

Date: February 10, 2004

To: North Carolina House Blue Ribbon Task Force on Medical Malpractice

Fr: Robert A. Bitterman, MD, JD, FACEP on behalf of the North Carolina College of Emergency Physicians.

Re: Impact of the medical malpractice insurance crisis on access to care and the delivery of emergency medical services in North Carolina.

I. Introduction and Objectives.

Dear Mr. Chairmen, Rep. William Culpepper III and Rep. Joe Kiser, and Members of the House Task Force on Medical Malpractice,

On behalf of the North Carolina College of Emergency Physicians and the millions of patients we serve each year in an emergency department, we thank you for the opportunity to address this critical issue.

We are here first, to affirm the existence of the current medical malpractice insurance crisis and inform the Task Force precisely how this crisis has detrimentally affected our ability to care for patients in the emergency department; second, to make clear the consequences of failure to decisively address this issue promptly, both by explaining what's clearly predictable downstream and examining what's already occurred in neighboring states worse off than North Carolina; and, third, offer concrete solutions to remedy the problem in both the near term and the long term. (Or, in medical terms, immediate therapy to stop the bleeding, so the patient doesn't die while you figure out how to apply an effective lasting therapy. The solutions offered will be supported by independent academic or governmental research studies.)

We are not here to assess culpability for the current crisis on the business acumen of insurers, a broken judicial system, negligent physicians, or problematic legislation and regulation. Blame won't solve this predicament; it will only delay and impede crafting a political solution.

Indeed, a political solution is what's necessary. Access to health care, accountability of health care providers, and appropriate utilization of limited resources are immense issues for our society as a whole, subject to, and solvable only on a political level. Neither physicians, nor any of the parties involved, can solve the malpractice crisis on their own; we need you, the legislature, to consider how the law can best serve the health care needs of the public at large in our State.

II. What is emergency medicine? What is our role in North Carolina's health care safety-net, and what are its current vulnerabilities?

A. Emergency medicine is the health care safety net of North Carolina.

I'd first like to take a few moments to explain how emergency care is delivered, and our role as safety-net providers in the health care system.

1. Emergency physicians staff hospital based emergency departments (EDs) 24 hours per day, 7 days per week, 52 weeks per year. We examine and treat anyone who presents to the ED – insured or uninsured, citizen or illegal alien, Medicare or Medicaid patients, children or adults.
2. Emergency medicine is a high risk practice.
 - Patients present to the ED suddenly, often in extremis needing immediate medical attention, and we have no preexisting relationship with the patients and no advance knowledge of their underlying medical problems. Acuity can be very high and adverse outcomes or death are not uncommon. Less than 10% of patients presenting to emergency departments are now considered as non-urgent.
 - Emergency physicians often practice with limited resources and specialty physician back-up. Technology and resources such as CT scanning, ultrasound, 24-hour radiology services, and on-call backup services, such as trauma surgeons or obstetricians are frequently unavailable due to economics or liability issues.
 - Ninety percent of our larger hospitals have saturated their capacity for treating patients resulting in ED overcrowding. Most trauma centers are currently overwhelmed. Ambulance diversion is common, ED waiting times have increased 33%, and the number of individuals seeking emergency care who leave the ED before being seen has tripled in some areas. (Bureau of the Census. Health Insurance Coverage, 1997. Washington, DC: Government Printing Office; 1998:60-202. Derlet RW. Overcrowding in emergency departments: increased demand and decreased capacity. Ann Emerg Medicine 2002;39:430-432.)

3. Emergency physicians and hospital emergency departments take care of everyone, including all those unable to obtain medical care anywhere else.
 - In fact, studies show that 20% of all the ambulatory patients seen in emergency departments had previously contacted another health care provider but were refused care, and instead told to seek care in an emergency department. Some patients were refused care because of lack of insurance, others refused because they were perceived as high liability risks. (Young GP, Walker MB, Kellerman AL, et al. Ambulatory visits to hospital emergency departments: patterns and reasons for use. J Amer Med Assoc 1996;276:460.)
 - Non-emergency physicians are referring more patients to emergency department and safety net hospitals, such as academic health centers, and are refusing to provide on-call ED coverage or accept referrals from emergency departments due to liability concerns. (E.g., see Berenson RA, Kuo S, May JH. Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places(ED's), Issue Brief No. 68, September 2003, Published by the Center for Studying Health System Change.)
 - Non-emergency physicians may choose which patients they treat in their private practices, and can decline to care for patients considered high-risk, litigious, uninsured, or underinsured such as Medicaid or Medicare. The ED is required to examine and treat everyone, regardless of economic or litigation status, because of federal law – EMTALA.
 - On average, the emergency department payer mix includes 25% who do not pay for the care provided and another 50% are covered by government sponsored programs, such as Medicaid and Medicare, which often don't cover the cost of care. The average emergency physician provides \$138,000 a year in uncompensated care due to the mandates of EMTALA, and additionally incurs the liability insurance costs for each non paying patient seen. (Source: Kane CK. Physician Marketplace Report: The Impact of EMTALA on Physician Practices. AMA Center for Health Policy Research 2003. Next highest were General Surgeons and Internal Medicine Subspecialties at around \$27,000/year.)
 - The emergency services delivery system truly is society's health care safety net.

B. Emergency care is subject to two independent types of liability lawsuits – ordinary malpractice actions under state tort laws and federal claims for statutory liability under EMTALA.

Emergency physicians, hospital emergency departments, and on-call physicians are subject to ordinary malpractice negligence claims under state laws just like all other health care providers. However, they are also subject to an additional distinct and independent system of regulatory and civil liability under federal law, the Emergency Medical Treatment and Labor Act (EMTALA), for screening, stabilization, and transfer of emergency department patients.

First, under EMTALA, physicians (and hospitals) are potentially liable for civil monetary penalties of \$50,000 for ordinary negligence regardless if any harm comes to the patient. These fines are not covered by malpractice insurance and some insurance carriers will not even defend the physicians in actions by the government to impose the fines.

Second, hospitals may be sued under EMTALA for any harm that occurs to an individual as a result of a physician or the hospital violating the law. EMTALA makes hospitals directly liable for acts of its emergency physicians and on-call physicians, and hospitals may recoup those losses from the responsible physician under state law indemnity provisions or contractual indemnity. EMTALA lawsuits are statutory liability claims; they are specifically NOT malpractice of negligence claims, though the damages available under EMTALA claims are those damages available in the state in which the hospital and the physician work.

Thus, whether we're sued under EMTALA (indirectly through the hospital) or sued under ordinary state law, it's the state's tort system that determines available damages. This is one of the reasons it is so important for our legislature to address the damages issue specifically. (See Section VI.A.1. below which addresses caps on damages.)

C. Availability of malpractice insurance coverage for emergency physicians.

1. Malpractice Premiums and Amount of Insurance Coverage Available.

Medical Mutual Insurance Company of North Carolina (MMIC) and GE Medical Protective (two NC insurance carriers) each has already shared data with you on the escalating premiums and decreasing coverage limits available for physicians in North Carolina. Please note this is a double effect. It's not just the premium that goes up; the actual amount of coverage also goes down. Physicians and hospitals then have higher deductibles, less coverage, and more exposure to future liability claims which are yet to be experienced through self-insurance vehicles.

