whether no-fault will work for the entire health care system.

No-fault compensation funds currently exist in Florida and Virginia for severe birth-related neurological injuries. In these programs, claims that meet this specifically defined condition receive total coverage of medical and other related expenses. Physician participation is voluntary and claims are eligible only if the physician participates.

Several states, such as Maine, have turned to practice guidelines—standards of care that, if followed, protect physicians from liability. Insurance market interventions, such as state-run, stop-gap medical malpractice insurance funds, also have been tested. Although these programs offer an immediate cure for states that are experiencing an insurance carrier availability crisis, they have been criticized as band-aid solutions that do little to improve affordability. In West Virginia, premiums offered through a similar program often were higher than those that had been commercially available.

In the end, the best alternative will depend on policymakers' ultimate goal. Reducing costs, ensuring quality of care, and protecting patients' rights carry equal weight in the fight to quell this newest medical malpractice crisis. Alternatives to litigation are not mutually exclusive of tort reforms, and legislators may find the most effective strategy is a combination of reforms. ✦

This issue of the *Digest* includes:

*Who Knows*—Interviews with Michelle Mello, Assistant Professor of Health Policy and Law at the Harvard School of Public Health and Rosalyn Bonanti, Associate Director of State Affairs at the American Trial Lawyers Association.

*What Works*—A look at "bad baby" laws and MICRA.

*On The Horizon*—Improving quality to reduce errors.

*Digging Deeper*—Organizations to contact for more information.

# In The Abstract

## NO-FAULT SYSTEMS

No-Fault Compensation for Medical Injuries: the Prospect for Error Prevention

**STUDY AND RESULTS:** The purpose of this study is to describe a “no-fault” alternative to litigation that does not require proof of negligence. The authors argue that there is a pressing need to test its feasibility. The traditional arguments against no-fault systems are concerns about cost and that eliminating liability will dilute incentives to deliver high-quality care. The authors argue that a focus on individual judgment may not only limit the effectiveness of error prevention but may actually exacerbate underlying causes of error. One reason is that a punitive environment chills providers’ willingness to discuss errors. Recent empirical work suggests that a compensation model designed around avoidable or preventable injuries as opposed to negligent ones would not exceed the costs of current malpractice systems in the United States. This model promises to promote quality by harmonizing injury compensation with patient safety objectives, especially if it is linked to reforms that make institutions, rather than individuals, primarily answerable for injuries.

**WHAT’S IMPORTANT:** Using the tort system to resolve medical malpractice claims is fundamentally at odds with attempts to reform medical systems to reduce errors that cause injury. A pressing policy question is how data on errors should be obtained. Possible reporting methods vary as to the degree of obligation placed on perspective reporters of errors, from voluntary to mandatory reporting, and from strictly confidential to public information. Epidemiological analysis and dissemination of both anecdotal and statistical reviews should follow data collection. Like industrial settings, harmful incidents in health systems frequently involve human error, but their causes and consequences cannot be meaningfully understood by examining provider behavior alone. According to the authors, the most promising patient safety initiatives seek to identify and correct latent errors.

**FIND THIS STUDY:** Studdert, David M., and Brennan Troyen. “No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention.” *The Journal of the American Medical Association* 286 (July 11, 2001):217-223.

The Jury Is Still In: Florida’s Birth-Related Neurological Injury Compensation Plan after a Decade

**STUDY AND RESULTS:** Florida’s Birth-Related Neurological Injury Compensation Plan (NICA) is the most significant experiment with compensation for medical injury undertaken in the United States. According to the authors, as NICA enters its second decade of operation, maintaining the scheme’s integrity has emerged as a key challenge for Florida policymakers. The authors explore the relationship that has emerged between NICA and the tort system as competing avenues for families to obtain compensation for severe birth-related neurological injury. The authors found a lively persistence of “bad baby” litigation, despite NICA’s implementation. This can be explained by the plan’s design, primarily the way in which “exclusive” jurisdiction over injuries is determined and the restrictive nature of the compensation criteria used. The authors found that NICA’s role in com-

pensating birth-related neurological injuries in Florida has been a modest one.

**WHAT’S IMPORTANT:** Several commentaries have suggested a causal link between NICA’s introduction and the more stable malpractice environment. According to the authors, however, such effects are difficult to prove, given the complex array of forces that determine claims frequency and outcomes in malpractice insurance rates. Florida’s experience with no-fault has become the primary focus for critics and proponents of alternatives to the medical malpractice system. The authors’ findings may aid efforts to consolidate NICA’s role in injury compensation and inform future design of alternative compensation systems.

