Annals of Health Law

Volume 13
Issue 2 *Summer 2004*

Article 8

2004

The Current Medical Liability Insurance Crisis: An Overview of the Problem, Its Catalysts and Solutions

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*Introduction by Christina O. Jackiw**

I. INTRODUCTION

Professor Barry R. Furrow gave the keynote speech at the Loyola University Chicago Institute for Health Law Annual Health Law and Policy Colloquium held in Chicago on November 14, 2003. Professor Furrow completed his undergraduate degree at Harvard College in 1967. Soon afterwards, he entered Harvard Law School where he received his law degree in 1971.

After doing a clerkship and working at a Boston law firm, Professor Furrow began teaching in law school. Since then, he has taught at the law schools of American University, George Mason University, the University of Detroit, the University of Michigan, and the University of North Carolina. In 1995, Professor Furrow received the Jay Healey Distinguished Health Law Teacher Award from the Health Law Section of the American Society of Law, Medicine and Ethics. In the spring of 1998, he was the Merck Visiting Scholar at Seton Hall Law School. Currently, he is a law professor and director of the Health Law Institute at Widener University School of Law. To date, Professor Furrow has published over four-dozen articles in various legal and health journals and is the lead author of the most widely used health law textbook.

Professor David A. Hyman offered a response to Professor Furrow's keynote speech. Professor Hyman received his undergraduate, law, and medical degrees from the University of Chicago in 1983, 1989, and 1991, respectively. Professor Hyman is a member of the Illinois and the District of Columbia bars and is licensed to appear before the 6th, 7th, and 10th Circuit Courts of Appeals and the United States Tax Court.

Professor Hyman began his teaching career in 1994 at the University of Maryland School of Law, where he continues to teach today. He has also

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taught as a visiting professor at the law schools of George Washington University and University of Texas. In addition to teaching, Professor Hyman serves as Special Counsel to the Federal Trade Commission and is an adjunct scholar at the Cato Institute. Professor Hyman has published numerous articles on a variety of topics, but is primarily interested in the areas of healthcare financing and delivery regulation and empirical law and economics.

In his keynote speech, Professor Furrow provided a view of the big picture—the medical malpractice insurance crisis, its causes, and proposed solutions. Professor Hyman's response provided more insight into healthcare quality and solutions to the crisis. These topics will be addressed in turn.

II. WHAT IS ALL THE CLAMOR ABOUT?

National news alarms went off when, in early 2003, thousands of doctors from various specialties closed their practice doors and joined together in protest against skyrocketing medical malpractice insurance premiums.[1] Among the physicians' chief complaints were that astronomical premiums were causing some of them to leave certain states and others to close up shop altogether.[2] They called for tort reform, in the shape of caps on non-economic damages, as a means of lowering their insurance costs.[3] Of course, these rallies across the country did not mark the beginning of the current medical malpractice insurance crisis, but helped bring the issue to the forefront of national news.

So, how high did these premiums go? In 2003, many states witnessed insurance premiums rising by more than twenty-five percent.[4] For example, internists' rates jumped thirty percent in Delaware, Idaho, Illinois, and Oklahoma; between forty and fifty-five percent in Connecticut, Missouri, New Jersey, New Mexico, and Tennessee; and an alarming 139% in Virginia.[5] In dollar amounts, among the highest premiums paid by internists in 2003 were $65,697 in Miami, Florida; $50,063 in Detroit, Michigan; $41,238 in Chicago, Illinois; $34,346 in Houston, Texas; and $29,667 in Philadelphia, Pennsylvania.[6]

Other specialties have received even bigger blows, particularly general

1. Jennifer Barrett, *How to Fix the Medical Liability System*, NEWSWEEK, Feb. 6, 2003.
2. *Id.*
3. *Id.*
4. Berkeley Rice, *How High Now? Premium Hikes of 25 Percent or More Are Now Common, with More Double-Digit Increases Expected for 2004*, MED. ECON., Jan. 9, 2004.
5. *Id.* (quoting Medical Liability Monitor study).
6. *Id.* (quoting Medical Liability Monitor study).

