



Medical Liability Reform **NOW!**

**The facts you need to know to address the
broken medical liability system**

2016 edition



Medical Liability Reform NOW!

Table of contents

Introduction.....	1
The system is broken	1
Research on caps.....	10
Public support for medical liability reform	12
State efforts to enact caps on noneconomic damages.....	12
Successful ballot initiatives.....	21
Federal efforts on liability reform	22
Judicial activity	26
Innovative reforms.....	29
Conclusion.....	33

Developed by the American Medical Association, this resource is provided for informational and reference purposes only and should not be construed as the legal advice of the AMA. Specific legal questions regarding this information should be addressed by one's own legal counsel.

This resource contains data from third parties. Though the AMA works diligently to supply reliable information, the AMA assumes no responsibility for the accuracy and/or completeness of the statements and data of third parties. This document includes links to third-party websites that are not under the control of the AMA and, therefore, the AMA assumes no responsibility for their content. Inclusion of any third-party information does not imply endorsement by the AMA.

The most current version of “Medical Liability Reform – Now!” is accessible electronically at ama-assn.org/go/mlrnow.

It is highly recommended that readers refer to only the most current version of the document. Information in this document is subject to change and may be outdated. The AMA accepts no liability resulting from reliance being placed upon outdated information contained in this document, nor for reliance upon outdated versions of this document. Users are cautioned to independently verify the correctness of information contained in the document that may have become outdated.



Introduction

The broken medical liability system remains one of the most vexing issues for physicians today. It places a wedge between physicians and their patients. It forces physicians to practice defensive medicine. It puts physicians at emotional, reputational and financial risk, and it drains resources out of an already financially strapped national health care system—resources that could be used for medical research or expanded access to care for patients. Now more than ever, the American Medical Association is committed to improving the medical liability system for both patients and physicians.

The AMA is pursuing legislative solutions at both the federal and state levels to address the problems with the current medical liability system and is actively collaborating with state medical associations and national medical specialty societies to advance these goals as well.

“Medical Liability Reform – Now!” provides medical liability reform (MLR) advocates with the information they need to advocate for and defend MLR legislation. It includes background on the problems with the current system, proven solutions to improve the liability climate and a discussion of innovative reforms that could complement traditional MLR provisions. We hope this document sheds light on this particularly complicated issue and provides direction for those looking to fix it. This is a crucial period for MLR as federal policymakers and their state colleagues implement health system reform.

The system is broken

The physician perspective is personal

The medical liability issue is a very personal matter for physicians. A 2007–2008 AMA survey found that 61 percent of physicians age 55 and older had been sued at some point during their careers. Nearly 40 percent had been sued two or more times. Among surgeons age 55 and older, nine out of 10 had been sued. Even more remarkable, 51 percent of obstetricians/gynecologists under age 40 had been sued.¹

Does this suggest that all of those physicians are practicing bad medicine? To the contrary, data from PIAA, an insurance industry trade association of medical liability insurers, shows that most liability claims are without merit. Sixty-five percent of claims that closed in 2013 were dropped, dismissed or withdrawn. Almost eight percent of claims were decided by a trial verdict, the vast majority—91 percent—of which were won by the physician defendant in the case.²

A series of articles, which was based on independent analysis of closed claims from a national professional liability insurer, supports the conclusions drawn from the AMA and PIAA data reported above. The first shows high rates of claim frequency, particularly among certain specialties.³ For example, the authors project that at age 65, 99 percent of physicians in high-risk specialties would have already been subject to a claim. The analysis also shows that the large majority of claims, more than 75 percent, do not result in an indemnity payment.

1. Kane CK. *Medical Liability Claim Frequency: A 2007–2008 Snapshot of Physicians*. Chicago, IL: American Medical Association; 2010. Policy Research Perspectives No. 2010-1. ama-assn.org/resources/doc/health-policy/prp-201001-claim-freq.pdf. Accessed March 4, 2013.
2. Guardado JR. *Professional Liability Insurance Indemnity Payments, Expenses and Claim Disposition, 2004–2013*. Chicago, IL: American Medical Association; 2014. Policy Research Perspectives No. 2013-4. ama-assn.org/resources/doc/health-policy/x-ama/prp-piaa-2014-final.pdf. Accessed Dec. 16, 2014.
3. Anupam BJ, Seabury S, Lakdawalla D, et al. Malpractice risk according to physician specialty. *N Engl J Med*. 2011;365:629–636.

A second article offers further insight into how claims are resolved and also suggests that most liability claims are without merit.⁴ Looking only at claims with a positive defense cost, it finds that 55 percent resulted in litigation (the filing and conduct of a lawsuit). In turn, 54 percent of the litigated claims were dismissed by the court.



The third article provides a rare look at the time required to close a malpractice claim and how this varies across a number of claim characteristics.⁵ The article focuses only on claims with an indemnity payment or at least some defense costs. Claims without either tend to indicate a preemptive report, perhaps by the physician, and one where no allegation of malpractice is ever made. The authors find that the average time from claim filing to close was 20 months. Among claims with an indemnity payment, 27 percent took three or more years to close; among claims without an indemnity payment, only 12 percent did. Time to closure also varied across severity and physician specialty. Based on a career length of 40 years, the authors estimate that an average physician spends nearly 11 percent of his or her career with an open unresolved claim.

The high cost of medical liability insurance is another reason that physicians are so sensitive to this issue. For some physicians in certain states, liability premiums can exceed \$100,000 and sometimes even \$200,000 per year.⁶

4. Anupam BJ, Chandra A, Lakdawalla D, et al. Outcomes of medical malpractice litigation against US physicians. *Arch Intern Med.* 2012;172(11):892-894.
5. Seabury SA, Chandra A, Lakdawalla D, et al. On average, physicians spend nearly 11 percent of their 40-year careers with an open, unresolved malpractice claim. *Health Aff.* 2013;32(1):111-119.
6. Medical Liability Monitor. Annual Rate Survey Issue. October 2014. Vol. 39, No. 10.

Access to care for patients is adversely affected

Because being sued is such a common event over the course of a physician's career, and because medical liability insurance is so costly, the fear of liability hangs like a cloud over physicians—and it never goes away. The liability environment influences how physicians practice and affects patients' access to care and treatment. According to results from the American Congress of Obstetricians and Gynecologists (ACOG) 2015 Survey on Professional Liability,⁷ 49.7 percent of obstetricians/gynecologists have altered their practices since January 2012 due to the risk/fear of liability claims and litigation, and 39.8 percent have made changes to their practice due to insurance affordability or availability concerns. Of those reporting obstetric changes due to affordability or availability concerns:

- 13.6 percent decreased the number of obstetric high-risk patients they accepted
- 9.6 percent reported more cesarean births
- 8.4 percent eliminated vaginal births after cesarean (VBACs) from their practice
- 6.4 percent reported an overall decrease in the number of total deliveries

The 2013 Massachusetts Medical Society Physician Workforce Study revealed that 36 percent of Massachusetts physicians have altered or limited their scope of practice for fear of being sued.⁸ In a 2008 national survey of physicians more than 60 percent agreed with the statement, "I order some tests or consultations simply to avoid the appearance of malpractice."⁹ A 2011 survey of physicians illustrates why the liability environment affects physicians' practice patterns—while 83 percent of physicians thought they could easily be sued for failing to order an indicated test, only 21 percent thought they could be sued for ordering a test that was not indicated.¹⁰

The 2010 Illinois New Physician Workforce Study

7. Carpentieri AM, et al. *Overview of the 2015 ACOG Survey on Professional Liability.* American Congress of Obstetricians and Gynecologists; 2015. www.acog.org/-/media/Departments/Professional-Liability/2015PLSurveyNationalSummary11315.pdf. Accessed Jan. 11, 2016.
8. Massachusetts Medical Society. *Physician Workforce Study.* 2013.
9. Carrier, ER, Reschovsky JD, Mello MM, et al. Physicians' fears of malpractice lawsuits are not assuaged by tort reforms. *Health Aff.* 2010;29(9):1585-1592.
10. Sirovich B, Woloshin S, Schwartz LM. Too Little? Too Much? Primary Care Physicians' Views on US Health Care. *Arch Int Med.* 2011;171(17):1582-1585.

provides insight into how new physicians—who are the future of medicine—are affected by the medical liability system. According to that survey, 49 percent of new Illinois physicians planned to relocate to a different state. Two-thirds of the new physicians who planned to leave Illinois cited the medical liability environment as an important or very important consideration in that decision.¹¹

A number of papers clearly show that the liability system affects not only how physicians practice, but where they practice as well. The research provides a convincing argument that physician supply is more plentiful and patients' access to care is enhanced in areas where physicians are under less pressure from the liability system due to the enactment of traditional MLR provisions, such as caps on noneconomic damages. Summaries of a number of such papers follow.¹² Matsa (2007) examined how physician supply responds to caps on noneconomic or total damages over the period from 1970 to 2000.¹³ He found that the positive impact of caps was concentrated in rural counties, and among surgical and support specialists within those counties. Overall, he found that the number of physicians per capita in the most rural counties was about 4 percent larger in states with caps than in similar counties in states without caps. For surgical and support specialties in rural counties, states with caps had about 10 percent more physicians per capita than rural counties in states without caps. His work also suggests that it takes at least six to 10 years for the full effect of caps on physician supply to be felt and that this long-term effect is approximately twice that of the short-term effect.

Klick and Stratmann (2007) used a somewhat different approach than Matsa (2007) to examine the impact of caps on physician supply during the 1980 to 2001 period.¹⁴ Using “low-risk” physicians as a control group for “high-risk” physicians, Klick and Stratmann showed that depending upon which specialties are defined as low- or high-risk, the number of high-risk physicians per capita in states with caps on noneconomic damages was between 4 percent and 7 percent larger than in states without caps.

Helland and Showalter (2006) examined caps on a different measure of physician supply, weekly hours of work, in 1983 and 1988.¹⁵ They found that a 10 percent increase in expected liability costs was associated with a 2.9 percent decrease in weekly hours worked. The effects for physicians in solo practice and for physicians age 55 or older were even larger, with decreases of 6.6 percent and 12.2 percent respectively, for those two groups.

Kessler, Sage and Becker (2005) examined physician supply using annual data for the period from 1985 through 2001.¹⁶ They found that direct tort reforms increased physician supply by 2.4 percent relative to non-reform states.¹⁷ They also looked at the impact on a number of high-risk specialties and found that the effect on emergency physicians was particularly large at 11.5 percent.

Encinosa and Hellinger's paper (2005) looked specifically at the impact of caps on noneconomic damages on physician supply and included only eight years of data from 1985 through 2000.¹⁸ Their results suggest that caps increased the number of physicians per capita by 2.2 percent relative to states without caps.

11. Illinois Hospital Association. 2010 *Illinois New Physician Workforce Study*. isms.org/Partners_and_Affiliates/ISMS_Resident_and_Fellow_Section/RFS_Rounds/rfs_winter_2011.pdf. Accessed Nov. 17, 2014.

12. Two recent AMA reports provide more extensive summaries of this research: (1) Kane CK, Emmons DW. *The Impact of Liability Pressure and Caps on Damages on the Healthcare Market: An Update of Recent Literature*. Chicago, IL: American Medical Association; 2007. Policy Research Perspectives No. 2007-1. ama-assn.org/resources/doc/health-policy/prp2007-1.pdf. Accessed Nov. 17, 2014. (2) Kane CK, Emmons DW. *The Impact of Caps on Damages. How are Markets for Medical Liability and Medical Services Affected?* Chicago, IL: American Medical Association; 2005. Policy Research Perspectives No. 2005-2. ama-assn.org/resources/doc/health-policy/prp200502caps.pdf. Accessed Nov. 17, 2014.

13. Matsa, DA. Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps. *J Legal Stud.* 2007;36(2):143–182.

14. Klick, J, Stratmann T. Medical Malpractice Reform and Physicians in High Risk Specialties. *J Legal Stud.* 2007;36(2):121–139.

15. Helland E, Showalter MH. The Impact of Liability on the Physician Labor Market. Rand Working Paper WR-384-ICJ. Santa Monica, CA: Rand Institute for Civil Justice; 2006. rand.org/pubs/working_papers/2006/RAND_WR384.pdf. Accessed Nov. 17, 2014.

16. Kessler DP, Sage WM, Becker DJ. *Impact of Malpractice Reforms on the Supply of Physician Services*. *JAMA.* 2005;293(21):2618–2625.

17. Direct reforms include caps on economic, noneconomic, or total damages, abolition of punitive damages, no mandatory prejudgment interest, and collateral source rule reform.

18. Encinosa WE, Hellinger FJ. *Have State Caps On Malpractice Awards Increased The Supply Of Physicians?* *Health Aff.* 2005; W5-250-W5-W258.

Helland and Seabury (2015) examined how physician supply responds to caps on noneconomic damages using state level estimates of the number of physicians per capita over the period from 1995 to 2010.¹⁹ They found that noneconomic damage caps were associated with increases in supply of between 1 percent and 7 percent for high-risk physicians depending on whether their classification of high-risk specialties was broad or narrow. Measuring risk directly by specialty-level estimates of claim frequency, they found that caps had a larger impact on specialties with higher frequency. They also noted that caps were more likely to be adopted in states experiencing slower than average growth in physician supply. The authors took measures to account for that disparity in their estimation of the impact of caps.

A 2006 literature review by the Robert Wood Johnson Foundation reached a similar conclusion to the research summarized above. It concluded that, “The best studies suggest that caps are associated with a small increase in physician supply.”²⁰

Accuracy and fairness

Research shows that the current system treats physicians and patients unfairly and that its outcomes are inaccurate. A review of closed claims showed that no injury had occurred in 3 percent of claims and that in another 37 percent there had been no error.²¹ The same research shows that in terms of compensation for medical errors, the system “gets it wrong” about equally on both sides. Twenty-seven percent of claims involving errors were uncompensated and, on the flip side, the same percentage of compensated claims did not involve an error. Earlier research that matched claim-level data with hospital records also suggested similar inaccuracies. In that work, the authors found that less than 15 percent of patients who suffered a negligent injury filed a claim and that negligence had occurred in only slightly more than 15 percent of filed claims.²²

19. Helland E, Seabury SA. Tort Reform and Physician Labor Supply: A Review of the Evidence. *Int'l Rev. L. & Econ.* 2015;42(June):192–202.
20. Mello MM. *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms*, The Robert Wood Johnson Foundation, Research Synthesis Report No. 10. 2006.
21. Studdert DM, Mello MM, Gawande AA. Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. *N Engl J Med* 2006;354(19):2024-2033.
22. Weiler PC. *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation*. Cambridge, MA: Harvard University Press; 1993.

Defensive medicine and other costs to our health system

From a number of perspectives, the current liability system is extremely costly. PIAA data shows that the median indemnity payment on settled claims that closed in 2013 was \$175,000. For tried claims decided in the plaintiff’s favor, the median indemnity payment was \$500,000. In addition to the costs generated by the amounts paid out to plaintiffs, claims are also costly to defend. The average defense cost for claims settled in 2013 was \$68,423. For tried claims, it was \$140,239 when there was a defendant victory and \$251,541 for a plaintiff victory. For dropped claims, the average was \$28,350.²³

Those per-claim costs add up to very large amounts. According to data from the National Association of Insurance Commissioners, total (incurred) indemnity losses in 2012 were \$4.2 billion, and defense costs were an additional \$2.4 billion.²⁴ These claim costs have a direct effect on the cost of medical care.

