The Council of State Governments
Evaluating State Approaches to the Medical Malpractice Crisis
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Operator: Ladies and gentleman, welcome to the Medical Malpractice conference call. Your host for today is Trudi Matthews. Miss Matthews, you may begin.

Trudi Matthews: Thank you Operator, and good day to everyone on the phone. Thank you for joining us for the Health Policy Monitor teleconference titled "Evaluating State Approaches to the Medical Malpractice Crisis." My name is Trudi Matthews, and I am Associate Director for Health Policy at the Counsel of State Government. As your moderator, I want to welcome you and thank you for joining us on this call.

Before we begin our teleconference proper, I want to put aside a few logistical points for our listeners. Please note that this conference call is being recorded, and that there are members of press on the line. Also, we encourage you to log on CSG's teleconference website to view additional resources and speaker biographies about the issues we discuss. You'll need to go to www.csg.org, type in the key word health, then click on the top story about the teleconference, that will take you to the biographies and other resources.

Another logistical note is CSG would like to thank the following CSG associates for their generous support for CSG's Health Policy Monitor teleconference series: The American Nurses Association, HCA – Hospital Corporation of America, Hoffmann-La Roche Inc., and Pfizer Inc. Their generous support enables CSG to offer these teleconferences free of charge to all state officials.

With that said, let's move on to the issue at hand. Over the last several years, state leaders have been forced to grapple with the rising cost of medical malpractice insurance. Some states have seen premiums climb as high as 100 percent or more, especially for certain fields such as obstetrics and orthopedics. States have responded in a number of ways, including caps on non-economic damages, efforts to decrease medical errors, insurance industry reform, creation of state sponsored malpractice insurance pools, premium assistance programs, and many more options. The question to consider now, however, is what has been the outcome of these policy changes, if any, and what can we expect in the future.

I am pleased to say that CSG has gathered a distinguished panel of experts, both at the national and state level, to share their perspectives on the development of the current medical malpractice crisis and the steps they have taken in response. We're pleased to have with us today William Sage who is Professor of Law at Columbia University. Bill, thanks for being with us.

Dr. William Sage: Sure, my pleasure.

Trudi Matthews: Also, Andrew Compton, Counsel to the President Pro Tempore of the Pennsylvania Senate. Andrew, thank you for being on the call.

Drew Crompton: Thank you.

Trudi Matthews: And also Assemblyman Bob Beers from the Nevada State Assembly. Thank you, Assemblyman, for being with us.

Assemblyman Beers: My pleasure.

Trudi Matthews: And thanks to each of the callers, also for being on the call. We look forward to your questions. And just a reminder, please visit the teleconference website for speaker bios and additional resources. To access the site, again, go to www.csg.org, keyword health, then click on the first story that comes up on the health home page.

Following the call, a transcript will also be made available on this site, so we encourage you to keep it nearby. Well, with that said, let's begin with some questions for our speakers.

We'll begin with Dr. Sage. Bill, you've been working for the last several years as Principal Investigator for the Pew Charitable Trusts project on medical liability in Pennsylvania. In the paper you wrote titled "Understanding the First Medical Malpractice Crisis of the 21st Century," you commented that the current crisis is unlike previous ones because this time "it's clearly connected to overall health policies". I wonder if you could talk a little bit about that, and tell us how this crisis is different.

Dr. William Sage: Certainly. My argument is usually that I think this crisis should be connected to health policy in ways that the reaction to prior crises has not been. I think of medical malpractice as the Rip Van Winkle issue in healthcare politics and policy, it wakes up every 15 or 20 years. I tend to point out one similarity between medical malpractice and the Rip Van Winkle legend and then one important difference. The similarity is that Rip Van Winkle slept through the American Revolution, and I'd argue that the changes in American healthcare since the 1980's are equally revolutionary. The difference is that when Rip Van Winkle wandered down from the hills, people noticed that his clothes were tattered and that his musket didn't work, and in malpractice it seems that the issue wakes up and we start arguing in exactly the same terms and debating, more or less, the same solutions that we considered 15 or 25 years previously. In doing so, we ignore the huge changes in the American healthcare system since the 1980's. And in the papers I read and in longer lectures that I give, I tend to talk about medical progress, about industrialization, and then about cost containment, and with the latter point reminding people that the 20 years that have intervened since the last major malpractice insurance crisis of the 1980's are 20 years in which reducing the rate of growth of healthcare spending has been the primary focus of both state and federal policy.

Overall, the message that I give in terms of health system change is that you should think about medical malpractice as primarily a reflection of the great success of modern medicine rather than a failure. And by way of illustration, there's a case that was reported in the literature from a year ago from Texas called Brownsville Pediatric Association v. Reyes. I have no reason to think this was an exceptional case, but I think it's quite reflective of the health system impact on malpractice policy. This was a case in which the courts upheld a jury verdict of $8.5 million in favor of a severely impaired newborn. This was a child who was born extremely prematurely, and was treated in a neonatal intensive care unit, received a host of sophisticated treatments. There were allegation that there had been negligence in intubation, mechanical ventilation exchange, transfusion, and the award included $6 million in economic damages, most of which was future medical expenses associated with intrathecal baclofen for the child's spasticity. It's worth thinking that the life expectancy assigned to this child in this case was not just a matter of months or a couple of years, but 53 years, and then there was a significant component to pain and suffering damages of roughly two million dollars. And if you think about it, this is a case that couldn't possibly have arisen 20 or 25 years ago, a child this premature wouldn't have survived, and the types of treatments that were alleged to have been done negligently really couldn't have been done at all. And someone with a degree of impairment that the child suffered would have had a much more limited life expectancy with a much more limited array of treatments that could have been administered. And this tells me that malpractice policy has to be considerably different from 15 or 20 years ago, and particularly on the issue of economic damages, which I think of as the elephant in the living room of malpractice policy.

