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Medical Malpractice Insurance in 2002:

Crisis or Opportunity For New Jersey Policymakers?

Background Information for . . .

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ISSUE: As the crisis of medical malpractice insurance escalates across the country, states are addressing the issue through various statutory and regulatory strategies – from tort reform and insurance market regulation to establishing mandatory medical error reporting and patient safety measures. How will New Jersey policymakers identify appropriate strategies for a problem that both poses a threat to health care access and quality and adds to overall increased health care costs?

INTRODUCTION

According to a July 2002 report prepared by the U.S. Department of Health and Human Services (DHHS), entitled "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System," both federal and individual state regulatory actions are called on to remedy several "threats" to the health care system, including:

- excessive litigation;
- defensive medicine tactics taken by physicians;[1]
- access issues related to doctors' limiting their practices and moving to states where legal reforms have yielded lower insurance premiums;[2] and
- quality issues such as the reluctance of hospitals, doctors and nurses "to report problems because they fear litigation" (DHHS, 2002; Institute of Medicine, 2000).

> ***The current medical malpractice insurance crisis follows a chronic cycle of crises and resolution and involves complex systemic elements cutting across the medical, legal, insurance, judicial, regulatory, economic and health care systems.***

The policymaking path to identifying solutions to any problem involves an understanding of the history and factors contributing to the issue at hand. The current medical malpractice insurance crisis follows a chronic cycle of crises and resolution and involves complex systemic elements cutting across the medical, legal, insurance, judicial, regulatory, economic and health care systems. Players from each sector view the current crisis from different and often contentious perspectives; however, there is agreement on one issue: the need for review and remediation of the current system.

A HISTORY OF CYCLES

"If not for medical malpractice litigation, organized medicine and the bar might have been allies."

William M. Sage, M.D., J.D.
Law Professor, Columbia University "The Lawyerization of Medicine" (2001)

[1] "Defensive medicine" is often defined as a medical practitioner's costly prescribing of medical tests, procedures and/or treatments for the purpose of reducing exposure to liability and avoiding possible litigation. Doctors report that they perform tests and provide treatments that they would otherwise not perform in order to protect themselves against incurring a possible lawsuit (DHHS, 2002). Marchev (2002), however, points out that the practice of defensive medicine may have other causes and "is not always a response to fear of malpractice," citing Glassman et al (1996), "Physicians' Personal Malpractice Experiences Are Not Related to Defensive Clinical Practices."

[2] The Consumer Federation of America criticized the Department's report for several inaccuracies including the Federation's charge that the report neglected to address the issue that the insurance industry is rife with fiscal mismanagement (www.consumerfed.org). The debate continues.

The environment of medical malpractice insurance is one that has experienced periods of oscillation since the mid-1970s.[3] The second wave of the crisis re-emerged as a significant problem during the mid-1980s, and again at this time in history as health care providers are experiencing sharp increases in liability insurance rates and as insurers are leaving the medical malpractice market. While the most significant increases are occurring among traditionally "high-risk" specialties such as surgeons and obstetricians/gynecologists, in some hard-hit states, such as Florida, premiums for internists have also doubled (*State Health Notes, 2002*).

Table 1: 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

National Trends

Premium Increases

The Health Policy Tracking Service of the National Conference of State Legislatures (NCSL) reports that medical malpractice costs are escalating, following several years of lower premiums as a result of price-cutting competition (2002). NCSL quotes a forecast by the Medical Group Management Association that medical malpractice costs will account for a tenth of the predicted increase in health costs for this year (2002).

In a 2001 statistical study, A. M. Best offered numbers to express how the problem of litigation and malpractice raises costs throughout the health care system:

- Doctors spent $6.3 billion to obtain liability coverage, while hospitals and nursing homes spent additional billions of dollars.
- Premiums for certain physician specialists — specifically internists, general surgeons and obstetricians/gynecologists — have increased in the range of 11 percent to 20 percent over the past 3 years. These specialists provide services that carry greater liability than those provided by other practitioners.

According to the Physician Insurers Association of America, these increases have varied widely across states, with some states experiencing increases of 30 to 75 percent. The states of Florida, Illinois, Ohio, Nevada, New York and West Virginia are among the states with the highest average medical malpractice insurance premiums. For the most part, these states have not reformed their litigation systems in any significant way.

