



“Road Map” of Talk



□ “The” Problem

- Immediate problem = liability insurance
- Special difficulties in already stressed rural areas
- Big problem = legal performance & patient safety

□ Solutions

- Short-term -- funding, insurance, law
- Farther-reaching -- new approaches



Extent of Problems



- Liability Insurers withdraw, retrench
- Prices rise ... & rejections of applicants
- “Piles on” caregivers already under other pressures
 - Managed care, public cutbacks -
 - Fewer patients have health insurance
 - Under-served areas hit hard, including rural



Assessing Problems

Battle of the Clichés



- ❑ Lawyers: “Déjà vu all over again”
 - It’s all insurance cycle
 - worldwide
 - interest-rate driven
 - also insurer misconduct
 - Tort reform doesn’t work
 - Regulate insurers
 - Blame doctors themselves for carelessness, lack of discipline
- ❑ Doctors/Insurers: “Perfect Storm”
 - Cycle, but much else:
 - Higher jury awards key, espec. mega-awards
 - Reinsurance up
 - Sept. 11th changed attitudes on risk bearing
 - Problems differ by state
 - Tort reform the key solution



All Lines Up, Medical Worst




Increases in Casualty Insurance Prices, Malpractice and Other Lines (during 3 mos., Jul.-Sept. 2004)

	Declines (in % ranges)				Increases (in % ranges)					
	20-30	10-20	1-10	0	1-10	10-20	20-30	30-50	50-100	>100
Business Interruption	0%	2%	19%	44%	28%	6%	1%	0%	0%	0%
Broker E & O	2%	0%	0%	5%	32%	38%	17%	6%	2%	0%
Commercial Auto	0%	2%	12%	35%	27%	22%	2%	0%	1%	0%
Commercial Property	1%	11%	35%	40%	7%	5%	1%	1%	0%	0%
Construction Risks	0%	1%	9%	25%	32%	22%	8%	1%	1%	0%
D & O	1%	2%	17%	27%	31%	20%	2%	0%	0%	0%
Employment Practices	1%	1%	14%	26%	40%	15%	5%	0%	0%	0%
General Liability	0%	1%	22%	42%	20%	15%	1%	1%	0%	0%
Medical Malpractice	0%	2%	2%	9%	19%	26%	26%	13%	2%	4%
Surety Bonds	0%	2%	3%	6%	73%	10%	8%	0%	2%	0%
Terrorism	1%	1%	7%	20%	61%	8%	1%	1%	0%	0%
Umbrella	0%	1%	15%	40%	27%	15%	2%	1%	0%	0%
Workers' Compensation	1%	2%	10%	32%	29%	25%	0%	1%	0%	0%

Source: national survey of membership by Council of Insurance Agents & Brokers (Oct. 2004).

