

KMA

MEDICAL LIABILITY REFORM

FACT V. FICTION

The Legislation

Fiction: **Bills addressing constitutional change enact malpractice caps.**

Fact: Constitutional amendments for medical liability reform – introduced in every legislative session since 2003 – simply open the door for discussion of a variety of reforms. Nothing will be enacted if voters pass the constitutional amendment in November of 2006. It will allow legislators to come up with a solution that is fair and reasonable, which may or may not include caps on non-economic awards.

Fiction: **A Constitutional Amendment takes the issue of medical liability reform away from the General Assembly.**

Fact: Actually, the exact opposite is true. If the constitutional amendment is placed on the 2006 November ballot and the voters say yes – an overwhelming majority support a variety of reforms, the General Assembly will finally have a say.

In the 1970's and 1980's, several reforms were passed by Kentucky legislators but ruled unconstitutional or thrown out by the court.

This statement by Tom Lewis, former Dean of the University of Kentucky Law School, should resonate with all legislators:

“Under the court’s interpretation...tort principles will be whatever the court decides they will be; **the merits or demerits of efforts by the General Assembly to modify these principles are irrelevant because it has no voice in the matter.”**

Constitutional amendments do not enact caps or any reform. It simply opens the door for discussion of a variety of medical liability reforms. Kentuckians favor reforms: 70% support a variety of liability reforms. (October 2002 survey, Marketing Research Institute) and 68% favor a limit on medical malpractice awards (February 2004, Courier-Journal Bluegrass Poll).

Physician Losses

Fiction: **Kentucky gained 314 physicians and 20 OB/GYNs from 2004 to 2005 and our medical students are not affected by the current medical liability system**

Fact: This is shallow interpretation of whether Kentuckians have sufficient access to physicians.

The KMA Physician Workforce Committee conducted a study of practicing physicians who have left the state or retired during a three-year period from January 2000 through December 2002. Information was obtained through the KMA database, the Kentucky Board of Medical Licensure and the American Medical Association Physician Movement Reports.

Findings from this study reveal that 1273 practicing physicians left the state and an astounding 58% of our physicians in the state’s residency programs also left. In addition, high-risk specialties have been the hardest hit, exposing our communities to a dangerous deficiency of physician specialists.

Note: The data from the study indicates gains and losses in practicing physicians – those who actually see patients. Analyzing the data only from the KBML provides information about licensed physicians, which includes those who are retired, out-of-state or not currently practicing.

(The KMA Physician Workforce Committee plans to update the physician movement information for January 2003 to December 2005 early next year.)

Also: A study by the University of Kentucky Center for Rural Health found that Kentucky needs an additional 600 doctors to meet residents health care needs. Only 15 counties in Kentucky have enough family physicians, the study said. Researchers found that keeping family physicians in rural counties can be difficult because of a workload that is far heavier than in metropolitan areas, and because of the increasing cost of malpractice insurance.

Results from the KMA Physician Movement Survey

Practicing Physicians –

- 1,273 have left the state
- 31% of the 1,273 went to the bordering states of Indiana, Tennessee and Ohio
- In addition, 281 actively practicing physicians retired from practice, but remained in Kentucky. Sixty of the 281 (21%) were less than 65 years of age. 30 (11%) were under age 60.
- **The total loss of practicing physicians – 1,554**

Breakdown by Specialty:

- 600 of the 1,554 were in a primary care specialty (FP, IM, PED, OBG)
- 36% of the Neurosurgeons left/retired
- 29% of the General Surgeons left/retired
- 28% of the Urologists left/retired
- 28% of the Ophthalmologists left/retired
- 26% of the Orthopaedic Surgeons left/retired
- 26% of the Radiologists left/retired
- 25% of the OB/GYNs left/retired
- 21% of the Emergency Physicians left/retired
- 20% of the Family Practice Physicians left/retired

Physicians in the state's residency programs who have left the state

466 have left the state (58% of those who trained here)

- 80% of the General Surgeons trained here have left
- 80% of the Ophthalmologists
- 66% of the Emergency Physicians
- 11% went to Indiana; 8% to North Carolina; 8% to Ohio

Total Losses

Practicing Physicians (1,554) plus Residents (466) = **2,020**

Total Gains (during this same period)

- Practicing Physicians (newly licensed) – 867
- Residents who stayed in Kentucky – 337
- Gains of **1,201** practicing physicians

NET LOSS OF 819 PHYSICIANS

Also, relying on the total number of licensed physicians in a state to track physician mobility is inappropriate. According to James Thompson, MD, President and CEO of the Federation of State Medical Boards of the U.S. (FSMB):

“The number of licensed physicians in a state is not an accurate measure of whether patients have adequate access to health care. Physicians may reduce their practice, stop treating high-risk patients, or stop practicing altogether and still maintain their license. Also, the number of licensed physicians is not an accurate indicator of the distribution of those physicians in underserved areas. Licensed physicians may work in administrative, academic or other settings where they may not have a clinical practice. Also, many retired physicians maintain a license. Information in the Federation of State Medical Boards' database shows that approximately 60% of physicians are licensed in more than one state which indicates that they are licensed in states where they do not maintain a full-time or part-time practice.”