[3] In the 40-year period between 1935 and 1975, 80 percent of all medical malpractice lawsuits were filed in the last 5 years of that period (Anderson, 2002).

Premium increases are not as significant in states that have reformed their litigation systems. For example, states with limits of $250,000 or $350,000 on non-economic damages[4] have an average combined highest premium increase of between 12-15 percent. By comparison, states without caps on non-economic damages have an average increase of 44 percent. Based on 2001 data, the average combined highest premium increase in New Jersey was 24 percent. In the state of California, which passed comprehensive reform in 1975, premiums have increased by 167 percent during the past two decades, compared to 505 percent for the rest of the country (Physician Insurers Association of America, 2002).

Table 2: 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.

[4] Non-economic damages are usually compensation for intangible losses, such as pain and suffering. This in comparison with specific economic damages, such as wage loss and health care costs.

The Insurer Market

During the current reform crisis, access to liability coverage is compromised by rising costs. At the same time, access to coverage is also affected by decreasing availability through insurers. Throughout the country, several major carriers are no longer offering malpractice insurance. For example:

- In December 2001, St. Paul Companies – which had been the largest malpractice carrier in the U.S. operating in 45 states – announced its decision to no longer offer medical liability insurance coverage. At its height, St. Paul Companies covered 9 percent of the country's doctors, or over 40,000 doctors, 750 hospitals and 73,000 other health care providers. Its decision was based on the fact that its medical liability division was losing millions of dollars.
- PHICO and Frontier Insurance Group – two other major carriers – have also left the market. The Medical Inter-Insurance Exchange (MIIX) group has reorganized during 2002 and will offer coverage only in New Jersey.
- According to a 2002 Conning Report on Medical Malpractice Insurance, estimates are that malpractice insurers will pay out approximately $1.40 for every premium dollar collected in 2001 and 2002 (Anderson, 2002). Physician Insurers Association of America data reveal that since 1990, claims costs have risen annually by 6.9 percent, or nearly three times the rate of inflation (ibid.). Overall, the average claim payment has increased by 60 percent over the past five years.

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Hospitals

In response to the current medical malpractice crisis, hospitals around the country have engaged in taking actions that range from closing obstetric wards to cutting back on trauma services. A survey released in June 2002 by the American Hospital Association (AHA) found that over 1,300 health care institutions have been affected by the medical malpractice crisis (Treaster, 2002). Other survey findings included that 20 percent of the AHA's 5,000 member hospitals and other health care organizations had cut back on services and 6 percent had eliminated some units.

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Identifying Factors Contributing to the Crisis

Several fundamental factors contributing to the current crisis include:

- increases in the frequency and severity of claims,
- underwriting loss, and
- investment loss as a result of lower interest rates and conditions in the stock market (Kinney, 2002; *State Health Notes*, 2002).

From the point of view of trial lawyers practicing in the field, the current crisis lies with:

- the insurance market – hard hit by the overall economic downturn and with reductions in financial reserves having in turn to increase medical malpractice premiums, and
- the medical professions' failure to keep track of doctors who are performing poorly (*State Health Notes, 2002*).

Both the trial lawyers and consumer advocate groups are concerned that putting limitations on the right to sue may harm those who have experienced legitimate hurt and loss as a result of medical negligence and would remove a critical patient protection measure.[5]

Another element adding to the current crisis involves the size of malpractice rewards. During 1994-2000, the number of malpractice awards for amounts over one million dollars increased exponentially:

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- During the period from 1994-1996, 34 percent of all verdicts that specified damages assessed awards of $1 million or more; by 1999-2000, 52 percent of all awards were in excess of $1 million (DHHS, 2002).