**FIND THIS STUDY:** Studdert, David, M., Lori A. Fritz, and Brennan A. Troyen. “The Jury Is Still In: Florida’s Birth-Related Neurological Injury Compensation Plan After a Decade.” *Journal of Health Politics, Policy and Law* 25, no.3 (June 2000).

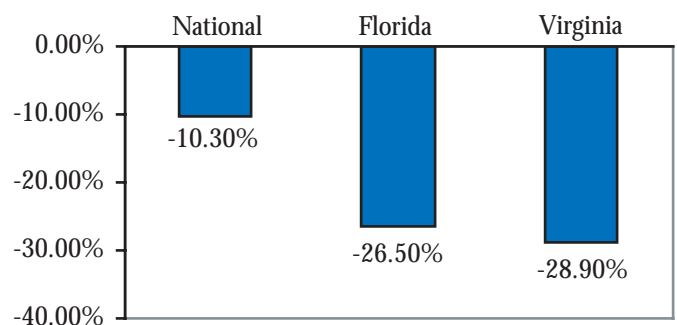
## ARBITRATION AND DISPUTE RESOLUTION

Arbitration Agreements in Healthcare: Myths and Reality

**STUDY AND RESULTS:** The study examines the widespread belief that alternative dispute resolution methods-particularly mandatory binding arbitration agreements-have become the rule in health care delivery. The authors found that, contrary to popular belief, arbitration agreements are not used widely in the medical setting and, when they are used, it is typically because organizational policy explicitly directs their use. The authors found that only 9 percent of the hospitals surveyed and 9 percent of the physicians surveyed used such agreements. Twenty percent of patients surveyed were admitted to hospitals that use such agreements. The percentage of physicians who currently use agreements is small but increasing. Most physicians who currently use agreements have adopted them since 1990. The authors’ survey indicates that most of those who use arbitration are either physicians whose insurer supports the use of the agreements, or who practice in an HMO setting.

**WHAT’S IMPORTANT:** This study concludes: Few disputes are on the arbitration track; although prevalence of arbitration agreements is

Percent Change in Obstetricians' Malpractice Premiums, 1989-1992



Source: Bovbjerg & Sloan, 1999.

## GUIDELINES

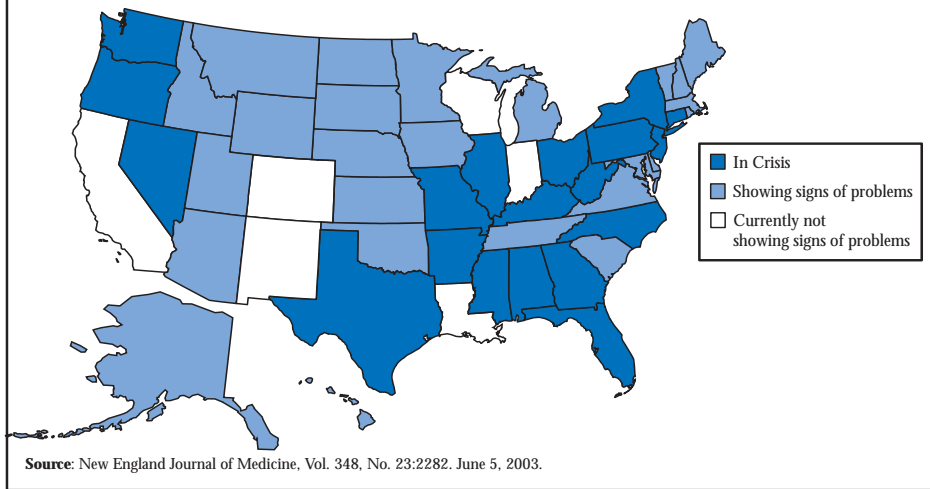
Practice Guidelines as Legal Standards Governing Physician Liability **STUDY AND RESULTS:** According to the authors, practice guidelines are a possible remedy for many of the health care industry's most pressing problems. In addition to helping physicians obtain better medical results for their patients, practice guidelines are expected to give public and private financiers of health services better tools with which to resist paying for, and thus discourage, inappropriate care. They also are viewed as a way to ameliorate the problems associated with the laws governing medical malpractice. According to the authors, practice guidelines could improve the ability of the legal system and liability insurers to determine when actionable medical negligence had occurred.