Jury Awards and Court Costs

Fiction: Since there have been relatively few jury awards for non-economic damages over \$250,000, medical liability reform is unnecessary.

Fact: Another shallow interpretation of a much larger issue.

Kentucky is in the flood plain of malpractice claims. Although a major jury award only comes around every so often, the constant threat of that jury award, plus the continual rainstorm of malpractice suits has driven malpractice rates to astronomical heights. The constant defense of claims has created an unstable, unpredictable market for malpractice insurance companies.

Medical liability insurers are required to report claims paid each year to the Department of Insurance but many do not report cases where there was no payment or cases were dismissed or dropped.

However, using the data that is reported, according to Kentucky Trial Court Review, from 1998 to 2002, 267 of 357, or 75% of cases that went to trial resulted in findings favorable to the defendant.

Also, based on the average cost of \$91,423 to defend a case won at trial, more than \$24 million in defense costs were paid by medical providers and their insurers for suits that had no merit.

In addition, when these 267 cases are subtracted from the 742 reported cases with zero payments, there were 475 other cases without merit that did not make it to trial. Using the average cost of \$16,160 to defend dismissed suits, medical providers had to pay an additional \$8 million to defend these frivolous suits.

Another \$30 million was paid to settle some 760 cases, many of which did not have merit but were settled to avoid increased defense costs associated with a jury trial.

Our physicians and our citizens are clearly paying the price for a lot of frivolous lawsuits.

Because thirty-three to forty percent of a victim's settlement or award is consumed by trial lawyer contingency fees, trial lawyers have a self interest in asking for outrageous awards to feather their own nest. Attorney contingency fees from settled or adjudicated cases from 1998 to 2003 was approximately \$63,500,000.

(Data: Physicians Insurers Association of America, May 2003).

Alternative Dispute Resolution

Fiction: Alternative Dispute Resolution would infringe on an individual's right to a trial by jury and would allow the insurance company to select the judge or jury.

Fact: First of all, a constitutional amendment doesn't enact any reform.

Secondly, constitutional amendments proposed in previous sessions have guaranteed a trial by jury.

However, if the General Assembly decided that alternative dispute resolution would be a good way to weed out frivolous lawsuits. Participants for such a review panel would consist of attorneys, doctors and other experts. Such panels in other states consist of three or five members where the defendant and plaintiff each select an equal number of experts and must agree on the final member.

It would simply be a way to screen malpractice claims and determine whether they have sufficient merit before proceeding to trial. This would discourage, but not prevent cases without merit from going to court, and it would help true victims of malpractice by prompting faster settlements, with each side avoiding additional costly legal fees. With a large percentage of medical malpractice lawsuits dropped, dismissed or ruled in favor of the medical provider and with providers facing an increase in the number of suits each year – Kentucky hospitals have seen a 25% increase in suits filed over the last three years – action must be taken to relieve the rising costs to providers of defending lawsuits without merit.

Insurance Company Investments

Fiction: Increases in medical liability premiums are a result of poor investment decisions by insurers.

Fact: Simply put, insurer investment practices have not precipitated this crisis. Typically medical liability insurers' holdings are conservative, with approximately 80% of their investments in bonds. These investments have yielded positive returns of 5-5.4% for the past five years. (A.M. Best).

In a report issued in January 2003, Brown Brothers Harriman & Co. (BBH) confirmed that there is no correlation between the premiums charged by the medical liability insurance industry, on the one hand, and the industry's investment yield, the performance of the U.S. economy, or interest rates, on the other hand. In a subsequent report using NAIC data, BBH found that over the last six years, medical malpractice companies' investment gains have not declined overall because a decline in equities was more than offset by capital gains in bonds due to declining interest rates.

Even if insurers lost money in the investments, Kentucky state regulations prohibit insurers from recouping past losses by raising premiums. The truth is increases in medical liability premiums are a result of insurance company losses from defending more frivolous lawsuits, entering into settlements to minimize litigation costs, and a trend of higher jury awards in Kentucky and the nation.

Significant Statistics

Fiction: Only 16 percent of Kentucky physicians are responsible for 100 percent of all claims.