Earlier we referenced a growing body of research based on independent analyses of closed claims from a national professional liability insurer.²⁵ Based also on these data, the same authors found that defense costs were more than twice as high for claims that resulted in indemnity payments than for claims where no indemnity payments were made. However, the authors concluded that there was still a meaningful cost tied to defending that latter group of claims, and considerable savings could be had if the costs of dispute resolution were lowered.²⁶

23. Guardado JR. *Professional Liability Insurance Indemnity Payments, Expenses and Claim Disposition, 2004–2013*. Chicago, IL: American Medical Association; 2014. Policy Research Perspectives No. 2014-4. ama-assn.org/resources/doc/health-policy/x-ama/prp-piaa-2014-final.pdf. Accessed Dec. 16, 2014.
24. National Association of Insurance Commissioners. *Profitability by line by State in 2012*. 2013. These figures are calculated by applying the indemnity and expense percentages to direct premiums earned. Expense payments are called “loss adjustment expenses” in this publication.
25. Anupam BJ, Seabury S, Lakdawalla D, et al. Malpractice Risk According to Physician Specialty. *N Engl J Med*. 2011;365:629–636. Anupam BJ, Chandra A, Lakdawalla D, et al. Outcomes of Medical Malpractice Litigation Against US Physicians. *Arch Intern Med*. 2012;172(11):892-894. Seabury SA, Chandra A, Lakdawalla D, et al. On average, physicians spend nearly 11 percent of their 40-year careers with an open, unresolved malpractice claim. *Health Aff*. 2013;32(1):111–119.
26. Seabury S, Chandra A, Lakdawalla D. Defense Costs of Medical Malpractice Claims. *N Engl J Med*. 2012;36:1354–1356.

High-dollar claims are an important driver of total indemnity payments. According to PIAA data, although only 8.7 percent of paid claims that closed in 2013 had an indemnity payment of \$1 million or more, indemnity payments on those large claims accounted for 35.5 percent of total indemnity payments.²⁷

Although defense costs on dropped claims are lower on a per-claim basis than those on claims that are settled or tried, dropped claims account for 37.9 percent of total defense costs given that there are so many of them.²⁸ In fact, total expenses incurred on claims have been rising much faster than total indemnity payments. In 2013 total indemnity payments were three times higher than in 1985. In contrast, the increase in total expenses was seven-fold. Consequently, the share of total costs incurred on expenses increased from 19 percent to 35 percent over that period.²⁹

The fear of liability affects health care spending

In addition to the direct effect that indemnity and expense costs have on medical spending, there is also a considerable indirect effect. Since the fear of lawsuits affects the way in which physicians practice, our medical liability system causes health care expenditures to be higher than they otherwise would be. This is called “defensive medicine.”

Much of the research on the cost of defensive medicine targets the Medicare population because of the lack of available expenditure data for the non-Medicare population.

Kessler and McClellan (1996) examined hospital expenditures over the course of a year by Medicare beneficiaries with new diagnoses of acute myocardial infarction (AMI) or ischemic heart disease (IHD)

in 1984, 1987 and 1990.³⁰ They compared those expenditures in states with direct, indirect or no tort reforms.³¹ They concluded that within three to five years after the adoption of late 1980s direct reforms, hospital expenditures were reduced by 5 percent to 9 percent as compared to expenditures in states that did not adopt reforms.³² Kessler and McClellan also tested for differences in mortality and complications, and found that these outcomes were similar regardless of whether a direct tort reform was in place. Because the additional spending in states without tort reform was not improving health, this further supports their conclusion that it was defensive medicine.

In an extension of their 1996 work, Kessler and McClellan (2002) examined whether physicians’ incentives to practice defensive medicine were affected by the increase in managed care enrollment from 1984 through 1994.³³ The authors found that for IHD patients, direct reforms had a larger negative impact on hospital expenditures in areas with low rather than high managed care penetration, leading to a decrease of 7.1 percent compared to 2.9 percent. Among AMI patients, the impact of tort reform was similar regardless of managed care penetration; it resulted in a 3.8 percent decrease in hospital spending.

Avraham and Schanzenbach (2015) used 1998 to 2009 data from the Nationwide Inpatient Sample (NIS) to examine the effect of caps on noneconomic damages on the treatment intensity of heart attack patients aged 45 to 90.³⁴ They found that the likelihood of receiving an invasive procedure (angioplasty or bypass) declined by 1.25 to two percentage points following enactment of a cap—caps were associated with a decrease in treatment intensity. At the same time, they found no evidence that the decrease in treatment intensity led to an

27. Guardado JR. *Professional Liability Insurance Indemnity Payments, Expenses and Claim Disposition, 2004–2013*. Chicago, IL: American Medical Association; 2014. Policy Research Perspectives No. 2014-4. ama-assn.org/resources/doc/health-policy/x-ama/prp-piaa-2014-final.pdf. Accessed Dec. 16, 2014.

28. *Id.*

29. *Id.*

30. Kessler DP, McClellan M. Do Doctors Practice Defensive Medicine? *QJ Econ.* 1996;111(2): 353-390.

31. Direct reforms include caps on economic, noneconomic, or total damages, abolition of punitive damages, no mandatory prejudgment interest, and collateral source rule reform. Indirect reforms include limits on contingency fees, mandatory periodic payments, joint and several liability reform, statute of limitations reform, and existence of a patient compensation fund.

32. The 5 percent reduction was for AMI; 9 percent for IHD.

33. Kessler D, McClellan M. Malpractice Law And Health Care Reform: Optimal Liability Policy In And Era Of Managed Care. *J Public Econ.* 2002;84:175-197.

34. Avraham, R, Schanzenbach, M. The Impact of Tort Reform on Intensity of Treatment: Evidence from Heart Attack Patients. *J. Health Econ.* 2015;39(January):273–288.

increase in mortality. Together, these results suggest that the extent of defensive medicine was reduced by caps on noneconomic damages.

In a 2006 background paper, the Congressional Budget Office (CBO) looked at the relationship between tort reform and hospital, physician and total Medicare expenditures on all beneficiaries over the 1980 through 2003 period.³⁵ The CBO concluded that hospital spending per beneficiary was 5 percent lower in states where noneconomic damages were capped, but attributed about half of that impact to the prospective payment system implemented in 1983.³⁶ While they found no impact of caps on physician spending, they estimated that total Medicare spending per beneficiary was 4 percent lower in states with caps.

Rather than comparing Medicare expenditures in states with and without tort reforms, some authors have examined whether Medicare expenditures are higher in states that have higher indemnity payments on liability claims.³⁷ Baicker, Fisher and Chandra (2007)³⁸ found that a 10 percent increase in average (per physician) indemnity payments between 1993 and 2001 was associated with a 1.5 percent to 1.8 percent increase in the utilization of half of the diagnostic and imaging procedures at which they looked.³⁹ For spending, they found that the same 10 percent increase in indemnity payments led to a 1 percent increase in Part B spending per beneficiary, but found no impact on total spending per beneficiary. The impact on spending on imaging stood out. It was 2.2 percent—larger than that of any other testing or procedure category.

Roberts and Hoch (2007) used 1998 through 2002 Medicare expenditure data and county-level data on the number of medical liability lawsuits in Mississippi.⁴⁰ The

authors found that an additional lawsuit per 100,000 persons led to increased Part B Medicare spending of \$1.40 to \$2.49 per beneficiary. This implied that in the average county in Mississippi, between 0.9 percent and 1.6 percent of Part B spending was due to the litigation climate (including the direct impact of payouts to plaintiffs on health care costs).⁴¹ In the county with the most lawsuits, 277 per 100,000 persons, 15.9 percent of spending on physician services was due to litigation.

Taken as a whole, the Medicare-based research suggests that defensive medicine affects Medicare spending, and this effect may be concentrated in some disease populations or procedures.

Two empirical papers provide estimates of the cost of defensive medicine in the non-Medicare population. Avraham, Dafny and Schanzenbach (2010) used a proprietary multi-employer database to examine the relationship between tort reform and the health insurance premiums of employer-sponsored health plans over the 1998 through 2006 period.⁴² The authors found that if implemented together, joint and several liability reform, caps on punitive damages, caps on noneconomic damages and collateral source rule reform would reduce the health insurance premiums of self-insured plans by 2.1 percent, driven largely by the latter two reforms.

Thomas, Ziller and Thayer (2010) used medical liability premiums as a measure of liability pressure.⁴³ They estimated how episode-of-care costs for Cigna Healthcare claims responded to changes in that measure over the 2004 to 2006 period, or to variation in the measure across areas. The authors' work showed that a 10 percent decrease in medical liability premiums would lead to a statistically significant decrease in costs in 2 percent of the *different types* of episodes in their data, which was equivalent to 35.8 percent of the *total number* of episodes over that period (the affected episodes were high-volume ones). They also concluded that a 10 percent decrease in premiums would result in a decrease in total cost of less than 1 percent.

35. U.S. Congressional Budget Office. *Medical Malpractice Tort Limits And Health Care Spending*, Background Paper (Washington, DC: U.S. Congressional Budget Office, April 2006).

36. CBO's work suggests that states that were under greater pressure from the PPS system to reduce expenditures were more likely than other states to enact caps. The 5 percent estimated impact of caps picks up some of this relationship.

37. When the authors looked at premiums as a measure of liability pressure rather than indemnity payments, their results were similar.

38. Baicker K, Fisher ES, Chandra A. Malpractice Liability Costs and the Practice of Medicine in the Medicare Program. *Health Aff.* 2007;26:841–852.

39. They found an impact on carotid duplex, echocardiography, electrocardiogram (EKG), and computed tomography (CT)/magnetic resonance imaging (MRI) scanning. They found no impact on prostate-specific antigen (PSA) testing, cardiac catheterization, chest x-rays and mammograms.

40. Roberts B, Hock I. Malpractice Litigation and Medical Costs in Mississippi. *Health Econ.* 2007;16(8):841–859.

41. The lower of the two estimates is from a regression that includes county fixed effects. The percentage impacts are calculated at the mean number of suits per 100,000 (16.05), with average Medicare physician spending per beneficiary of \$2431 ($\$1.40 * 16.05 / \$2431 = 0.009$, for example).

42. Dafny RA, Schanzenbach MM. *The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums*. 2010.

43. Thomas WJ, Ziller EC, Thayer DA. Low Costs of Defensive Medicine, Small Savings From Tort Reform. *Health Aff.* 2010;29:1578–1584.

The total cost of defensive medicine

Because few research papers have addressed defensive costs in the privately insured population, it is difficult to precisely estimate the total cost of defensive medicine. One approach has been to assume that Kessler and McClellan's (2002) carefully constructed "5 percent to 9 percent"⁴⁴ estimate among Medicare beneficiaries with heart disease applies to health spending at large. Using that approach, a 2003 U.S. Department of Health and Human Services (HHS) report issued during the last medical liability crisis put the cost of defensive medicine between \$70 and \$126 billion per year.⁴⁵ Applied to health spending in 2012 (\$2,793.4 billion⁴⁶) this method would suggest a range of \$140 and \$252 billion per year. A more recent and conservative approach puts the 2008 cost of defensive medicine at \$45.6 billion.⁴⁷ In comparison, applying the Kessler and McClellan estimates to health spending in 2008 (\$2,411.7 billion⁴⁸) results in a range of \$120.6 and \$217.1 billion.

A recurring problem

The problems with the medical liability system are not new. The medical liability insurance system experienced a period of crisis in the early 1970s when several private insurers left the market because of rising claims and inadequate rates. This exodus of capacity resulted in an availability crisis and created an affordability issue for those physicians and hospitals lucky enough to find insurance. Over the next 15 years, various attempts were made to ease the explosion in claims costs: tort reform, increased diagnostic testing, improved peer review and increased communication between physicians and patients. Aggressive campaigns to reform state laws governing medical liability lawsuits began in the 1970s and were successful in a number of states including California, Louisiana, Indiana and New Mexico.

In California, between 1968 and 1974, the number of medical liability claims doubled, and the number of losses in excess of \$300,000 increased dramatically, from three to 34. Losses amounting to \$180 for each \$100 of premium led most commercial insurers to conclude that the practice of medicine was uninsurable, and they refused to provide medical liability insurance at any price. In California, access to care was threatened, and a special session of the California legislature led to enactment of the Medical Injury Compensation Reform Act of 1975 (MICRA).⁴⁹

During the 1980s, the second liability crisis—characterized by a lack of affordability—shook the industry, as claim frequency and severity increased again and premiums rose rapidly. The affordability crisis had a dramatic effect. Physicians in specialties such as obstetrics and gynecology cut back on high-risk procedures and high-risk patients to reduce risk and hold down their premiums. Some physicians closed practices in states where premiums and the risk of being sued were especially high.

The third liability crisis started early last decade. Liability premiums skyrocketed, and access to care was threatened in many states.

Access to care during the last liability crisis

At the height of the third liability crisis in the mid-2000s, 45 percent of hospitals reported that the professional liability crisis resulted in the loss of physicians or reduced coverage in emergency departments.⁵⁰ According to a 2006 ACOG survey, the lack of affordable liability insurance forced 70 percent of obstetricians/gynecologists to make changes to their practice in the preceding three year period. Of those who made changes, liability concerns forced 7 percent to stop practicing obstetrics. Finally, ACOG reported that close to 90 percent of obstetricians/gynecologists have had at least one liability claim filed against them over the course of their career with the average being

44. Kessler DP, McClellan M. Do Doctors Practice Defensive Medicine? *QJ Econ.* 1996;111(2):353-390.

45. Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept of Health and Human Servs., *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care 11* (2003) [hereinafter *Addressing the New Health Care Crisis*].

46. Martin AB, Hartman M, Whittle L, Catlin A and the National Health Expenditure Accounts Team. *National Health Spending In 2012: Rate Of Health Spending Growth Remained Low For The Fourth Consecutive Year.* *Health Aff.* 2014;33(1):67-77.

47. Mello MM, Chandra A, Gawande AA, et al. National Costs of the Medical Liability System. *Health Aff.* 2010;29(9):1569-1576.

48. *Supra* note 46

49. Anderson RE. *Commentaries Defending the Practice of Medicine.* *Arch Int Med.* 2004;164(11):1173-8.

50. Am. Hosp. Ass'n., *Prof'l Liability Ins. Survey* (2003).



2.6 claims per obstetrician/gynecologist.⁵¹ Residents and students also expressed grave concerns about the liability situation and their ability to practice medicine in high-risk specialties at the height of the third liability crisis. In a 2003 survey, 62 percent of medical residents reported that liability issues were their top concern, surpassing any other concern. This represented an enormous increase from 2001 when only 15 percent of residents said liability was a concern.⁵²

Students, too, were affected by the third liability crisis. In fact, half of the respondents to an AMA survey indicated the medical liability environment was a factor in their specialty choice.⁵³ Thirty-nine percent said the medical liability environment was a factor in their choice of state in which to complete residency training.⁵⁴ Sixty-one percent of students reported they were extremely concerned that the current medical liability environment was decreasing physicians' ability to provide quality medical care.⁵⁵

At the height of the third crisis, a majority (59 percent) of physicians believed that the fear of liability discouraged open discussion and thinking about ways to reduce health care errors.⁵⁶ More than three-fourths (76 percent) of physicians believed that concern about medical liability litigation negatively affected their ability to provide quality care.⁵⁷ Fear of medical liability suits caused some emergency room physicians to order

more hospitalizations and medical tests than other emergency room doctors.⁵⁸

Premiums during the last liability crisis

The *Medical Liability Monitor* (MLM) reports medical liability premiums from many of the leading medical liability insurance carriers for obstetrics/gynecology, general surgery and internal medicine in each state where they provide liability coverage. The premium data on page 9, which are from the Annual Rate Survey (October) editions of the MLM, illustrate the explosive premium growth faced by physicians during the third medical liability crisis. The table also shows premiums for California—a state that passed strong tort reforms in 1975—to illustrate the relative stability in premiums in that state compared to others.