- For example, Mission St. Josephs in Ashville now must cover a \$25,000 deductible for each of its employed physicians; and a group of emergency physicians staffing 3 hospitals in the Piedmont must cover the first \$10,000 of any settlements and are only insured for 1/3 the amount of coverage they had previously. These deductibles and lower per claim and aggregate coverage limits will significantly impact the sustainability of providing care for both hospitals and physicians in the future, and bode poorly for diminishing the continual draining of resources from the health care safety net.
- The average malpractice insurance premium for emergency physicians, if insurance is even available, increased over 50% per year for the last two years in North Carolina.
- Emergency physicians have little means to pass the increased costs of insurance onto third party payers or the individual patients themselves. Uninsured or no-pay patients who don't pay for the cost of their care obviously don't cover their liability costs either. Medicaid and Medicare pay fixed fees, regardless of the physician's insurance costs. Similarly, managed care companies have limited the ability of physicians to cost shift these increased malpractice costs onto other patients. Thus, emergency physicians essentially absorb all the increasing cost of liability into their practice themselves, which then limits their ability to provide those services and recruit quality physicians into their practice.

2. Availability of malpractice insurance for emergency physician.

You already heard testimony from a number of commentators concerning the difficulty emergency physicians have recently experienced in obtaining liability coverage or that insurance was secured at the last minute at much higher rates for much less coverage. Unquestionably, insurers are becoming more restrictive in writing coverage for emergency physicians.

Medical Mutual Insurance Company of NC (MMIC), our own state physician-owned liability insurance carrier, turns down over 70% of emergency physicians applying for liability coverage.

- MMIC states that emergency physicians are "rapidly becoming uninsurable risks".
- MMIC also refuses to write insurance for 85% of the obstetricians and neurosurgeons in North Carolina.
- Are 70% of the emergency physicians and 85% of the obstetricians and neurosurgeons in North Carolina "bad doctors" or incompetent? Of course not!

- In North Dakota, emergency physicians pay on average less than \$2 per patient in malpractice insurance premiums. In North Carolina, the cost ranges from \$4 to \$12 per patient; and in south Florida, the cost is \$25 per patient ED visit. Are physicians in North Dakota 6 times better than physicians in North Carolina? Are physicians in Florida twice as negligent as physicians in North Carolina? Of course not!
- The insurance cost differences have nothing to do with the quality of care provided; they have everything to do the litigation system and tort laws of the individual states.

Examples of malpractice insurance availability problems for emergency physicians in North Carolina:

- Catawba, Caldwell, Burke, and Alexander Counties.
As I write this document (Friday, February 6th), a group of emergency physicians who staff hospitals serving 125,000 patients per year in four counties, Catawba, Caldwell, Burke, and Alexander, may be forced to cease practicing next week because they can't obtain malpractice insurance at any price. On December 9, 2003, the group received a notice of non-renewal from GE Medical Protective effective February 9, 2004, leaving only two months to procure malpractice insurance. In January 2004, Mag Mutual, after earlier assurances that it intended to insure the group, declined to do so citing "changing market conditions," and stating that emergency medicine is now "simply too high a risk".

MMIC told the group that it was no longer writing coverage for any emergency physicians. The group then spoke to dozens of different insurers including commercial insurers, off shore and overseas carriers, in state and out of state brokers, and even a bankrupt company, PhyAmerica, about obtaining insurance. The best quotes they received, including from Lloyds of London and other companies, were for approximately \$12 a patient, or an eight times increase over the year before, for one third less coverage. (Instead of \$2 million/\$6 million coverage, they were being quoted prices for \$1 million/\$3 million coverage on a claims-made policy.) Thus, their total insurance costs are projected to increase from less than \$200,000 per year to over \$1.4 million per year. Additionally, since the proposed coverage is for a claims-made policy, if any of the physicians leave the practice they would have to pay a tail of up to \$80,000 per physician. (The average emergency physician typically earns around \$180,000 a year.)

This group of physicians provides services to an underserved area in western North Carolina. Twenty percent of their patients are no-pay patients, persons unable or unwilling to pay anything for the services provide by the hospitals or the doctors. For these patients, under the proposed insurance package, the doctors would have to pay \$360,000 out of their own pockets in order to see these patients

for free just to cover their insurance costs. Additionally, 50 percent of the patients they serve are Medicare and Medicaid patients and Medicaid clearly (sometimes) doesn't even cover the cost of insurance let alone reasonable fees for treating the patients.

Furthermore, since these emergency physicians provide a substantial portion of the medical direction for ambulance units (EMS or Medics), this area of the state may lose its advanced ambulance services.

These four counties now are at risk of having absolutely no emergency services available in their communities, at least not from their existing group of emergency physicians. This could result in catastrophic consequences to emergency medical care in western North Carolina.

- Asheville area.

An emergency physician group in Asheville received a 45 day non-renewal notice from their insurance carrier. They were finally able to obtain coverage from another company at triple the price for half the amount of coverage, an effective six fold increase in their malpractice premiums in one year.

However, the insurer would not cover the physicians for providing EMS direction, jeopardizing the area's EMS system, ground and helicopter transport facilities and educational and training programs. (To solve the problem the local hospital 'hired' the physicians to provide EMS medical services, as a way to cover their potential liability under the hospital's self-insurance pool. Notice that such 'solutions' simply shift the risk exposure to the hospitals instead of an insurance carrier or the physicians themselves. Claims related to these services will simply dilute the hospitals capital and future ability to fund patient care services.)

The hospital also lost a number of its obstetrical on-call physicians, so patients with no prenatal care now show up in the emergency department seeking delivery from physicians who do not have sufficient skill, training, or the experience to deal with obstetrical emergencies and delivery.

- Asheboro area.

An independent emergency physician group in Asheboro lost two of their physicians who had relatively minor past-claim histories due to the restrictive underwriting position taken by their insurer. The group has been unable to replace the physicians because no carrier will insure potential recruits to the facility.

- Piedmont area.

An emergency physician group covering three hospital EDs in the Piedmont area, all well trained board certified physicians, was recently dropped by GE Medical Protective with less than two months notice. The group 'turned over every rock' to find insurance coverage. Only one company, MagMutual, was willing to offer them a malpractice insurance policy, subject to annual review to determine if the policy would be renewed. The physicians were also forced to relinquish all settlement rights to the insurance company, thus losing control of litigation that could tarnish their reputations, future insurability, and even future employability.

The policy cost the group between two and three times their previous coverage and imposed a new \$10,000 deductible for ANY settlement. Their cost of purchasing tail coverage at the time of switching carriers was around \$250,000 for 18 physicians. Furthermore, since their new policy is also a claims-made policy they will have to purchase additional tail coverage yet again in the future.

3. Claims-Made Malpractice Insurance Tail Coverage Issues.

Almost all emergency physicians no longer have access to occurrence coverage; only claims-made coverage is available. This means when they leave their practice, or move from one hospital to another, they must purchase a 'tail' to cover potential malpractice claims from their past practice. If the hospital or physician group provides the tail they become reluctant to let go marginal physicians because of the high cost of tail coverage, which can be as much as \$80,000 per physician. Similarly, if the individual physician must purchase their own tail coverage, quality physicians are reticent to join emergency practices with claims-made insurance due to the high tail expense. A number of emergency physician groups in North Carolina have had difficulty recruiting well trained board certified physicians due to the liability costs and tail issues in our state.

There has been a trend towards large contract groups absorbing independent practice groups because the contract group can provide insurance coverage or physicians being amalgamated into hospital employees or migrating to covered medical entities that can provide malpractice coverage for them, such as public health clinics or university or health safety net type communities.