Fact: This figure conveniently ignores that a large percentage of claims are frivolous and filed by trial lawyers searching for the pot of gold. The opponents of medical liability reform continually use shreds of data in an attempt to make their point.

Also, this figure is based on the flawed use of data from the National Practitioner Data Bank (NPDB). Reports filed with the NPDB are for jury awards and settlements.

It goes without saying that settlements are not indicative of negligence and in fact the current litigation climate encourages settlements of meritless cases because juries tend to base awards on the extent of a plaintiff's injury not negligence.

In many situations involving a bad medical outcome, even with the best possible medical treatment, a physician may decide to settle a claim rather than risk a "lottery"-type award. Yet this results in a report to the NPDB and is counted as an incident of malpractice.

The fact is our current medical liability system is broken. The vast majority of claims filed never result in payment to the plaintiff, yet a substantial amount of money is spent defending against such claims.

The current liability climate deters providers from reporting errors for fear of being sued. The Kentucky legislature on three occasions enacted confidentiality of peer review so that physicians could openly discuss performance of their peers.

However, on each occasion, the Kentucky Supreme Court ruled confidentiality of peer review to be unconstitutional. Therefore, KHA and KMA support confidential peer review protection as an important element to improve performance and quality of care.

Fiction: You have a 1 in 200 chance of dying from a medical error if admitted to a hospital. And it is estimated that 44,000 to 98,000 people die annually due to medical errors.

Fact: There is no verifiable data anywhere that suggests you have a 1 in 200 chance of dying of a medical error if admitted to a Kentucky hospital. Their stat is inflammatory and simply a lie.

As for the estimation regarding the number of people who die annually due to medical errors, the data comes from a study conducted in 1980. Only 3 or 4 hospitals in New York were studied and the data gleaned was extrapolated to form a national view.

By the lowest standards, this data is polluted. In addition, there have been great strides in healthcare over the past 24 years. Once again, the opponents will stoop to anything as they try to make a point.

Fiction: The medical liability crisis has had no impact on access to care – the General Accounting Office (GAO) report from August 2003 agrees.

Fact: The GAO report confirms many instances where the medical liability crisis has affected access to health care. In those limited instances where the authors conclude there is no crisis, their methodology fails to accurately reflect the severity of the current crisis. For example, the author's reliance on state licensure data to measure physician mobility and access to care is inappropriate because many physicians who move to another state, retire early, or do not practice clinical medicine still maintain a license.

In fact, according to data from the Federation of State Medical Boards, approximately 60% of licensed physicians are licensed in more than one state, implying that many physicians maintain licenses in states in which they do not practice. Licensure data also fails to account for physicians who no longer perform certain high-risk procedures. Also by aggregating physicians across the state, **the authors minimized the impact of the loss of physicians in rural areas. It is precisely these areas, which are already in dire need of essential health care services, where any loss in services or providers is traumatic.**

Second, the GAO relied on Medicare data to measure utilization of health care services, however, this data focuses on one subset of the population and does not include information on obstetric or emergency room services: two of the hardest hit specialties. In addition, this data is based on information that predates the current crisis so it does not capture any decreases in access to care resulting from recent premium increases. The GAO also failed to compare data between different time periods within the same state, which might provide more useful information. Furthermore, the GAO correctly recognized that the extent of premium increases varies considerably among specialties, yet the authors did not review any specialty specific data in looking at the access problem.

The fact is that, in Kentucky, access to care has already been reduced. Two hospitals have had to shut down obstetrics services because their OBGYNs could no longer afford the insurance to continue delivering babies. The busiest emergency room in the state was recently just nine days away from closing when emergency room physicians who had been cancelled by their insurer could not find coverage. More than 100 of Kentucky's counties are federally designated as medically underserved – Kentucky clearly cannot afford to lose its doctors.

A.M. Best calls the access situation an *Epidemic of National Proportions*. It also views the outlook for the medical malpractice sector as “negative.” And if that’s not enough to scare you, The Insurance Information Institute, based on A.M. Best’s combined ratio data, estimates that Medical Professional Liability is one of the most dangerous lines of insurance, second only to earthquake (property) coverage.

Tort Reform Motives

Fiction: Tort Reforms are Intended to Let Negligent Doctors Off the Hook.

Fact: The medical malpractice reforms that constitutional change would allow legislators to consider would not prevent full recovery of economic loss – past, present, and future medical costs, lost wages, and replacement services – for the true victims of medical negligence. Tort reforms are needed to protect good doctors who have done nothing wrong from having to defend against an onslaught of frivolous lawsuits.