Premiums in many states more than doubled during the 2000–2004 period. As the table shows, some Florida obstetricians/gynecologists faced premiums that were upwards of \$275,000 in 2004. According to the Florida Association of Realtors and the University of Florida Real Estate Research Center, that was more than the median sale price for a house in that area at that time (\$273,900).⁵⁹

Crisis states during this period

During the last crisis, the AMA identified the following states as crisis states: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode

51. Wilson N, Strunk AL. Overview of the 2006 ACOG Survey on Professional Liability. *ACOG Clinical Review*. 2007;12(2):1–16.
52. Meritt, Hawkins & Assoc., Summary Report: 2003 Survey of Final Year Med. Residents 5 (2003).
53. AMA Division of Market Research & Analysis. AMA Survey: Med. Students' Opinions of the Current Medical Liability Environment. 2003.
54. *Id.*
55. *Id.*
56. Harris Interactive Inc. *Common Good, Common Good Fear of Litigation Study: The Impact on Med.* 65. 2002.
57. *Id.* See also, Taylor S, Thomas E. *Civil Wars*. Newsweek, Dec. 15, 2003 (detailing America's increasingly litigious culture and its repercussions in the day-to-day work of physicians and other professionals).

58. *Malpractice Fears Guide Behavior of Some ER Physicians, Study Says*. Health Care Daily. July 13, 2005.
59. <http://media.living.net/statistics/2004/YearEnd2004.pdf>. Accessed Nov. 17, 2014.

Island, Tennessee, Texas, Washington, West Virginia and Wyoming. Premiums were increasing in these states; patients were losing access to health care, and physicians were struggling to stay in practice. For example, liability premiums in Connecticut, New Jersey and Pennsylvania nearly tripled during this time frame.⁶⁰ More than 1,600 Florida physicians gave sworn statements to a state Senate panel in August 2003 detailing how the state’s medical liability crisis forced them to change their practices, including no longer providing services such as delivering babies and

performing complex surgeries.⁶¹ The only Level 1 trauma center in Las Vegas had to close temporarily due to skyrocketing liability premiums.⁶² And in Philadelphia, the city lost 11 maternity wards between 1997 and 2007, with the *Philadelphia Inquirer* citing liability concerns as one of the main reasons for these closures.⁶³ The last liability crisis was very detrimental to patients and to physicians, and the AMA is advocating on behalf of patients and physicians constantly to prevent a recurrence of this event.

61. Florida Medical Association.
 62. PR Newswire, April 21, 2003.
 63. Burling S. *Demise of Maternity Wards is Inducing the Baby Scramble*. *Philadelphia Inquirer*. May 6, 2007.

60. *Medical Liability Monitor*. Annual Rate Survey Issue. (October 2007)

Medical professional liability insurance premiums for \$1M/\$3M policies, 2000–2004

Obstetrics/gynecology	2000	2001	2002	2003	2004
California (Los Angeles, Orange)	52,874	52,874	54,563	60,259	63,272
Connecticut	63,292	77,533	94,978	123,470	148,164
Florida (Miami-Dade)	147,621	166,368	201,376	249,196	277,241
Illinois (Cook, Madison, St. Clair, Will)	78,880	88,928	102,640	139,696	147,540
New Jersey	68,000	68,000	70,720	102,643	128,304
New York (Nassau, Suffolk)	115,429	115,429	115,431	123,853	133,787
Pennsylvania (Philadelphia, Delaware)	37,556	45,938	100,045	134,335	161,211
Texas (Brownsville, Laredo, El Paso)	73,660	91,894	92,326	92,326	81,247
General surgery					
California (Los Angeles, Orange)	32,507	32,507	36,740	45,421	54,505
Connecticut	32,651	34,283	36,854	42,385	57,220
Florida (Miami-Dade)	110,068	124,046	174,268	226,542	277,241
Illinois (Cook, Madison, St. Clair, Will)	52,364	59,016	68,080	92,576	102,700
New Jersey	32,333	38,800	41,516	58,786	63,489
New York (Nassau, Suffolk)	62,733	62,733	65,870	74,211	80,163
Pennsylvania (Philadelphia, Delaware)	33,684	35,793	82,157	108,038	128,524
Texas (Brownsville, Laredo, El Paso)	50,911	67,555	71,200	71,200	62,656
Internal medicine					
California (Los Angeles, Orange)	10,097	10,097	11,164	12,493	14,237
Connecticut	7,736	9,863	13,820	21,420	28,917
Florida (Miami-Dade)	32,744	38,378	56,153	65,697	69,310
Illinois (Cook, Madison, St. Clair, Will)	19,604	22,060	26,404	35,756	38,424
New Jersey	11,359	12,495	13,620	20,893	23,818
New York (Nassau, Suffolk)	21,648	21,648	21,648	23,228	25,091
Pennsylvania (Philadelphia, Delaware)	7,390	7,853	18,429	24,546	27,505
Texas (Brownsville, Laredo, El Paso)	18,783	25,563	26,334	26,334	23,174

The dollar amounts in the table are examples of manual premiums for professional liability insurance that were reported in the “2001–2004 Annual Rate Survey” (October) issue of the *Medical Liability Monitor* (MLM). This table is an excerpt from a 2009 AMA report on MLM premiums.* It does not include all the rates reported for the geographic areas in the table, nor does it include the premiums paid by physicians in other areas of the country, which may be higher or lower. These rates reflect the manual rates for one of the state’s market share leaders. The MLM reports that these rates do not reflect credits, debits, dividends or other factors that may reduce or increase the actual rates charged to physicians. The AMA alone is responsible for the accuracy of the information in the table and believes the rates listed are a reasonable benchmark to demonstrate professional liability insurance trends for select specialties in certain geographic areas. Connecticut 2003–2004 rates are for \$1 million/\$4 million limits, and New York 2004 rates are for \$1.3 million/\$3.9 million limits. Pennsylvania premiums include PCF surcharges. To obtain the MLM survey or to verify its accuracy, visit mlmonitor.com or call (312) 944-7900.

* The MLM data were summarized by Guardado JR. in *Medical Professional Liability Insurance Premiums: Changes and Levels, 2004–2009*. Chicago, IL: American Medical Association, 2009. Policy Research Perspectives No. 2009-5. ama-assn.org/resources/doc/health-policy/x-ama/prp-200905-mlm-summary.pdf. Accessed Nov. 17, 2014.

Research on caps

Caps on noneconomic damages have proven to be successful at maintaining a stable liability climate in states that enact them. A large and growing body of research shows that caps on noneconomic damages lead to improved access to care for patients, lower medical liability premiums and lower health care costs. The AMA is committed to advocating for traditional reforms—such as caps on noneconomic damages—as the cornerstone to fixing the broken liability system. The AMA is also calling for testing of innovative reforms to see if any of them can be proven successful as well.

The following articles, most of them conducted independently and subject to peer review in academic journals, show the beneficial effects that caps have on premiums, costs and the federal deficit. Their effect on patient access to care was addressed in an earlier section of this document.⁶⁴

Kessler and McClellan (1997) looked at the relationship between tort reform and the medical liability premiums paid by physicians and their claim frequency.⁶⁵ Both the premium and the frequency data were from 1985 through 1993 surveys of physicians conducted by the AMA. The authors found that direct reforms reduced premiums by 8.4 percent within the first three years after a reform, and reduced the likelihood that a physician would be sued by 2.1 percent.

Thorpe (2004) examined the impact of various types of caps that were enacted in the mid to late 1980s.⁶⁶ He found that medical liability premium revenue was 13 percent to 17 percent lower in states that capped noneconomic or total damages than in states that did not.

Viscusi and Born (2005) examined the impact of caps and other tort reforms that were enacted in the mid

to late 1980s.⁶⁷ They found that insurers in states that enacted caps on noneconomic damages had losses 17 percent lower than those of insurers in other states. Earned premiums were 6 percent lower. In addition, they found that losses and premiums of insurers in states where punitive damages were not allowed were 16 percent and 8 percent lower, respectively, than losses and premiums of insurers in states that allowed punitive damages. Caps on punitive damages had, predictably, smaller impacts than the prohibition of punitive damages, only 7 percent on losses and no impact on premiums.

Born, Viscusi and Baker (2006) found that insurers whose business was concentrated in states with caps had smaller losses than other insurers.⁶⁸ On average over the 1984 to 1993 period, a 10 percent increase in the share of business in states with noneconomic caps led to a 4 percent decrease in ultimate⁶⁹ losses. The effect was more pronounced for firms with higher losses per premium dollar—those firms had the large claims that are likely to be affected by caps. Similar but slightly different-sized effects were found for caps on punitive damages. The authors also examined incurred⁷⁰ losses and found a smaller impact than for ultimate losses. This suggests that the caps had a larger impact than the insurers initially expected.

Kilgore, Morrisey and Nelson (2006) investigated the association between a number of different types of tort reforms and medical liability premiums over the 1991 to 2004 period.⁷¹ Their results showed that, on average, internal medicine premiums in states with caps on noneconomic damages were 17.3 percent smaller than in states without caps. The impact of caps on general surgery and obstetrics/gynecology premiums was larger, 20.7 percent and 25.5 percent, respectively. Moreover,

64. See footnote 13 for two AMA reports that provide more lengthy and detailed summaries of these and related research papers.

65. Kessler DP, McClellan MB. The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care. *Law and Contemp Problems*. 1997;60(1):81–106.

66. Thorpe KE. The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms. *Health Aff*. 2004;W4-20-W4-30. <http://content.healthaffairs.org/content/early/2004/01/21/hlthaff.w4.20/suppl/DC1>. Accessed Nov. 17, 2014.

67. Viscusi WK, Born PH. *Damage Caps, Insurability, and the Performance of Medical Malpractice Insurance*. *J Risk and Ins*. 2005;72(1):23–43.

68. Born PW, Viscusi K, Baker T. *The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses*. Cambridge, MA: National Bureau of Economic Research; 2006. NBER Working Paper 12086. nber.org/papers/w12086. Accessed Nov. 17, 2014.

69. The ultimate loss on a claim is the known amount that is actually paid out after a claim has closed.

70. The incurred loss on a claim is the *estimated* amount that will be paid out on a claim once it has closed.

71. Kilgore ML, Morrisey MA, Nelson LJ. Tort Law and Medical Malpractice Insurance Premiums. *Inquiry*. 2006;43:255–270.

and consistent with what one might expect, the authors found that every \$100,000 increase in a cap raised premiums by 3.9 percent. Their results suggest that enacting a \$250,000 cap in states without caps, or with higher-level caps, would result in premium savings of \$1.4 billion.

Seabury, Helland and Jena (2014) examined the impact of caps on noneconomic damages and the impact of other types of tort reform on average indemnity payments made on medical liability claims closed between 1985 and 2010.⁷² They found that noneconomic damage caps reduced average indemnity payments by \$42,980, a reduction of about 15 percent relative to the average payment over their sample period. The largest impacts in dollar terms were in pediatrics and obstetrics/gynecology, where average payments were reduced by more than \$100,000. Seabury, Helland and Jena also tested whether caps set at lower levels had a larger impact on average payments than caps set at higher levels. They found that \$250,000 caps reduced average payments by almost \$60,000, or by 20 percent. They did not find a statistically significant impact of \$500,000 caps. When looking at specialty specific effects they found impacts of \$250,000 caps on average payments in all specialty categories except ophthalmology. Again, the largest dollar impacts were in obstetrics/gynecology (\$124,005) and pediatrics (\$146,481). Caps set at \$500,000, on the other hand, only had a statistically significant impact in three specialties: general surgery, internal medicine and obstetrics/gynecology.

In addition to the original research summarized above, a number of literature reviews, or extrapolations based on original research, have also concluded that caps on noneconomic damages work to reduce claim severity and premiums. The Office of Technology Assessment (1993) concluded that, “caps on damage awards were the only type of state tort reform that consistently showed significant results in reducing the malpractice cost indicators.”⁷³ The CBO (1998) concluded that caps

on noneconomic damages were one of two reforms that “have been found extremely effective in reducing the amount of claims paid and medical liability premiums.”⁷⁴ The other reform was collateral source offset provisions.

Using a variety of data sources, Hamm, Frech and Wazzan (2014) examine the impact of California’s MICRA. They conclude that:

- A cap lowers medical liability insurance premiums by reducing insurers’ loss costs
- A cap on noneconomic damages reduces health care costs, making health care more affordable
- The MICRA cap has not reduced access to the courts for individuals with meritorious claims
- Notwithstanding the MICRA cap, the rate of increase in medical liability damages awards in California far exceeds the rate of inflation
- An increase in the cap on noneconomic damages would significantly increase the cost of health care in California⁷⁵

The non-partisan CBO estimated that tort reform similar to what exists in California would reduce total national health care spending by 0.5 percent.⁷⁶ The CBO also estimated that those reforms would lower the federal deficit by \$62.4 billion over the 10-year period from 2012 through 2021.⁷⁷

Finally, a 2006 literature review by the Robert Wood Johnson Foundation concluded that, “Overall, caps appear to be associated with a 23 percent to 31 percent reduction in average awards,” and that, “the most recent controlled studies show that caps moderately constrain the growth of premiums.”⁷⁸

72. Seabury SA, Helland E, Jena AB. Medical Malpractice Reform: Noneconomic Damages Caps Reduced Payments 15 Percent, With Varied Effects By Specialty. *Health Aff.* 2014;33(11): 2048-2056.

73. Office of the Tech. Assessment. *Impact of Legal Reforms on Medical Malpractice Costs*. OTA-BP-H-119. 1993. The OTA was a nonpartisan analytical agency that provided assistance to the U.S. Congress for 23 years through 1995.

74. U.S. Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options*. cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf. Accessed Dec. 16, 2014.

75. Hamm WG, Frech HE, Wazzan CP. MICRA and Access to Healthcare. 2014. micra.org/studies-research/FINAL2014MICRAReport01.21.14.pdf. Accessed Nov. 17, 2014.

76. U.S. Congressional Budget Office. Letter to Honorable Orrin G. Hatch. (Washington, D.C.: U.S. Congressional Budget Office: Oct. 9, 2009).

77. U.S. Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options*. cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf. Accessed Nov. 17, 2014.

78. Mello MM. *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms*. The Robert Wood Johnson Foundation; 2006. Research Synthesis Report No. 10.



Public support for medical liability reform

The American public continues to support MLR. Numerous polls have confirmed this support.