Jury Verdict Research reported that the national median award in medical malpractice claims rose 43 percent during the same period – from $700,000 in 1999 to $1 million in 2000 (*State Health Notes*, 2002). Marchev (2002), however, points out that the data are inconclusive as to "whether there has been an increase in medical malpractice claims greater than that which corresponds to a growth in population, an increase in the number of doctors and hospitals or growth in technological advancements."[6] She further avers that the data are inconclusive as to the efficacy of tort reform and that previous rounds of tort reform have not prevented a recurrence of malpractice insurance crises, nor do tort reforms address the issue related to patient safety (ibid.).[7]

Factors Involving Quality and the Reporting of Medical Errors

During the recent two years following the Institute of Medicine's report *To Err Is Human: Building a Safer Healthcare System* (2000), coalitions of experts have come together to develop evidence to identify errors and/or practices that may lead to medical errors.[8] By collecting information from a broad range of providers and hospitals, problems related to medical errors can be identified, especially complex failures in the system itself. In a report prepared by the National Coalition for Healthcare as early as 1998, the author emphasized that quality improvement opportunities "hold the promise of not only significant improvements in patient health outcomes, but also reductions in medical costs as much as 30 percent" (Berwick, 1998).

The current challenge facing the health care industry vis-a-vis the issue of quality is to remove the obstacle of fear of litigation in order to break the silence about reporting and identifying the root causes of medical errors. In its 2000 report, the Institute of Medicine (IOM) report strongly pointed out that fear that information from reporting systems may potentially be used to prepare a lawsuit — even when parties are not negligent — acts as a deterrent for doctors and hospitals from making reports. The authors stressed: "The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system." The charge to health and public policymakers in addressing this accountability shift raises the question of the appropriateness of enterprise liability. Kinney (2002) points out that enterprise liability "locates liability in the entity in charge of the system for reducing medical error and improving the quality of care." Liability would shift from the individual physician to the institution; e.g., hospitals and other health care facilities, large medical groups, and health plans.

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[5] Marchev notes that a significant majority of patients injured by medical negligence do not file a malpractice claim; of those who do file, only a third receive any compensation for their injuries (2002).

[6] Reference is made to the National Academy for State Health Policy's comprehensive report: The Medical Malpractice Insurance Crisis: Opportunity for State Action by M. Marchev, July 2002.

[7] Tort is a wrongful act for which relief may be obtained in the form of damages. "A private or civil wrong or injury, including action for bad faith breach of contract, for which the court will provide a rememdy in the form of an action for damages." Black's Law Dictionary, Sixth Edition, West Publishing Co., 1990.

[8] The IOM report found that medical errors cause between 44,000 and 98,000 deaths annually in the U.S. The total national cost of medical errors is estimated to range between $17 billion and $29 billion annually.

State Trends

Strategies of Reform from the States

One way in which states have tried to stem the growth in malpractice settlement awards is to place caps on non-economic damages. The state of California led the way for states that since the 1970s focused on tort reform as a way to control costs. Through a bipartisan effort, California's Governor and Legislature passed the Medical Injury Compensation Reform Act of 1975 (MICRA), which included a number of substantial reforms, such as:

- placing a $250,000 limit on non-economic damages and retaining unlimited compensation for economic damages;
- decreasing the time in which lawsuits could be brought to three years; and providing for periodic payments of damages.

According to the National Conference of State Legislatures' tracking survey, since 1975 fifteen other states have adopted similar caps on non-economic damages, ranging from $250,000 to $1.25 million. Some findings, however, suggest that tort reforms that followed the malpractice insurance crises of the 1970s and 1980s have not succeeded in preventing waves of rises in premium costs (Marchev, 2002). Kinney points out that: "only damage caps and collateral source offsets affect claim severity and/or liability insurance and only statutes of limitation restrictions curtail claim frequency substantially" (2002). Marchev goes on to point out that even in states when tort reforms do become law they often face constitutional challenges in courts, and many of the reforms passed in the 1970s and 1980s were later found to violate state constitutional provisions (2002).[9]

New Jersey in Focus

> "The difficult market, which began last summer (2001) and grew worse after September 11, reveals itself each day. Policyholders in all sectors are seeing changes in rates as they renew their coverage. For some physicians in New Jersey, the increases are far beyond what anyone imagined."
>
> (*News Release*, Commissioner Holly Bakke, N.J. Department of Banking and Insurance, May 3, 2002).

New Jersey is one of several states currently facing a crisis regarding medical malpractice liability insurance. State regulators throughout the country are responding through the introduction of legislation and in some cases, such as our neighboring state Pennsylvania, the passage of laws that include tort reform, patient safety measures and the establishment of requirements for the reporting of medical errors.

New Jersey is one of several states currently facing a crisis regarding medical malpractice liability insurance.