Trudi Matthews: Well, given those changes and those differences between then and now, what do you think are some policy options that states should consider, and how do you evaluate some of the options that have been considered currently?

Dr. William Sage: Well, I think one has to think of all three aspects of the problem to get a malpractice system. Yes, a lot has to do with the legal system, but a lot has to do with the process of delivering healthcare, which has not only changed in terms in technology, but has changed in terms of our understanding and the professions understanding of its successes and its failures. The entire literature on patient safety and medical error, as you know, is an outgrowth of the 1980's malpractice crisis and the Harvard medical practice study, and then reached to the public awareness in the late 1990's with the Institute of Medicine's report "To Err Is Human."

And I think you have to also consider the malpractice liability insurance system, which, you know, in the general politics of this, it's usually finger-pointing between it's the lawyer's fault and it's the insurer's fault. But I think in that process, what's often missed is that the liability insurance system that we have, really, hasn't kept pace with demands that the healthcare system places on it. It's financed primarily by physicians, even though physicians make up only a small portion of overall health system spending, which I would argue is what ultimately drives liability costs. It's sort of each boat on its bottom with respect to physician specialties.

There are many things I think that could be done within the insurance system. Just to mention a couple fairly specific things, I mean one think I think that does need to be considered at the state level is a different risk pooling structure for malpractice liability insurance. It's perfectly rational for a private insurer to charge physicians according to the legal risk associated with their specialty, but I'd argue that it makes no sense from a public policy perspective. None of the usual arguments that you would give for class rating liability coverage makes sense in healthcare. Healthcare's really a collaborative enterprise. It's not that we need fewer neurosurgeons or fewer obstetricians; it's not that we want to discourage those types of riskier activities. Ultimately the whole system is going to stand or fall based on its weakest link, and I think that State needs to give very serious consideration to the way in which liability costs are shared among physician specialties between physicians and the institutional components of healthcare, and ultimately with some degree of greater public participation and risk bearing that has been the case.

In terms of the process of medicine, something that I think is quite promising, Pennsylvania and Nevada are among a very small number of states that require some degree of disclosure to patients when medical errors occur. I think that those provisions have often been negotiated in a highly suspicious climate of overall malpractice politics, but I actually think - it's certainly been the case in Pennsylvania - that having an active provision like that, things can really improve. And this is not so much the political process continuing to regulate, but what happens when well-intentioned people on all sides of healthcare get together and figure out it really is the right thing to tell patients when there's been an error to learn how to discuss compensation, to learn how to share information, to learn how to improve medical practice, and it's not that that's a panacea to a malpractice insurance crisis, but I think it's something that other states can learn from and can really make some difference.

Ultimately, I think states have to consider, and hopefully with some federal support, more comprehensive reforms. I don't want to necessarily use the Workers' Compensation model, but ultimately I think we are talking about an administrative non-litigation base system that not only reduces financial exposure and stabilizes insurance, but ends up improving medical care and providing compensation to a much larger percentage of injured patients than is the case with the tort system. I think this type of system is particularly important for two reasons. First, it can speed the process up. So many things that I think of as wrong with the current malpractice system have to do with how slow it is, and this is not just a matter of patient compensation information, it's a matter of quality feedback to healthcare providers, and ultimately the stability of private insurance markets. And the other thing that I think is really an argument for more comprehensive reform is that I think for many reasons having to do fundamentally with healthcare, liability needs to be more and more at the institution level. And I think that the real core insight from the academic and policy community these days is that you don't have to legislate any new system that applies across the board because medicine is not, infact, practiced uniformly. What you can do is set up a system that the best institutions, whether they're medical practices or hospitals or what have you, earn their

way in to it in exchange for being sheltered from litigation, they have other forms of accountability, and really show that they provide quality medical care.

Trudi Matthews: Okay. Well, I notice in your list that one of the things that wasn't mentioned in there was a cap on non-economic damages. In the states that we at CSG have monitored, this has been a very hot button issue. And partially, I know, because the current crisis seems to have bypassed states like California that adopted caps in its 1975 MICRA law. I wonder if you could comment very briefly on your perspective on caps on non-economic damages, and either the pros and cons of using them. Again, real briefly since we want to move on to our next speaker.

Dr. William Sage: Certainly. As I wrote in the paper that you mentioned, legislators often think of the academic community as being polarized between supporters of capping damages and opponents of capping damages. There's actually a fairly substantial academic consensus, which is that it would be desirable to move to some more comprehensive administrative system. If you did that, you would have to cap damages. But there's a trade-off, you're not just reducing damages for people who happen to find their way in to the system, you're providing meaningful compensation and other ways of reducing injury rates for people who don't currently find their way in to the Tort system. I tend to think of the general debate over caps on damages as kind of missing the point of integrating a damage cap with an overall compensation system. I tend to think of it more as a function of the general politics of this issue. As strongly as doctors tend to feel about damage caps because doctors, for many good reasons, don't like the malpractice litigation process, I tend to view most of the political debate as being a larger debate not limited to healthcare about whether personal injury lawyering is good or bad for the economy, and good or bad for society. I think that's a legitimate and important social issue, but it's not an issue that is likely to be solved in a way that really benefits healthcare.

Trudi Matthews: Okay, well I appreciate your thoughts. I'm sure that our callers will have a lot of questions about your insights.