- A February 2003 Gallup poll showed that 72 percent of Americans supported limiting the amount patients can be awarded for “pain and suffering.”
- In a 2006 Harris Interactive poll, 76 percent of those surveyed favored a law that would guarantee an injured patient full payment for lost wages and medical expenses and place reasonable limits on awards for “pain and suffering” in medical liability cases. Three-quarters of the Americans surveyed said they wanted their elected representatives in Washington to support comprehensive MLR.
- An October 2009 National Quorum poll found that 62 percent of those surveyed wanted federal representatives to support comprehensive MLR; 72 percent believed that affordable, high-quality care was at risk because of medical liability costs; 70 percent supported full payment for lost wages and medical expenses and reasonable limits on noneconomic

damages, and 64 percent believed that medical liability lawsuits were a primary reason for rising health care costs.

- A December 2009 Rasmussen Reports poll found that 57 percent of voters nationwide favored limiting the amount of money a jury can award a plaintiff in a medical liability suit.
- A December 2009 Associated Press poll conducted by Stanford University found that 54 percent of Americans supported limits on medical liability lawsuits while only one-third indicated that they were opposed. The support for MLR was strong across political affiliation—58 percent of independents, 61 percent of Republicans and 47 percent of Democrats favored making it more difficult to sue.

State efforts to enact caps on noneconomic damages

Background

As of January 2015, about half of the states have enacted some variation of a cap on noneconomic

damages while six states place a cap on total damages. (Colorado places a cap on both noneconomic damages and total damages and is listed in both categories.) However, the caps in these states vary greatly by amount, exceptions and causes of action covered, and only a handful of the state caps are as strong as those in California and Texas.

States with a cap on noneconomic damages for personal injury, wrongful death and/or both related to medical liability claims include: Alaska, California, Colorado, Florida, Hawaii, Idaho, Kansas, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia and Wisconsin. States with a cap on total damages include: Colorado, Indiana, Louisiana, Nebraska, New Mexico and Virginia.

A cap's effectiveness depends on the specific provisions of the legislation. For example, some states have a hard cap on noneconomic damages while others have a soft cap on noneconomic damages. A hard cap, like the \$250,000 cap found in California's MICRA, is not subject to exceptions, does not adjust over time and applies irrespective of the number of defendants or plaintiffs. By contrast, a "soft" cap may be subject to (1) numerous exceptions for various injuries or legal findings, (2) annual increases (e.g., indexed for inflation), (3) increases based on a set schedule, or (4) individual application to every defendant or plaintiff, thereby allowing several caps for a single claim. Recognizing the limitations of a soft cap, several states, such as Alaska, Mississippi and Missouri, have enacted legislation to strengthen their caps. Likewise, Nevada voters adopted a ballot initiative in 2004 to replace a cap riddled with exceptions with a hard cap of \$350,000 on noneconomic damages. A cap on noneconomic damages that is set too high will also have a limited effect. For example, prior to modifying legislation in 2003, West Virginia had a \$1 million cap on noneconomic damages, which was too high to be effective.

State caps on noneconomic damages enacted since 2000

Alaska

In Alaska, Gov. Frank Murkowski signed into law Senate Bill (S.B.) 67 on June 7, 2005. The legislation strengthened Alaska's existing cap on noneconomic damages by establishing a \$250,000 cap on noneconomic damages awarded in a personal injury cause of action, and a \$400,000 cap on noneconomic damages awarded in a cause of action involving wrongful death or a severe permanent physical impairment that is more than 70 percent disabling.⁷⁹ A single cap applies regardless of the number of health care providers against whom the claim is asserted or the number of causes of action filed.

Florida

After four special sessions, Florida's legislature enacted S.B. 2-D, which was signed into law by Gov. Jeb Bush on Aug. 14, 2003. In its final form, the bill did not provide the level of reforms advocated by Gov. Bush's task force or by the Florida Medical Association (FMA). In particular, the language on noneconomic damages and exceptions to the cap added during late stages of negotiations prohibited the FMA from supporting the legislation in its final form.⁸⁰

S.B. 2-D provided a separate cap on noneconomic damages for practitioners and non-practitioners. For practitioners, the cap is \$500,000 per claimant regardless of the number of defendants. For non-practitioners, the cap is \$750,000 per claimant regardless of the number of defendants. The cap can increase to \$1 million for practitioners and \$1.5 million for non-practitioners if the negligence resulted in death or a permanent vegetative state, or if the court finds a manifest injustice would occur if the cap was not increased because the noneconomic harm sustained by the patient was particularly severe, and the defendant's negligence caused a catastrophic injury to the patient.

79. Alaska Stat. § 09.55.549 (2007)

80. Fla. Stat. § 766.118 (2004).

In April 2006 Gov. Bush also signed legislation that repealed the doctrine of joint and several liability, an act that should bring greater equity to the civil justice system by restoring overall predictability. Joint and several liability permits a disproportionate level of liability to be assessed to a party regardless of their level of fault in a matter, such that a defendant can be held liable for the entire amount of damages even if only marginally responsible for an injury.⁸¹

Georgia

On Feb. 16, 2005, Gov. Sonny Purdue signed into law S.B. 3.⁸² As enacted, S.B. 3 created a Texas-style cap on noneconomic damages. The new law established a hard \$350,000 cap on noneconomic damages awarded in a medical liability action, including wrongful death, against all health care providers and a separate \$350,000 cap on noneconomic damages awarded against a single medical facility that can increase to \$700,000 if more than one facility is involved. No more than \$1.05 million can be awarded in a medical liability cause of action. The caps apply to each claimant, but the term “claimant” is defined in the law as including all persons claiming to have sustained damages as a result of the bodily injury or death of a single person. In a controversial ruling, the Georgia Supreme Court ruled in 2010 that the cap was unconstitutional.⁸³

Kansas

On April 17, 2014, Gov. Sam Brownback signed S.B. 311, which will gradually increase the state’s \$250,000 cap to \$350,000 over an eight-year span.⁸⁴

Idaho

On March 26, 2003, Gov. Dirk Kempthorne signed into law House Bill (H.B.) 92 that included a \$250,000 cap on noneconomic damages (Idaho previously had a \$400,000 cap on noneconomic damages that adjusted annually for inflation since 1988). The new cap also adjusts annually for inflation based on the average annual wage as of July 1, 2004. The cap does not apply to causes of action arising out of willful or reckless misconduct or felonious actions.⁸⁵

Illinois

On Aug. 25, 2005, Gov. Rod Blagojevich signed into law an MLR bill that included a \$500,000 cap on noneconomic damages⁸⁶ for awards in a medical liability cause of action (including wrongful death) against a physician, the physician’s business or corporate entity, and the physician’s employees or other health care professionals. The new law also established a separate \$1 million cap on noneconomic damages for awards in a medical liability cause of action (including wrongful death) against a hospital and its personnel or hospital affiliates. Both caps apply to all plaintiffs in any civil action arising out of the care. The caps apply to injuries that occur after the effective date of the act. The Illinois cap was also stricken down in 2010.⁸⁷

Maryland

Enacted in January 2005, Maryland’s H.B. 2 (2004) established a separate cap on noneconomic damages for personal injury and wrongful death suits involving two or more claimants or beneficiaries. Noneconomic damages awarded against a physician for personal injury were capped at \$650,000 until Jan. 1, 2009, after which the cap began to increase \$15,000 each year.⁸⁸ The cap applies in aggregate to all claims and all defendants arising from the same medical injury. (The cap also applies in wrongful death actions if the claim involves only one claimant or beneficiary). For wrongful death claims involving two or more claimants or beneficiaries, the total cap on noneconomic damages is \$812,500 (i.e., 125 percent of the current \$650,000 noneconomic damages cap in personal injury claims).

Mississippi

On June 3, 2004, the Mississippi Legislature enacted H.B. 13, a civil justice reform bill that further strengthened Mississippi’s MLR laws. Most importantly, the bill created a hard \$500,000 cap on noneconomic damages for medical liability causes of action filed against a health care provider. This provision deleted exceptions to the original 2002 law, as well as scheduled increases to the cap.⁸⁹

81. *Gov. Bush Signs Important Fla. Tort Reform Legislation*, Ins J. 2006. insurancejournal.com/news/southeast/2006/04/27/67621.htm. Accessed Nov. 17, 2014.

82. Ga. Code Ann. § 51-13-1 (2007)

83. *Atlanta Oculoplastic Surgery v. Nestlehutt, et al.* 691 S.E.2d 218 (Ga. 2010)

84. Kan. Stat. Ann. 60-19a02 (2014).

85. Idaho Code Ann. § 6-1603 (2004)

86. 735 Ill. Comp. Stat. 5/2-1706.5 (2008)

87. *Lebron v. Gottlieb Mem'l Hosp., et. al.* 930 N.E.2d 895 (Ill. 2010)

88. Md. Code Ann., Cts. & Jud. Proc. § 3-2A-09 (2007)

89. Miss. Code Ann. § 11-1-60 (2007)

Missouri

On May 7, 2015, Gov. Jay Nixon signed into law S.B. 239, which reinstated Missouri's cap on noneconomic damages. With passage of S.B. 239, Missouri now has a statutory \$400,000 cap on noneconomic damages and a higher cap of \$700,000 for catastrophic personal injury or death.⁹⁰ Both are subject to an annual index of 1.7 percent for inflation, and the cap applies irrespective of the number of defendants. The Missouri cap was previously struck down in 2012.⁹¹

Nevada

As a result of the passage of the "Keep Our Doctors in Nevada" initiative in 2004, Nevada has a \$350,000 cap on noneconomic damages in medical liability cases.⁹²

In August 2002, Nevada enacted Assembly Bill (A.B.) 1, which, in part, establishes a \$50,000 cap on civil damages for claims arising from care necessitated by a traumatic event demanding immediate attention that is rendered in good faith to a patient who enters the hospital through the emergency room or trauma center. This limit does not apply to any act or omission in rendering care or assistance that occurs after the patient is stabilized (unless surgery is required within a reasonable time after the patient is stabilized), that is unrelated to the original traumatic injury, or that arose out of gross negligence or reckless, willful or wanton conduct.⁹³

In cases where the physician provides follow-up care to a patient treated in the above circumstances and the patient files a medical liability claim based on a medical condition that arose during follow-up care, there is a rebuttable presumption that the medical condition is the result of the original traumatic injury, and the \$50,000 limit applies.

North Carolina

On July 25, 2011, the North Carolina General Assembly overrode a gubernatorial veto of S.B. 33. S.B. 33 includes a cap on noneconomic damages for medical liability actions (including actions for personal

injury or death), but it does not limit the recovery of economic damages. Under this legislation, the total amount of noneconomic damages that can be awarded against all defendants cannot exceed \$500,000. Further, noneconomic damage awards cannot exceed \$500,000 against individual defendants for all claims brought by all parties arising out of the same professional services. Under the bill, the cap shall be indexed for inflation on Jan. 1 of every third year, beginning with Jan. 1, 2014, and there shall be no limit on the amount of noneconomic damages if the trier of fact finds both of the following:

- The plaintiff suffered disfigurement, loss of use of part of the body, permanent injury or death.
- The defendant's acts or failures, which are the proximate cause of the plaintiff's injuries, were committed in reckless disregard of the rights of others, grossly negligent, fraudulent, intentional or with malice.⁹⁴

Ohio

On Jan. 10, 2003, Gov. Robert Taft signed into law S.B. 281, an MLR bill to address the growing crisis in Ohio. Among other provisions, the bill established a sliding cap on noneconomic damages. The cap is the greater of \$250,000 or three times the plaintiff's economic loss up to a maximum of \$350,000 for each plaintiff or \$500,000 per occurrence. The maximum cap is \$500,000 per plaintiff or \$1,000,000 per occurrence for a claim based on either (1) a permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or (2) a permanent physical functional injury that permanently prevents the injured person from being able to care for oneself independently and perform life-sustaining activities.⁹⁵

Oklahoma

On April 5, 2011, Gov. Mary Fallin signed H.B. 2128. The act established a cap on noneconomic damages in Oklahoma. The act became effective on Nov. 1, 2011, and applies to all civil actions filed on or after this date. Under the bill, in any civil action arising from a claim

90. Mo. Rev. Stat. § 538.210 (2015)

91. *Watts v. Lester E. Cox Med. Ctr.*, 376 S.W.3d 633 (Mo. 2012)

92. Nev. Rev. Stat. § 41A.031 (2004)

93. *Id.* at § 41.503

94. N.C. Gen. Stat. § 90-21.19

95. Ohio Rev. Code Ann. § 2323.43 (2004)

for bodily injury, the amount of compensation that the trier of fact may award a plaintiff for economic loss shall not be subject to any limitation. However, in such actions, a trier of fact may award a plaintiff a maximum of \$350,000 for noneconomic damages, regardless of the number of parties against whom the action is brought or the number of actions brought. There shall be no limit on the amount of noneconomic damages that may be awarded in a claim for bodily injury resulting from negligence if a judge and jury find, by clear and convincing evidence, that the defendant's acts or failures to act were:

- In reckless disregard for the rights of others
- Grossly negligent
- Fraudulent
- Intentional or with malice

The bill does not apply to actions brought under the Governmental Tort Claims Act or to actions for wrongful death.⁹⁶

South Carolina

Signed into law by Gov. Mark Sanford on April 4, 2005, S.B. 83 establishes a \$350,000 cap on noneconomic damages⁹⁷ in a medical liability action against a single health care provider or single health care institution. If the award is against more than one health care provider or more than one institution, the total award for noneconomic damages cannot exceed \$1.05 million, with each defendant not liable for more than \$350,000. The cap applies separately to each claimant and adjusts annually based on an increase or decrease in the Consumer Price Index.

Tennessee

On June 16, 2011, Gov. Bill Haslam signed the Tennessee Civil Justice Act of 2011 (H.B. 2008/S.B. 1522). The bill establishes a \$750,000 limit on compensation for noneconomic damages for all injuries and occurrences in a civil action, including health care liability actions. The limit on noneconomic damages applies regardless if the action is based on a single act or

omission or on a series of acts or omissions. The limit on compensation for noneconomic damages may increase to \$1 million in cases of catastrophic loss or injury, which may include:

- Spinal cord injuries resulting in paraplegia or quadriplegia
- Amputation of two hands or two feet or one of each
- Third-degree burns covering 40 percent of the body or the face
- Wrongful death of a parent with a minor child(ren)

The limit shall not apply to personal injury or wrongful death cases when one of the following conditions is met:

- The defendant had a specific intent to inflict serious physical injury
- The defendant intentionally falsified, destroyed or concealed records containing material evidence for the purpose of evading liability in the claim
- The defendant was under the influence of alcohol, drugs or other intoxicant or stimulant resulting in substantial impairment and causing the injury or death⁹⁸

Texas

On June 11, 2003, Gov. Rick Perry signed H.B. 4 into law. The bill contains sweeping tort reforms, many of which exclusively address medical liability litigation against physicians. Of these reforms, perhaps the most important is the hard cap of \$250,000 on noneconomic damages per claimant in any judgment against a physician or health care provider, regardless of any applicable theories of vicarious liability, the number of defendants involved or the number of causes of action asserted as part of the claimant's case against the physician. The law also places a hard cap of \$250,000 on noneconomic damages per claimant in any judgment against a health care institution in a medical liability cause of action. A judgment against two health care institutions may not exceed \$500,000 in noneconomic damages, with each institution not liable for more than \$250,000 in noneconomic damages.⁹⁹ All persons

96. Oklahoma House Bill 2128 (2011)

97. S.C. Code Ann. § 15-32-220 (2006)

98. Tenn. Code Ann. § 29-39-102

99. Tex. Civ. Prac. & Rem. Code Ann. § 74.301 (2004)

claiming to have sustained damages as a result of the bodily injury or death of a single person are considered a single claimant.

