Pennsylvania and California: Studies of Reform

Pennsylvania is struggling with medical liability issues similar to those faced by California in the mid-seventies.

In March 2002, the Governor of Pennsylvania signed into law a medical liability reform bill. Pennsylvania's effort represents the latest in a series of legislative actions taken by the State to alleviate pressure on providers for the following reasons:

- Insurers faced heavy losses when declining returns on investment exposed expenses significantly above premiums collected;
- Large jury awards began to put upward pressure on premiums;
- Changes in Pennsylvania law in the mid-1990s required insurers to increase coverage — from limits of $200,000 in 1996 to $500,000 in 2001 — and drove up premiums; and
- The three largest insurers, PHICO, PIC and PIE became insolvent and no longer offered medical liability insurance.

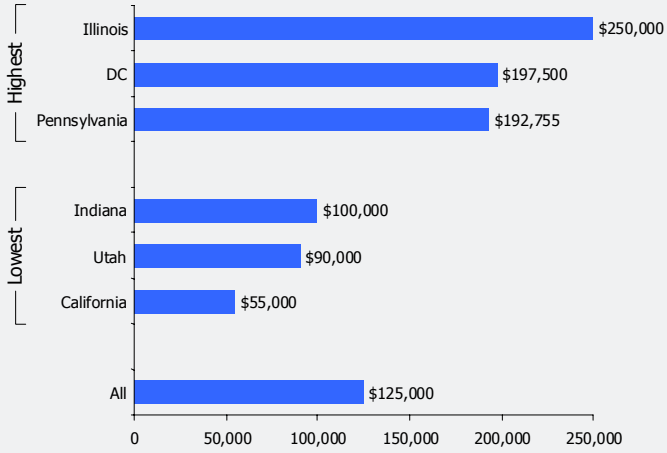
While the law signed in March does not include a cap on damages, it does allow hospitals and doctors to appeal if paying those damages would force a doctor out of business or force a hospital to cut services, thereby affecting access to care in the community. In addition, it allows judgments for future medical costs to be spread out over time, and it incorporates patient protections by requiring hospitals to report medical errors to the State.

Because the effects of tort reform take time to be fully realized, in part due to the long tail of claims, the effects of the legislation in Pennsylvania remain to be seen. But, California, under similar pressure over 25 years ago, implemented sweeping changes of its own in the form of the Medical Injury Compensation Reform Act (MICRA). Physician groups and many other supporters view MICRA as having successfully saved health care dollars, discouraged frivolous claims, and controlled the escalation of premiums while protecting patient access to care and compensating victims of medical errors.

Certain provisions of MICRA face periodic challenges in the California legislature by those who believe that it reduces accountability and creates disincentives for attorneys to represent those harmed by medical errors. Opponents of MICRA support increasing the cap on non-economic damages for those most seriously injured. Thus far, MICRA has withstood those challenges and informed the debate on national reform bills.

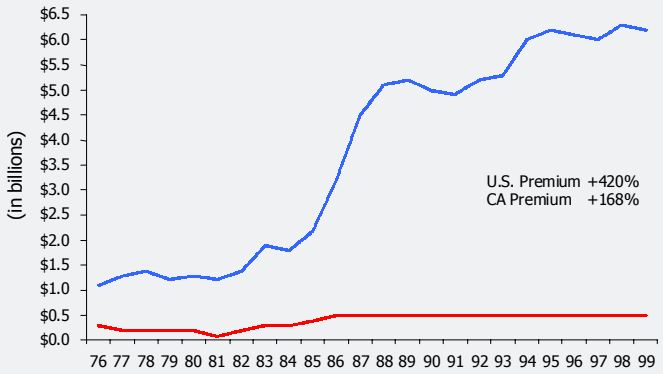
MICRA reforms in California have helped to control increases in payments...

Chart 14: Median Physician Medical Liability Pay-out, 2000



...and premiums.

Chart 15: Medical Liability Premiums, CA vs US (in billions), 1976-1999



MICRA Provisions

- Cap of $250,000 on non-economic damages
- Caps on attorneys' fees
- Collateral source rule
- Statute of limitations on filing a suit
- Periodic payments

Opposing view points

"The capping of liability invites unacceptable negligent conduct."
— Thomas Kline, Malpractice Lawyer, Philadelphia

"Do we want to continue a capless system or do the people in Georgia really want health care in rural communities? One thing is certain: We cannot continue both." — Jim Peak, CEO, Memorial Hospital and Manor, Bainbridge, GA

Policy Issues and Questions

The current medical liability insurance crisis is likely to drive additional states to implement reform and providers to seek alternative methods of obtaining coverage. Rising premiums and the exit of carriers from the market are having an impact on access to care in some communities. The liability reform debate will continue to evolve as the current crisis unfolds. While premium levels are the focus of current concerns, the medical liability issue also affects the cost and quality of the health care system in other ways. Fearing lawsuits, providers may practice "defensive medicine" ordering more tests than medically justified or take other administrative actions to reduce risk. The punitive legal environment also makes providers less willing to share information on medical errors — information that could be used to prevent future errors.