surgery and obstetrics and gynecology.[7] In 2003, the five highest premiums for general surgeons ranged from $98,319 in the Chicago metropolitan area to $226,542 in the Miami metropolitan area.[8] However, insurance rates for obstetricians and gynecologists created the most sticker shock, with the five highest rates ranging from $141,704 in Las Vegas, Nevada to an astonishing $249,196 in Miami, Florida.[9]

Much to everyone's dismay, many insurance companies have announced that they will continue to raise their rates in 2004, even in states that were not significantly affected in 2003.[10] These companies predicted that again, the increases would be in the double digits.[11] Therefore, there seems to be no impending relief, at least not in the near future.[12]

Higher insurance premiums are not the only cause for concern, however.[13] Many physicians are facing stricter eligibility criteria, cutbacks in coverage, policy cancellations, or, most significantly, complete lack of available coverage.[14] For instance, twenty out of the forty insurance carriers in Florida have withdrawn from the market in the last ten years.[15] Similarly, three insurance carriers in New Jersey, providing coverage for fifty-five percent of the physicians in the state, discontinued their malpractice lines in less than one year.[16] In Pennsylvania and Washington, the states' largest malpractice insurance providers have been forced into liquidation and receivership, respectively.[17] The worst upset of all, however, came when the largest malpractice insurer in the country, The St. Paul Companies, declared in December of 2001 its plan to discontinue its services to the medical community, sending shockwaves and affecting doctors across the entire country.[18]

The lack of affordability and in some cases, complete unavailability, of

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7. *Id.* (quoting Medical Liability Monitor study).
8. *Id.* (quoting Medical Liability Monitor study).
9. *Id.* (quoting Medical Liability Monitor study).
10. Rice, *supra* note 4 (citing Medical Liability Monitor study).
11. *Id.* (citing Medical Liability Monitor study).
12. *Id.*
13. *Id.*
14. *Id.*
15. JOINT ECON. COMM., 108TH CONG., LIABILITY FOR MEDICAL MALPRACTICE: ISSUES AND EVIDENCE 15 (Comm. Study 2003).
16. *Id.* at 16.
17. *Id.*
18. MIMI MARCHEV, NAT'L ACAD. FOR STATE HEALTH POLICY, THE MEDICAL MALPRACTICE INSURANCE CRISIS: OPPORTUNITY FOR STATE ACTION 6 (July 2002), *available at* http://www.nashp.org; U.S. DEP'T OF HEALTH & HUMAN SERVS. (HHS), CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 14 (July 2002), *available at* http://www.aspe.hhs.gov/daltcp/reports/litrefm.htm.

medical malpractice insurance has created new barriers for patients in obtaining much needed medical care.[19] For example, in Nevada, the University of Nevada Medical Center closed its Las Vegas Level One trauma center for ten days in July of 2002 because its surgeons quit after not being able to afford their insurance premiums, some of which rose from $40,000 to $200,000 per year.[20] This posed an enormous access threat to emergency care since the next closest trauma center is located five hours away.[21] Likewise, in Pennsylvania, Frankford Hospital's twelve orthopedic surgeons all resigned in 2001 when their premiums almost doubled to $106,000 per year.[22] Furthermore, community hospitals in rural counties of West Virginia shut down their obstetric facilities because their obstetricians could not keep up with rising insurance costs.[23]

Worst of all, doctors who used to volunteer at medical clinics for the poor or at the Medical Reserve Corps have curbed their services because they have no malpractice insurance coverage.[24] This, of course, has posed extraordinary challenges in providing care to low-income patients and has placed a massive financial burden on the clinics which, in order to continue providing services, must obtain their own insurance coverage.[25] Other states, such as Arizona, Florida, Georgia, Mississippi, New Jersey, Ohio, Texas, Washington, and West Virginia have also witnessed the sharp insurance increases causing an exodus of physicians from the states, early retirement of physicians, and the curtailment of certain high-risk procedures.[26] Consequently, certain facilities have closed, further impeding patients' access to medical care.[27]