I want to move on now to our next speaker, Drew Crompton. And Drew, I know that in your position as Chief Counsel in the office of the Senate President, you have been right in the middle of everything that happened in Pennsylvania. And I wonder if for those of our listeners who might not be familiar with Pennsylvania's situation if you could give us a real brief history of what happened in Pennsylvania.

Drew Crompton: Let me just say that it's a pleasure to be on the call, and it's always good to speak about the issue, even though the issue is trying for all of us. I think that the one thing I would say is that back in 2001 and 2002 was really when Pennsylvania started to be extremely troubled as several other states did. I know the Pennsylvania Medical Society puts out a report every year on the states, or I think they call it the Troubled States list. I think there was originally six states on it, Pennsylvania was one of them. It grew to 12, we stayed on the list, and I think that it's up to 18 states now, and we're still on the list. So Pennsylvania has been a hot bed as has Nevada and a

couple of others have been for real trying times as it relates to medical malpractice insurance premiums skyrocketing, especially starting a little bit in 2000, but going up to the current day.

A couple of things we did, we did a comprehensive law in March of 2002. I always laugh because everybody that participated, which was insurers, hospitals, doctors, trial lawyers, business, knew that whatever reforms we enacted, whether they were Tort reforms or otherwise, it would take several years to phase in, and see real progress in the state. And then about three months lapsed after the passage of the Bill in March of 2002, and most of those interest groups were back asking why the Tort reforms and other reforms hadn't kicked in yet.

So it's always funny how we expect these things to take a while, and they truly do, but nobody wants to wait. What did we do? We did a statutory repose, we did a collateral source rule, we did periodic payments, those are some of the Tort reform things. I think we're going to talk a little bit about the patient safety components of the Bill. But it really was comprehensive, and I think it's going to show some good results, but it's going to take probably a couple more years until we really know the comprehensive measure that we did in 2002 is going to show fruit. We've done some interim things since 2002 because, as I said, the pressure was there, and we'll talk about a few of those as well as we move forward in our discussion, and then probably some questions and answers as well.

Trudi Matthews: Okay. With one of the big issues being caps, some of our listeners asked, what can be done when a state's constitution prohibits caps, how can they be instituted fairly, et cetera, and I wondered if you could talk about Pennsylvania's experience.

Drew Crompton: Well, in March of 2002, we tried to address all the issues other than caps and the primary reason was because caps are strictly prohibited under the Pennsylvania constitution. There's about three or four other states, I believe, in the nation that have a similar provision or prohibition in their individual state constitutions. So, we've now taken that issue up in the interim since the passage of the major piece of legislation that I referenced in 2002, and we're starting through the process of possibly amending the constitution to allow caps on non-economic damages. Some people want it very broad to deal with all sorts of business and all sorts of medical actions. The general assembly in Pennsylvania passed a Bill that lifted the prohibition of capping non-economic damages, and then would allow caps in any type of civil action. The Senate recently, just a couple of weeks ago, passed a measure that would allow the capping of non-economic damages in medical malpractice cases only. We don't know how the House will react to that yet. If we pass it before the end of June, or we agree on a version by the end of June, then we have to pass it the next session which starts January of next year, and then it has to go on the ballot, and then the majority of the people voting have to approve it. A couple other states have walked through similar measures, Texas being one of them. They just recently did a constitutional provision type of change to their non-economic damages. So I'm not quite sure if we're going to

move through that process, but it's difficult to pass constitutional amendments in Pennsylvania. I would argue that that's the way it's supposed to be. Whether we get there on this issue or not, I think we probably will. I think in either May of 2005 or November of 2005, the people of Pennsylvania will be given a choice. Do they want to allow the General Assembly to cap non-economic net damages or don't they. I think the one difficulty in all this is that we have not set an amount or a floor, if you will, on what we would cap those damages at. So the campaign, if you will, that surrounds caps will be very interesting because people will be asked to allow the General Assembly to decide what a reasonable amount for those caps is. And I think that is going to cut both ways, and I don't know if the people of Pennsylvania will approve such an amendment to their constitution or not.

Trudi Matthews: Well, we'll certainly stay tuned as that moves forward. I wonder too about some of the other alternatives and some of the things that Pennsylvania looked at. For instance, your Patient Safety Authority and also the certificate of merit and venue. If you could talk about those features, and whether they've made an impact or not.

Drew Crompton: Sure. The Patient Safety Authority in Pennsylvania is something that we're really proud of. If anybody is interested, the website is www.psa.state.pa.us. We established it in 2002, and we've been trying to get it up and running. It's just recently hit the ground. The hospitals are now incorporated in this Patient Safety Authority. Infact, in March of 2002, the hospitals agreed to fund this enterprise at a cost of about five million dollars a year. What is the Patient Safety Authority? The Patient Safety Authority is just a panel of 13, I think, members. But what they do is they track every medical error that occurs in surgical centers or hospitals across Pennsylvania. We put the onus on hospitals to say that if something does go wrong in your hospital, you either have 24 or 48 hours to report that in this computer system, and then the Patient Safety Authority tracks those mistakes, and if they feel compelled, they put out warnings or guidelines, if in fact there's some sort of pattern that they notice over the course of weeks, possibly even as short as days, to warn the other hospitals, hey, the blue pills looks like pink pills or whatever the mistake is occurring, and therefore other hospitals know that these medications may look similar, or these tubes may look similar, and that there's been problems in other facilities. It's not a finger-pointing exercise, it's not a way of trying to get at the hospitals, but it's a way of saying to patients hey, you need to know if the facilities that you're going to and that you're relying on are safe, and if there are mistakes, the hospitals report those to the state.