III. Emergency physicians can't do it alone. To provide effective emergency care we need EMS-Ambulance systems, hospital resources, and our on-call physician colleagues.

Even if emergency physicians can survive the liability insurance crisis and maintain their practices, patients will still suffer if we don't save the support systems we need to provide quality emergency care. Unlike depictions on the TV show "ER", emergency physicians can't take care of every illness or injury on our own: we need EMS providers in the field, hospital resources and nursing services, and the specialty expertise of our on-call colleagues such as surgeons, neurosurgeons, obstetricians, internists, cardiologists, pediatricians, and orthopedic surgeons.

Our ability to treat emergencies depends on the continued availability of this triad of health care providers. The malpractice insurance crisis has already eroded their availability, diminished access to care, and threatens the continued existence of our safety-net system.

A. Emergency Medical Services (EMS) – Ambulance Systems.

Medical direction of ambulances, rescue helicopters, and EMS units is a generally a service provided free of charge to the denizens of our state by almost all practicing emergency physicians in North Carolina. Emergency medical technicians and paramedics who staff ambulance units must practice under the license of physicians, and require medical direction, according to state law. Limitations on our liability coverage would seriously limit our ability to provide EMS direction under our licenses.

For example, when the emergency physician group in Asheville was recently non-renewed by their insurance carrier, the policy they were finally able to obtain from a different carrier would not cover the physicians for providing EMS direction, jeopardizing the area's EMS system, ground and helicopter transport facilities and educational and training programs. (Ultimately, a hospital 'hired' the physicians to provide EMS medical services, and covered their potential liability under the hospital's self-insurance pool.)

B. Hospital Resources.

North Carolina hospital liability rates have tripled in the past two years, but that's only part of the problem. Besides their rates tripling, hospitals coverage has decreased resulting in increased exposure through high deductibles or self-insurance vehicles.

If a hospital's insurance premium jumped from \$3 million to \$9 million in two years, that's \$6 million per year that is unavailable to provide health care, which translates into less nurses in the emergency department, loss of ultrasound techs at night, loss of immediate readings from radiologists, less ICU beds available, and less funds to procure or contract for on-call physician services to the emergency department.

For example, I recently accepted a transfer of a major trauma victim from a hospital in the eastern part of the state, well over two and half hours away from Charlotte, because it had lost some of its trauma resources and closer facilities that usually accepted its cases in transfer either had no physicians willing or able to accept the patient in transfer or had no intensive care services available to treat the patient. Certainly, a two plus hour delay to definitive treatment is not optimal trauma care.

Another ominous issue for our hospital partners is their ability to fund future capital acquisition needs. The American Hospital Association (AHA) states that approximately a third to a half of all hospitals are operating negative margins. Even if a hospital's margin is one to two percent, if their liability cost eats up that one or two percent, then they have no free cash flow to fund capital programs, and must seek endowments or alternative sources of funding rather than operating funds.

Money diverted from capital programs to cover insurance, especially in the rural areas, is jeopardizing the future of hospitals to provide technology, buildings, and additional or upgraded services; at the very time the needs for such services is predicted to accelerate as the baby boomers age.

The diversion of resources from patient care into liability costs threatens the very existence of emergency services in our state. In the last 25 years over a 1,000 hospitals in the US have ceased operating emergency departments; simultaneously, the number of ED visits has grown from 37 million per year to well over 110 million ED visits per year.

C. On-Call Physician Expertise Necessary to Treat Emergency Patients.

An increasing number of hospitals are wholly unable to provide specialty emergency care, particularly neurosurgery, thoracic surgery, orthopedics, psychiatry, hand or plastic surgery, and ear, nose and throat surgery or must transfer patients they could treat because physicians decline to participate in hospital ED on-call lists. (GAO Report (GAO-01-747) on the impact of EMTALA on hospital emergency departments, the delivery of emergency care, and CMS/OIG enforcement, June 22, 2001.)

Numerous studies confirming the erosion of on-call coverage of our hospital emergency departments are collated in the references. For one specific example see Berenson RA, Kuo S, May JH. Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places(ED's), Issue Brief No. 68, September 2003, Published by the Center for Studying Health System Change.

- Non-emergency physicians are referring more patients to emergency departments, safety net hospitals, and academic health centers due to fear of litigation.

- Physicians are unwilling to provide on-call ED coverage, particularly those practicing in high-risk specialties, because of malpractice liability concerns.
- EMTALA has also been affected by malpractice litigation concerns. Combine the fact that many ED patients are uninsured, liability concerns have contributed to certain specialists declining to provide on-call coverage and/or demanding payment from hospitals for taking calls or caring for uninsured patients.
- Similarly, the converse is also true: many specialists are refusing referrals from emergency departments or safety net clinics and health centers especially for the uninsured or underinsured patients such as Medicaid patients.

Loss of on-call physician services delays patient access to necessary emergency care and increases the number of patients that must be transferred to obtain the required services. Unfortunately, the declining capacity of many of our secondary and tertiary facilities increase the delay and difficulty in arranging such transfers, or increases the distance, and thus the health care risk, they must travel to go to obtain competent emergency care.

Additionally, on-call physicians are necessary for the larger hospitals to be able to accept patients in transfer from emergency physicians in the rural or smaller hospitals that don't have such specialty resources on a regular basis. The decreasing availability of on-call physicians means patients have fewer services available.

Examples of Lost On-Call Physician Services in North Carolina.

- Hendersonville lost its only neurosurgeon who stated he was leaving the state because his premiums had risen to nearly \$200,000 a year. The physician states he had never had an adverse judgment or settlement against him. The hospital is now without neurosurgical coverage available for emergency patients.
- In many hospitals across the state, such as University Hospital in Charlotte, the surgeons on staff have relinquished trauma privileges for a number of reasons, including liability concerns, which necessitates trauma victims be transferred to other nearby hospitals.
- Rowan Regional Medical Center and Nash General Hospital both lost neurosurgeons and ceased providing 24/7 neurosurgical coverage for their emergency departments.
- Certain hospitals in Charlotte lost on-call specialty surgeons capable of treating facial trauma for a period of time, and others lost ophthalmologists necessary to treat eye injuries.

- MMIC acknowledges that many neurosurgeons are declining to accept emergency room calls because of the high liability risk. (See testimony of Mr. David Sousa, MMIC General Counsel on December 2, 2003.)

Physicians are learning that they can't define their practice anymore to a local community, regional referral area, or limit the volume of cases they must accept. When on call, they are an agent representing the hospital, not their private practice, and as such they have no choice over which patients they must accept and treat. As the neurosurgeons have learned, when on-call for one hospital they are literally on call for the entire United States. If any hospital anywhere lacking a neurosurgeon asks them to accept a patient with a neurosurgical emergency, they have a legal duty under EMTALA to accept that patient in transfer on behalf of their hospital.

Predictably, physicians respond by figuring out creative ways to avoid ED services. First, they curtail those hospital privileges related particularly to emergency department patients. Many of you on the Task Force understand this in the realm of obstetrics. Obstetrician/gynecologist physicians have dropped privileges to deliver babies, so they no longer have to take care of those high risk scenarios. Recognize that other physicians are doing the same thing in a gradually increasing fashion, such as surgeons dropping privileges to take care of trauma; orthopedic surgeons limiting various traumatic privileges, sub-specialists eliminating things privileges as facial fractures or jaw fractures, which they know typically come in to our emergency departments on a Saturday night after a bar fight where litigation is assured and the patient typically uninsured.