Appendix I includes a table referencing medical malpractice bills currently pending in the New Jersey Legislature. Identical bills introduced in the Assembly and Senate would establish a Medical Malpractice Liability Insurance Study Commission in the state (SJR33 and AJR33, 2002).

[9] See Marchev, specifically, where provisions capping damages were passed and found to be unconstitutional in Alabama, Florida, New Hampshire, South Dakota, Texas and Washington; abolishment of the collateral source rule was found unconstitutional in Alabama (in part), Kansas and Kentucky; and, abolishment of joint and several liability was found unconstitutional in Illinois and Montana.

A recent American Medical Association (AMA) survey of states, which included review of state laws, found that 12 states are experiencing a medical malpractice crisis and that 30 other states are beginning to exhibit signs of problems.[10] The National Conference of State Legislatures reports that during 2001 and 2002 a number of states — including Arizona, Indiana, Louisiana, Minnesota, New Jersey, New York, Pennsylvania, South Dakota Virginia, Washington, West Virginia and Wisconsin — enacted a wide variety of measures to address the issue of medical malpractice, ranging from tort reform to insurance market reform and patient safety measures. Specific measures have included:

- studying medical malpractice reform options;
- limiting attorney's fees;
- limiting awards;
- expert witness requirements;
- mediation;
- shortening the statute of limitations for filing claims; and,
- establishing supplement and state insurance programs.[11]

In 1975, the New Jersey Legislature enacted the "Medical Malpractice Liability Insurance Act," P.L. 1975, c.301 (NJSA 17:30D-1 et seq.) in order "to ensure that medical malpractice liability insurance is readily available to licensed medical practitioners and health care facilities by establishing a reinsurance association. . . . " In 1982, the Commissioner of Insurance deactivated the New Jersey Medical Malpractice Reinsurance Association.

During the current malpractice crisis, New Jersey has experienced the loss of several companies withdrawing from the medical malpractice insurance market, including the St. Paul Companies, the Zurich American Insurance Company and the recent bankruptcy of PHICO Insurance Group. New Jersey physicians are reporting notices of premium increases that range from 30 to 50 percent, and close to half of the state's 24,000 doctors have lost coverage during the past year (Warner, 2002). A recent survey by the New Jersey Hospital Association indicated that hospital malpractice insurance, which covers hospital staff, increased 152 percent from 1999 to 2002, for an average of $942,000 a year (ibid.).

According to the Association of Trial Lawyers' New Jersey chapter, "unjustified payments" for medical malpractice are uncommon in the state and "the amount of payment correlated closely with the severity of the injury" (Brown, 2002). The federal government has reported that during a period of over 10 years ending December 2000, there were only 5,556 medical malpractice payments by physicians in New Jersey, and the median payment was $115,000 — ranking New Jersey 13 of 50 states (ibid.).

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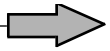
In testimony before the New Jersey Assembly Health and Human Services Committee and the Assembly Banking and Insurance Committee, attorney Bruce H. Stern, New Jersey Chapter President, offered the association's view that caps and tort reform will not result in lower medical malpractice premiums (2002). He stressed that regulatory focus should be on the business practices of the insurance market, as well as on the issues of patient safety and medical errors (ibid.).

[10] The 11 other states cited in the AMA survey were Florida, Georgia, Mississippi, Nevada, New York, Ohio, Pennsylvania, Oregon, Texas and Washington.

[11] National Conference of State Legislatures, Health Policy Tracking Service, 2002



New Jersey's Medical Malpractice Insurers in Evolution

The Princeton Insurance Company and the Medical Inter-Insurance Exchange (MIIX) have been the two largest New Jersey medical malpractice carriers. At present, the Princeton Insurance Company holds approximately 36 percent of the market.

MIIX was formed in the 1970s (during an earlier medical malpractice crisis) and was started as a reciprocal insurer, a non-profit company owned by the New Jersey physicians who were its policyholders. During the 1990s, the company's focus changed, and it began entering markets outside of New Jersey. In 1999, it converted to a publicly traded company. In May, MIIX announced it would close down operations as questions of solvency arose and after losing $200 million in over one year (Warner, 2002). At the time, the MIIX Group insured 37 percent of all the physicians in New Jersey.