One thing that we instituted that was very controversial - and the hospitals and the doctors agreed to which we're actually thankful that they did – is written notice to individuals who have been injured in a surgical facility or a hospital. So not only does the hospital bear the burden of reporting the error to the Patient Safety Authority, they must also give an explanation to the individual or to the family member if the individual dies, telling them of the error, telling them what happened, why it happened, and explaining it to them. I really see this as, what I call 'mini mediation.' And it's a way of saying to the hospitals you need to mediate these incidents immediately, and go to the

families and explain the situation. I will say this, hospitals so far in Pennsylvania have not done a good job of doing this written notice. They're showing very good promise to reporting to the Patient Safety, and as I said, that system is up and going. But unfortunately, right now the written notice is a little bit of a rub. But we have plans in the next few months of calling in the hospitals, to talk to their representatives and try to really get the written notice underway. As I said, not because we want law suits, just the opposite. We want to create a mechanism where individuals who are harmed for whatever reason, and there may not be negligence involved. For whatever reason, they are then talked to by the hospitals, and therefore, they can hopefully remedy their situation long before litigation occurs.

Dr. William Sage: Drew, if you don't mind my interrupting for just a second.

Drew Crompton: Sure.

Dr. William Sage: Part of the Pew Project I've been running, we've been working with several hospitals in eastern Pennsylvania to operationalize this error disclosure requirement. And using a mediation model, and we've had significant success, infact, we're running a small conference at the end of this month in Philadelphia funded by the federal Agency for Healthcare Research and Quality, explaining to hospitals how to do this well, and drawing on the successes that we've had. So I think there's momentum in the private sector to learn how to do these things right.

Drew Crompton: That's interesting Dr. Sage, I wasn't aware of that. I think, you know, every state wants to put out their state of the model. Look, Pennsylvania does plenty of things wrong. I think one thing that we're moving in the direction of doing right is under the establishing of the Patient Safety Authority. It's a good model, it was nit and picked as we drafted this legislation. I spent months with the hospitals and the trial lawyers and the doctors on every word. And that is because they had legitimate fears, the doctors in the hospitals, saying look, this can't be a mechanism where we have to file a piece of paper and basically give them the imprimatur of a law suit. And we understood that. So a lot of these documents are protected, they're confidential, and they're rightly so because we want to encourage reporting. I think one thing about the certificate of merit and venue; we can talk about those issues if people want to raise those issues as the rest of the call goes forward.

Trudi Matthews: Okay. If there's anyone who's on the call who wants to find out more about those, we can have them ask the question as we go along. In the interest of time, I'm going to go ahead and move over to Assemblyman Beers. Thanks, Drew, for your comments. And we want to hear about what's happened in Nevada. It seemed that Nevada was one of the first states hit by the medical malpractice crisis as well. Assemblyman Beers, can you give us a brief history of what happened in Nevada, and how you all responded to it?

Assemblyman Beers: Sure. We are a state that convenes its legislature four months every two years, then is not in session for 20 months. So to respond, we had a special

session over this in the summer of 2002. The session was relatively short, probably, it was definitely less than a week, and the primary size of this for the doctors and the trial attorneys, both hired lobbyists, and much of the work was hammered out in a small room. There were three primary components to the legislation that we passed. One was a partial, I guess we call it a partial, cap on pain and suffering awards. It's partial because we wrote a $350,000 cap, but it was actually a cap on each defendant rather than each claim. So, to the extent multiple medical providers could be pulled in to the complaint, the cap grew commensurately. As well, there were several circumstances written in to the law where the cap could be violated. One was basically on a judges say so, and I think in retrospect, definitely in retrospect, we've not seen a significant improvement in premiums, we've not seen insurance companies wanting to come in to Nevada and write policies. So there's a perception, certainly amongst the doctors, that this program was a failure, and that's why they have brought a citizen's initiative to the ballot this November, which I'll talk about in a minute.

The second major component was a requirement that damages be reduced by the amount of any compensation received by the plaintiff for reasonable expenses incurred as the result of malpractice. So that if an injured person had their problem fixed by an insurance company already that could be brought in as a reduction to the award. That still was not allowed to be discussed in front of the jury before they determined the award. So there's some speculation now that if we were to, infact, that's a component of what they're doing this year. If you were to bring the information before the jury that this person suffered less than it would initially appear because their problem was promptly fixed, that that might reduce some of the non-economic damages as well.

And then the third major component was adding, basically giving plaintiffs a choice between a lump sum and period payments. And those were the primary components of our special session, past legislation two years ago.

Trudi Matthews: Well, I know that Nevada being in close proximity to California where premiums remain fairly stable, that this had an effect on the policy-making environment. Can you talk about that a little bit, and also about the effect that some of those legislative changes have made?

Assemblyman Beers: Yeah, I think we do look to California in many areas. This is certainly one, and MICRA is hard to argue now that it's been there for 25 years. I think California physicians pay ten percent of the malpractice loss payments, and have 15 percent of America's doctors. So, you know, there's statistics from insurance companies that patients get higher compensation, and a faster result as well. There was a great deal of comparison to California MICRA and our trial attorneys greatly fear California MICRA, and the result was the negotiated settlement or legislation was that we enacted what we enacted.

The thing that the doctor community in Nevada is bringing to the ballot this November in Nevada is pretty much MICRA. One of the changes is a cap of $350,000 instead of $250,000 in non-economic damages, and the other is doing away with the joint and

severed liability. We've got some anecdotal cases in Nevada of doctors who were found five percent negligent in an injury, but the 95 percent negligent folks have gone away, leaving the fellow the five percent negligence to pay the entire multi-million dollar assessment. And so that's an additional component that's not in MICRA that the doctors here have included in their ballot initiative. Their polling, and I have not seen any of the trial lawyers polling, their polling indicates that about 77 percent of the citizens are going to vote in favor of this thing.