Based on the growing threats of medical malpractice insurance unaffordability and unavailability and healthcare inaccessibility, in July 2003, the American Medical Association designated nineteen states to be suffering from a full-scale medical liability "crisis."[28] In addition, it placed twenty-five states and the District of Columbia in the category of "states

19. HHS, *supra* note 18, at 2.
20. *Id.*; JOINT ECON. COMM., *supra* note 15, at 15-16.
21. HHS, *supra* note 18, at 2.
22. *Id.* at 3.
23. *Id.*
24. *Id.* at 4.
25. *Id.*
26. *Id.* at 3-4; JOINT ECON. COMM., *supra* note 15, at 15-17.
27. HHS, *supra* note 18, at 3-4; JOINT ECON. COMM., *supra* note 15, at 15-17.
28. AM. MED. ASS'N (AMA), AMERICA'S MEDICAL LIABILITY CRISIS: A NATIONAL VIEW (July 2003) (designating Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, and Wyoming).

showing problem signs."[29] Only six states were deemed to be "currently okay."[30] Therefore, all the clamor is a reaction to a real problem wreaking havoc on this country's healthcare community.

III. THE CATALYSTS

There seems to be no doubt nor debate that the American healthcare industry is presently undergoing a medical malpractice insurance crisis. What remains in passionate dispute between the many players involved, however, is what in fact has caused this crisis.[31] A National Academy for State Health Policy report aptly sums up the various arguments:

> Insurers and doctors blame "predatory' trial attorneys, "frivolous" lawsuits, and "out of control" juries for the spike in insurance premiums. In turn, consumer groups accuse insurance companies of "price gouging," while plaintiffs' attorneys point to an exorbitant rate of medical errors and the need to deter malpractice and provide compensation to injured patients.[32]

In his speech, Professor Furrow addressed these theories and provided his explanation for the current medical malpractice insurance crisis.

Patients have often been charged with triggering the malpractice liability crisis because of their excessive litigiousness.[33] Professor Furrow dispelled this theory. He indicated that although more people file claims than actually have valid ones, there are many more injured victims of negligence than actually file suit for negligence.[34] This means that many real victims of medical malpractice never file claims.[35] Furthermore, Professor Furrow indicated that there is not much data showing an explosion in tort litigation.[36] Lastly, although judgments are becoming increasingly large, Professor Furrow noted that the figures are not at all conclusive on this point.[37] Therefore, due to the lack of definitive research on the frequency

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29. *Id.* (designating Alabama, Alaska, Arizona, Delaware, Hawaii, Idaho, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, and Virginia).

30. *Id.* (designating California, Colorado, Indiana, Louisiana, New Mexico, and Wisconsin).

31. MARCHEV, *supra* note 18, at 1.

32. *Id.*

33. INS. INFO. INST., MEDICAL MALPRACTICE INSURANCE 5 (2003).

34. JOINT ECON. COMM., *supra* note 15, at 3.

35. MARCHEV, *supra* note 18, at 2.

36. *Id.*

37. *Id.* According to Jury Verdict Research, the median jury award doubled from $500,000 to $1,000,000 between 1995 and 2001. INS. INFO. INST., *supra* note 33, at 16

and severity of claims, it is inappropriate to blame patients for fueling the current crisis.

Trial lawyers have also been targeted for causing the crisis because, among other things, they exploit the broken tort system and file frivolous lawsuits.[38] Again, Professor Furrow dismissed this claim. Professor Furrow's reasoning was that the tort system, in its current state, under compensates victims of negligent injury.[39] Only about half of the claimants who file complaints actually receive any compensation.[40] Furthermore, he noted that it is entirely unclear whether the tort system actually deters physicians from acting negligently.[41] Finally, Professor Furrow indicated that medical malpractice claims are very difficult to bring because they are very costly and are always faced with fierce defenses. Thus, such realities of the tort system and the litigation process pose significant challenges to trial lawyers, removing the luxury of filing every claim that comes their way but requiring close scrutiny of all claims for merit and viability.

Although Professor Furrow dismissed certain theories of culpability, he did find merit in others. Therefore, according to Professor Furrow, there are three main forces that have contributed to the current medical liability crisis: (a) medical error, (b) the insurance industry cycle, and (c) inflation of healthcare costs.