Guidelines can assist in setting legal standards of care, which is both clearer and more rational than the system the courts currently are using to identify professional negligence. As an alternative to practice guidelines, the article recommends encouraging the development of competing guidelines that might take different positions on specific issues. Formulating better prescriptive standards of medical practice would improve the tort system as a program of quality assurance regulation. Guidelines would serve as the exclusive standard used by licensing authorities, peer reviewers, and malpractice courts in evaluating performance of individual physicians.

**WHAT'S IMPORTANT:** The author's main message in this article is that tort law overregulates medical malpractice. The view of practice guidelines ultimately advanced in this article implies a long overdue shift from tort to contract. His main contention is that the development of practice guidelines should be fostered with a deregulatory, decentralizing objective in mind.

**FIND THIS STUDY:** Havighurst, Clark, C. "Practice Guidelines as Legal Standards Governing Physician Liability." *Law and Contemporary Problems* 54 (1991):87-117. ✦

**States In or Near a Liability Insurance Crisis, According the American Medical Association.**



low, their diffusion and application is dynamic; a major obstacle to use of arbitration is physician opposition; and organizational policies drive the use of agreements.

**FIND THIS STUDY:** Rolph, Elizabeth, Erik Moller and John Rolph. "Arbitration agreements in healthcare: Myths and Reality." *Law & Contemporary Problems* 60 (Winter/Spring 1997):153.

Technical Report: Dispute Resolution in Medical Malpractice

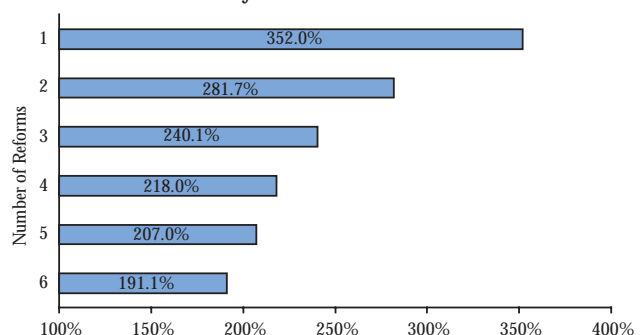
**STUDY AND RESULTS:** The purpose of the report is to educate doctors about past crises within the professional liability insurance industry, the difficulties of the tort system, and alternative strategies for resolving malpractice disputes that have been applied to medical malpractice actions. This report helps to provide an understanding of common alternative dispute resolution (ADR) strategies; the distinctions between various ADR methods — negotiation, mediation, arbitration and the pretrial screening panel—in terms of process and outcome, risks and benefits, appropriateness to the nature of the dispute, and long-term ramifications; and compares their relative advantages and disadvantages to remedy allegations of medical negligence. The report also defines other, less frequently used ADR methods and hybrid techniques.

**WHATS IMPORTANT:** By knowing these concepts, doctors faced with malpractice claims will be better equipped to participate in decision making with legal counsel on whether to settle, litigate or explore ADR options.

**FIND THIS STUDY:** Fraser, John J. "Technical Report: Dispute Resolution in Medical Malpractice." *Pediatrics* 107, no.3 (March 2001):602.

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**Changes in Malpractice Claims Costs by Number of Major Reforms, by State 1985-1998\***



\*Excludes Ohio, Louisiana and Texas  
**Source:** Insurance Information Institute, 2002.

# Who Knows

An interview with **Michelle Mello**, Assistant Professor of Health Policy and Law, Department of Health Policy and Management, Harvard School of Public Health

## What should lawmakers know about the current “crisis” in medical malpractice?

First, believe providers when they say they are in crisis. For high-risk specialties, the increases in liability insurance premiums over the last few years have been staggering. The evidence suggests that the increases in premiums are based on an alarming deterioration in insurer loss ratios that stems from an increase in claims severity (payouts), especially among the highest-end awards.

Second, be suspicious of simple genesis stories. The best evidence suggests that the “insurance cycle” and the upswing in litigation both play a role. Litigation trends are driven by several factors, including public awareness of medical errors, plaintiff attorneys capitalizing on that, permissive juries in some jurisdictions, and idiosyncratic legal rules and insurance arrangements.

Third, count on the crisis recurring unless something significant is done. This is the third malpractice crisis in the last quarter-century, and there is every reason to believe that the factors that have brought us to this point will bring us back there in the future in the absence of reform.