The law states that the cap on noneconomic damages applies per “claimant,” which is defined as “a person, including a decedent’s estate, seeking or who has sought recovery of damages” in a medical liability claim. The law also states the cap applies regardless of the number of defendants or causes of action asserted.

The caps provision states as follows: “(a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages of the physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based, (b) in an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant, (c) in an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution is, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$500,000 for each claimant.”

On Sept. 13, 2003, the people of Texas approved Proposition 12, a ballot initiative to amend the state

constitution to specifically allow the legislature to enact laws that place limits on noneconomic damages in medical and health liability cases.¹⁰⁰ The final vote was 51.12 percent in favor of Proposition 12 and 48.88 percent against.¹⁰¹

Utah

On March 23, 2010, Gov. Gary Herbert signed S.B. 145, which contains three amendments to Utah’s Health Care Malpractice Act.¹⁰² The amendments include a \$450,000 hard cap on noneconomic damages. Under the bill, in a liability action against a health care provider, an injured plaintiff may recover noneconomic losses to compensate for pain, suffering and inconvenience. The amount of damages awarded for noneconomic loss may not exceed \$450,000 for causes of action arising on or after May 15, 2010. The previous, inflation-adjusted cap will stay in effect for causes of action arising between July 1, 2002, and May 14, 2010.

West Virginia

On March 11, 2003, West Virginia Gov. Bob Wise signed into law H.B. 2122. As enacted, the bill contained a number of reforms including a \$250,000 cap on noneconomic damages applied per occurrence regardless of the number of defendants or plaintiffs. The cap increases to \$500,000 per occurrence for cases involving a permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system, or permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life-sustaining activities. The cap will be adjusted annually for inflation up to \$375,000 per occurrence or \$750,000 for injuries that fall within the exception.¹⁰³

The bill also included a \$500,000 cap on civil damages for any injury to or death of a patient as a result

100. A tribute to the effectiveness of Proposition 12 came soon after its passing when personal injury trial attorney and member of the Oklahoma legislature Stratton Taylor sent a letter to his ATLA colleagues in Texas to offer the services of his firm to any Texas attorney wishing to forum-shop and file suit in Oklahoma—where there are still no caps. Editorial, *Oklahomal*, *The Wall St. J.*, Dec. 19, 2003.

101. *Tex. Const. Art. III, § 66*

102. *Utah Code Ann. § 78B-3-410 (2010)*

103. *W. Va. Code § 55-7B-8 (2004)*

of health care services rendered in good faith and necessitated by an emergency condition for which the patient enters a health care facility designated as a trauma center. This limit also applies in the following circumstances: (1) to health care services rendered by a licensed emergency medical services (EMS) agency or employee of a licensed EMS agency, or (2) any act or omission of a health care provider in rendering continued care or assistance in the event that surgery is required as a result of the patient's emergency condition.

This limit does not apply if the care is rendered in willful and wanton or reckless disregard of a risk of harm to the patient or in clear violation of established written protocols for triage and emergency health care procedures developed by the Office of Emergency Medical Services. Likewise, the limit does not apply to any act or omission in rendering care that occurs after the patient has been stabilized and is considered a non-emergency patient or care that is unrelated to the original emergency condition.

If the physician who provided care to the patient when the patient was presented with an emergency condition provides follow-up care to the same patient and a medical condition arises during the course of this follow-up care that is directly related to the original emergency condition, there is a rebuttable presumption that the medical condition was the result of the original emergency condition and, therefore, the cap applies. There is also a rebuttable presumption that a medical condition that arises in the course of follow-up care provided by a health care provider in the trauma center is directly related to the original emergency condition, where the follow-up care is provided within a reasonable time after the patient's admission to the trauma center.¹⁰⁴

Wisconsin

On March 22, 2006, Gov. Jim Doyle signed A.B. 1073. This bill limits noneconomic damages in medical liability cases to \$750,000¹⁰⁵ for each occurrence. The bill covers all health care providers acting within the scope of their employment and providing health care

services. The bill does not place a limit on the recovery of economic losses, such as lost wages and medical costs. A.B. 1073 came in response to a Supreme Court of Wisconsin decision in 2005 that struck down the state's previous cap on noneconomic damages.¹⁰⁶ The current cap has not yet faced judicial scrutiny.

Results from the states

California's solution: MICRA

In 1975 California enacted the Medical Injury Compensation Reform Act (MICRA), which largely eliminates the lottery aspect of medical liability litigation in that state.¹⁰⁷ California's experience with MICRA shows that MLR works. MICRA has been held up as "the gold standard" of MLR and a model for repeated attempts at federal reform legislation. A study by the RAND Corp. showed that MICRA was successful at decreasing insurer payouts and redistributing money from trial lawyers to injured patients. MICRA's contingency fee reform and limit on noneconomic damages caused plaintiff attorney fees to be reduced 60 percent while net recoveries to patients and their families were only reduced 15 percent.¹⁰⁸ According to the National Association of Insurance Commissioners, while total premiums in the rest of the United States rose 873 percent between 1976 and 2012, the increase in California premiums was less than one-third of that amount (241 percent).¹⁰⁹

According to HHS, "The percentage of claims resolved through settlement and arbitration has increased in California, saving money for injured patients,"¹¹⁰ and "premiums for specialists in Los Angeles are substantially less than for specialists in metropolitan areas in states without reforms such as Florida, Illinois and Nevada."¹¹¹ For example, an obstetrician/

104. *Id.* at § 55-7B-9C

105. Wis. Stat. § 893.55 (2007)

106. *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440 (Wis. 2005).

107. Cal. Civ. Code § 3333.2 (2004).

108. Pace NM, Golinelli D, Zakaras L. *Capping Noneconomic Awards in Medical Malpractice Trials* xxiv. RAND Corp.: 2004.

109. National Association of Insurance Commissioners. *Profitability by line by State in 2012*. National Association of Insurance Commissioners, Insurance Products & Services Division; 2013. Statistics presented in *MLR—Now!* have been derived from this and previous versions of the report dating back to 1975.

110. Office of the Assistant Sec'y for Planning and Evaluation. *Update on the Medical Litigation Crisis: Not the Result of the "Insurance Cycle."* Office of the Assistant Sec'y for Planning and Evaluation, U.S. Dep't of Health and Human Services; 2002. [hereinafter *Insurance Cycle*]

111. *Id.*

gynecologist in Los Angeles might pay \$49,804 per year for liability insurance while the same obstetrician/gynecologist could pay \$186,772 in New York.¹¹²

Illinois

In 2010 the Illinois Supreme Court ruled that the state's cap on noneconomic damages was unconstitutional.¹¹³ This was a highly disappointing decision based on the positive results stemming from the 2005 law. According to the Illinois Department of Insurance, the state saw these results after the 2005 law:

- A decrease in medical malpractice premiums—gross premium paid to medical malpractice insurers declined from \$606,355,892 in 2005 to \$541,278,548 in 2008
- An increase in competition among companies offering medical malpractice insurance—in 2008, 19 companies offering coverage to physicians/surgeons each collected more than \$500,000 in premiums, an increase over 14 such companies in 2005
- The entry into Illinois of new companies offering medical malpractice insurance—in 2008, five companies collected more than \$22,000,000 in combined physicians/surgeons premiums (and at least \$1,000,000 each in premiums)—that did not offer medical malpractice insurance in 2005¹¹⁴

According to Milliman Inc., Illinois medical liability carriers will face an 18 percent jump in costs based on this ruling.¹¹⁵

Mississippi

In Mississippi, the Mississippi State Medical Association reports that the liability climate has improved significantly since the enactment of MLR. Liability premiums decreased for the largest liability carrier by 5 percent in 2006, 10 percent in 2007, 15.5 percent in 2008, 20 percent in 2009 and 10 percent in 2010. Insured physicians also received significant refunds

during this time period as well. This is in stark contrast to the crisis years when premiums increased 12.5 percent in 2000, 11.1 percent in 2001, 10 percent in 2002, 45 percent in 2003 and 19.4 percent in 2004.¹¹⁶

An article based on data from the Medical Assurance Company of Mississippi (MACM) also shows that the Mississippi reforms have had a beneficial impact. It concluded that the average number of lawsuits per year against MACM-insured physicians dropped 277 percent (from 318 to 140) from the five-year period that preceded the reforms to the five-year period that followed them.¹¹⁷

Missouri

According to the Missouri State Medical Association, since 2005 when Missouri's new MLR provisions went into effect:

- The number of claims filed has fallen 61.6 percent (67.2 percent in the physician sector).
- The number of claims open at year end fell 47.1 percent (48.2 percent for physicians).
- The average indemnity fell 22.1 percent.
- The insurance industry's total losses fell 31.9 percent, and incurred losses fell 69.9 percent.
- Defense expenses fell 54.2 percent.
- In the three years leading up to tort reform, Missouri lost 225 physicians. Since the first full year of MLR, the state has added 486 new licensed physicians.
- One new mutual company and two new stock companies have entered the Missouri market since MLR was enacted.
- Medical Liability Alliance announced a 6 percent across-the-board rate reduction in July 2007; PPIA implemented a 14 percent reduction in base rates effective Jan. 1, 2008, and some stock companies are offering as much as 50 percent in credits over their filed rates in some instances.
- Despite gaining nearly 500 physicians, Missouri saw a \$13-million decrease in medical liability insurance premiums between 2006 and 2008. And for all health care providers, the reduction was \$25.7 million.¹¹⁸

112. *Medical Liability Monitor* (October 2010) Note: California – \$1 million/\$3 million limits; New York – \$1.3 million/\$3.9 million limits.

113. *Lebron v. Gottlieb Mem'l Hosp., et. al.* 930 N.E.2d 895 (Ill. 2010).

114. Illinois Department of Insurance—Press Release Feb. 20, 2010.

115. Illinois Med-Mal Ruling to Boost Insurers' Costs 18%. *Crain's*. Feb. 22, 2010. chicagobusiness.com/article/20100222/NEWS03/200037194/illinois-med-mal-ruling-to-boost-insurers-costs-18-study. Accessed Nov. 17, 2014.

116. Mississippi State Medical Association Correspondence – 2010.

117. Behrens MA. Medical Liability Reform: A Case Study of Mississippi. *Obstet Gynecol.* 2011;118(2):335–339.

118. Missouri State Medical Association Correspondence – 2010

Nevada

Nevada reforms have stabilized Nevada's liability climate. One example is the Independent Nevada Doctors Insurance Exchange, which lowered its premiums for internists and surgeons by more than 20 percent in 2007.¹¹⁹ Rates have held steady since this decrease.

Ohio

In Ohio the good news continues regarding MLR after a comprehensive MLR package was enacted in 2003. A study of 2011 medical professional liability claims found that:

- Medical liability lawsuits in the state are down 41 percent since 2005
- Since 2006 premium rates have decreased 31 percent
- Ohio now has 15 liability carriers in 2011—an increase from five in 2003¹²⁰

In addition, 75 percent of the claims closed in Ohio in 2011 were closed without payment.¹²¹

Texas

The liability climate in Texas has improved dramatically since the passage of Proposition 12 and the state's 2003 landmark liability reforms. According to the Texas Medical Association:¹²²

- The Texas physician work force has outpaced population growth every year since 2007.
- Overall, Texas has enjoyed a 61 percent greater growth rate in newly licensed physicians in the past four years compared to the four years preceding reforms.
- Since 2003, Texas has added nearly 5,800 more physicians with in-state licenses than can be accounted for by population growth.
- The ranks of high-risk specialists have grown more than twice as fast as the state's population.
- Pediatric sub-specialists have grown 10 times faster than the state's population.

- The number of geriatricians has more than doubled.
- The ranks of rural obstetricians have grown nearly three times faster than the state's rural population.
- Since 2003, 35 rural Texas counties have added at least one obstetrician, including 16 counties that previously had none.
- Forty-six counties that did not have an emergency medicine physician now do. Thirty-nine of those counties are rural.
- Fifteen counties that did not have a cardiologist now do. Fourteen of those counties are rural.
- Texas doctors have received, on average, a 46 percent reduction in their liability premiums since 2003, resulting in \$1.9 billion in reduced premiums. Premium reductions include both rate cuts and dividends.
- Since the passage of reforms, four rate-regulated carriers have entered the Texas market. Thirty-eight risk retention groups, captives, surplus lines and other unregulated insurers have entered the market.
- Most Texas counties have seen a 50 percent or greater drop in medical liability lawsuits.

An article based on data from an academic medical center also shows that the Texas tort reforms have had a beneficial impact. According to that data, the prevalence of lawsuits filed per 100,000 general surgery procedures decreased from 40 before reform to eight after reform. Liability and defense costs per year in the general surgery group were reported to have fallen from \$595,000 per year before tort reform to only \$515 per year after tort reform.¹²³

Some groups have voiced concerns that caps on noneconomic damages have had a disproportionate effect on the elderly. A 2011 working paper by researchers typically opposed to tort reform finds that is not the case. Based on Texas closed claim data, the authors conclude that after 2003, there was a similar drop in claims and payouts per claim for elderly and non-elderly adults.¹²⁴

119. *Medical Liability Monitor*. Rate Survey Edition. October 2007.

120. Ohio Department of Insurance. Ohio 2011 Medical Professional Liability Closed Claim Report. insurance.ohio.gov/Legal/Reports/Documents/2011ClosedClaimReport.pdf. Accessed Nov. 19, 2014.

121. *Id.*

122. Texas Medical Association. Proposition 12 Produces Healthy Benefits. texmed.org/tortreform. Accessed Nov. 17, 2014.

123. Stewart RM, Geohegan K, Myers JG. Malpractice Risk and Cost Are Significantly Reduced after Tort Reform, 212. *J Am Coll Surg*. 2011;212:463–467.

124. Paik M. *How Do the Elderly Fare in Medical Malpractice Litigation, Before and After Tort Reform? Evidence from Texas, 1988–2007*. Institute for Policy Research Northwestern University, Working Paper Series WP-11-03. ipr.northwestern.edu/publications/papers/2011/ipr-wp-11-03.html. Accessed Nov. 17, 2014.

West Virginia

Results have been positive for West Virginia physicians since the reforms were enacted, too. According to the West Virginia Offices of the Insurance Commissioner, as award values became more predictable and claims dropped, insurance rates have declined.¹²⁵ The average premium dropped from \$40,034 in 2004 to \$24,959 in 2011.¹²⁶ Further, the state has seen an increase in the number of licensed physicians from 5,182 in 2003 to 6,282 in 2013.¹²⁷

Successful ballot initiatives

In addition to Texas, three other states—Florida, Nevada and Wyoming—had successful ballot initiatives related to MLR that went before voters in the November 2004 elections. In addition, California successfully defeated a ballot initiative intended to raise the state’s cap on noneconomic damages. The following is a summary of these initiatives and what voters decided.