The company announced plans to withdraw from most out-of-state markets (ultimately selling policies in 25 other states) and again focus to solely on New Jersey. In May 2002, New Jersey's Department of Banking and Insurance accepted a plan for a solvent run-off of MIIX in order to protect policyholders and patients. In explaining the Department's decision, Commissioner Holly Bakke stated: "If our doctors cannot practice because they can't get insured, New Jersey's patients lose. Today's action is a step toward preserving access to health care in New Jersey" (News Release, May 3, 2002).

In August 2002 MIIX Advantage Insurance Company of New Jersey was granted a Certificate of Authority by the New Jersey Department of Banking and Insurance to provide insurance coverage in New Jersey. MIIX Advantage, however, will cover only about half of the doctors who had been insured by the former MIIX, because of its smaller size (Warner, 2002).

Strategies from Other States – Taking the Option of Tort Reform

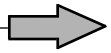
Table 3, "Common Tort Reform Measures," summarizes current strategies in place implemented by states across the country: damage caps, periodic payment of damages, abolition of the collateral source rule, limiting attorney contingency fees and abolition of joint and several liability.

Table 3: Common Tort Reform Measures

Damage Caps Damages in liability cases are classified as economic and non-economic. Economic damages include actual monetary losses due to negligence such as medical bills and loss of future earnings. Non-economic damages refer to money awarded to a victim for unquantifiable losses such as pain and suffering or loss of consortium.*	AK, CA, CO, HI, ID, IN, LA, ME, MD, MA, MI, MO, MT, NE, NH, NM, ND, PA, SD, TX, UT, VA, WV, and WI.
Punitive damages may also be awarded with the intention of punishing an egregious offender. Many states have put a limit on non-economic damages. A few states have limited the total amount of possible damage award.	Passed but later held unconstitutional in: AL, FL, IL, NH, SD, TX, and WA.
Periodic Payment of Damages Periodic payment allows a defendant to pay a damage award over time as opposed to one lump payment. The argument for this reform is that it will prevent bankrupting providers who lose malpractice suits. Patient advocates argue that it is unfair to victims because it takes away the possibility of investing the large sum which may be necessary in the case of a person severely disabled through medical negligence.	AL, AK, AZ, AR, CA, CO, DE, FL, ID, IL, IN, IA, LA, ME, MD, MI, MN, MO, MT, NH, NM, NY, ND, SD, UT, VA, WA, and WI.

*Consortium is the legal right of one spouse to the company, affection, and assistance of the other.

Common Tort Reform Measures	
Abolition of the collateral source rule The collateral source rule prohibits juries from hearing evidence that claimants have been fully or partially compensated from other sources (e.g., medical insurance) for their injuries.	AK, AZ, CA, CO, CT, DE, FL, ID, IL, IN, IA, ME, MA, MI, MN, MT, NE, NV, NJ, NY, ND, OK, OR, PA, RI, SD, TN, UT, WA, and WI. Passed but later held unconstitutional in: AL, KS, and KY.
Limiting attorney contingency fees Attorneys for plaintiffs in tort cases almost always work on a contingency fee basis, receiving a percentage of the damage award. This arrangement makes it possible for people of all economic levels to bring suit for injuries resulting from negligence. Reformers argue that attorneys' fees are often excessive, take away from the victims' compensation, and encourage attorneys to bring frivolous suits.	CA, CT, DE, FL, IL, IN, ME, MA, MI, NJ, NY, OK, TN, UT, WI, and WY.
Abolition of joint and several liability Joint and several liability is designed to protect victims in cases where more than one party has been found liable or responsible for the injuries inflicted by holding that each is completely responsible for the damages if any other party fails to pay its portion. This is designed to ensure that an injured person will receive his or her entire damage award, i.e., be "made whole," even if one or more of the responsible parties fails to pay. The counter argument is that this rule encourages plaintiffs to sue hospitals or doctors with "deep pockets" or substantial insurance policies. The alternative is comparative or contributory negligence under which rule a jury is asked to apportion responsibility, each defendant paying its share of the damages.	AK, AZ, CO, CT, FL, GA, HI, ID, IA, KS, KY, LA, MS, NE, NV, NH, NJ, NM, NY, ND, OR, PA, TX, UT, VT, WA, and WY. Passed but later held unconstitutional in: IL and MT.
SOURCE: National Academy for State Health Policy, July 2002	