Trudi Matthews: Well, I wondered too if you could talk a little bit about the state-base medical malpractice insurance fund in Nevada. Some other states are looking at this option.

Assemblyman Beers: I would say ask us in 15 years. Insurance is a tricky business, and in these cases, much of it is based on actuarially calculating out a future cost for expected injuries. And so there's a fair amount of grey area in it. The situation we were facing was doctor's leaving the state. In the year of 2002, which is when we did this, we ended up having a net gain of like seven doctors. Normally, an average from '82 through '01 was 108 per year gain. Of course, we're a rapidly growing state. So our number of new doctors' net gain plummeted in that year. I know that two of the three doctors that have cut my body over my tender young lifetime left practice, one left the state and one retired at the age of about 50. And so the insurance community was pulling coverage, rapidly escalating prices and that put us in the mood to create a state-sponsored medical insurance program. We just don't know. The premiums were less than the private sector was charging, but like I said, ask us in 15 years. We may be giving our children the legacy of a billion dollar unfounded liability.

Trudi Matthews: Well, I appreciate your perspective on this. I want to also put our callers on notice that we're going to go to our phone lines in just a minute. So I want you to get your questions ready. Before, as you're doing that, I want to just give a couple of instructions to our callers. We know that we have a lot of folks on the line today, and so we'd like it if you could go ahead and keep your questions as brief and to the point as possible, and then also too, when you're done speaking the operator will mute your line, and then we'll move on to the next caller. So there won't be really an opportunity for additional follow up. Just want to let you know that because we do want to make sure we get through as many questions as possible.

Operator, can you give us some instructions for our callers on how to pose questions?

Operator: Ladies and gentlemen, if you have any questions at this time, please press the one key on your touchtone telephone. If your question has been answered, and you would like to withdraw yourself from the queue, please press the pound key.

Trudi Matthews: Okay. So that's one on your touchtone pad. So while we're waiting for some of our participants to get on the line, I'd like to ask a question for all of our panellists and have you all respond. We've talked a little bit about some of the ways that states have reacted to this medical malpractice crisis, and it seems like generally

that whenever a medical malpractice crisis occurs, it is a very reactive process. And I wonder if we could discuss a little bit about how states might be able to head off a crisis before it occurs, and possibly proactive options for addressing medical liabilities, medical errors, and increasing patient safety.

Assemblyman Beers: This is Bob Beers in Nevada. As I was dealing with this as a representative to my constituents, my sense was that this thing is much more a series of anecdotes than measuring the slope of a line on a chart. It strikes me that it is, by its nature, reactive. Perhaps as we get medical reporting processes in place, we'll be able to see these things and quantify them. But it was very much a case of individual constituents calling their legislators and their Governor, and saying hey, you know what, my doctor just moved out of state. It was particularly acute in the OB-GYN community, and you know, moms and babies and stuff are pretty dear to us politicians' hearts.

Trudi Matthews: Sure. Well I wonder, I know Drew, you spent a little bit of time talking about the Patient Safety Authority in Pennsylvania, and I know Bill, that you we were on the line earlier talking about some of these issues. Do you think that patient safety opportunities raise the possibility that some of the medical liability out there can be decreased over time?

Drew Crompton: I think the short answer probably is yes. I think we have seen some sort of success in Pennsylvania. Our supreme court just did release the numbers on the case filings in the year 2003. And they were down 30 percent compared to 2001 and 2002. I think we have worked very hard to try to make it more difficult to file at least illegitimate cases, and probably have also made it more difficult in Pennsylvania to file legitimate cases. And therefore, we've seen a little bit of success. I'm not quite sure in Pennsylvania if we go forward with capping non-economic damages what else we could do. I'm personally not necessarily a fan of an idea of going in to some sort of, and it's always called a Workers' Comp model, and I think Dr. Sage did a nice job saying the differences of such a thing, but I'm not quite sure. The insurers tell us in Pennsylvania we need to do period payments, we need to do collateral source rule, those two things we've done, and we also need to do caps on non-economic damages, which we might also do. But after that, I'm not sure what we could do. And I guess there's one other thing I would highlight, and that was based on what the legislators said from Nevada. We have had state run malpractice, we call it our M-Care fund, which requires doctors to buy a portion of their premiums from a state run fund. We can't wait to get out of it. It has been a very difficult and bad situation for probably all the medical practitioners in Pennsylvania. We are trying to phase ourselves out of it, and hope by the year 2009 it will be no more. We carry about a two billion dollar unfunded liability associated with that fund. So I chuckle to myself when he noted that they were worried about long-term effects, we've suffered through this for about 20 years with the fund, and let me tell you, they're great in the beginning because they don't have to pay many claims. But as the years go on and more claims build up, they become a real difficulty. And one of the ways that we think we can better the environment in the future in Pennsylvania is to get ourselves out of our state run medical malpractice fund.

Dr. William Sage: This is Bill Sage. Building on that a bit and getting to Trudi's question about the reactive posture. The two sort of go together. The M-Care fund in Pennsylvania is unique among the dozen or so states that have patient compensation funds in that it is funded on a pay-as-you go basis, and it's been the accrued liability that's been crippling for that fund. Other states that have patient compensation funds have done them on a funded basis, and haven't' had nearly that much problem. Of course, Pennsylvania is really the only state with a patient compensation fund, except for New York, that adopted the fund as a reaction to a major insurance crisis. And, of course, it's in those instances that you end up doing a pay-as-you-go fund. The other states that have them have managed them successfully tend to be states that are not widely seen as being in crisis.