A. Medical Error

Professors Furrow and Hyman agreed that medical error is one of the major catalysts of today's medical malpractice insurance crisis. In a 2000 report, the Institute of Medicine announced that between 44,000 and 98,000 American patients die each year due to medical error.[42] Both the high and low estimates place medical error on the list of the top ten causes of death in the United States for 1997, alongside well-known killers such as heart disease (726,974 deaths), cancer (539,577 deaths), cerebrovascular disease

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(citing Jury Verdict Research data). Another figure, provided by the Center for Justice and Democracy, shows that the average plaintiff's award is $30,000 and has been such for the last ten years. CTR. FOR JUSTICE & DEMOCRACY, A SHORT GUIDE TO UNDERSTANDING TODAY'S MEDICAL MALPRACTICE INSURANCE "CRISIS" 12 (2002) (citing data from a 2001 Consumer Federation of America study). The Congressional Budget Office offered yet another figure that the average medical malpractice claim payout increased from $95,000 in 1986 to $320,000 in 2002. CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE (Jan. 2004) (citing data from Physician Insurers Association of America), *available at* http://www.cbo.gov.

38. MARCHEV, *supra* note 18, at 1.
39. HHS, *supra* note 18, at 8; JOINT ECON. COMM., *supra* note 15, at 1.
40. HHS, *supra* note 18, at 1; JOINT ECON. COMM., *supra* note 15, at 10.
41. JOINT ECON. COMM., *supra* note 15, at 1.
42. INST. OF MED., TO ERR IS HUMAN 26 (Linda T. Kohn et. al. eds., 2000).

(159,791 deaths), chronic obstructive pulmonary disease (109,029 deaths), diabetes (62,636 deaths), suicide (30,535 deaths), and nephritis (25,331 deaths).[43]

Fortunately, not all medical errors result in death. Nevertheless, they do cause injury to the patient. According to the Harvard Medical Practice Study, which examined hospitals in New York State in 1984, 2.1% of all hospitalized patients were injured due to medical error, causing disability or extended hospital stay.[44] The predominant types of medical errors that occurred were errors in surgery or procedure (35%), failure to take preventive measures (22%), misdiagnosis (14%), and inappropriate drug treatment (9%).[45] The Colorado-Utah study, which investigated hospitals in Colorado and Utah in 1992, echoed the earlier study's findings.[46] There 1.9% of all hospitalized patients suffered from injuries due to medical error, causing disability or lengthened hospital stay.[47] Although most of those iatrogenic injuries were temporary (78%), 7% of them did indeed result in death.[48]

Professor Furrow stressed that medical errors associated with drug treatment are on the rise due to increased dependence on drug therapy.[49] Between 1983 and 1993, the number of deaths in hospitals due to medication errors jumped from 2876 to 7391.[50] Furthermore, in 1993, there were 8.48 times as many deaths in outpatient facilities as a result of medication errors as in 1983.[51]

Not surprisingly, medical error translates into additional costs to the healthcare system and society as a whole.[52] These costs include healthcare costs associated with correcting the error and providing appropriate care for the injured patient, disability costs, and loss of productivity costs, such as lost income and lost household production.[53] The estimated national cost of medical error is seventeen billion dollars per year.[54] This cost, in turn, is reflected in medical malpractice litigation, driving up the dollar amounts of

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43. SHEILA LEATHERMAN & DOUGLAS MCCARTHY, QUALITY OF HEALTH CARE IN THE UNITED STATES: A CHARTBOOK 61 (2002).

44. *Id.* at 62 (citing Harvard Medical Practice Study).

45. *Id.*

46. INST. OF MED., *supra* note 42, at 30.

47. LEATHERMAN & MCCARTHY, *supra* note 43, at 63 (citing Harvard Medical Practice Study).

48. *Id.*

49. INST. OF MED., *supra* note 42, at 32-33.

50. *Id.*

51. *Id.*

52. *Id.* at 40.

53. *Id.*

54. *Id.* at 41.

claims and their payouts and consequently, causing malpractice insurance premiums to rise.