## What should states know about caps in damage awards?

Damage caps have a very intuitive appeal—if high-end awards are driving premium increases, then let’s get rid of them. There are good studies that show an association between caps and decreased claim severity. The effect on premiums is less clear; study findings have been mixed. Overall, caps will probably result in some premium stabilization over the medium- to long- term, but not immediately. Moreover, the imposition of caps raises equity concerns because they disparately affect claimants with the most devastating injuries and result in undercompensation of severely injured people.

## What are some promising alternatives to damage award caps that states should consider?

Unfortunately, there is no silver bullet. We know that most traditional tort reforms haven’t had much of an impact on litigation costs, so there is a growing interest in alternatives. One idea that has received attention is alternative compensation systems for medical injuries (sometimes called “no-fault” systems). Such schemes have significant advantages: the administrative costs are lower, claims are processed faster, damage awards can be rationally limited, and the system is easier for injured patients to access so more people are compensated.

## What effect do you think these reforms will have on patient safety?

You could posit two effects. If you think the tort system does a good job of deterring negligent behavior, then limiting liability might be expected

to result in decreased patient safety. If you think providers have perverse responses to the threat of litigation—like not communicating well with patients and colleagues, not admitting and analyzing mistakes, etc.—then limiting liability might result in improved safety. The best kind of reform would relieve the fears that lead to perverse behaviors but retain some incentives to improve patient safety. Administrative compensation systems can achieve this if the premiums that providers pay are rated to reflect their claims experience or safety record.

An interview with **Roselyn Bonanti**, Associate Director of State Affairs, the American Trial Lawyers Association

## What should lawmakers know about the current crisis in medical malpractice?

State legislators are being told by insurance company lobbyists that high medical malpractice awards are driving up the cost of medical malpractice insurance. They have been lobbying state legislators to implement measures that would dramatically restrict the rights of patients to hold bad doctors accountable. Before overhauling the civil justice system, legislators should be told the truth about the medical malpractice “crises.” First, lawsuits have not caused the current malpractice insurance circumstance and second, tort reform will not reduce medical malpractice insurance premiums.

In a commentary written for International Risk Management Institute, Charles Kolodkin, of Gallagher Healthcare Insurance Services, explains that medical malpractice companies cut premiums to compete for greater market share. Insurers then used the capital generated by the premiums to invest in what was then a booming stock and bond market. When the economy took a downturn, insurers lost money and had inadequate revenue to cover their losses.

A recent report by Weiss Ratings said damage caps did not reduce the burden on insurers, and premium rates rose regardless of caps. They listed six factors driving premiums more than claims or lawsuits: these include medical inflation, bad underwriting in soft markets, too rapid a catch up strategy, poor reserving practices, sharp declines in investment income, and resulting general financial safety that requires higher premiums to shore up.

Just as the liability insurance crisis of the mid-1980s was ultimately found to be caused by poor business decisions, it’s insurers’ bad business practices, not jury awards, which are the driving force behind skyrocketing medical malpractice insurance premiums.

## What should states know about damage award caps?

Noneconomic damage caps deprive seriously injured patients of legitimate compensation and discriminate against children, women, senior citizens and minorities. Noneconomic damage caps have a significantly negative effect on those who are permanently injured, especially children who may live for many years with brain damage or other debilitating injuries and women who suffer reproductive injuries and miscarriages.

Continued on p. 6

# What Works

## NO-FAULT SYSTEMS

In response to the third medical malpractice crisis in 30 years, states are looking for alternatives to the tort system. One such alternative is the no-fault system. No-fault systems do not use negligence as a criterion for payment and allow people to seek compensation without using an attorney. Florida and Virginia pioneered this approach in the late 1980s to solve problems related to lack of access to obstetrical care and high insurance costs.

Both state's systems are designed to be exclusive remedies for compensating birth-related neurological injuries. Physicians who deliver babies do not have to participate, but most do. Each state limits families' access to the court system. In Florida, a lawsuit can be filed only before a no-fault claim is made and if malice and negligence are involved. In Virginia, a lawsuit cannot be filed unless gross or willful negligence is shown. In Florida, state courts have ruled that families can file suit if they were not informed during treatment that their physician participated in the program.