I think that the reactive posture interferes with policy making in a couple of ways. One is that it's precipitated by the exit of private liability insurers, and therefore, the political framing of the problem is often how do we get the private liability insurers back. And I think that's sometimes the wrong question, that part of the right question is how do we make the insurance system inherently more stable. And I think the acuity of this crisis in some states, and here just to be absolutely blunt, I think has resulted from a such a loss and mass irretrievable exitor insolvency of private liability insurers, that to a degree they've removed themselves from the political table as well. And I think by and large, that's probably a step in the right direction because one of the things that I think states should be considering are alternatives to the traditional ways of funding liability coverage. That doesn't mean making a public structure, it doesn't mean freezing private insurance companies out of the business, but it does mean having the question of liability coverage be viewed from the perspective of what's going to make the healthcare system more stable and predictable and good quality and offering reasonable compensation provisions over the long run rather than what seems to serve the stability of particular insurance businesses doing business in a way that hasn't changed much over the years.

Trudi Matthews: Well I appreciate your thought on that. I wonder if we could go to our callers. Operator, do you have anybody on the line?

Operator: There are no questions at this time.

Trudi Matthews: Okay, let me go to a question that I have that came from one of our listeners. It seems like that everyone has their own definition of success when looking at medical malpractice reform - do premiums stabilize, are there are fewer law suits, are there fewer instances of medical errors, are insurers coming back in to the market. How do you think a state should measure success? What indicates success to you? How can states evaluate whether or not what they've done is working or if they need to do anything else?

Drew Crompton: I think the one thing I would say, and I think that's why this call is good because you can see that the different perspectives between a policy is strictly policy view and some of the political view. I think most of the people that I represent

consider the factors just as you just said them Trudi, are premium stabilizing. In Pennsylvania, they went up this year about ten to 15 percent. Although a dramatic increase, a whole lot less than they had in the two or three previous years. They look at the number of insurers. We were never down to two insurers, although some people said Pennsylvania was, we had always had an, well not always, but in the last two or three or four years, we've had a very limited amount of pool of insurers, and one of the reasons is because of that Dr. Sage said, we suffered through bankruptcy of a couple of big, big insurers. But now we have 18, 20 different type of insurers that are working medical malpractice in Pennsylvania. So they see that as a positive thing. And then, of course, everyone looks at payouts. And no matter how legitimate some of those payouts may be, as long as there's big payouts for certain cases, at least some legislators will say that that's still a failing of the medical malpractice system in this state, and I'm sure in others. But they look at the key components just as you said. How many cases are being filing, for how much are they being paid out, and are there insurers, and what are the rates, and those are the things that in Pennsylvania at least we're stabilizing a little bit, and we've showed good signs in the last 12 months, but nothing to the sense that could get us off that trouble list that I referred to early on, or even that we think the environment is one that people no longer are talking about the issue of medical malpractice.

Dr. William Sage: Let me add one personal rule of thumb. I mentioned it before, but I'd like to emphasize it because it doesn't make the usual list. I think a measure of success is how quickly disputes get resolved, which also means how quickly problems get identified and discussed. To my mind, if legislators are looking for a rule on thumb on whether a particular piece of legislation is good or bad: If it speeds the process up, it's good, if it slows it down, it's likely to be bad. Speeding the process up does a whole lot of good things. It gets information, first of all, to patients who need it quickly, and patients who get information are less likely to end up in lawyers' offices. It allows people who need compensation to get compensation earlier; it allows healthcare providers who have been involved in medical errors or bad outcomes even to learn something from the process. You learn nothing from, you know, a judgement being rendered or a settlement reached five, six, seven years out, and ultimately a lot of the instability in liability coverage is the long tail function. And the long tail function has to do with the amount of time that passes between an event having occurred and a settlement or a judgement being reached, and that puts more pressure on insurer's investment income, it puts more pressure on sort of the structure of insurance, it makes the legal climate and changes in the legal climate much more relevant to the stability of the insurance business than it would be if the time between event and resolution were shorter, and I think that's something that the people really can focus on.

Trudi Matthews: So let me see, for those callers who are on the line, if you want to ask a question, you can push one on your touchtone phone. Do we have any callers waiting to ask a question operator?

Operator: Yes ma'am.

Trudi Matthews: Okay.

Operator: Your first question comes from Peter Yankowski from Vermont.

Trudi Matthews: Alright. Go ahead Peter.

Peter Yankowski: Thank you. In Vermont, luckily enough, our med mal premiums are in the bottom ten percent of the entire country. However, they're high for the physicians and other medical providers in the state, and we're going to be looking at doing a huge study this summer if it gets to our legislature, and I'm trying to get a grip on the best way of approaching it as I will have a role in it as the Deputy Insurance Commissioner. And may I ask more than one question or ...

Trudi Matthews: Sure.

Peter Yenkowski: Okay, thank you. The one thing is one of your panel members just mentioned taking a look at alternate market structures for med mal. Now, I think of the traditional commercial insurance company, the position on company, captive company, you spoke briefly about the mandatory reinsurance models like they had in Pennsylvania. What else might there be beyond those that you were referring to?