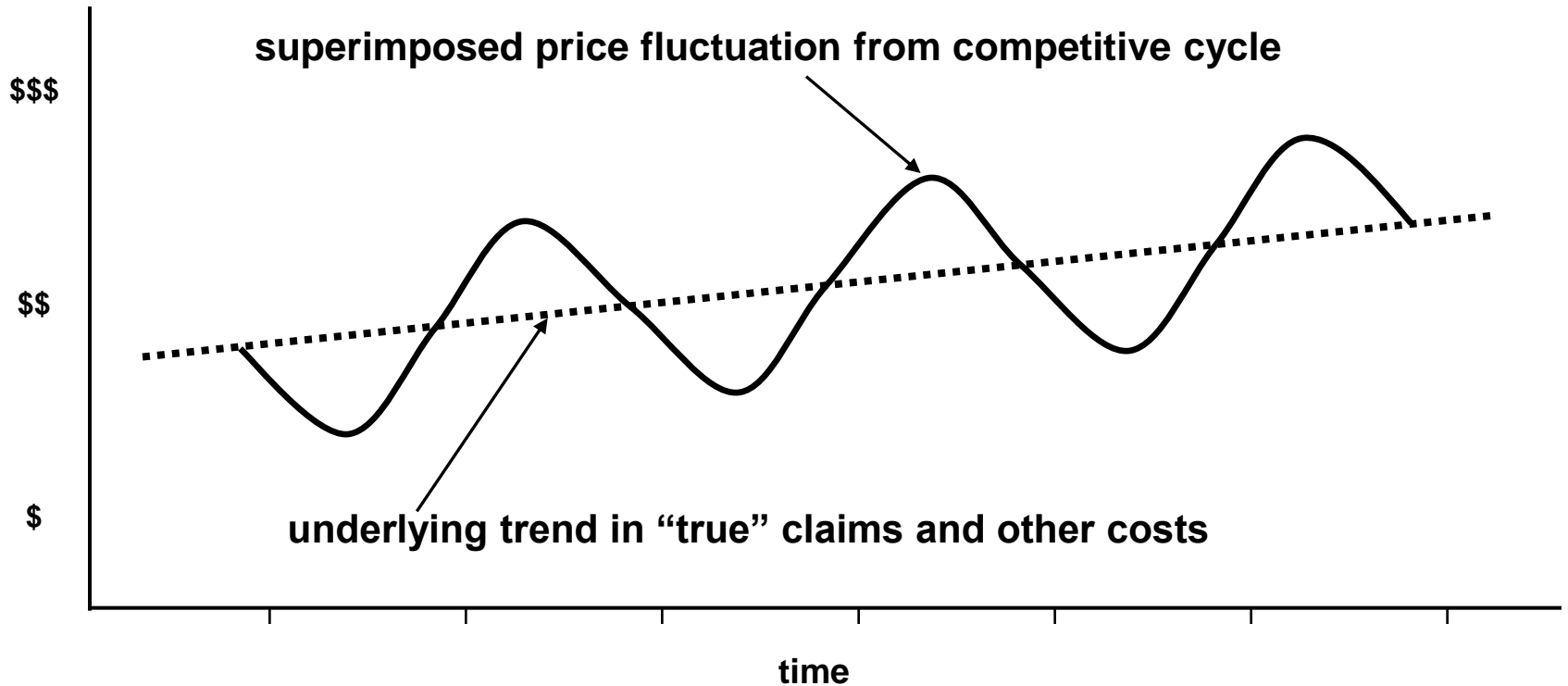
Notes: CIAB says members place 80%, \$90+ billion, of US insurance products and services; percentages omit respondents not placing particular lines (e.g., 5% for general liability, 38% for surety bonds); totals may not add to 100% because of rounding.

 median rate range

 modal range (most common)



Cycles and Costs





Policy Scorecard



- ❑ Main cost of malpractice insurance is malpractice claims [Duh]
- ❑ Interest earnings have effect b/c they're a negative cost, but don't drive cycle
- ❑ Crises not all same, nor return to "normalcy"
- ❑ Big differences across states, even within state



Effects on Access to Care



- ❑ Physician flight - many anecdotes, some overblown
- ❑ Some studies of physician supply find positive effect of liability caps, can be substantial (eg, long-term difference of 12%)
- ❑ Unknown effects on intrastate physician distribution
- ❑ Defensiveness w.r.t. procedures, patients