And if these physicians don't have the privileges to treat certain maladies at their own hospital, then they don't have to accept patients with those maladies in transfer from other hospitals.

Second, physicians limit the number of days they accept ED call duties. If a hospital's three orthopedic surgeons insist on taking call once a week rather than every third day, then instead of having 24/7 orthopedic coverage, the hospital has orthopedists available less than half the week. The other four nights of the week the emergency department must then work to arrange transfers or outpatient care for patients with orthopedic injuries. The global erosion of on-call coverage across the state makes it increasingly difficult to transfer patients, they must travel longer distances, and the accepting hospitals reach saturation capacity and can't accept additional patients in transfer.

Third, physicians resign privileges from certain hospitals altogether. Typically, these are from our smaller hospitals, forcing them to transfer many ED and inpatients out to the larger hospitals, and leaving the community completely without certain specialty services. Many primary care physicians have dropped all hospital privileges and practice only office based care, primarily so they don't have to take ED call.

Fourth, physicians open specialty hospitals without an ED so they can avoid ED patients altogether and possibly avoid the EMTALA requirement to accept patients in transfer from other hospitals that lack their specialty expertise.

Physicians will continue to withdraw from the provision of emergency services as they more fully comprehend the onerous ramifications of EMTALA. Hospitals will continue to abandon acute care specialty services or will close all together under the burden of the combined cost of providing uncompensated physician and hospital emergency care and increased liability exposure.

IV. What will happen if the legislature fails to act?

A. What's already booked to occur downstream in North Carolina.

If nothing changes, and even if premiums level off, all hospitals and physicians will suffer still greater malpractice losses in the years ahead. Providers are increasingly self insured, have purchased less coverage (because less coverage is available or the cost of first dollar coverage prohibitive), and/or have higher deductibles before their insurance kicks in. Thus, providers will shoulder greater risk and pay larger portions of the amounts awarded in settlements or by juries than they have in past years. Hospitals will continue to divert capital to cover litigation costs, decreasing funds available for services or capital improvements necessary for providing future health care.

For example, the GAO found that 60% of physicians are now covered by physician owned entities, and that an increasing number of large hospital and physician groups have left the commercial insurance market entirely, and begun to self-insure in a variety of ways, exposing themselves to greater financial responsibility for malpractice claims and greater risk of insolvency. (GAO Report (GAO-03-702). Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates.)

These events bode poorly for the future, even if the size of awards and number of claims moderate, as this increased risk exposure of the hospitals is yet to be measured in their present or future loss experiences.

B. What's already occurring in other states, and is a harbinger of what will befall North Carolina in the future if we fail to avoid the errors of neighboring states.

You have no doubt heard many anecdotes of the adverse consequences due to the malpractice crisis. However, the most definitive objective study of the issue was done by the General Accounting Office (GAO), a non-partisan independent research agency of the federal government, titled "Medical Malpractice: Implications of Rising Premiums On Access to Health Care".

- The GAO examined the experiences in five states with reported malpractice related problems, Florida, Nevada, Pennsylvania, Mississippi, and West Virginia; and, also, four states without reported problems, California, Colorado, Minnesota, and Montana.
- The GAO confirmed that in all five crisis states access to emergency services had been reduced, particularly for trauma and obstetrical emergencies, and transfers of patients increased substantially.
- All five crisis states suffered a decrease in the availability of on-call physicians to their emergency departments, particularly on-call specialists such as surgeons, orthopedic surgeons, and neurosurgeons. The reduced ED coverage by on-all specialists resulted in delay in access to care and frequently resulted in patients being transferred up to 50 to 100 miles away in order to receive care.
- The GAO contacted 49 hospitals and 26 confirmed a reduction in surgeons available to provide on-call coverage to the emergency room.
- A whole section of West Virginia lost all its neurosurgical coverage for two years requiring patients to be transferred for greater than 60 miles away for urgent neurosurgery care.
- Every state in the study sustained trauma centers closings and lack of orthopedic surgeons available to provide trauma services. For example, in Las Vegas, the University of Nevada Medical Center trauma center, the state's only level-one trauma center, closed for eleven days late 2003 because physicians declined to provide on-call coverage due to liability costs. The next closest available trauma center to provide patient care was over 100 miles away. Similar trauma center 'closing' events occurred in Pennsylvania and West Virginia. In each instance, the crisis was resolved only after the state stepped in to provide liability insurance coverage for the on-call physicians, or the physicians were made employees of the county government, which capped their liability for non-economic damages.
- The GAO found that physicians were limiting their on-call coverage in certain geographic areas (rural areas were the hardest hit), and/or dropping certain types of medical staff privileges that typically were reflected in emergency patients, so as to avoid treating emergency department patients.
- This study is a clear example of what's ahead for NC if we don't address the issue now, before it reaches the crisis proportions sustained in neighboring states.

(GAO-03-0836 August 2003. Medical Malpractice: Implications of Rising Premiums On Access to Health Care.) Please also see the references listed below in Section VII for additional compelling data on the adverse affects the malpractice insurance crisis is having on access to care.

Emergency departments are an essential public service and serve as our state's health-care safety-net. But that safety-net is unraveling. We simply have no 'standby capability' or 'availability' for the existing patients in need, let alone for potential large scale disasters. Our lack of capacity endangers all denizens of our state; it's not just the poor or uninsured who are finding it difficult to obtain timely, competent emergency care.

Our emergency safety net and our entire health care system need all parties to function effectively. The liability crisis doesn't affect emergency physicians in a vacuum; it affects the hospital resources, the medical staff services, and on-call physician expertise essential to our capability to deliver emergency services.

If we as a society value access to emergency care then there should be a quid pro quo - adequate funding, qualified liability immunity, or some other form of consideration.

C. Going without malpractice insurance coverage – 'going bare' - an option?

More than 5% of Florida's 47,700 actively practicing physicians don't have malpractice insurance, up from 4% of doctors a year ago - a 25% increase in the number of physicians going bare. In Miami-Dade County, in South Florida, nearly 20% of the county's 6,360 active physicians have no malpractice liability insurance.

(Source: Florida Department of Health Statistics.)

The data for physicians without malpractice insurance in North Carolina are not known, but there have been reports of hospitals rescinding the medical staff requirement that physicians carry insurance as a condition of obtaining privileges to work at the hospital.

V. We need the legislature to act. Access to health care is a public policy issue which requires a political solution.

We ask you to address this crucial public social issue, and to accept responsibility for public policy that works in the best interests of our patients in the emergency departments and your constituencies.

The cost of health care, the litigation issues related to health care and access to health care are all complex issues. Clearly, traditional 'tort reform' alone won't solve the litigation problem or the access to care problem, but it will decrease the rate of malpractice premiums, which ultimate society as a whole pays, and slow down the extraction of dollars out of the emergency health care system.

Tort reform may also stem an exodus of skilled physician services, decrease defensive medicine, and help emergency physicians, hospitals, employers and employees, and the denizens of our state to afford health care in North Carolina. Obviously, one must balance between an injured plaintiff's right to sue and society's interest in quality, affordable, available health care. Our collective goal is to circumvent a potential collapse of the emergency health care safety-net in North Carolina.