Common sense civil justice reforms are necessary to stabilize the medical liability insurance market so that physicians and other health care providers can continue to serve their patients. **Kentuckians recognize this: 70% support a variety of liability reforms. (October 2002 survey, Marketing Research Institute) and 68% favor a limit on medical malpractice awards (February, Courier-Journal Bluegrass Poll).**

The existing medical liability system is inefficient and structured in a manner that exploits plaintiffs and defendants. It breeds fear in health care professionals, who act “defensively” and run superfluous tests to avoid being sued, which increases costs across the health care system.

Awards and defense costs have risen by percentages exponential to increases in the rates of inflation or the cost of living. Insurers respond by drastically increasing professional liability insurance rates. In many cases, this forces physicians and other health care providers to discontinue providing high risk services, or worse yet, move or quit practicing altogether. And the cycle continues.

Doctors want affordable insurance coverage so they can provide the best possible medical care for their patients.

Fiction: Physicians are Trying to Cover-Up Medical Errors.

Fact: Organized Medicine has been on the forefront of the patient safety movement, which focuses on improving the delivery of medical care and reducing the number of medical errors that occur.

The American Medical Association formed the Patient Safety Foundation in 1996, which has pioneered this movement and played a pivotal role in advancing this cause. In fact, the AMA and KMA strongly advocated for patient safety legislation that passed Congress in 2005.

Physicians across the nation are working with hospitals, drug companies, private organizations and other health care professionals to develop and implement “best practices” that avoid systemic errors that might otherwise occur in the course of delivering medical care.

The KMA and Kentucky Board of Medical Licensure have supported initiatives in recent legislative sessions to improve patient safety. For instance, both organizations advocated for passage of legislation that permits the board to conduct background investigations on physicians. With tools like that and others, the Board was rated first in the nation at handling disciplinary actions against doctors.

In addition, KMA and the Kentucky Hospital Association (KHA) recently supported passage of e-Health legislation that establishes an infrastructure for a statewide e-Health network that will provide administrative and clinical support to physician offices and hospitals. KMA and KHA support the use of technology to improve patient safety.

The KMA and KHA also support creation of a *confidential and non-punitive* climate where discussion and review of errors will occur so that the information can be used to improve the system and avoid errors in the future. To this end, the AMA continues to actively lobby for strong federal legislation creating patient safety programs.

In addition, Kentucky's hospitals already report such information to oversight organizations. The Joint Commission on Accreditation of Hospitals, which accredits 99 of 104 Kentucky hospitals, requires hospitals to report sentinel events and perform a root cause analysis of each event.

In addition, 69 Kentucky hospitals are reporting data on nationally developed patient safety indicators through The Quality Initiative, an effort sponsored by the Centers for Medicare and Medicaid to provide useful and valid information about hospital quality to the public and to foster hospital quality improvement.

In April 2003, the Board of Trustees of the Kentucky Hospital Association adopted a resolution supporting the Quality Initiative and made a commitment to obtain 100 percent participation from all eligible hospitals.

Other States

Fiction: Physicians in other states e facing the same types of increases as Kentucky.

Fact: A Mt. Sterling Obstetrician left Kentucky for Indiana in 2002. In Kentucky, he would have paid \$109,000 in medical liability insurance premiums. In Indiana, he paid \$29,000 and that included a contribution to Indiana's state patient contribution fund. Indiana passed medical liability reform in the mid-1970.

In states where reforms have recently passed, they have made a difference. Texas, for example, has seen virtually every liability insurer in the state lower its premiums and it has been removed from the list of AMA state's in crisis. Ohio has more liability carriers entering its market and creating more competition. And, according to West Virginia's Commissioner of Insurance, doctors are staying there because of the recently passed reforms.

Fiction: MICRA works because California passed incredibly strong insurance regulation in 1988 called proposition 103, which prevents insurance companies from raising rates.

Fact: Proposition 103 was passed in 1988 – more than a decade after MICRA. This measure has had virtually no effect on physicians' professional liability premiums and in fact only about one half of the physicians in California are insured by an entity regulated by Proposition 103.

Contrary to what some consumer groups and the trial bar state, Proposition 103 does not prohibit insurers from raising rates. It implements a basic rate standard that "no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory, or otherwise in violation of this chapter." Under Proposition 103 insurers must file a rate increase with the Department of Insurance (DOI) and requires the DOI to grant a hearing for a challenge to any rate increase above 15%. This has occurred only once in the medical liability market because MICRA has kept rates stable.

The bottom line is that while physicians in California have seen their rates increase 182% since 1976, physicians in the rest of the United States have seen their rates rise 569% during that time. MICRA is the reason for California's lower rates and stable market – not Proposition 103.