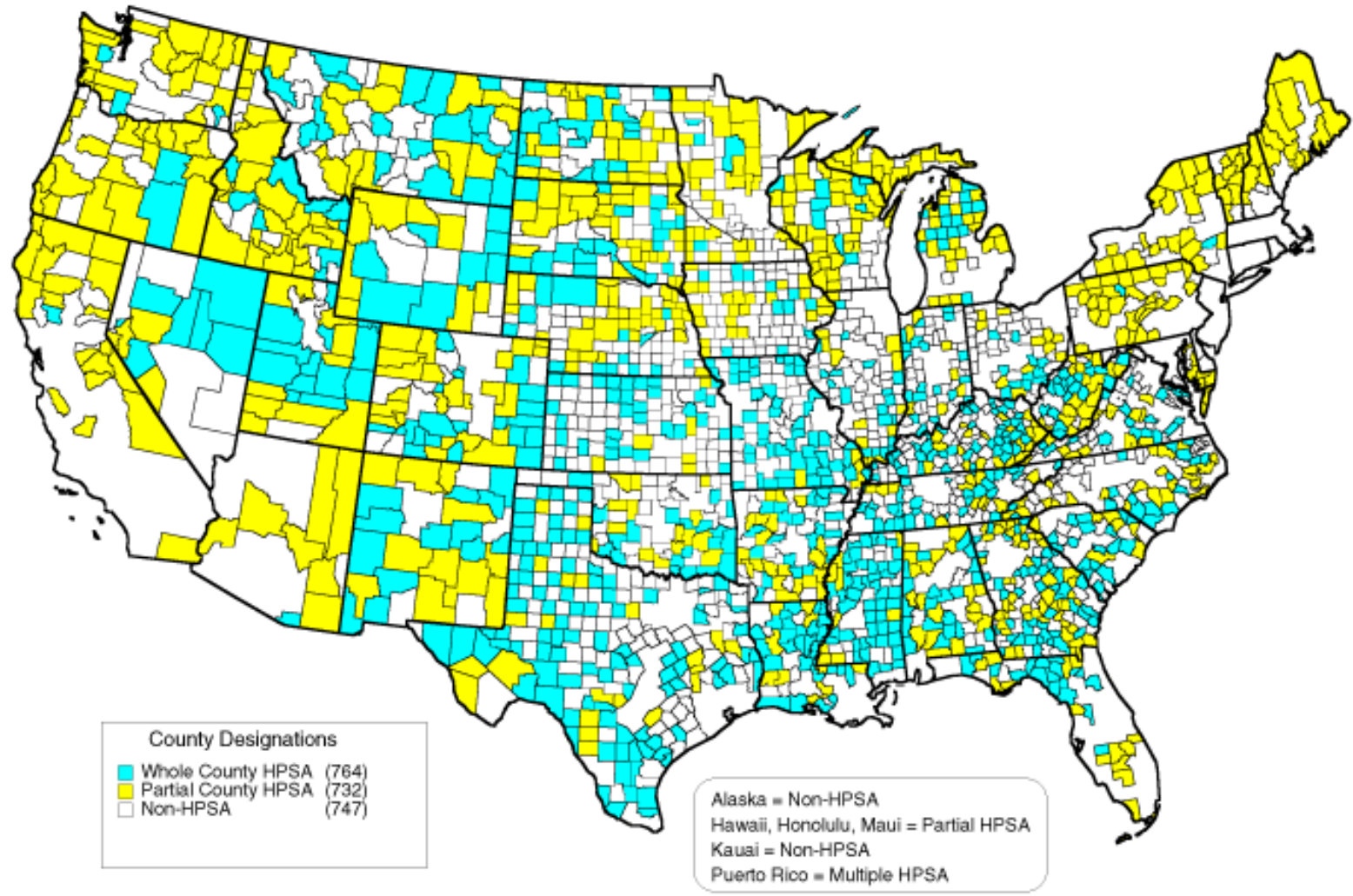


Rural Supply - Gen. Issues



- Rural supply traditionally lower than urban
 - lower incomes, smaller firms, higher uninsurance
 - referral/collegial issues
 - social/lifestyle issues
- Heavy reliance on Medicare/caid, fiscal stress
- Medical supply \Leftrightarrow economic development
 - Medical infrastructure attracts residents & firms, developed economy funds care

PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREAS (HPSAs), 1996



Source: Division of Shortage Designation, BPHC, DHHS, 1996.

Produced by: North Carolina Rural Health Research and Policy Analysis Center,
Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.



Rural Supply - Malpr. Issues



- Liability insurance rate-making
 - Rural litigation, verdicts low -- but not rates
 - Statewide or broad area rating (law of large ##)
 - “Lumpy” rates by specialty, procedure, eg, any OB rated same

- Particular problems in OB
 - Many practitioners need to deliver (some) babies
 - EMTALA gives “right” to hospital delivery
 - Hard to retire gradually - long “tail” coverage needed



Potential Solutions



-
- ❑ Today's top three: tort reform, tort reform, & tort reform
 - ❑ Insurance market interventions, other near-term reforms
 - ❑ Broader reforms - replace part or all of current liability system



Conventional “Tort Reforms”

(first generation)



- Goals: insurance availability, affordability
- Legal cut-backs: caps on awards, shorter times to sue, no double recovery, etc.
 - cuts claims costs, also premiums; calms insurance markets -- BUT:
 - such “take aways” face legal challenges, erosion in application over time
 - ... and do nothing for patient safety