The increase in malpractice insurance premiums are borne by all Americans in some capacity, either through increased health care premiums, drug prices, vaccine costs, increased deductibles, increased co-pays, or loss of health insurance coverage. Today, a increasing number of employees are declining health insurance coverage through their employers even when available, and an increasing number of employers are not offering health care coverage, both due to ever escalating cost increases.

We offer potential remedies to the insurance crisis below, both short term and long term options, and respectfully suggest to the committee that these solutions should be driven by public policy, i.e., what is in the best interests of the health and well being of our patients, your constituents, and the state as a whole, as opposed to the interests of a single individual (aggrieved plaintiff) or particular special interest group (doctors, lawyers, insurers, hospitals, et cetera).

We respectfully propose that if you ask your constituencies which they would prefer, access to health care or potential mega-jury awards for malpractice injuries, their answer would be a resounding request for access to available, affordable, quality health care.

VI. Recommended Remedies.

A. Recommended Short Term Remedies. (Halt the bleeding ...)

1. Place caps on damages.

States with tort reform, which include caps, have experienced both a decrease in the escalation of premiums and an increase in the number of doctors practicing in that state as compared to states without tort reform. Similarly, health care costs could decrease 5% to 10%, without adversely affecting quality of care, if tort reform was enacted.

Non-economic damages are clearly not quantifiable, and no amount of money can adequately compensate for the loss of a loved one, but limiting the amount of damages leaves a greater amount of dollars in the health care system for treatment of patients who need care. This issue needs to be recast from 'physicians vs. plaintiff attorneys and potential large damage awards' into what's in the best interest of society as a whole. From a public policy perspective, damage caps benefit society by assuring access to available emergency services at reasonable prices.

Similarly, caps would lower the insurance costs for all who pay their own health care costs, not just the cost of parties who pay malpractice insurance and liability costs.

Setting damage caps is also absolutely necessary so that insurers know the potential limits of losses in any individual case. Insurers can't set rates with any predictability if they can't predict sustained losses. Otherwise, they simply have open-ended liability. This was primarily the reason St. Paul Insurance Company exited the medical malpractice market. St. Paul determined that the medical tort system was uncontrollable, unpredictable, and with no foreseeable reasonable tort reform, they concluded that medical malpractice was a wholly uninsurable market. The St. Paul's insight is proving prophetic.

It is recommended that the legislature enact the following:

- a. Caps on non-economic damages (pain and suffering component of damage awards - 75-77% of all damage awards are for non-economic damages.).

- (1). Caps on non-economic damages in non-emergency care cases.

Cap non-economic damages at \$250,000 per occurrence, regardless of the number of plaintiffs and number of defendants. Exceptions: increased the cap to \$500,000 per occurrence, regardless of the number of plaintiffs and number of defendants, for wrongful death or permanent and substantial loss of limb or bodily function (and such other exceptions as determined by the legislature; and +/- annual adjustments for inflation).

- (2). Caps on non-economic damages in emergency care safety-net cases.

Cap non-economic damages at \$150,000 per occurrence, regardless of the number of plaintiffs and number of defendants, for safety-net providers (hospital emergency departments, emergency physicians, trauma physicians, on-call physicians, and EMS systems) who act on an emergency basis pursuant to obligations imposed by government mandates, such as EMTALA, and who do not have a pre-existing physician-patient relationship for the presenting emergency medical condition. The cap on non-economic damages for emergency safety-net providers cannot be pierced for any reason.

- b. Caps on the total amount of civil damages available on cases arising out of emergency care or trauma care (safety-net emergency services).

Place a \$500,000 cap on civil damages (not just non-economic damages) for any injury or death as a result of health care services rendered in good faith and necessitated by an emergency condition for which the patient presented at a 'dedicated emergency department' (as defined by HHS – CMS in its new EMTALA regulations effective November 10, 2004) or designated trauma center. The limit should also apply to health care services rendered by a licensed EMS agency or employee of a licensed EMS agency. The limit should not apply in cases of willful and wanton conduct or 'gross negligence' (which should be carefully defined).

Any legislative language capping damages must use appropriate language that includes damages available under EMTALA or other federal claims. EMTALA is not a negligence claim or a malpractice action; it is statutory liability for harm due to violation of the federal statute, but the damages available are those available under state laws. Inexact language drafting would allow lawsuits to be brought under EMTALA in order to circumvent state damage caps (in additions to other state procedural tort reforms, such as North Carolina's expert witness requirements).

Other state laws, such as those recently enacted in Florida or long in effect in California, can serve as models for enacting effective legislation in here in North Carolina.

2. Eliminate the Collateral Source Rule (i.e. eliminate double recovery of damages.)

Public policy should be to make persons whole for the damages suffered due to medical negligence. Society should not pay twice and should be allowed to utilize all resources available, including resource available directly to injured party, to make them whole.

Otherwise, it just increases the costs to the system, i.e., to all of us. The 'doctor' doesn't benefit from the patient's outside sources of compensation - society does, in terms of decreased health care costs and increased availability of quality medical services. A reasonable approach would be:

- Defendants may introduce into evidence payments the plaintiff received from collateral sources.
- Plaintiffs may present evidence of the value of payments or contributions made to secure benefits from collateral sources.
- Courts must reduce the plaintiff's award by the amount the plaintiff received from collateral sources offset by payments or contributions made to secure such benefits.

3. Impose periodic payments.

Again, compensation for damages due to medical negligence should make people whole, not provide a windfall.

4. Eliminate joint and several liability.

If tort laws are meant to punish the negligent, then it's only just and equitable that individuals should pay only in proportion to their degree of negligence.

5. Limit attorneys' fees.

Again public policy reasoning; compensation should be adequate but it should not provide windfalls that distort markets. The argument that an attorney should be able to charge what the market will bear isn't tenable in a non-market system. Emergency physicians don't get to charge what the market can bear; they are paid fixed fees that the government is willing to pay, if they are paid at all for providing care required by government mandates. If government can set the fees for physicians in providing their services to these patients, it can set the fees for the attorneys to providing their services to the very same patients.

Both physicians and the attorneys claim to be protecting the best interests of the patients. But it's clearly in the best interests of the state, and its ability to provide health care coverage to all individuals in the state, that when controlling its cost for health care it should also control the ancillary costs of that health care, such as litigation costs.

6. Loser pays all costs. This is especially applicable to instances when physicians are named speciously and only released from the case after incurring significant defense and legal costs, and black marks on their claims records. Today, virtually ANY claim portends significant ramifications for individual physicians related to obtaining insurance, maintaining insurance, the cost of that insurance, and even their future employability. Senate Bill 802 does a nice job of addressing this issue after the hearing impaneled to determine presence or absence of negligence in the case.

Section 2.6 and 2.7 of Senate Bill 802 regarding the panel of referees and the use of their report as evidence at trial and in allocating costs to the non-prevailing party and its use to limit damages at trial are all commendable efforts. The use to limit damages at trial should be amended to include damage caps.

7. Modify Jury Instructions. The court should inform the jury that it cannot make a negligence determination *solely* based on a bad outcome suffered by the plaintiff. (Studies have shown that whether a jury will award a plaintiff damages correlates much more with the extent of the plaintiff's injuries (jury sympathy) than on proof of negligence. See, for example, Brennan TA, et al. "Relation between negligent adverse events and the outcomes of medical-malpractice litigation". *New England J of Medicine*, 1996;335(4):245.)