California

On Nov. 4, 2014, California voters rejected Proposition 46, an initiative that threatened to raise MICRA’s noneconomic damage cap to \$1.1 million with annual automatic increases. The measure, if passed, also would have called for physicians to:¹²⁸

- Check a prescription drug tracking database before prescribing controlled substances
- Undergo random drug and alcohol testing
- Undergo mandatory drug and alcohol testing after an unexpected death or injury occurs
- Report any witnessed medical negligence or substance misuse by other physicians
- Be automatically suspended if they test positive for alcohol or drugs while on duty

In addition, hospitals would have been required to report any positive drug or alcohol test results to the state medical board.

125. West Virginia Offices of the Insurance Commissioner. *State of West Virginia, Medical Malpractice Report Insurers with 5% Market Share*. 2012. wvinsurance.gov/Portals/0/2012%20Med%20Malpractice%20Report%20on%20Insurers%20with%20over%205%25%20market%20share.pdf. Accessed Nov. 17, 2014.

126. *Id.*

127. West Virginia Board of Medicine. wvbom.wv.gov/activity.asp. Accessed Nov. 17, 2014.

128. California Secretary of State, California General Election Propositions. voterguide.sos.ca.gov/en/propositions/46. Accessed Nov. 17, 2014.

California voters voted down Proposition 46 by a nearly 2-to-1 margin, with more than 61 percent of voters casting a ballot against the initiative.¹²⁹ The measure was defeated in every county in the state.¹³⁰

Florida

Voters approved constitutional Amendment 3, stating that an injured claimant who enters into a contingency-fee agreement with an attorney for a medical liability claim is entitled to no less than 70 percent of the first \$250,000 and 90 percent of any damage award over \$250,000.¹³¹ Subsequently, the Florida Supreme Court issued a rule that permits patients to waive this requirement.¹³²

Voters also approved two amendments sponsored by trial attorneys. One of them, Amendment 7, gives the public access to any records made or received by a health care provider or facility related to an adverse medical incident.¹³³ The Florida Legislature attempted to permit only prospective access to records,¹³⁴ but the Florida Supreme Court ruled that access is granted retroactively.¹³⁵

The other, Amendment 8, denies licensure to a physician who has been “found to have committed” three or more incidents of medical liability.¹³⁶ The language “found to have committed” means a finding of a physician’s medical liability by either: (1) a final judgment of a court; (2) a final administrative agency decision; or (3) a decision resulting from binding arbitration. “Found to have committed” does not, therefore, include settlements of medical liability claims. Nor does it include a report to a medical liability insurance carrier that a claim has, or will be, filed. Further, such qualifying incidents must be proven by clear and convincing evidence.¹³⁷

129. California Secretary of State, State Ballot Measures By County. <http://elections.cdn.sos.ca.gov/sow/2014-general/pdf/88-ballot-measures.pdf>. Accessed Nov. 17, 2014.

130. *Id.*

131. Fla. Const. Art. I, § 26

132. Fla. Bar Reg. R. 4-1.5

133. Fla. Const. Art. X, § 25

134. Fla. Stat. § 381.028 (2005)

135. *Fla. Hosp. Waterman, Inc. v. Buster*, 984 So.2d 478. (Fla. 2008).

136. Fla. Const. Art. X, § 26

137. Fla. Stat. § 456.50 (2010)

Nevada

Voters approved the “Keep our Doctors in Nevada” initiative (Question 3), which amended Nevada’s MLR statute to include MICRA-style reforms.¹³⁸ The approved initiative amended Nevada’s existing MLR statute by: (1) deleting the current exceptions to Nevada’s \$350,000 cap on noneconomic damages in medical liability cases; (2) strengthening the existing joint and several liability reform law by applying it to both economic and noneconomic damages; (3) requiring periodic payment of future damages over \$50,000 at the request of either party; (4) placing limits on attorney contingency fees; and (5) strengthening Nevada’s existing statute of limitations.

Voters also defeated two ballot initiatives (Questions 4 and 5) sponsored by trial lawyers. Question 4 called for auto, homeowner and medical liability insurers to roll back their rates to the amount charged on Dec. 1, 2005, and reduce them an additional 20 percent. Question 5 focused on frivolous lawsuits. If approved, both measures would have invalidated any reforms enacted by the legislature or voters, including Question 3.

Wyoming

In Wyoming voters approved one constitutional amendment¹³⁹ and defeated another. The approved amendment, Amendment C, allows the legislature to pass laws creating medical screening panels or other alternative dispute resolution systems in medical liability cases. Amendment D, which was defeated, would have allowed the legislature to enact a cap on noneconomic damages in medical liability cases. Wyoming is currently one of five states where the state constitution explicitly prohibits the legislature from enacting limits on damages.¹⁴⁰

Both amendments were previously passed by the legislature during a special session in July 2004. For a constitutional amendment to pass in Wyoming, it requires a simple majority of votes cast in the general election. But voters who do not cast a vote either way

for an amendment are counted as “no” votes. This means an amendment sometimes will fail even if it receives more than half the votes cast on that ballot question.

Federal efforts on liability reform

While stakeholders are attempting to address the medical liability crisis at the state level, a federal solution is also needed. Many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions that limit reform. The following outlines the most recent federal efforts to achieve national liability reform.

Activities in the 114th Congress

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015, permanently repealing the Medicare sustainable growth rate (SGR) formula. MACRA incorporates the Standard of Care Protection Act, which prohibits federal quality program standards and performance metrics from establishing a “standard of care” in medical liability actions. The AMA strongly supported this language and its inclusion in the SGR repeal legislation and is pleased that this MLR effort garnered bipartisan support and was enacted into law.

The AMA has also endorsed and continues to monitor the Sports Medicine Licensure Clarity Act. Passage of this legislation would ensure that athletic trainers are covered by their liability insurance when they provide care services to their team while traveling. On Feb. 12, 2015, Reps. Brett Guthrie (R-Ky.), Cedric Richmond (D-La.), and Steve Womack (R-Ark.) introduced this legislation as H.R. 921 to protect sport medicine professionals when they travel with their teams or athletes and provide care in another state. They have since obtained 103 additional co-sponsors in the House. On March 10, 2015, Sens. John Thune (R-S. Dak.) and

138. Nev. Rev. Stat. Ann. § 41A.035 (2004)

139. Wyo. Const. Art. 10, § 4 (2007)

140. *Id.*

Amy Klobuchar (D-Minn.) introduced a companion bill in the Senate as S. 689 and have since been joined by six additional co-sponsors.

In addition, the AMA has supported the Good Samaritan Health Professionals Act. Under this bill's protections, health care professionals who volunteer during a federally declared disaster would be protected from liability exposure. Rep. Marsha Blackburn (R-Tenn.) and 10 co-sponsors re-introduced this bill on Feb. 11, 2015, as H.R. 865. Twenty-five additional co-sponsors have since signed on. Despite bipartisan support, the bill has not yet been re-introduced in the Senate. However, in October 2015, H.R. 865 was incorporated into a larger legislative package introduced in the House.

On Oct. 7, 2015, Sens. Thune and Robert Casey (D-Pa.) introduced the Family Health Care Accessibility Act legislation as S. 2151. This bill would provide Federal Tort Claims Act (FTCA) medical malpractice coverage to all qualified health care professionals who volunteer at community health centers—or through offsite programs or events carried out by such centers—by deeming them employees of the Public Health Service. Two additional co-sponsors have since signed on. This legislation would extend the Patient Protection and Affordable Care Act's (ACA's) provision of FTCA coverage to officers, governing board members, employees and contractors of free clinics to also apply to volunteers sponsored by these clinics.

The AMA continues to assist House and Senate members considering revisions to the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2011. The HEALTH Act contained the most comprehensive liability reform package at the federal level, which was based off of California state liability protections. While looking for new sponsors, the AMA is simultaneously working to update the legislation and address previous concerns so that it garners more support.

Activities in the 113th Congress

Congressional efforts to address the debt, deficit and the SGR spurred discussions about enacting federal liability reform in 2013–2014. The AMA strongly advocated for the inclusion of MLR legislation, promoting the significant cost savings associated with these reforms.

Promising legislation considered by the 113th Congress and supported by the AMA included the Standard of Care Protection Act, previously known as the Provider Shield Act. This legislation received bi-cameral support, introduced in the House by Rep. Phil Gingrey, MD, (R-Ga.) as H.R. 1473, and in the Senate by Sen. Pat Toomey (R-Pa.) as S. 1769. The bill's protections would shield health care providers from new liability exposure based on quality standards or practice guidelines enacted under the ACA, Medicare or Medicaid. The law clarifies that these provisions do not establish a standard of care or duty owed by a health care provider in any medical malpractice case. Importantly, this legislation was included in the SGR replacement legislation that received bi-partisan support and was signed into law on April 16, 2015.

There was also interest on Capitol Hill to support federal legislation that would limit the liability of health care professionals who volunteer to provide health care services during a federally declared disaster. The Good Samaritan Health Professional Act (S.2196/H.R. 1733) generated support from both Houses; however, the bill was not incorporated into any larger legislative package in the 113th Congress.

In addition, the AMA endorsed bi-cameral legislation aimed at protecting sport medicine professionals, S. 2220/H.R. 3722. Passage of this bill would ensure that athletic trainers are covered by their liability insurance when they provide care services to their team while traveling to another state. The AMA has continued to work with the new Congress to re-introduce this bill and garner more support to promote its passage.

Congressional members in both the House and Senate also considered the HEALTH Act. This legislation, which is supported by the AMA and has been

introduced in previous Congresses, is modeled after the successful California MICRA statute. In particular the bill would support federal legislation based on proven MLR laws already working in states such as California and Texas to reduce health care costs and keep physicians caring for patients.

These reforms include:

- Limit noneconomic damages to \$250,000
- Set a statute of limitations of three years after the date of manifestation of injury or one year after the claimant discovers the injury, with certain exceptions
- Make each party liable only for the amount of damages directly proportional to such party's percentage of responsibility
- Allow the court to restrict the payment of attorney contingency fees
- Allow the introduction of collateral source benefits and the amount paid to secure such benefits as evidence
- Authorize the award of punitive damages only where: (1) it is proven by clear and convincing evidence that a person acted with malicious intent to injure the claimant or deliberately failed to avoid unnecessary injury that the claimant was substantially certain to suffer; and (2) compensatory damages are awarded
- Provide for periodic payments of future damage awards
- Allow states to keep/adopt greater procedural or substantive protections for physicians, and protect current and future state laws that limit damages

The AMA also supports federal funding of pilot projects for innovative proposals—including early disclosure and compensation programs, health courts and safe harbors for the practice of evidence-based medicine—to gauge whether these concepts will improve the nation's flawed medical liability system. (For more information see the "Federal grants" section of this document.) Specifically, the concept of adopting evidence-based medicine (EBM) guidelines as liability safe harbors has garnered increased attention from federal lawmakers. Congressmen Andy Barr (R-Ky.) and Ami Bera, MD, (D-Ca.) have drafted the Saving Lives, Saving Costs Act, H.R. 4106, which would enact federal safe harbor guidelines that would serve to protect against certain

malpractice claims. The AMA has worked with both Congressmen as they plan to re-draft this legislation and introduce it in the 114th Congress, and will specifically urge that these innovative reforms first be tested as pilot programs or demonstrations before being implemented more broadly.

Activities in the 112th Congress

As the 112th Congress convened in 2011, the AMA immediately pressed for meaningful MLR and advocated for the following: the re-introduction and advancement of comprehensive federal MLR legislation like the HEALTH Act; the appropriation of \$50 million for additional grants to states to test alternative liability reform models; and an amendment to the ACA to indicate that any guideline or standard of care in the new law cannot be used against a physician in a liability claim or lawsuit.

On Jan. 21, 2011, AMA Board of Trustees Chair, Ardis D. Hoven, MD, testified before the U.S. House Judiciary Committee during its first hearing of the year entitled "Medical liability reform: Cutting costs, spurring investment, creating jobs." Dr. Hoven spoke to the need for federal reforms given that the nation's medical liability system has become increasingly irrational and driven by time consuming litigation and open-ended, noneconomic damage awards that bring instability to the liability insurance market. In addition, she urged Congress to enact effective liability reforms based on California's MICRA laws and Texas reforms.

On Jan. 24, 2011, Phil Gingrey, MD, (R-Ga.), Rep. David Scott (D-Ga.) and Rep. Lamar Smith (R-Texas) introduced H.R. 5 (the HEALTH Act of 2011), which includes liability reforms similar to California's MICRA and is described in more detail under the section for the 113th Congress.

The HEALTH Act of 2011 also includes provisions that protect existing and future state liability reforms, including caps on damages. The AMA issued a strong letter of support for the bill and signed on to a letter along with 99 state and specialty medical societies

commending the sponsors for introducing the HEALTH Act of 2011. In May 2011, Sen. Mark Kirk (R-Ill.) and Sen. Roy Blunt (R-Mo.) introduced S. 1099, the Senate companion bill of the HEALTH Act of 2011.

On Jan. 26, 2011, Sen. John Ensign (R-Nev.) introduced S. 197 (the Medical Care Access Protection Act of 2011). This bill includes proven reform provisions that would:

- Set a statute of limitations of three years after the date of manifestation of injury or one year after the claimant discovers the injury, with certain exceptions
- Require sanctions for the filing of meritless lawsuits
- Limit noneconomic damages to \$250,000 from the provider or health care institution, but no more than \$500,000 from multiple health care institutions
- Make each party liable only for the amount of damages directly proportional to such party's percentage of responsibility
- Allow restriction of the payment of attorney contingency fees; limit the fees to a decreasing percentage based on the increasing value of the amount awarded
- Prescribe qualifications for expert witnesses
- Allow awards of punitive damages only where: (1) it is proven by clear and convincing evidence that a person acted with malicious intent to injure the claimant or deliberately failed to avoid unnecessary injury that the claimant was substantially certain to suffer; and (2) compensatory damages are awarded; limit punitive damages to the greater of two times the amount of economic damages or \$250,000
- Prohibit a health care provider from being named as a party in a product liability or class action lawsuit for prescribing or dispensing an FDA-approved prescription drug, biological product or medical device for an approved indication
- Provide for periodic payments of future damage awards

On Feb. 18, 2011, Dr. Gingrey introduced H.R. 816 (the Provider Shield Act of 2011), which shields health care providers from new liability exposure from national care and practice standards while preserving state



medical and product liability laws. On March 3, 2011, the AMA issued a letter of support for the bill, which improves the ACA and other statutes by providing needed legal protections to physicians for using standards, guidelines and/or their clinical judgment to meet their patient's particular care and needs.

On Oct. 3, 2011, the AMA urged the Joint Select Committee on Deficit Reduction to include liability reforms in the deficit reduction legislation given that a package of reforms, including caps on noneconomic damages, has been estimated by the Congressional Budget Office to reduce the federal budget deficit by \$62.4 billion over 10 years. A total of 98 state and specialty medical societies joined the AMA in asking the committee members to include meaningful liability reforms in their final legislative package.