Drew Crompton: Well, coming from Vermont, you know, risk retention groups are, of course, the favorite topic. And there are various risk retention models that are being tried. There's some innovative ones in Pennsylvania that I'm aware of where it's, you know, groups of hospitals, groups of doctors where there actually is a law firm that's been involved in structuring though not funding a new type of liability carrier. And I think all of these offer advantages. And I think, you know, just to step back, the broad health policy terms, one of the problems with sort of the regulatory climate of healthcare forever has been that either it's done at the full blown state level, or else it's down to the individual physician's self regulation model. And one of the nice things about many of these risk retention alternatives is it puts the accountability and self regulation at an intermediate institutional level, you know, either a hospital or a group of hospitals. And I think that the incrementalism that's really productive here is going to be incrementalism where you offer models and then let people earn their way in to those models. And those models will involve not just changes in insurance regulation, but probably changes in legal liability.

Peter Yenkowski: Okay. Another question for anyone who's on the line, if we're going to put a big effort in to studying the alternative solutions to held the med mal situation, and you've used comprehensive approach, and if you take a look at some information that's in from the National Governor's Association, there are loads and loads and things that go from caps to partial payments and everything else that you can think of. But if we're looking at these dozens and dozens of things, what I'd like to be able to find is some kind of a facilitator that could help move us along and so we don't' waste a lot of time, you know, struggling with things. Are there are any consultants or facilitators in med mal that anyone is aware of?

Trudi Matthews: Bill, do you want to put your services up for sale?

Dr. William Sage: Except that I'm booked solid from now until I'm 85. Yes, there's a lot of research that's out there, and you know, the Pennsylvania work that we're doing and some work that other groups are doing is trying to make this information more accessible to state legislators. You know, I'd be happy to have an offline discussion, I'm perfectly delighted to talk to anybody, you know, if they email me and I'll try to put you in touch. But, you know, there are things that work and things that work less well. I mean of the proposals that have been discussed not in terms of comprehensive reform, but I mean, the medical screening panels have been tried many times over the years, and the academic consensus out of a fairly good set of empirical studies is that they don't work particularly well.

And, you know, there's some new flavors like medical courts, and I think that it's when evaluating those types of proposals that it would be most useful to have someone be able to separate the wheat from the chaff and these are the things we actually know about. For the truly comprehensive restructurings, you, I think, would want to bring somebody in with considerably expertise and have that in either other states, the Virginia Court of Compensation Funds or really comprehensive systems that have been put in to place in other countries, in Scandinavia, in New Zealand. I was part of an Institute of Medicine project back in 2002 for proposal for a federally funded state based demonstration projects, and that report, which was issued in October of 2002 called Fostering Rapid Advances, has some of the more comprehensive alternatives outlined.

Drew Crompton: Let me just say one thing if I could, and I think it's a trend we may see in other states, which, you know, I sit here and brag about some things that Pennsylvania has done. One thing we have done that I am not proud of, and one thing that we may see a little more slippage in other states and I think we recently have seen in New Jersey, and that is basically just using state tax dollars to lower premiums. And for those who are listening and say, well, you know, the good thing is we'd never do that, don't be so sure. In 2001, when we started our comprehensive measures, the one thing we said we would not do is to put up money.

Now, in this case, it goes to the fund that I referenced. But since doctors get half of their insurance premiums from this fund, and have to, that we wanted to help with that with those high premiums. And the one thing we said we wouldn't do would put in state money, and then low and behold when we passed the Bill in March of 2002, we put 40 million dollars guaranteed per year for the next ten years, which was 400 million, and we all weren't particularly proud of this public dollars for this case. Low and behold, then in 2004, what do we do? We raise the cigarette tax by 25 cents in Pennsylvania, yielding about 180 to 200 million dollars a year, which all of which we have devoted now to physicians to lower their premiums in Pennsylvania. So now we're making about a 220 million dollar tax payer dollars investment per year, at least for the next couple of years, and I'm not quite sure it's going to go away. So people say well, gee, physicians and hospitals need short-term relief. What do they mean by short-term relief? They

mean something, usually money, to lower their premiums immediately, which is exactly what we did in Pennsylvania. It's costing the tax payers 200 million dollars plus a year, and I'll tell ya, there's been no fall-out, if you will, yet, but I'm not quite sure people aren't going to really struggle with the fact that we're making that type of financial investment with state tax payer dollars.

Trudi Matthews: Thank you very much, Peter, for your questions. And I'd like to offer you my email address for you and any of the other callers to have follow up information that you'd like from our panellists or if we can get you some additional information, we'll be happy to do that. Go ahead and email me at tmatthews@csg.org, and we'll see what we can do to get you in touch with the right people.

Operator, do we have another caller on the line.

Operator: Yes ma'am.

Trudi Matthews: Okay, go ahead.

Operator: Your next question comes from Christine Evans from North Carolina.

Trudi Matthews: Okay Christine, go ahead.

Christine Evans: Hi. I'm just interested in hearing more from Dr. Sage. He seems to be proposing more structural changes than the band-aid approaches that I've seen, basically all of the states take, looking for the more short-term drops in liability reform. Dr. Sage?

Dr. William Sage: Well, I'm the academic, that's my job. I'm supposed to be talking about the more sweeping changes. I mean, I'm very sensitive to what Drew was saying about, you know, if you're going to be giving tax payer money to somebody in the state, giving it to physicians seems quite counter-intuitive. You know, you want to give it to your schools, you want to give it to your poor people, you want to give it to a whole lot of other constituencies that may seem to need it more. On the other hand, I do think that it's shown that the way that this has actually played out does show that there is truly a financial issue. This go around – a factor not present back in the '80's and the 1970's – is a crisis that involves the financial resilience of the system. And in a way, although it would be nice not to use tax dollars as a way out of it, one of the things that I think does make for a somewhat more constructive discussion rather than a discussion that's very much limited to caps, is that even the traditional constituencies that wanted caps understand that even if caps where to "work" in the sense of reducing insurance premiums, they're going to work over time and they need something else. And because they need something else, I think they're more open to having a more systematic discussion, including the patient safety issues and including several other things.