B. The Insurance Industry Cycle

Another chief contributor to the current medical liability crisis, as discussed by Professor Furrow, is the cyclical nature of the insurance industry. The purpose of medical malpractice insurance is to cover the defense costs and damages imposed in a negligence case.[55] Due to the risks of practicing medicine, practically all healthcare providers purchase such insurance.[56] The typical policy held by a physician offers one million dollars of coverage for each incident and a maximum of three million dollars of coverage per year.[57] To ensure coverage in the event of a malpractice claim, the healthcare provider pays a premium to the insurer.[58] The insurer, in turn, invests the premium in the bond and stock markets.[59] In this way, the insurance cycle begins.

An accurate description of the insurance cycle was offered by the National Academy for State Health Policy:

> Insurance underwriting practices are cyclical with periodic adjusting of rates after the fact to reflect actual losses during a given period. The premiums are invested and the return on investment is factored in as part of a company's profits and losses. During times of high interest rates or a strong stock market, insurance companies keep their premiums low in order to remain competitive, increase their market share, and acquire revenue to invest. This is possible because their income is augmented from the high rate of return on investments. A downturn in the stock market or a drop in interest rates results in a lower rate of return on investments and leads to an increase in premiums.
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> After premium increases in the 1970s and again in the 1980s, the medical malpractice market remained stable through the economic boom years of the 1990s. During this period, medical liability insurance was one of the most profitable lines in the industry, and new companies entered the market enticing customers with bargain rates. This price war for new customers prompted many insurers to sell malpractice coverage at rates

55. JOINT ECON. COMM., *supra* note 15, at 3.

56. U.S. GEN. ACCOUNTING OFFICE (GAO), PUB. NO. GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 6 (June 2003), *available at* http://www.gao.gov.

57. *Id.*

58. *Id.* at 7.

59. *Id.*

> too low to cover the costs of subsequent claims. When the boom stock market went bust, exacerbated by the September 11th terrorist attacks, many of these companies suffered large losses and either went out of business, drastically raised premiums, or stopped offering medical malpractice insurance.[60]

As Professor Furrow noted, there is one telltale sign that a crisis is underway—a decline of medical malpractice insurance carriers' profits. Between 1990 and 2001, these insurance companies experienced a consistent drop in their net profits, from 17.4% to -4.7% as a percentage of their net worth.[61] The most dramatic plunge occurred between 2000 and 2001, where net profits transformed into net losses, from 5.4% to -4.7% of net worth.[62]

These insurance losses, coupled with rising premiums, have put the insurance cycle into a downward plunge and have caused another medical malpractice insurance crisis to emerge.[63] The current crisis is the third of its kind in the last thirty years, following the first in the 1970s and the second in the 1980s.[64] Just as today's crisis, the first two crises surfaced almost concurrently with the downturn of the insurance cycle.[65] Thus, this pattern of insurance cycle lows followed by medical malpractice crises clearly demonstrates that the insurance industry cycle is again a major force behind the current medical malpractice insurance crisis.

C. Inflation of Healthcare Costs

According to Professor Furrow, the third main cause for the current malpractice crisis is the rising cost of healthcare. The United States Department of Health and Human Services announced that in 2001, 1.4 trillion dollars were spent on healthcare in the United States.[66] That amount of spending accounted for 14.1% of the gross domestic product of the United States.[67] Furthermore, it is estimated that by the year 2012, healthcare expenditures will make up 17.7% of the country's gross domestic product.[68] These figures demonstrate that healthcare is a huge

60. MARCHEV, *supra* note 18, at 6.
61. GAO, *supra* note 56, at 29.
62. *Id.*
63. AMS. FOR INS. REFORM (AIR), MEDICAL MALPRACTICE INSURANCE: STABLE LOSSES/UNSTABLE RATES 4 (2002); MARCHEV, *supra* note 18, at 6.
64. *Id.*
65. MARCHEV, *supra* note 18, at 6.
66. INS. INFO. INST., *supra* note 33, at 16 (citing HHS).
67. *Id.* at 17 (citing HHS).
68. *Id.*

player in the nation's economy. Consequently, rising healthcare costs drive up the amounts of medical malpractice claims and awards, which reflect current costs of medical care.[69] In fact, according to Americans for Insurance Reform, malpractice judgments have increased at approximately the same rate as medical inflation.[70] Therefore, soaring healthcare costs also contribute to the medical liability crisis by imposing higher judgment payouts on medical malpractice insurers who then react by raising their premiums.