Other state-activity highlights on the issue:

- The National Conference of State Legislatures reports that physicians in several states (including Louisiana, Maine, Maryland and Utah) have formed and are joining mutual plans as a way to avoid commercial rates. The Physician Insurers Association of America reports that 60 percent of doctors practicing in the U.S. insure through a self-owned plan
- The Governor of Mississippi called a special session of the state Legislature for September 5, 2002 to address medical malpractice proposals for reform; it is expected that if a plan is passed in Mississippi, it will include some state-run insurance (*The New York Times*, August 24, 2002)
- In response to its surgeons leaving because they could no longer afford malpractice insurance, the University of Nevada Medical Center closed its trauma center for 10 days in July 2002.[12] Some premiums in the state have increased from $40,000 to $200,000. In mid-August, Nevada's governor signed Nevada Assembly Bill No. 1 into law – the state's first comprehensive package addressing the medical malpractice insurance crisis. Included in the law are a $350,000 cap on non-economic damages and a $50,000 cap on care provided to trauma patients.
- In March 2002, the Governor of Pennsylvania signed into law medical malpractice insurance legislation that combines tort reforms with patient safety measures. Provisions in the law are expected to lower medical malpractice insurance by as much as 20 percent (www.aha.com). It does not, however, place caps on jury awards for non-economic damages. The law includes the requirement that hospitals report medical errors to a newly formed Patient Safety Authority and the state Department of Health to help identify preventable trends and problems. The law also puts the state's Medical Professional Catastrophe Loss Fund (CAT) under the Insurance Department's jurisdiction, privatizing it over six years and transfers $40 million a year over the next ten years from the automobile CAT fund to lower malpractice rates.
- Legislators in West Virginia during a special session in fall 2001 passed a bill that provides, among other options, a tax credit for certain medical liability insurance premiums and reestablished the Board of Risk and Insurance Management, which will operate preferred and high-risk medical liability insurance programs for providers unable to obtain private coverage. The state is facing access problems for obstetrics where in several rural areas of the state the only community provider hospitals have closed their OB units because the doctors cannot afford malpractice insurance.[13]

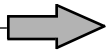
Kinney (2002) points out many "second generation" medical malpractice reforms that have been identified by researchers but have not been adopted by either state legislatures or Congress on any broad basis. These reforms include the use of medical practice guidelines to set the standard of care; no-fault approaches; scheduling of damages and the mandated use of alternative dispute resolution methods in lieu of trial (ibid.).

Related Federal Activities

The federal government is one of the largest payers for health care through its funding of Medicaid and Medicare and its direct care provision of services for the country's military, veterans and the Indian Health Service program. The U.S. Department of Health and Human services estimates that the direct cost of malpractice coverage and the indirect cost of defensive medicine increases the amount that

[12] *The Washington Post*, July 4, 2002.

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



Federal government spends by $28.6 to 47.5 billion per year (2002).[14] The July 2002 Department of Health and Human Services report discusses the Administration's proposal for national minimum standards for medical liability reforms, including caps on non-economic damages and a provision for payments of judgments over time rather than in a single lump sum.

The U.S. Department of Health and Human services estimates that the direct cost of malpractice coverage and the indirect cost of defensive medicine increases the amount that Federal government spends by $28.6 to 47.5 billion per year (2002).

The Federal "Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act" was introduced in July 2002 in the U.S. Senate by Senator John Ensign (R-NE). Its companion bill in the house — H. R. 4600, The Medical Malpractice RX Act — was introduced by Congressman Jim Greenwood (R-PA) with close to 100 bipartisan sponsors. The Act, which is modeled after California's MICRA reforms, would enact measures to provide a $250,000 cap on non-economic damages without preempting existing state law. It also ensures speedy resolution of claims; fair allocation of responsibility and a greater percentage of awards to patients, not to fees for lawyers. In his statement regarding the introduction of his bill, Congressman Greenwood pointed out that at any given time, approximately 120,000 lawsuits are pending against the country's 500,000 physicians (www.hospitalconnect.com (June 13, 2002)).

Policy Implications

Legal, actuarial and policy experts in the field of medical malpractice analyze the issue through a complex lens of strategic approaches and contingencies. They speak of "generations" of reforms and evaluate their appropriateness based on the factors emerging in this particular cycle of medical malpractice issues. At present, potential remedies are grounded in each stakeholder's definition of the problem. How can a working consensus of problem definition be achieved so that efforts towards improvement are not blocked by defensive position-holding?