8. Eliminate punitive (exemplary) damages for health care cases. If our state laws do not eliminate punitive damages entirely for medical injury cases, then require that the standard of proof be greater than gross negligence and require the jury to be *unanimous* with regard to liability for punitive damages and for the amount of damages to be awarded.

B. Recommended Long Term Remedies.

In addition to capping non-economic damages and passing the other tort reform measures listed above, we recommended that the legislature specifically address the liability issues of our State's safety-net providers by changing the standard of liability by which they are judged.

1. Change the standard of liability.

The most equitable and balanced method is to change the standards of liability specifically for safety-net providers (hospital emergency departments, emergency physicians, trauma physicians, on-call physicians, and EMS systems) that care for patients on an emergency basis under government mandates, such as EMTALA. (See the Florida model, enclosed below, which sets a 'reckless disregard' standard, instead of an ordinary negligence standard, for liability of safety-net providers.)

Fla. Stat. § 768.13 (2002) Good Samaritan Act; immunity from civil liability

(1) This act shall be known and cited as the "Good Samaritan Act."

(2)(a)

(2)(b) 1. Any hospital licensed under chapter 395, any employee of such hospital working in a clinical area within the facility and providing patient care, and any person licensed to practice medicine who in good faith renders medical care or treatment necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center, or necessitated by a public health emergency declared pursuant to s. 381.00315 shall not be held liable for any civil damages as a result of such medical care or treatment unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a **reckless disregard** for the consequences so as to affect the life or health of another.

2. The immunity provided by this paragraph does not apply to damages as a result of any act or omission of providing medical care or treatment:

- a. Which occurs after the patient is stabilized and is capable of receiving medical treatment as a non emergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the immunity provided by this paragraph applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery; or
- b. Unrelated to the original medical emergency.

3. For purposes of this paragraph, "**reckless disregard**" as it applies to a given health care provider rendering emergency medical services shall be such conduct which a health care provider knew or should have known, at the time such services were rendered, would be likely to result in injury so as to affect the life or health of another, taking into account the following to the extent they may be present;

- a. The extent or serious nature of the circumstances prevailing.
- b. The lack of time or ability to obtain appropriate consultation.
- c. The lack of a prior patient-physician relationship.
- d. The inability to obtain an appropriate medical history of the patient.
- e. The time constraints imposed by coexisting emergencies.

4. Every emergency care facility granted immunity under this paragraph shall accept and treat all emergency care patients within the operational capacity of such facility without regard to ability to pay, including patients transferred from another emergency care facility or other health care provider pursuant to Pub. L. No. 99-272, s. 9121.

Alternatively, the legislature could grant qualified immunity for safety-net providers treating emergencies in the ordinary course of their duties, exactly as that provided under our current North Carolina Good Samaritan Act for treating emergencies on a volunteer basis.

2. Create a special medical malpractice tribunal to adjudicate medical injury cases.

Utilize expert malpractice tribunals, rather than using the jury system, to adjudicate medical negligence cases, and utilize independent expert panels instead of hired expert witnesses.

3. Permit individuals and companies to opt out of the litigation system.

Allow entities to avoid the current litigation system through contracts or arbitration clauses that offers some sort of alternative dispute resolution. For example, you may pay a certain amount of premium for a managed care health insurance policy that offers arbitration or alternative dispute mechanisms but not lawsuits; if you want to buy a policy that includes the option to sue, you pay for the cost of insurance in your premium.

4. Protect risk management activities that promote patient safety from lawsuits.

The current culture of malpractice makes it impossible for health care providers to initiate performance improvement actions similar to other industries. Individuals will never come forward and volunteer errors in the current litigation environment.

Respectfully submitted, on behalf of the North Carolina College of Emergency Physicians,

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VII. References

A. Evidence that the malpractice insurance crisis is detrimentally affecting access to emergency care, especially through loss of on-call physician services to hospital emergency departments and loss of hospital-based services.

GAO-03-0836 August 2003 Medical Malpractice: Implications of Rising Premiums On Access to Health Care. <http://www.gao.gov/new.items/d04128t.pdf>

The GAO examined the experiences in five states with reported malpractice related problems, Florida, Nevada, Pennsylvania, Mississippi, and West Virginia; and, also, four states without reported problems, California, Colorado, Minnesota, and Montana.

The GAO confirmed that in all five crisis states access to emergency services had been reduced, particularly for trauma and obstetrical emergencies, and transfers of patients increased substantially.

The GAO contacted 49 hospitals and 26 confirmed a reduction in surgeons available to provide on-call coverage to the emergency room.

This study is a clear example of what's ahead for NC if we don't address the issue now, before it reaches the crisis proportions sustained in neighboring states.

HHS report - Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care. March 3, 2003.
<http://aspe.hhs.gov/daltcp/reports/mediab.pdf>

This study concludes that the malpractice crisis is impairing patient's access to care, as well as the cost and quality of health care.

The study also cites a doctor in a small town in North Carolina who took early retirement, because he was unable to afford his practice expenses after his malpractice premium skyrocketed by a factor of five fold.

Berenson RA, Kuo S, May JH. Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places, Issue Brief No. 68, September 2003, Published by the Center for Studying Health System Change.
<http://www.hschange.org/CONTENT/605/tr1>

Non-emergency physicians are referring more patients to emergency departments and safety net hospitals or academic health centers, and these physicians are refusing to provide on-call ED coverage and declining elective referrals from safety net providers such as emergency departments.

Physicians, particularly those practicing in high-risk specialties, are unwilling to provide ED on-call coverage because of malpractice liability concerns.

HHS Report. Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System. July 24, 2002. See also the HHS Special Update on Medical Liability Crisis. September 2002.
<http://aspe.hhs.gov/daltcp/reports/mlupd1.htm>

HHS concludes that access to health care and the patient safety-net system are jeopardized by the malpractice liability crisis.

Wanerman R. The EMTALA Paradox. Ann Emerg Medicine 2002;40:464-469; and Bitterman RA (Editorial). Explaining the EMTALA Paradox. Ann Emerg Medicine 2002;40:470-475.

These two articles specifically discuss the problems of obtaining on-call physician coverage of our nation's emergency departments due to increased liability concerns, uncompensated care, and EMTALA mandates.

American Hospital Association Professional Liability Insurance Survey, March 2003
Percent of hospitals in crisis states (which includes North Carolina) reporting specific effects of increased professional liability expenses.

- More difficult to recruit physicians, 53%
- Loss of physicians and or reduced coverage in emergency departments, 45%
- Negative impact on hospitals' ability to provide services, 35%

American Hospital Association 2002 Trendwatch Report.

Twenty percent of hospitals reacted to the liability crisis by cutting back on services and/or eliminating patient care units such as obstetrics or trauma centers.

HHS report <http://aspe.hhs.gov/daltcp/reports/medliapr.htm>.

HHS study shows problems in health care system are worsening as medical litigation crisis deepens. March 3, 2003.

TrendWatch by American Hospital Association and The Lewin Group.

This study examined the changing physician environment. The report describes demographic shifts in the physician population, economic pressures facing physicians due to liability insurance costs, regulatory burdens, and decreasing reimbursement from government programs and insurance companies, changes in the way physicians practice, and the future supply and demand for physicians.

<http://www.ahapolicyforum.org>. View under "TrendWatch."

The American Medical Association list of states in medical crisis because of the liability problem include: Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia, Arkansas, Connecticut, Illinois, Kentucky, Missouri and **North Carolina**. In those states, doctors reported reducing or discontinuing medical services because of high insurance premiums. March 7, 2003.