No-fault systems limit the total compensation paid by keeping punitive damage awards low. Payments for pain and suffering are capped at \$100,000 in Florida and are not allowed in Virginia. In both systems, compensation from collateral sources is deducted dollar-for-dollar.

To finance the system, Florida made a one-time contribution of \$40 million and uses contributions from both physicians and hospitals. Participating obstetricians contribute \$5,000 per year, other physicians \$250 per year, and private hospitals \$50 per birth. Virginia collects \$5,000 from participating physicians and \$50 per delivery per year from hospitals, with a maximum of \$150,000.

Florida and Virginia have reaped benefits: the number of tort claims is down, compensation payments for severe birth-related injuries are down, administrative costs are low, and families have received compensation much more quickly than from the tort system. Patient satisfaction has been solid in both states. This suggests that similar no-fault programs may be an approach other states may want to consider.

## MICRA—THE GOLD STANDARD FOR TORT REFORM

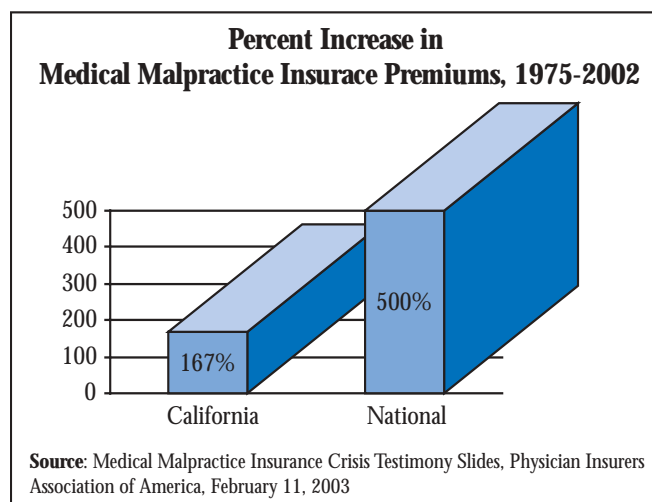
In 1975, a medical malpractice insurance crisis threatened to shut down California's health care system. The state Legislature was called into special session by then-Governor Jerry Brown. What emerged from the early-summer session came to be known as MICRA—the Medical Injury Compensation Reform Act of 1975, considered by many to be the gold standard for tort reform. With U.S. Senator Dianne Feinstein looking at introducing a plan for a national version in Congress, MICRA once again is being hotly debated.

Legislators developed MICRA as a comprehensive way to address the crisis. The series of statutes is designed to test several different theories of how to control the malpractice system. The ultimate goal of MICRA was to slow the rise in malpractice insurance premiums. The means to that end was requiring changes of everyone—patients, providers, lawyers and insurers.

The keystone of the statutes is a \$250,000 cap on noneconomic (i.e., "pain and suffering") damages. Lost earnings, medical care and rehabilitative costs are considered economic damages, and are not subject to the cap. Payments for economic damages of more than \$50,000 can be paid either in a lump sum or in a series of periodic installments, thus easing the cost burden on both provider and insurer while providing regular financial relief to the victim. The act also allows parties to enter into binding arbitration. In addition, MICRA established a scale for attorney's compensation that specifies what percentage of a settlement or award can pass to a defendant's legal counsel.

The statute of limitations requires that someone must file a claim within one year of discovery of an injury or within three years of the injury's occurrence. Furthermore, the act requires a defendant to file a written notice of intent to sue 90 days in advance, offering both sides a chance to reach an out-of-court settlement before legal costs begin to mount.

How has MICRA affected medical malpractice insurance premiums? Between 1975 and 2002, the increase in premiums slowed to a crawl compared to the national average—167 percent in California versus 500 percent nationally. However, experts have not reached consensus about whether this approach is best, and parts remain controversial. ✦