Questions for policy-makers and providers include:

- How does the current insurance cycle differ from those in the past?
- To what extent will the market failures currently being experienced by certain specialties and certain states become more widespread?
- What immediate steps can be taken to protect access to health care in the areas hit hardest by premium increases?
- How can providers utilize "best practices" to minimize medical errors and better manage risk?
- How can a non-punitive environment be created which encourages the reporting of medical errors and the development of error prevention systems?

Quotes from the Field

"I'm standing ready, willing, and able in a part of the country that is underserved and I can't provide the care because I can't afford the insurance." — Scott Nelson, Family Physician who stopped delivering babies, Mississippi

"Medical liability is one of the most significant problems facing practicing surgeons and their patients. It adversely affects access to and quality of care as well as health care costs." — Samuel A. Wells, Jr., MD, Fellow, American College of Surgeons

"Yes, health care providers do make mistakes at times and yes, there are times when we should pay a claim. But to award somebody hundreds of thousands or even millions of dollars in one settlement, there is no way that a small, rural hospital can stay in business." — Cindy Turner, COO, Bacon County Hospital, Alma, GA

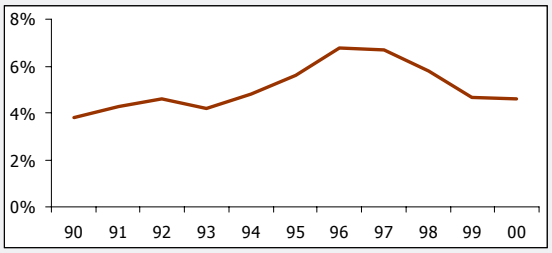
"The alternative is not to practice. For a lot of physicians, that may be a real option." — Deborah McPherson, MD, American Academy of Family Physicians

"It's too much of a medical liability to take calls in emergency rooms. People come in with no prenatal care ready to deliver, and anything can happen. These are the most high-risk patients, and all it takes is one bad outcome to end your career medically." — Bob Comeau, Obstetrician, Clark County, Nevada

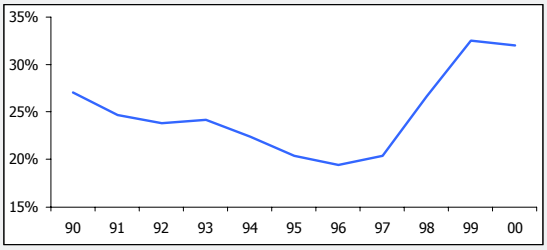
Stats to know

Hospital Sector

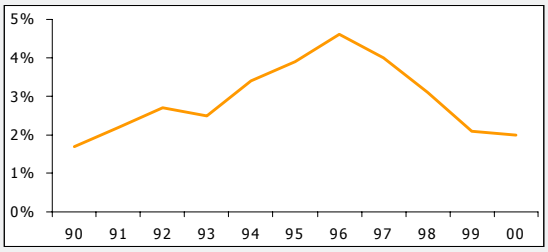
Total Margin: 90 to 00 Trend	1998	1999	2000
	5.8%	4.7%	4.6%



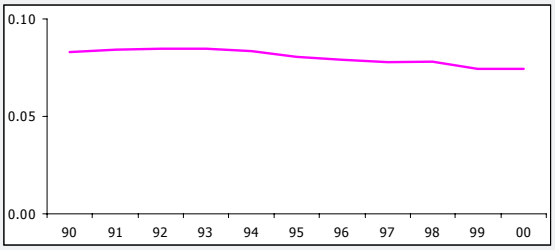
Percentage of Hospitals with Negative Total Margin: 90 to 00	1998	1999	2000
	26.6%	32.5%	32.0%



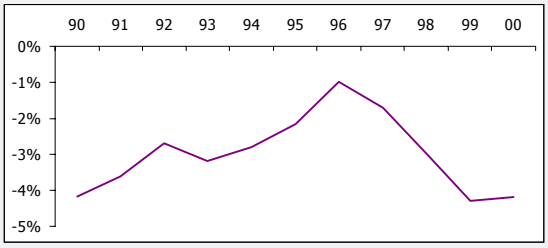
Operating Margins: 90 to 00 Trend	1998	1999	2000
	3.1%	2.1%	2.0%



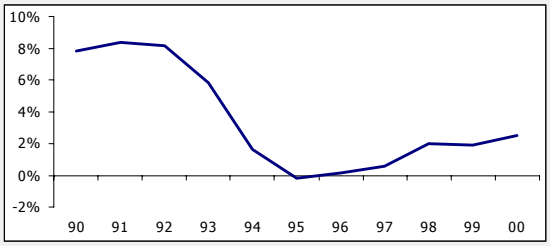
FTEs per Adjusted Admission: 90 to 00 Trend	1998	1999	2000
	0.08	0.07	0.07