BCBS study on malpractice premium increases found that the number of physicians refusing to see patients in crisis states is more than two times that in non-crisis states and physicians are reducing ED calls approximately three times more often in crisis states as opposed to non-crisis states. []

Dr. Jeffrey Houpt, Dean of the UNC School of Medicine testified that the increase in the number of claims over \$1 million has forced the UNC Medical School to divert resources to the litigation system and away from providing patient care. (May 6, 2003)

Medical Mutual Insurance Company of North Carolina (MMIC) acknowledges that many neurosurgeons are refusing to accept emergency room calls because of the high liability risk. (See testimony of Mr. David Sousa, MMIC General Counsel, on December 2, 2003.)

Rosenblatt RA et al. Tort Reform and the Obstetrics Crisis. Western J of Medicine 1991;154:693-699.

Escalating malpractice insurance premiums and concern over being sued has been shown to limit the number of physicians delivering babies.

Malpractice concerns are driving career choices of new physicians.

Washington Post, January 25, 2004, B6.

In 2003, for the first time ever, *none* of the graduates of the University of Maryland School of Medicine chose to enter a residency (training program) in obstetrics.

Merritt, Hawkins & Associates

According new survey found that 25% newly trained physicians would select a field other than medicine if they could begin their careers again, up from 5% in 2001. The residents were most concerned about professional liability, with 62% of respondents to the 2003 Survey of Final-Year Medical Residents indicating the issue was a significant concern, up from 15% in 2001. Dealing with managed care was their 2nd most significant concern. The survey report is available online at <http://www.merrithawkins.com/merrithawkins/surveys.jsp>.

AMA News Survey 8/25/03.

One-third of new physicians shied away from entering certain specialties because of fear of greater liability exposure.

Defensive Medical Costs

Though intangible, greater than 80% of doctors agree, according to various studies, that physicians order wholly unnecessary testing solely to prevent or defend against potential malpractice lawsuits. The costs of defensive medicine are nearly impossible to quantify, but it is certainly real to anybody and everybody who practices emergency medicine. As long as a zero miss rate is essential to avoid litigation, physicians will be compelled to "consider every test" as a way of protecting themselves from the grief and cost of the liability system.

The Health and Human Service Department (HHS) itself estimates the government would save \$28 billion to \$48 billion per year in costs to Medicare and Medicaid on defensive costs alone if the malpractice situation is brought under some control. (HHS report - Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care. March 3, 2003.

<http://aspe.hhs.gov/daltcp/reports/medliab.pdf>.)

B. Do caps on non-economic damages reduce malpractice costs?

Yes. Virtually every academic, independent, and government study concludes that caps definitely decrease insurer loss ratios and provider premium levels.

HHS Office of Technology Assessment: Impact of Legal Reforms on Medical Malpractice Costs (September 1993).

Report found that caps on damages awards consistently reduced the size of claims, and, in turn, premium rates for malpractice insurance.

The study also found that limiting joint and several liability, reducing statutes of limitation, and offsetting awards by the value of collateral-source benefits were effective in slowing the growth of premiums.

Liability premiums 17% lower in states that have capped awards.

An analysis published January 21, 2004 by Health Affairs finds medical liability insurance premiums are 17.1% lower in states that have capped court awards. The report by Kenneth Thorpe, chairman of the health policy and management department at the Emory University Rollins School of Public Health, examines recent trends in liability insurance and the impact of tort reform on premiums. Thorpe, who advised the Clinton administration on health policy issues, said three factors have mainly driven the increase of malpractice premiums: growing awards and settlements, increased frequency of lawsuits, and declines in the investment incomes of insurance companies. Caps were associated with both lower loss ratios and lower premiums. The report can be found at <http://www.healthaffairs.org>.

HHS report - Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care. March 3, 2003.

<http://aspe.hhs.gov/daltcp/reports/mediab.pdf>

HHS determined that medical litigation significantly worsened in the past year, sparked by a rise in million dollar jury awards and settlements, particularly for non-economic damages.

Largest cause of increased premiums was non-economic damages lost on filed claims. Premium increases were 2.5 times higher over a two year span in states without caps on non-economic compare to states with caps on non-economic damages.

If legislation placed limits on non-economic damages, it would save \$70-126 billion in health care costs per year.

GAO Report (GAO-03-702). Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates. <http://www.gao.gov/new.items/d03702.pdf>.

GAO concludes that the largest part of increasing premiums is due to losses on malpractice claims.

The GAO also notes that 60% of physicians are now covered by physician owned entities, and that an increasing number of large hospital and physician groups have left the commercial insurance market entirely, and begun to self-insure in a variety of ways, exposing themselves to greater financial responsibility for malpractice claims and greater risk of insolvency.

The GAO analyzed premium rates in seven states (California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania and Texas) and determined multiple factors, including falling investment income and rising reinsurance costs, have contributed to recent increases in premium rates, but found that losses on medical malpractice claims are the driving factor behind the huge rate increases.

Congressional Budget Office (CBO) - Limiting tort liability for medical malpractice (January 8, 2004).

Evidence from the states indicates that premiums are lower when tort liability is restricted than they would be otherwise. Available at www.cbo.gov. (See also the CBO report of The Economics of US Tort Liability: A Primer (October 2003).)

GAO-03-0836 August 2003 Medical Malpractice: Implications of Rising Premiums On Access to Health Care. <http://www.gao.gov/new.items/d04128t.pdf>.

The GAO examined the experiences in five states with reported malpractice related problems, Florida, Nevada, Pennsylvania, Mississippi, and West Virginia; and, also, four states without reported problems, California, Colorado, Minnesota, and Montana.

The GAO found that the growth in malpractice premiums has been slower in states that enacted tort reforms that included caps and faster in states that do not have caps, by a factor of 10% vs 29% over the past two years.

California's medical malpractice insurance premiums went from the highest in the nation to lower than the median cost after passage of tort reform. From 1976 to 2000, premiums in the US rose an average of 505%, but California's only increased 167% during the same time period.

Congressional Budget Office: Cost Estimate for H.R.5 (Health Act of 2003) March 2003. Based on its own research on the effects of tort restrictions, the Congressional Budget Office (CBO) estimated that provisions of the Health Act of 2003 (H.R.5) would lower premiums nation wide by an average of 25%-30% from the levels likely to occur under current law. Available at www.cbo.gov.

American Hospital Association Professional Liability Insurance Survey - A Growing Crisis. March 2003

An AHA study found professional liability expenses have doubled for nearly half of the hospitals in states experiencing a liability crisis, but were lower in states that had enacted liability reform.

Professional liability expenses per staff bed was \$11,435 in crisis states but \$4,228 in states that have enacted tort reform.

Average professional liability expense growth over the past two years in crisis states is 158% compared to 74% in reform states.

Advisory Board Company research study on malpractice costs, October 4, 2003.

The study found that physicians in 'crisis states' and in states with only limited tort reform face premium increases significantly larger than average states. Premiums were between two and two and a half time greater in crisis states and in non-reform states as opposed to those in tort reform states.

Employment Policy Foundation Study.