Most Heated Argument Is for and against Caps



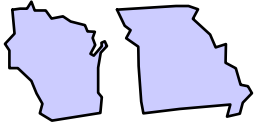
- ❑ Design -- total award, only component of loss (eg, “pain and suffering”)
- ❑ Doctors -- only caps are more than “band-aids”
- ❑ Lawyers -- unconstitutional, hurt the worst hurt
- ❑ Insurers -- like caps, OK to lose premiums, gain predictability
- ❑ Scorecard -- about half of states have some form of cap, now sought federally as well



States & Caps (samples)



IL: no cap (unconst., Best v. Taylor Machine, 1997)



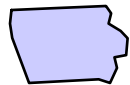
WI, MO: “Non-economic” cap \$350K, indexed



CA: non-econ. cap \$250K, unindexed



IN: tot cap - indiv. \$250K, PCF to \$1.25M (fr '99; '75 = 100/500)



IA: Noneconomic bar in auto felony cases



Caps, Continued



- ❑ Flat caps on awards
 - Clearly work to cut claims costs, biggest of reforms
 - Premiums eventually follow, less well documented
- ❑ Caps are a zero-sum game
 - Transfer from defendants (and their insurers) to claimants (and their attorneys)
- ❑ CA often seen by medical interests as ideal
 - 45% of winners cut by ave of 30% (more in death cases)
 - att'ys cut 60%, so net loss by claimants only 15%
 - hits most severe injuries the worst (by design)



Insurance Changes - Public



- ❑ Regulation / antitrust (lawyers' preferences)
- ❑ State provision of insurance
 - Insurer of last resort - Joint Underwriting Ass'n
 - High-end risk - Patient Compensation Fund or reinsurance
- ❑ Hospital-physician collaboration
 - “Channeling” programs at acad. med. centers
 - A new risk-bearing pool with some positive attributes
 - Availability of Alternative Risk Mechanisms
 - Multi-state arrangements?



Insurance Changes - Private



- Alternative Risk Mechanisms (ARMs)
 - Mainly hospitals, seem more common this crisis
- Some hospitals able to help physicians
- Hospital-physician pools in rural areas?
 - “Channeling” programs at acad. med. centers
 - New risk-bearing pool, with positive attributes
 - Innovation facilitated by ARM
 - Savings on investigation, defense
 - Create new mode of cooperation on safety
 - Multi-state arrangements?



What's Missing in Conventional Debate?



- Major under-performance of law's 3 key goals:
 - Compensation
 - Deterrence
 - Justice

- Far too much preventable injury goes uncompensated and un-prevented
 - ... after several generations of increased legal and regulatory pressure



What's Different Today?



- New capabilities in “patient safety”
 - Fix the problem, not the blame
 - Regulation, punishment can help, but fall short
 - “Surface” problems, analyze, change processes, monitor, repeat
 - “Idiot”-proofing, simplification, fail-safes, teamwork
- Early successes in medicine
- BUT, fear of blame and liability inhibits openness needed for safety



Less Familiar Reforms

(second generation)



- ❑ New subsidy from health insurers, premium support from government
- ❑ Conventional legal reform, with new wrinkles
 - Better “transparency,” a.k.a. disclosure
 - Early-offer reform to reward disclosure
 - Sliding scale in place of flat caps on awards
 - Alternative forum, other alternatives
- ❑ Improve safety with reporting, discipline



Greater Transparency (Theory)



- ❑ More “transparent” disclosure to patients
 - may or may not involve settlement offer
- ❑ Has ethical basis, seems good business practice
- ❑ Many say it should happen, incl. AMA, JCAHO
- ❑ Many say they disclose, actual extent unclear
- ❑ One VA hospital saw higher ## claims, lower \$\$
- ❑ Might reduce defensiveness, facilitate safety



Full Transparency Trial Run?