On Dec. 7, 2011, Rep. Cliff Stearns (R-Fla.) introduced H.R. 3586 (the Good Samaritan Health Professionals Act of 2011). This federal bill provides liability protections to health professionals, including physicians, who volunteer to help victims of federally declared disasters. On Jan. 3, 2012, the AMA issued a letter of support for the Good Samaritan Health Professionals Act.

On March 22, 2012, the full House of Representatives considered and passed H.R. 5 (the HEALTH Act), renamed the Protecting Access to Healthcare Act. During floor consideration, four amendments to H.R. 5 were adopted that would: repeal the Independent Payment Advisory Board, extend the Federal Tort

Claims Act protections to emergency care, restore the application of antitrust laws to the business of health insurance by amending the McCarran-Ferguson Act, and grant limited civil liability protection to health care professionals who volunteer at federally declared disaster sites.

On April 25, 2012, both the House Judiciary and Energy and Commerce Committees passed the Protecting Access to Healthcare Act as part of the budget reconciliation process. The full House of Representatives passed its budget reconciliation bill, H.R. 5652 (the Sequester Replacement Reconciliation Act of 2012), which included the Protecting Access to Healthcare Act, on May 10, 2012.

Judicial activity

The courts in the following states have upheld caps on noneconomic damages statutes: Alaska, California, Colorado, Idaho, Indiana, Kansas, Maryland, Michigan, Minnesota, Missouri, Ohio, Oregon, Texas, Utah and West Virginia.¹⁴¹ Courts in Indiana, Louisiana, Nebraska, New Mexico and Virginia upheld caps that encompass both economic and noneconomic damages.¹⁴²

Courts in the following states struck down caps on damages: Alabama, Georgia, Illinois, Kansas, Missouri, New Hampshire, North Dakota, Oklahoma, Oregon,

Washington and Wisconsin.¹⁴³ In Florida caps were struck down in part.¹⁴⁴ More details on recent cases follow.

Recent rulings

California

On Sept. 1, 2011, California's Fifth District Court of Appeal upheld MICRA's \$250,000 cap on noneconomic damages (*Stinnett v. Tam*). The court rejected claims by the appellant that MICRA was unconstitutional based on equal protection grounds. It also denied the appellant's claim that MICRA violated her right to a jury trial. Appellant argued unsuccessfully that improvements in California's medical liability climate negated the need for MICRA's cap on noneconomic damages.¹⁴⁵

On Sept. 23, 2013, the Second Appellate District similarly rejected constitutional claims of violation of the right to a jury trial, equal protection and separation of powers.¹⁴⁶ The court said that the plaintiff's argument that the MICRA cap should be indexed for inflation "should be directed to the legislature."

On Aug. 22, 2014, the Fourth Appellate District, in an unpublished decision, upheld MICRA against a claim that it violated the right of trial by jury, equal protection of the laws and separation of powers.¹⁴⁷

On June 9, 2015, the First Appellate District upheld MICRA against a claim that violated the right of due process, trial by jury and equal protection of the law. In connection with the equal protection argument, the court rejected the assertion that circumstances had changed since enactment of MICRA. It observed, "generally, modification or repeal of a statute made

141. See *Smith v. Botsford*, 419 F.3d 513 (6th Cir. 2005); *Evans v. State*, 56 P.3d 1046 (Alaska 2002); *Hoffman v. U.S.*, 767 F.2d 1431 (9th Cir. 1985); *Fein v. Permanente*, 695 P.2d 665 (Cal. 1985); *Stinnett v. Tam*, 130 Cal.Rptr.3d 732 (Cal. Ct. App. 2011); *Hughes v. Pham*, No. E052469, LEXIS (Cal. App. Aug. 22, 2014); *Scholz v. Metro. Pathologists P.C.*, 851 P.2d 901 (Colo. 1993); *Kirkland v. Blaine County Med. Ctr.*, 4 P.3d 1115 (Idaho 2002); *Plank v. Comm. Hosp. of Indiana, et al.*, 981 N.E.2d 49 (Ind. 2013); *Samsel v. Wheeler Transp. Serv.*, 789 P.2d 541 (Kan. 1990); *Miller v. Johnson*, 289 P.3d 1098 (Kan. 2012); *Murphy v. Edmunds*, 601 A.2d 102 (Md. 1992); *DRD Pool Serv. v. Freed*, 5 A.3d 45 (Md. 2010); *Zdrojewski v. Murphy*, 657 N.W.2d 721 (Mich. Ct. App. 2002); *Schweich, et al. v. Ziegler*, 463 N.W.2d 722 (Minn. 1990); *Adams v. Children's Mercy Hosp.*, 848 S.W.2d 535 (Mo. Ct. App. 1993); *Arbino v. Johnson & Johnson*, 880 N.E.2d 420 (Ohio 2007); *Hughes v. PeaceHealth*, 178 P.3d 225 (Or. 2008); *Watson v. Hortman, et al.*, 844 F.Supp.2d 795 (E.D. Texas 2012); *Judd v. Drezga*, 103 P.3d 135 (Utah 2004); *Robinson v. Charleston Area Med. Ctr.*, 414 S.E.2d 877 (W. Va. 1991); *MacDonald v. City Hospital*, 715 S.E.2d 405 (W. Va. 2011); *Verba v. Ghaphery*, 552 S.E.2d (W. Va. 2001).

142. *Johnson v. St. Vincent Hosp.*, 404 N.E.2d 585 (Ind. 1980); *Johnson v. St. Vincent Hosp.*, 404 N.E.2d 585 (Ind. 1980); *Arrington v. Galen-Med*, 947 So.2d 724 (La. 2007); *Oliver v. Magnolia Clinic, et al.*, 85 So.3d 39 (La. 2012); *Prendergast v. Nelson*, 256 N.W.2d 657 (Neb. 1977); *Gourley ex. rel. Gourley v. Neb. Methodist Health Sys.*, 633 N.W.2d 43 (Neb. 2003); *Fed. Express Corp. v. U.S.*, 228 F. Supp. 2d 1267 (N.M. 2002); and *Etheridge, et al. v. Med. Ctr. Hosp.*, 367 S.E.2d 525 (Va. 1989).

143. See *Moore v. Mobile Infirmary Ass'n*, 592 So.2d 156 (Ala. 1991); *Atlanta Oculoplastic Surgery, P.C. v. Nestlehurst*, 2010 Ga. LEXIS 272 (Ga. 2010); *Lebron v. Gottlieb Mem. Hosp.*, 930 N.E.2d 895 (Ill. 2010); *Kan. Malpractice Victims Coalition v. Bell*, 757 P.2d 251 (Kan. 1988) (new law enacted in 1988); *Watts v. Lester E. Cox Med. Ctr.*, 376 SW 3d 633 (Mo. 2012); *Carson v. Mauer*, 424 A.2d 825 (N.H. 1980); *Arneson v. Olson*, 270 N.W.2d (N.D. 1978); *Woods v. Unity Health Center, Inc.*, 196 P.3d 529 (Okla. 2008); *Lakin v. Senco Products, Inc.*, 987 P.2d 463 (Or. 1999); *Sofie v. Fibreboard Corp.*, 771 P.2d 711 (Wash. 1989); *Ferdon v. Wis. Patients Comp. Fund*, 701 N.W.2d 440 (Wis. 2005).

144. See *Univ. of Miami v. Echarte*, 618 So.2d 189 (Fla. 1993) and *Estate of McCall v. United States*, 134 So.3d 894 (Fla. 2014).

145. *Stinnett v. Tam*, 130 Cal.Rptr.3d 732 (Cal. Ct. App. 2011).

146. *Rashidi v. Moser*, 219 Cal.App.4th 1170 (Cal. Ct. App. 2013).

147. *Hughes v. Pham*, No. E052469, LEXIS (Cal. App. Aug. 22, 2014).

obsolete by changed conditions is a legislative, not a judicial, prerogative.”¹⁴⁸

Florida

On March 13, 2014, the Florida Supreme Court, by a split decision, found that in a wrongful death action the cap on noneconomic damages was without a rational basis. According to the court, the cap imposed “unfair and illogical burdens on injured parties when an act of medical negligence gives rise to multiple claimants.” Accordingly, the court held that the cap violated the Equal Protection Clause of the Florida Constitution.¹⁴⁹

Georgia

On March 22, 2010, the Georgia Supreme Court struck down the state’s cap on noneconomic damages (*Atlanta Oculoplastic Surgery, P.C., v. Nestlehutt*).¹⁵⁰ The Supreme Court ruled that the cap violated the right to a trial by jury provision of the Georgia Constitution. The Georgia statute being challenged included a \$350,000 cap on noneconomic damages against all health care providers in a claim; a separate \$350,000 cap on noneconomic damages against a single medical facility that can increase to \$700,000 if more than one facility is involved; and a \$1.05 million total limit on noneconomic damages in a medical liability claim.

Illinois

On Feb. 4, 2010, the Illinois Supreme Court upheld a lower court ruling that held that Illinois’ cap on noneconomic damages for medical liability claims (\$500,000 for physicians/\$1 million for hospitals) was unconstitutional (*Lebron v. Gottlieb Memorial Hospital*).¹⁵¹ The Supreme Court ruled by a 4–2 majority that the legislatively created cap violated the state’s separation of powers requirement by establishing a legislative remittitur.¹⁵² The MLR legislation was enacted in 2005 and included other liability provisions, such as an apology inadmissibility provision and expert witness requirements. All were nullified by the ruling based on the statute’s inseverability provision.

Indiana

In January 2013 the Indiana Supreme Court rejected a challenge to the state’s \$1,250,000 cap on damages in medical liability cases.¹⁵³ The plaintiff complained that the trial court had denied him an opportunity to prove that the cap no longer served the purposes for which it was originally enacted and was thus unconstitutional. The court held that such evidence might be allowed in a proper case, but here the plaintiff had forfeited his right to challenge the cap because he had not raised the issue properly in the trial court.

Kansas

In October 2012 the Kansas Supreme Court upheld the state’s \$250,000 noneconomic damages cap in medical liability cases.¹⁵⁴ The case marks the second time the Kansas Supreme Court has upheld the cap, which was enacted in 1988.¹⁵⁵ The court’s analysis turned on the fact that physicians, hospitals and other health care professionals are required by law to carry liability insurance and participate in the Health Care Stabilization Fund, which taken together, provide a guaranteed source of recovery for patients injured through medical negligence. The court considered this as a *quid pro quo*, wherein individuals give up the right to recover unlimited noneconomic damages in return for an assured source of recovery.

Louisiana

In 2007 the Louisiana Supreme Court reinstated the state’s cap on total damages in medical liability cases.¹⁵⁶ The \$500,000 cap¹⁵⁷ (excluding future medical care) was struck down by the 3rd Circuit Court of Appeals in 2006.¹⁵⁸ The court of appeals determined that the current cap did not provide an adequate remedy and was unconstitutional because of this finding. The Louisiana Supreme Court set aside and vacated the judgment based on pleading and appellate errors. The court then sent the *Arrington* case back to the other procedural level for consideration of the remaining issues in those cases. In 2012 the Louisiana Supreme Court reaffirmed

148. *Chan v. Curran*, 237 Cal. App. 4th 601 (Cal. Ct. App. 2015).

149. *Estate of McCall v. United States*, 134 So.3d 894 (Fla. 2014).

150. *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 691 S.E.2d 218 (Ga. 2010).

151. *Lebron v. Gottlieb Mem. Hosp.*, 930 N.E.2d 895 (Ill. 2010).

152. Remittitur is the process by which excessive jury verdicts are reduced by a court.

153. *Plank v. Comm. Hosp. of Indiana, et al.*, 981 N.E.2d 49 (Ind. 2013).

154. *Miller v. Johnson*, 289 P.3d 1098 (Kan. 2012).

155. *Samsel v. Wheeler Transp. Serv., Inc.*, 789 P.2d 541 (Kan. 1990).

156. *Arrington v. Galen-Med*, 947 So. 2d 724 (La. 2007).

157. La. R.S. 40:1299.42 (2007)

158. *Arrington v. ER Physicians Group*, 940 So.2d 777 (La. Ct. App. 2006).

that the state's \$500,000 limit on total medical liability damages, once again declaring the cap constitutional and applicable to all health care providers.¹⁵⁹

Maryland

In 2010 Maryland's highest court ruled that the cap on noneconomic damages in general tort claims is constitutional.¹⁶⁰ It based this decision on the legal doctrine of *stare decisis*. This means that the court followed precedent on this issue.¹⁶¹

Michigan

On Aug. 18, 2005, the U.S. Court of Appeals for the 6th Circuit upheld Michigan's cap on noneconomic damages.¹⁶² Specifically the court held the cap does not violate the Seventh Amendment or Equal Protection Clause of the U.S. Constitution.¹⁶³

Missouri

In August 2012 the Supreme Court of Missouri threw out the state's \$350,000 noneconomic damages cap on medical lawsuits, which was established in 2005.¹⁶⁴ Prior to 2005, Missouri had a less restrictive cap on noneconomic damages of \$579,000 (adjusted for inflation). The court's August decision overturned the 1992 state Supreme Court decision that was the basis for the previous cap.¹⁶⁵

Oklahoma

In 2008 the Oklahoma Supreme Court struck down several medical liability statutes as "special laws" that violate the Oklahoma Constitution.¹⁶⁶

Oregon

In 2008 the Oregon Supreme Court ruled that a cap on noneconomic damages in wrongful death cases is not a violation of the Oregon Constitution.¹⁶⁷

Texas

In March 2012, in a one-page ruling, a federal

judge upheld Texas' \$250,000 cap on noneconomic damages.¹⁶⁸ This cap was established in 2003 through the Medical Malpractice and Tort Reform Act of 2003, a law that was later approved via constitutional amendment, Proposition 12. In Texas, the plaintiffs sought relief in federal court because of the state's constitutional amendment that permits caps; however, the federal judge rejected their claims and ruled that the cap should stay in effect.

Utah

In an opinion issued Nov. 5, 2004, the Utah Supreme Court upheld Utah's cap on noneconomic damages¹⁶⁹ as constitutional. Specifically the court held that the cap does not violate the open courts, uniform operation of laws or due process provisions of the Utah Constitution. The court also held the cap does not violate the separation of powers or right to a jury trial as protected by the Utah Constitution.¹⁷⁰

West Virginia

On June 22, 2011, the West Virginia Supreme Court of Appeals upheld the state's cap on noneconomic damages (*MacDonald v. City Hospital*). It rejected claims by the appellant that the cap on noneconomic damages violated the right to a jury trial, separation of powers, equal protection, special legislation and/or the "certain remedy" provision of the West Virginia Constitution.¹⁷¹

Wisconsin

In a 4–3 opinion issued July 14, 2005, the Wisconsin Supreme Court struck down Wisconsin's cap on noneconomic damages, which had been in place since 1995. Specifically, the court held that Wisconsin's \$350,000 cap (adjusted for inflation) on noneconomic medical malpractice damages set forth in Wis. Stat. §§ 655.017 and 893.55 (4)(d) violated the Equal Protection Clause of Wisconsin's Constitution. In numerous prior cases, the Wisconsin Supreme Court had addressed the constitutionality of various provisions in Wis. Stat. § 655, including the cap on noneconomic damages, upholding the provision as constitutional each time.¹⁷²

159. *Oliver v. Magnolia Clinic, et. al.*, 85 So.3d 39 (La. 2012).