Estimated that limiting damage awards in medical liability cases could save \$54.8B to \$97.5B annually, or 7.2% to 12.7% of the \$765B spent on hospital and physician services each year. The analysis found significant cost differences between states with non-economic damage award caps and states without limits. For example, medical liability premiums increased 505% nationwide between 1976 and 2000, while premiums in California, which caps non-economic damage awards, increased just 167%. The report says rising liability costs reduce access to care and artificially inflate health care expenditures by encouraging medically unnecessary tests and diagnostic procedures. It estimates curbing medical liability excesses would reduce employer-sponsored health plan costs by \$17.4B to \$30.9B annually, and reduce the employee share of annual health plan costs by \$59 to \$109 per employee annually. June 21, 2003 at <http://www.epf.org/>.

Malpractice Insurance Losses Jump When Caps Removed.

In 1998 caps on non-economic damages were ruled unconstitutional in the state of Oregon. Losses had remained steady over the previous 7 years with the cap in place. After removal of the cap, annual losses tripled in less than 3 years. (Data from A.M.Best Database Services. See also the Tillinghast report.)

Cohen, H .Congressional Research Service Report for Congress. Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive and Noneconomic Damages. Order Code RL31692 Updated May 14, 2003.

Discusses the pros and cons of the malpractice liability reform bill passed by the US House of Representatives, H.R. 5 (The HEALTH Act), on March 13, 2003. It includes a discussion on the effectiveness of caps.

Actuarial and Analytics Practice of Aon's Risk Services, Inc.

Aon conducted a hospital professional liability and physician liability benchmark study and concluded that the "real problem" is the growing size of liability awards and that caps do limit award sizes. The study was published in January of 2004.
<http://www.aon.com> and click on "2003 Benchmark Analysis".

States with Caps on Noneconomic Damages Also Have More Physicians.

(I.e., Sutton's Law applies to physician behavior too!)

DHHS Agency for Healthcare Research and Quality (AHRQ), Hellinger FJ & Encinosa WE. "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians". States with caps on non-economic damages experienced 12% more physicians per capital than States without such a cap. Moreover, States with relatively high caps were less likely to experience an increase in physician supply than States with lower caps. Twenty four states have damage caps laws. July 7, 2003.
<http://www.ahrq.gov/research/tortcaps/tortcaps.htm>.

Tort Reform Along the California Model.

In the malpractice crisis of the 1970s, California was one of the worse states in the nation. Today it's one of the better states in the nation because it passed sensible comprehensive tort reform that in no way limited the access of persons injured because of medical malpractice to recovery of their economic damages and losses and reasonable compensation for their pain and suffering (a totally immeasurable element).

HHS Update on the Medical Litigation Crisis: Not the Result of the "Insurance Cycle".

November 2002. <http://aspe.hhs.gov/daltcp/reports/mlupd2.htm>. Also see Kipp R, Cookson JP, & Mattie LL. Health Insurance Underwriting Cycle Effect on Health Plan Premiums and Profitability. Published by Milliman, USA, April 10, 2003.

C. The current tort system is a poor way to prevent and redress injury from medical negligence.

Societal Purposes of the Tort Law:

1. Compensate negligently injured persons.
2. Deter unsafe practices that lead to injury.

The current tort system does not meet either of these two goals well. Most studies confirm that 60% of the dollars awarded are spent to cover the administrative costs of the system (primarily attorney fees of both the plaintiff and defendant), and only 40% of the dollars awarded actually go to the injured party.

Tillinghast-Towers Perrin: US Tort Costs: 2003 Update Trends and Findings On the Cost of the US Tort System.

US tort system is highly inefficient returning less than 50 cents on the dollar to the people designed to help and returning only 22 cents to compensate for actual economic loss. This inefficiency has increased over time. Total growth and tort costs have escalated from 1980 to 2002 compounding at an average of approximately 12% per year. At approximately \$25 billion in 2002, medical malpractice costs translated to about \$85 per person and contributed an increase in health care costs. The 13.3% rate of growth in tort costs in 2002 greatly exceeded overall economic growth of 3.6%. In 2002 tort costs accounted for approximately 2.5% of GDP, the highest ratio to GDP since 1990.

Institute of Medicine (IOM) to Err is Human: Building a Safer Health System, National Academy Press, Washington, DC (2000).

“There is widespread agreement that the current system of tort liability is a poor way to prevent and redress injury resulting from medical error. Most instances of negligence do not give rise to lawsuits and most legal claims do not relate to negligent care.”

There are very clear signs that malpractice insurance pressures are altering physician treatment decisions and effecting patient care through unexpected avenues.

Harvard Medical Malpractice Group failed to show correlation between jury awards, settlements, and defendant misconduct (same for products liability and securities liability i.e. torts in general).

Studdert DM et al. Health Policy Report: Medical Malpractice. NEJM 2004;350:283-292

Mello MM, Studdert DM, & Brennan TA. The New Medical Malpractice Crisis. NEJM 2003;348:2281-2284.

Localio AR, Lawthers AG, Brennan TA et al. Relation between malpractice claims and adverse events due to negligence. New Engl J of Medicine. 1991;325:245-51.

Brennan TA, Sox CM, Burstin HR. Relation between negligent adverse events and the outcomes of medical malpractice litigation. New Engl J of Medicine 1996;335:1963-7.

D. Emergency Medical Treatment and Labor Act (EMTALA)

EMTALA is the federal law which requires Medicare participating hospitals to examine and stabilize all persons presenting to their emergency department, and accept patients in transfer from lesser capable hospitals.

1. Bitterman RA. Providing Emergency Care Under Federal Law: EMTALA. Published by the American College of Emergency Physicians in January 2001 (available from ACEP's publication department at 1-800-798-1822, touch 6, or on ACEP's web site at www.acep.org/bookstore.) A supplement addressing the impact of the new EMTALA regulations effective November 10, 2003 will be available from ACEP in the spring of 2004.
2. 68 Fed. Reg. 53,221-53264 (2003): the new final EMTALA regulations on EMTALA published by CMS in the Federal Register on September 9, 2003.

The new regulations became effective November 10, 2003, and most experts believe they relax the on-call requirements and will lead to fewer specialists taking call for local emergency departments and more transfers of patients due to the lack of available services at more hospitals.

A copy of the new EMTALA rules can be found though the Federal Register Online GPO Access at: http://www.access.gpo.gov/su_docs/fedreg/a030909c.html under "Separate parts in this issue."

3. CMS's Interim Guidance to state surveyors and its regional offices regarding the enforcement of EMTALA under the new regulations is available on line at <http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp>.

4. Dame LA. EMTALA: The Anomalous Right to Health Care. Health Matrix 1998;8:3.
5. GAO Report (GAO-01-747) on the impact of EMTALA on hospital emergency departments, the delivery of emergency care, and CMS/OIG enforcement, June 22, 2001. Available on the internet at www.gao.gov/new.items/d01747.pdf.
6. Wanerman R. The EMTALA Paradox. Ann Emerg Medicine 2002;40:464-469; and Bitterman RA (Editorial). Explaining the EMTALA Paradox. Ann Emerg Medicine 2002;40:470-475.

These two articles specifically discuss the problems of obtaining on-call physician coverage of our nation's emergency departments due to increased liability concerns, uncompensated care, and EMTALA mandates.

7. Bitterman RA. A critical analysis of the federal COBRA hospital "antidumping law": Ramifications for hospitals, physicians, and effects on access to healthcare. University of Detroit Mercy Law Review. 1992;70:125-190.
8. Fields W, ed. Defending America's Safety Net [White Paper]. Dallas, TX: American College of Emergency Physicians; 1999.