- ❑ Disclosure theory good, but reality?
- ❑ May need better carrots/sticks
- ❑ Push it hard at public institution(s) with sovereign immunity?
- ❑ Beef up patient safety from inside, not outside
- ❑ Demonstrate utility of approach (or not)



“Early Offer” Incentive



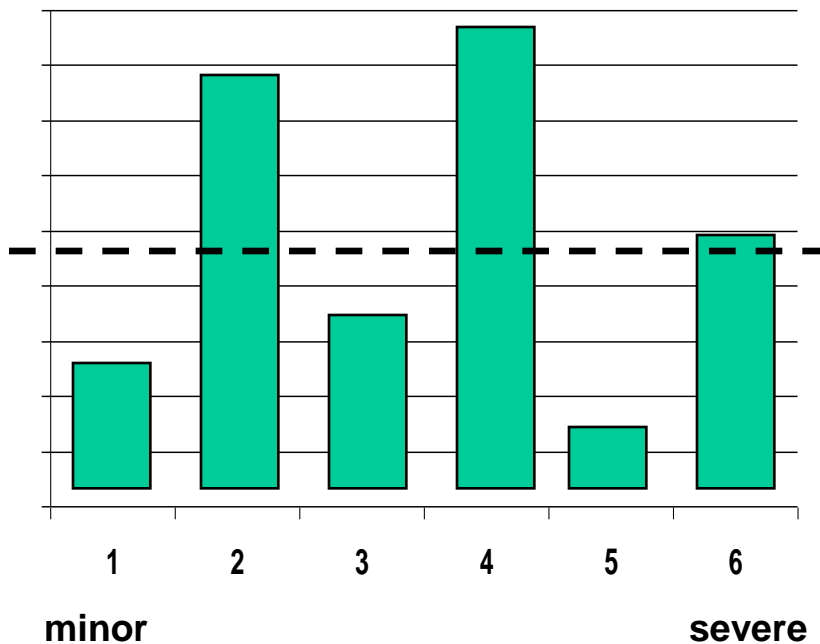
- ❑ Encourage disclosure
- ❑ Allow those offering to pay full out-of-pocket losses to avoid paying any pain and suffering
- ❑ Objected to as inviting strategic behavior (gaming)
 - i.e., offer only in obvious, big-ticket cases
- ❑ More incentive for broader disclosure may be needed



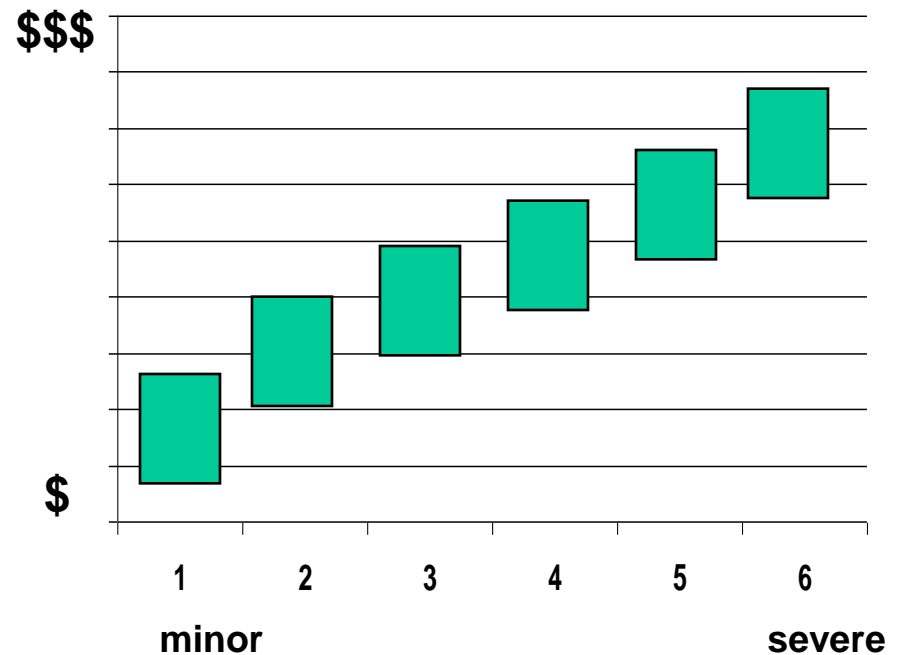
Limits on “Pain & Suffering”



“Traditional” Flat Cap



Sliding Scale



level of injury

Source: Author's schematic



Other Medium-Term Alternatives



- ❑ Special court or administrative agency to decide fault cases
- ❑ Improve legal administration
 - More active management of cases by judges
 - Judicial data on timeliness, costs, awards
 - Data on lawyers' performance
 - Legislative hearings or antitrust?