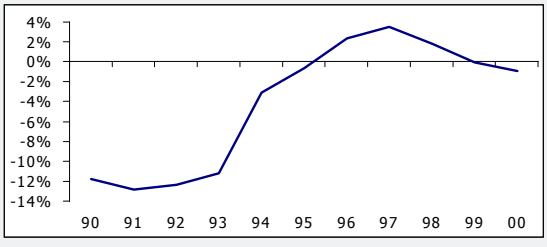
Patient Margins: 90 to 00 Trend	1998	1999	2000
	-3.0%	-4.3%	-4.2%



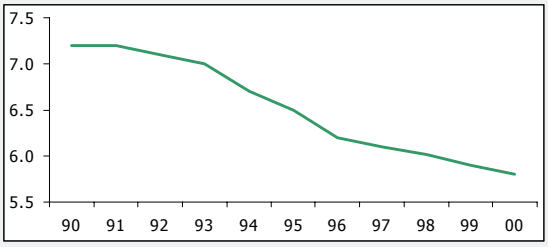
Percent Change in Expense per Adj. Admission: 90 to 00 Trend	1998	1999	2000
	2.0%	1.9%	2.5%



Medicare Margins: 90 to 00 Trend	1998	1999	2000
	1.8%	-0.1%	-0.9%



Average Length of Stay (in Days): 90 to 00 Trend	1998	1999	2000
	6.0	5.9	5.8



Endnotes:

Page 1: [1] Hospitals and Health Networks, April 2002

[2] Florida Hospital Association, FHA Survey on Availability and Affordability of Liability Coverage in Florida Hospitals, January 2002; Health Care Insurance Resources, Inc. and McNeary Insurance Consulting, Inc. Study of Georgia Hospitals, 2000-2001

[3] Survey distributed to members of the American Society for Healthcare Risk Management (ASHRM), including approximately 1,250 hospital-based risk managers, 132 responded

[4] Survey distributed to members of ASHRM, including approximately 1,250 hospital-based risk managers, 132 responded; respondents chose all responses applicable

Page 2: [1] Adapted from Physician Insurers Association of America (PIAA) Claim Trend Analysis, 2000 Edition

[2] Reports refer to all medical liability payment reports submitted to the National Practitioner Databank

Page 3: [1] American Healthline, May 6, 2002

Page 4: [1] Map values represent caps for **non-economic** damages except for the following states in which they refer to **total** caps: Indiana, Louisiana, Nebraska, New Mexico, South Dakota, and Virginia

Sources:

Chart 1: Hospitals and Health Networks, April 2002

Charts 2-4: American Hospital Association/ASHRM Survey of Hospital Experience with Professional Liability Insurance, 2002

Chart 5: National Practitioner Databank, Annual Report, 2000

Chart 6: Jury Verdict Research, *Medical Malpractice: Verdicts, Settlements and Statistical Analysis*, 2002

Chart 7: PIAA Claim Trend Analysis, 2000 Edition

Chart 8: A.M. Best, "Negative Investment Trends Pressure Earnings", Special Report, April 23, 2001

Chart 9: Medical Group Management Association, 2001 Cost Survey (2000 Data)

Chart 10: Harvard Medical Institutions, 1999

Chart 11: Medical Liability Monitor, Trends in 2001 Rates for Physicians' Medical Professional Liability Insurance

Chart 12: Health Care Liability Alliance website, 2002

Chart 13: Health Care Liability Alliance website, 2002

Chart 14: National Practitioner Databank, Annual Report, 2000

Chart 15: National Association of Insurance Commissioners Profitability Study cited in AHA's *Health Care Liability Crisis 2002* presentation

Sources for "Stats to Know":

Total Margin: Lewin Group analysis of American Hospital Association Annual Survey, 1990-2000
Operating Margins: Lewin Group analysis of American Hospital Association Annual Survey, 1990-2000
Patient Margins: Lewin Group analysis of American Hospital Association Annual Survey, 1990-2000
Medicare Margins: Lewin Group analysis of American Hospital Association Annual Survey, 1990-2000
Percentage of Hospitals with Negative Margin: Lewin Group analysis of American Hospital Association Annual Survey, 1990-2000
FTE/Adjusted Admission: Lewin Group analysis of American Hospital Association Annual Survey, 1990-2000
Percent Change in Total Expense per Adjusted Admission: Lewin Group analysis of American Hospital Association Annual Survey, 1990-2000
Average Length of Stay: Lewin Group analysis of American Hospital Association Annual Survey, 1990-2000

TrendWatch is a series of reports produced by the American Hospital Association and The Lewin Group highlighting important and emerging trends in the hospital and health care field.

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