# On The Horizon

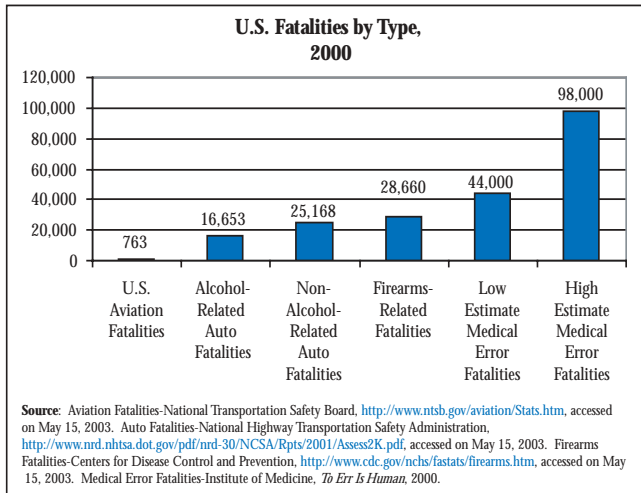
## Reducing Errors, Reducing Lawsuits

“I’m going to be fired! I’m going to be sued!” This panic surges through providers’ minds each time they are involved in or witness a mistake. The threat of punishment or termination, coupled with fear of a malpractice lawsuit, prevents many people from coming forward. In the mid-1990s, recognizing that better reporting improves knowledge and thus patient safety, the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA)—the nation’s largest health care system—scrapped its punitive patient safety mechanisms, overhauled its quality reporting and dis-

ciplinary systems, and instituted a “culture of safety.” Far from its reputation of old, the VHA was named by the Institute of Medicine (IOM) as one of the nation’s best health care systems in 2002.

Medical errors are pervasive. The IOM estimated in 1999 that as many as 98,000 people die in our nation’s hospitals each year because of medical errors. To reduce errors, the VA began to computerize parts of its system and to change providers’ habits. In 1997, the VHA initiated the Bar Code Medication Administration system. It also switched to electronic patient records and several methods to collect and analyze information on adverse events and near misses. To coordinate the effort, the VHA established the National Center for Patient Safety (NCPS). The NCPS has four Patient Safety Centers of Inquiry; each studies a specific quality of care issue, researches problems and barriers to safety, and offers potential solutions to improve services.

Integral to quality improvements are those who staff the VHA. A person involved in an incident, or a witness to one, may file a report internally or externally. Reporting of adverse events is mandatory. Following a report, an interdisciplinary committee uses a five-step process to determine why an event occurred and then makes recommendations about how to best prevent it from happening again. To supplement the internal system—and to assuage a worker’s fear of termination—the VHA also has a Patient Safety Reporting System (PSRS) patterned on a similar program at the National Aeronautics and Space Administration (NASA). Simple, one-page forms, found in employee lounges and downloadable from the Web, are sent to PSRS. Reports are anonymous. ✦



# Digging Deeper

NCSL maintains a wealth of resources of medical malpractice, which can be found at: [www.ncsl.org/programs/insur/medmal.htm](http://www.ncsl.org/programs/insur/medmal.htm).

The **National Governors’ Association Center for Best Practices** published a 15-page issue brief on medical malpractice in December 2002, which is available at: [www.nga.org/cda/files/1102MEDMALPRACTICE.pdf](http://www.nga.org/cda/files/1102MEDMALPRACTICE.pdf).

The **American Medical Association** offers its guidance on how to assess insurance carriers and evaluate specific insurance policies. These resources are at [www.ama-assn.org/ama/pub/category/4583.html](http://www.ama-assn.org/ama/pub/category/4583.html).

## Who Knows, cont. from p. 4

Since these losses cannot be measured in terms of lost wages, non-economic damages often are their only recourse.

**What are some promising alternatives to damage award caps that states should consider?**

Before enacting unnecessary restrictions on a patients’ civil rights, state legislators should consider enacting effective insurance reforms and implementing a strong patient safety system to reduce medical

The **Association of Trial Lawyers of America’s** Web site is [www.atla.org](http://www.atla.org).

The **American Tort Reform Association** is a broad-based, bipartisan coalition of businesses, corporations, municipalities, associations and professional firms that support civil justice reform. ATRA’s review of state laws on medical liability is posted at [www.atra.org/show/7338](http://www.atra.org/show/7338).

The **Physician Insurers Association of America** posts a variety of resources on its Web site, including a glossary of useful terms, clinical reports on high-risk specialties and links to other research publications: [www.thepiaa.org/Physician\\_Researcher.htm](http://www.thepiaa.org/Physician_Researcher.htm). ✦

errors. Effective insurance reforms include taking away the insurance companies’ anti-trust exemption to keep them from colluding and price-fixing; requiring prior rate approval; and requiring them to demonstrate the need for a rate increase in a public hearing. These will go a long way in preventing the cyclical medical liability crises faced by the insurance industry. Preventing errors from occurring in the first place by developing effective patient safety plans, with full disclosure, will reduce the number of medical malpractice claims made in this country. ✦