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Advocates of the medical malpractice reform movement are in equal number as the critics: those on one side claiming that a reform of the litigation system is critical and those on the other side asserting that the current need to increase premiums is a result of mismanaged pricing and accounting by medical malpractice insurers. The issue of inconclusive data regarding the efficacy and effectiveness of previous generations of liability reforms makes all the more significant the need for dialogue and input from all stakeholders to ensure informed policymaking. How will oftentimes polarized players come together on developing strategies to address the current crisis?

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How do policymakers in their efforts to address the current medical malpractice insurance crisis balance the need to protect from harm and ensure access to care for all citizens while addressing the health and insurance market issues of high costs and the integrity of the overall health care system and business environment?

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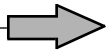
The Center for Studying Health System Change reported on a nationwide trend that as early as 1997 doctors were reducing or eliminating the time that they volunteered and practiced in free clinics and other charity organizations, including the Medical Reserve Corps, because of their concerns about malpractice insurance (Community Tracking Study, 1999). How will states ensure access to care for their most vulnerable populations?

[14] This amount includes $23.66-42.59 billion for the cost of defensive medicine; $3.91 billion in liability insurance paid to Medicare, Medicaid, Veteran's Affairs and other federal programs; $246 million in liability insurance paid through health benefits for its employees and retired employees and $778 million in lost tax revenue from self-employed and employer-sponsored health insurance premiums that are excluded from income.



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APPENDIX

NEW JERSEY STATE LEGISLATURE BILLS 2002-2003
MEDICAL MALPRACTICE

Bill Number	Bill Description
A148 Last Session Bill Number: A1495	Requires payment of Medical Malpractice policy proceeds in certain circumstances
A2085 Identical Bill Number: S1408	Permits Medical Malpractice liability insurance purchasing alliances among physicians
A2234 Identical Bill Number: S1431	Limits liability of physicians to their Medical Malpractice insurance coverage
A2458 Identical Bill Number: S1673	Establishes moratorium until July 1, 2003 on cancellation and nonrenewal of Medical Malpractice liability insurance and prohibits premium increases during that time
A2473	Limits minor's filing of Medical Malpractice actions for injuries to minor's 10th birthday
A2531 Identical Bill Number: S1609	Limits pain and suffering awards to $250,000 in Medical Malpractice actions
A2568 Identical Bill Number: S1667	Requires Medical Malpractice liability insurers to offer policy deductibles and prohibits premium increases for Medical Malpractice liability claims unless resulting in settlements, judgments or awards
A2569 Identical Bill Number: S1668	Modifies statute of limitations for Medical Malpractice liability actions
A2570 Identical Bill Number: S1570	Reduces statute of limitations for Medical Malpractice liability actions to four years
A2580	Prohibits premium increases in Medical Malpractice liability insurance for claims unless they result in settlements, judgments or awards
A2590 Identical Bill Number: S1680	Requires Medical Malpractice insurers to provide certain information to DOBI concerning physicians, podiatrists and nurses they insure
A2592	Establishes standard of review for excessiveness or inadequacy of jury awards in Medical Malpractice liability actions
A2596	Requires Medical Malpractice insurers to provide certain information to DOBI concerning the medical practitioners they insure
A2643	Prohibits excessive rate increases in Medical Malpractice liability insurance premiums
A2646	Limits noneconomic damages to $500,000 in Medical Malpractice actions
S1684 Identical Bill Number: A2576	Provides that the amount of damages to be awarded in Medical Malpractice cases would be determined by a judge of workers' compensation
SJR33 Identical Bill Number: AJR33	Establishes Medical Malpractice Liability Insurance Study Commission
S579 Last Session Bill Number: S1802	Eliminates requirement for 90-day notice of claim in Medical Malpractice actions against public entities
S1571 Identical Bill Number: A2572	Limits pain and suffering awards to $500,000 in Medical Malpractice actions
S1572 Identical Bill Number: A2571	Provides standards for expert witnesses in Medical Malpractice actions against physicians
S1640	Limits minor's filing of Medical Malpractice actions for injuries to minor's 10th birthday