Over the long term, I think that states need to have at least the flexibility to start debating non-litigation based administrative alternatives, which is going to involve

capping damages, but is also going to involve finding institutions that are accountable for patient safety, identifying errors, offering fair compensation early. You know, for some of the states that are undergoing constitutional issues right now, I mean Pennsylvania, you know, I find myself in a bit of a personal quandry. I think that the legislature should have every right to debate caps on damages, and I'm very uncomfortable with state constitutional restrictions that debate. On the other hand, I don't think that once the state has that power, and the legislature goes ahead and adopts just caps on damages, it'll be doing something that's good for the malpractice system. I am concerned in Pennsylvania because the state constitutional language that's being proposed has only to do with caps on damages, and wouldn't, by its terms, allow Pennsylvania to adopt some type of, for lack of time to explain it, call it a Workers' Compensation approach. And I would caution all states that are in the constitutional mode right now to try to leave your options open beyond just caps, but to include, you know, really systematic reforms. That's probably all I can say in the time.

Trudi Matthews: Yeah, we can also pass along that your paper is available on CSG's website, on our teleconference website, and that's also a good resource for some of those more structural changes. Let's go ahead and take one more real quick question from our callers. Operator, do you have someone else on the line.

Operator: Yes ma'am.

Trudi Matthews: Go ahead.

Operator: The next question comes from Robert Burns from Washington, D.C.

Trudi Matthews: Okay Robert, go ahead.

Robert Burns: Hi, this is Bob Burns from the National Governors Association. I appreciate your reference to our document earlier from one of the callers. I just had a question around measuring success, and I guess I'd say it in two parts. Number one, I didn't hear anyone refer to provider capacity as a good measure of whether your results are being successful in terms of whether you're increasing the number of providers in your state or they're decreasing or you're simply retaining them, and whether the capacity, however it's affected by the medical malpractice insurance rates, is currently or will be in the long term sufficient to meet the public's demand for services. And I just wanted to hear about that. And I guess the second one is would you see any radical differences in the numbers or in the measures of success that you did list if you broke out the claims based on the medical practice area or specialty, or based on the provider type.

Dr. William Sage: Let me respond, it's Bill Sage, to the first question about provider capacity. I think asking the question about access to healthcare is the right question. We've done, as part of the work that I'm involved in, some preliminary cuts of general national overtime data looking at correlations between traditional Tort reforms, caps on damages and the supply of physicians. What we do find is that states that have

adopted those damage caps tend to have more physicians, all other things being equal, that the mode of change is usually a function of retirement decisions and entry in practice decisions rather than relocation. We don't find much evidence, this is not in the current crisis, but over, you know, it's the same period of physicians really moving state to state. But there is a correlation. That said, there are two significant qualifications. Qualification one is that we really don't have good baseline information about what the right number of doctors is. And qualification two, which everybody in state government for healthcare understands, is that the distribution of physicians by field, and even more by geographic area, is often what really counts. So you don't want to make decisions based on aggregate information about physician supply, if it's not going to lead to better distribution of physicians by specialty and geography.

Trudi Matthews: Are there any other comments from any of our other panellists about those issues?

Drew Crompton: Well, I'll just quickly say that one, the numbers that I referenced in the downturn of the number of claims from 2003 versus 2001, 2002 were not broken out by specialty, and we wouldn't even have the number of claims filed in Pennsylvania had it not been for our supreme court stepping up and requiring the counties to go back and analyze this data and report to them on it. So I think it's a very good question, but we don't have any information by specialty.

As it relates to provider capacity, I mean, to me it's a little bit different slant on the issue that we hear time and time again, and something that we really haven't addressed in the hour, and that is whether the doctors are leaving Pennsylvania. It's not exactly the same, and I understand Dr. Sage's differences that he just raised. I don't know if doctors are leaving in Pennsylvania. I know that we had more people respond to the 200 million dollars that I referenced in order for their share of it, if you will, to lower their premiums than we thought we had doctors in Pennsylvania. So certainly there are more doctors practicing in Pennsylvania than we're even aware of, and those numbers seem to be considerably higher than the number of Pennsylvania doctors we had in 2002/2001. That's not to mean that we're not losing specialists in some very key components of our state, in fact, we are. And that's one of the reasons why we've continued to talk about med mal for the last three years in Pennsylvania. And I think the legislator from Nevada was very right to pinpoint OB-GYN as a very sensitive spot. We've lost some OB-GYN's in Pennsylvania, and because of the loss of some of these specialties in Pennsylvania, have been the real reason why we're continuing to look for answers as it relates to med mal.

Trudi Matthews: Those are good. Any other thoughts or comments? Okay, good. Well I think that's all the time that we have for questions today. I want to thank our panellists for doing such an excellent job of answering questions and for providing some great information for our callers. I want to thank our callers as well for participating today. And again, I want to give you my email address if you have any follow up questions, I encourage you to contact me and let me know what those are, and I'll

forward those on to our panellists and any other folks who might be answer to the question. My email address again is tmatthews@csg.org.

Just a reminder, the transcript from the call today will be available in just a few days on CSG's conference website for those are interested in going back and examining some of the issues that were discussed. Also, a four page issue brief is going to be prepared by CSG staff, and will be mailed to all participants in the coming weeks, and will also be made available on CSG's website.

We thank you all for taking time out of your busy schedules to be with us, and hope that this has been helpful to you. I know I learned a lot, and appreciated the conversation. And we again want to thank you for being with us, and hope you have a great day. Bye now.