160. *DRD Pool Serv. v. Freed*, 5 A.3d 45 (Md. 2010).

161. *Oaks v. Connors*, 660 A.2d 423 (Md. 1995); *Murphy v. Edmonds*, 601 A.2d 102 (Md. 1992).

162. MCLS § 600.1483 (2008)

163. *Smith v. Botsford General Hosp.* 419 F.3d 513 (6th Cir. 2005).

164. *Watts v. Lester E. Cox Med. Ctr.*, 376 S.W.3d 633 (Mo. 2012).

165. *Adams By and Through Adams v. Children's Mercy Hosp.*, 832 S.W.2d 898 (Mo. banc 1992).

166. *Woods v. Unity Health Center, Inc.*, 196 P.3d 529 (Okla. 2008).

167. *Hughes v. PeaceHealth*, 178 P.3d 225 (Or. 2008).

168. *Watson v. Hortman, et. al.*, 844 F.Supp.2d 795 (E.D. Texas 2012).

169. Utah Code Ann. § 78-14-7.1

170. *Judd v. Drezga*, 103 P.3d 135 (Utah 2004).

171. *MacDonald v. City Hospital*, 715 S.E.2d 405 (W. Va. 2011).

172. *Ferdon v. Wis. Patients Comp. Fund*, 701 N.W.2d 440 (Wis. 2005).

Judicial support for caps on noneconomic damages

Favorable state case law establishes a rationale for supporting legislative reforms.¹⁷³

Equal protection clause

Under the “deferential rational relationship” test, a number of courts have upheld damages caps as a permissive and rational means of achieving the legitimate state goal of reducing insurance premiums paid by physicians. Other societal goals supporting the implementation of caps that have been upheld by the court include:

- Ensuring the availability of physicians in the state
- Continuing the existence of state compensation funds
- Continuing the existence of insurance for physicians in the state
- Assuring medical related payments to all claimants

Some courts have held it constitutional for damage caps to differentiate between medical liability tort claimants who have suffered injuries valued at a level below the damages cap, and those who have suffered damages valued above the damages cap amount based upon the legitimate purpose of the legislature.

Due process clause

Court analysis of due process challenges in some cases also has proceeded under the rational relationship test, where damages caps have been found to be neither arbitrary nor irrational legislative goals.

Right to trial by jury

After a plaintiff is awarded damages up to the amount of the statutory cap, the determination of damages is removed from consideration by the jury and given to the court. This is not a denial of the right to trial by jury, since the jury already has completed its fact-finding mission, determining that the plaintiff is owed compensation. Deciding how much a patient will recover is a question of law for the court. The court implements the policy decision of the legislature. Reviewing courts also have held that it is within the legislature’s power to modify common law and statutory rights and remedies, as was done with the caps.

Open court challenge

Some courts have struck down the argument that a damage cap impermissibly allows the legislature to intrude on the judicial process. Instead of being an impermissible barrier to the courts, the cap is merely a limitation on recoveries.

Intrusion on the rulemaking power of the judicial branch

Some courts did not find that caps allow the legislature to overstep its constitutional powers. Instead, the courts found that the legislature has full purview over questions of policy, as opposed to procedural questions. Damage caps are questions of policy, properly within the legislature’s power.

Innovative reforms

While the AMA remains fully committed to the enactment of proven MLR laws, such as MICRA, the AMA is also calling for the implementation and evaluation of innovative reforms to see if they are able to improve the nation’s medical liability climate. The AMA has called for federal funding for pilot projects to test such concepts as health courts, liability safe harbors for the practice of evidence-based medicine, early disclosure and compensation models, expert witness guidelines and affidavits of merit, to name some of the more promising options. These reforms could either complement traditional MLR provisions, such as caps, or they may be able to improve the liability climate in a state that is not able to enact traditional MLR provisions for political or judicial reasons. Implementation and evaluation of these innovative reforms are needed to determine their effectiveness.

Health courts

Health courts are an idea that gained attention during the most recent liability crisis. Policymakers seeking an innovative solution to fix the medical liability system were intrigued with the concept, and the AMA supports the testing and evaluation of health court pilot projects as an innovative way to address the medical liability

173. See cases cited *supra*, note 123.

problem. Health court proponents suggest that such courts could:

- Lead to a fairer and more expedited resolution of medical liability claims
- Lead to verdicts being based more on whether or not there was a deviation from the standard of care rather than emotional appeals to juries
- Provide compensation to those harmed by medical negligence in a fairer and more streamlined fashion
- Dismiss meritless claims in a timely manner

However, there is not unanimous support for health courts from the medical community. Those skeptical of health courts have expressed concern about their ability to decrease costs and concern about the judicial appointment process.

The AMA adopted a detailed list of health court recommendations in 2007 to serve as legislative guidelines for state medical associations interested in establishing a health court. Included on the list are six main health court principles:

- Health courts should be structured to create a fair and expeditious system for the resolution of medical liability claims—with a goal of resolving all claims within one year from the filing date
- Health court judges should have specialized training in the delivery of medical care that qualifies them for serving on a health court
- Negligence should be the minimum threshold for compensation to award damages
- Health court judgments should not limit the recovery of economic damages, but noneconomic damages should be based on a schedule
- Qualified experts should be consulted to assist a health court in reaching a judgment
- Health court pilot projects should have a sunset mechanism in place to ensure that participating physicians, hospitals and insurers do not experience a drastic financial impact based on the new judicial format

Liability safe harbors for the practice of evidence-based medicine

In 2009 the AMA adopted principles related to liability safe harbors for physicians when they practice in accord with evidence-based medicine (EBM) guidelines. This is a concept that has garnered increased attention in the health system reform debate.

While EBM guidelines hold potential for improving patient care and lowering health care costs, they may also expand physician liability if policymakers do not establish protections for physicians who comply with EBM guidelines. The AMA principles are meant to offer guidance to federal, state or local policymakers as they seek to implement and evaluate pilot projects on this concept.

In the early 1990s, a handful of states attempted to implement programs that offered EBM guideline protections to physicians. The program in Maine was the most thorough and lasted for close to a decade. The Maine program was sunset eventually due to a lack of use by physicians, but several of the provisions included in the Maine program are relevant to current efforts and could be used by lawmakers as a starting point.

The following AMA principles and legislative recommendations include several aspects of the Maine statutory and regulatory framework. The principles are broad enough to provide state or local entities with necessary flexibility as they implement such a program, but they also highlight the key provisions that are needed to ensure that the program offers sufficient liability protections to physicians to make it successful.

- Participation in a pilot program relating to evidence-based guidelines would be voluntary for patients and physicians
- Physicians who elect to participate in the program would follow evidence-based guidelines that could include a decision support process/application based on the guidelines
- Participating physicians who follow evidence-based guidelines should receive liability protections for

diagnosis and treatment in compliance with the guidelines

- Such liability protections could include, but are not limited to:
 - Civil immunity related to the claims
 - An affirmative defense to the claims
 - A higher burden of proof for plaintiffs
- There would be no presumption of negligence if a participating physician does not adhere to the guidelines
- Admissibility of a guideline by a plaintiff(s) should be prohibited unless the physician introduces that guideline first
- The evidence-based guidelines should be developed and promulgated by national medical specialty societies or other public or private groups that provide physicians with substantial representation on oversight committees and with central decision-making roles in the development of the guidelines
- Implementation of the evidence-based guidelines in the pilot program should be done in accord with AMA policy H-410.980 (Principles for the Implementation of Clinical Practice Guidelines at the Local/State/Regional Level)

Expert witness requirements

In 2005 the AMA adopted a model bill that was drafted to help states strengthen their expert witness requirements. The 2005 model bill builds on the AMA's 1989 model bill that called for expert testimony that is false or completely without medical foundation to be unprofessional conduct and subject to sanctioning by a state medical board. The AMA's goals in drafting the second model bill were to ensure that expert witnesses are qualified to provide the testimony that they are offering and to provide state medical boards with the authority to review and sanction improper testimony. Nearly every state requires expert testimony to prove a medical liability claim, but the requirements to qualify as an expert vary. Under the AMA model bill, a person may qualify as an expert witness on the issue of the appropriate medical standard of care if the witness:

- Is licensed in the state, or some other state, as a doctor of medicine or osteopathy
- Is trained and experienced in the same discipline or

school of practice as the defendant or has specialty expertise in the disease process or procedure performed in the case

- Is certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or by a board with equivalent standards
- Within five years of the date of the alleged occurrence or omission giving rise to the claim, was in active medical practice in the same discipline or school of practice as the defendant or has devoted a substantial portion of his time teaching at an accredited medical school or in university-based research in relation to the medical care and type of treatment at issue

The model bill also calls for the temporary deeming of out-of-state experts with an in-state license for the purpose of providing expert testimony. This will give the in-state medical board the right to review and possibly discipline an out-of-state expert for improper testimony. In 2011 Florida enacted a law that requires the department of health to issue a certificate to an out-of-state physician seeking to provide testimony in a medical liability case. The statute subjects the out-of-state physician to the jurisdiction of the department of health or board of medicine for fraudulent or deceptive testimony.¹⁷⁴

Affidavit of merit

An affidavit of merit, sometimes called a certificate of merit, is a procedural tool that some states employ to limit the adjudication of meritless lawsuits. In some states, a plaintiff must file an affidavit along with the complaint to establish that the claim has merit. In other states, plaintiffs must file such an affidavit following a defendant's answer to the complaint. It is usually signed by a health care professional who qualifies under state law as an expert witness. As with other pre-trial mechanisms, affidavits of merit help eliminate meritless lawsuits that burden the court system and can save defendants the costs of litigation. About half of the states have some form of certificate or affidavit of merit requirement in place.

174. Fla. Stat. § 458.3175 (2011)

In 2007 the AMA drafted model legislation for states to use if they wish to consider an affidavit of merit provision. The AMA model bill calls on the plaintiff or the plaintiff's attorney to file an affidavit with the court stating that he or she has obtained the written opinion of a legally qualified health care provider that states that the defendant health care provider failed to use such care as a reasonably prudent and careful health care provider would have under similar circumstances and that such failure to use such reasonable care directly caused or directly contributed to the cause of the damages claimed in the petition. The model bill uses the suggested expert witness requirements from the AMA's model bill on this topic as well.

Early disclosure and compensation

In recent years, early disclosure and compensation (EDC) programs have received increasing attention as an innovative option that health systems might use to address adverse events and the risk management concerns that result from them. Several states, including Iowa¹⁷⁵, Massachusetts¹⁷⁶ and Oregon¹⁷⁷, have enacted legislation to support such initiatives. Several of the health systems that are implementing such programs have reported positive results. An example of an EDC program is the one operated by the University of Michigan Health System (UMHS).¹⁷⁸ UMHS follows three basic principles in its program:

- Compensate quickly and fairly when unreasonable medical care causes injury
- Defend medically reasonable care vigorously
- Reduce patient injuries (and, therefore, claims) by learning from patients' experiences

Recent federal funding will facilitate the implementation of new EDC programs and the expansion of ongoing programs in several states. These expanded efforts will help to answer some of the key questions about EDC programs, including: whether or

not they will increase the frequency of liability claims; whether they can succeed in states without traditional liability reforms; if they can be expanded outside of large integrated health system settings; and will they be sustainable if and when the liability climate worsens in a state.

Federal grants

As part of its health system reform efforts, the AMA urged the Obama administration and Congress to fund demonstration projects on innovative reforms, such as health courts, safe harbors for the practice of evidence-based medicine, and early disclosure and compensation models. AMA advocacy resulted in two grant programs. The first is being implemented by the Agency for Healthcare Research and Quality (AHRQ), and the second is part of the Affordable Care Act (ACA).

Agency for Healthcare Research and Quality

In 2009 the Obama administration announced that it was providing \$25 million in funding to establish medical liability and patient safety demonstration grants and planning grants that would be available to states and health systems. The demonstration grants spanned three years and were intended for programs that are ready to be implemented. The planning grants lasted for one year and focused on projects that are still in the design phase. AHRQ was charged with implementing the programs.

After a thorough application and review process, AHRQ announced the grant recipients on June 11, 2010. The program awarded a total of \$23.2 million in funding, providing seven demonstration grants (\$19.7 million total) and 13 planning grants (\$3.5 million total). To highlight a few models, early disclosure and compensation models were implemented in Illinois, Massachusetts, New York and Washington. The New York grant established a special docket that has several elements that a health court model would include, such as specially trained judges. Finally, Oregon used its grant to review the safe harbor concept.

175. Iowa Senate File 426 (2015)

176. Mass. Gen. Laws ch 3 § 38C (2012).

177. Or. Rev. Stat. § 31.250 (2013).

178. For a detailed analysis of the UMHS program, please see Boothman RC, Blackwell AC, Campbell DA, et al. *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience.* *J. Health & Life Sci.* L. 2009;2(2):125–159. med.umich.edu/news/newsroom/boothman%20et%20al.pdf. Accessed Nov. 17, 2014.

Further information on all of the grant recipients, including a progress report from each grant recipient, is available on the AHRQ website.

The final grant programs concluded in the summer of 2013. AHRQ then contracted with JBA/RAND to conduct a comprehensive evaluation of the program to look at the effects of various types of reforms, focusing on issues of patient safety, liability premiums and the number of medical liability lawsuits. Based on this evaluation, AHRQ plans to develop model liability programs that highlight successes from the demonstrations, including developing a comprehensive patient safety and medical liability toolkit that can be implemented in the hospitals that participated in the program.

President's budget request for additional funding for state grants

The president's fiscal year 2012 and 2013 budgets requested \$250 million for Department of Justice grants to states in order to test a variety of alternative liability reform proposals; however, this funding was not appropriated by Congress. Most recently, the president's fiscal year 2014 and 2015 budgets did not include any explicit funding for state medical liability reform programs.

Affordable Care Act grants

In addition to the Obama administration patient safety and MLR grant program, Congress created a separate medical liability grant program in the ACA. Under the ACA program, states are required to develop an alternative liability reform that: (1) allows for the resolution of disputes over injuries allegedly caused by health care providers or organizations; and (2) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data.

Each state would have to identify the sources from and methods by which compensation would be paid, and demonstrate that its proposed alternative to tort litigation meets certain goals and criteria. Each state receiving a

grant would be required to submit a report to the HHS secretary covering the impact of the activities funded on patient safety and on the availability and price of medical liability insurance.

The ACA authorizes Congress to appropriate \$50 million for this program, and the AMA is calling on Congress to provide this funding.

Conclusion

As this document has articulated, medical liability remains a continuing concern for physicians. It affects both how and where they practice. The ramifications of the broken liability system are wide-ranging, from patients who now have limited access to health care to the financial implications on the health care system as a whole. A growing number of policymakers from both sides of the aisle agree that this issue needs to be addressed. The AMA remains committed to advocating for proven reforms—such as caps on noneconomic damages—to fix the problem. The AMA is also advocating for innovative reforms, such as health courts, safe harbors, and early disclosure and compensation models, as a way to complement traditional reforms. This AMA effort is occurring at both the federal and state levels.

Please visit ama-assn.org/go/liability for more information on the AMA's medical liability reform efforts.

Are you an AMA member?

The support of our members makes the AMA's advocacy work possible. Help sustain our advocacy efforts on issues important to you and your patients. Join today.

ama-assn.org/go/join