Further-Reaching Alternatives

(third generation)



- ❑ Better compensation
 - faster, lower overhead
 - more predictable and consistent results - improve equity, vertical and horizontal
- ❑ Friendlier to patient safety
- ❑ Preventability rather than fault as basis
 - Non-judicial mechanisms
 - Not fear of erratic liability, but consistent pressure for improvement
 - Justice recast: not individual combat by trial but consistent rules, broader application



Third-Generation Addresses the Really Big Problem



- ❑ Substantial no. of preventable medical injuries
- ❑ Safety of patients obviously not optimal now
 - despite liability, peer review, discipline
- ❑ “Patient safety” a very promising alternative
 - but hampered by fear of individual blame and liability, which inhibits openness for learning
- ❑ Need to reduce legal fears, raise accountability



Elements of Alternatives



- ❑ Definition of the compensable event
- ❑ Decision rules for valuing injuries
- ❑ Processes for evaluating claims, resolving disputes
- ❑ Means of delivering compensation (over time)
- ❑ Funding source(s) and mechanism(s)
- ❑ Reforms “mix and match”



State Experimentation -1



- ❑ Proposed Nov. 2002 in IOM report to DHHS
- ❑ Non-judicial, patient-centered, safety-friendly new injury resolution system
- ❑ Federal liability reinsurance to encourage state action (cover very high level of losses)
- ❑ State legislation to try one of two approaches



State Experimentation - 2



- ❑ Two approaches similar in goals, differ in locus
- ❑ First is state administrative compensation
 - Cover preventable injuries (not full “no fault”)
 - Similar to Workers’ Comp, other nations’ systems
 - Case-by-case rulings (as under W.C.) or advance listings of avoidable events
- ❑ Require some general safety practices, data
- ❑ Still dependent on claims brought by patients
- ❑ Not grounded in operations of medical entities



State Experimentation - 3



- ❑ Second approach is provider-groups' systems
- ❑ Large alignments of health entities, practitioners
 - where injuries occur and heavy lifting of change must occur
 - consistent with systems approach of IOM
 - benefit from improvement b/c self-insured or experience rated
- ❑ Other points
 - Cover preventable injuries, probably through advance listings of “ACEs” = avoidable classes of events
 - Damages structured, early offers
 - Cases resolved through insurance process
 - Dispute resolution thru arbitration, other non-judicial system



Implementation



- ❑ State law, administrative practice
 - for agency panel approach
- ❑ Private contract
 - for provider groups (sanctioned by state, in IOM model)
 - Provider-patient contracts
 - Employer/health plan-enrollee contract
 - Potential for choice at time of service, PPO model
- ❑ Nature of oversight an open issue



Existing Models: VA & FL



- ❑ Birth-related neurological injury compensation
- ❑ Successes ...
 - Feasible to run program with one listed event
 - Maintained access to OBs' liability insurance
 - Cut OBs' premiums 2.5 times below trend
 - Settles in 1/3 time after filing, has 1/5 the administrative costs
 - Comparable compensation, satisfaction
- ❑ But ...
 - Too small, some variability in application
 - Political and legal attacks



Summing up: Options for Action



- ❑ Some short-term fixes
 - targeted subsidies
 - perhaps reconsider insurance regulation
 - cycle will turn, availability return, but at higher prices, with higher industry concentration
- ❑ New risk-bearing ARMs for rural areas?
- ❑ Some tort reform -- targeted, fair
- ❑ Improve patient relations, patient safety
- ❑ Experiment with alternative compensation plus patient safety

OFFICIAL SYMPATHY SURVEY

IN THE CONTINUING BATTLE OVER MEDICAL MALPRACTICE COSTS, WHOM DO YOU FEEL SORRY FOR?



(A) The poor, downtrodden doctors



(B) The lowly, underpaid lawyers



(C) The small, struggling insurance industry

NOTE: YOU CAN ONLY VOTE FOR ONE.

WASSERMAN FOR THE BOSTON GLOBE
OF THE L.A. TIMES SYND.



Final Thought

Ideally, caregivers would tell patients and families when problems occur. Reasonable compensation would follow for avoidable injuries, and safety management would constantly be informed by experience. Patients treated decently are mainly grateful, not vengeful. Practitioners need to worry more about patient outcomes than legal outcomes, and systems of accountability need to make it easier for caregivers and medical institutions to do the right thing.



End



□ Time for questions