IV. THE SOLUTIONS: MORE THAN JUST TORT REFORM

Solutions to the medical malpractice insurance problem are another area subject to hot debate.[71] Again, the report by the National Academy for State Health Policy provides the best synopsis of the different perspectives:

> Insurers and physicians demand tort reform, changes in the legal system that will limit the frequency of litigation and the amount of damage awards. Attorneys argue that past legal reform has unfairly blocked victims' access to the courts while doing nothing to bring down the costs of malpractice insurance. They see the solution in regulation of the insurance industry. Patient advocates focus on safety and suggest mandatory reporting of medical errors and no-fault approach to victim compensation.[72]

As Professor Furrow indicated, there is no single magic solution to this complex problem.[73] Rather, he offered various suggestions that can be used in conjunction with each other as a means of bringing relief.[74] The majority of solutions he addressed can be divided into three main categories: (a) tort reform, (b) insurance market stabilization, and (c) patient safety.

A. Tort Reform

The main objectives of tort reform are to restrict the amount of claims brought and to limit the dollar amounts of judgments.[75] Presently, Congress is considering a federal bill which aims to restructure the entire medical liability system on a federal level.[76] The House of Representatives passed

69. AIR, *supra* note 63, at 4.
70. *Id.*
71. MARCHEV, *supra* note 18, at 9.
72. *Id.* at 2.
73. *Id.*
74. *Id.* at 21.
75. *Id.* at 9.
76. JOINT ECON. COMM., *supra* note 15, at 19.

the bill in March 2003, but the Senate postponed its vote when it last revisited the issue in July 2003.[77] The proposed bill contains numerous provisions.[78] First, it proposes to set no limits on economic damages amounts awarded to medical malpractice plaintiffs, maintaining the law as it stands today.[79] However, non-economic losses, such as pain and suffering, would be restricted to a maximum award of $250,000.[80] Similarly, punitive damages would only be awarded in cases where the plaintiff can prove intentional wrongdoing and would be limited to $250,000 or two times the amount of economic damages, whichever is more.[81] Attorneys' contingency fees would also be restricted to a certain percentage of the total award, ranging from forty percent for the first $50,000 to fifteen percent for all awards over $600,000.[82] Further, the bill establishes a universal statute of limitations with certain exceptions granted to minors, requiring plaintiffs to bring medical malpractice lawsuits within three years of their injury or one year after they discover, or should have discovered, their injury.[83] The proposed legislation creates a fair share rule, allocating liability to each defendant commensurate with his/her share of fault.[84] This concept abolishes joint and several liability where a defendant may be obligated to pay the full amount of damages notwithstanding how much he/she actually contributed to the injury.[85] In addition, the bill allows evidence of collateral sources at trial, thereby limiting plaintiffs to collecting damages from only one source.[86] Finally, the proposed legislation allows for future losses to be paid over time as opposed to requiring one instant lump-sum payment of all damages.[87]

While Professor Furrow did suggest certain steps that could be taken by the federal government, such as funding demonstration projects and enforcing healthcare quality, he did not recommend a federal overhaul of the tort system. He noted that since the crisis hits harder in certain areas, the states are closer to the problem and can provide solutions on a more localized level.

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77. *2003: Year in Review: The Stories That Shaped and Shook Healthcare*, MOD. HEALTHCARE, Dec. 22, 2003.
78. JOINT ECON. COMM., *supra* note 15, at 19.
79. JOINT ECON. COMM., *supra* note 15, at 20; HHS, *supra* note 18, at 19.
80. JOINT ECON. COMM., *supra* note 15, at 20; HHS, *supra* note 18, at 19.
81. JOINT ECON. COMM., *supra* note 15, at 20; HHS, *supra* note 18, at 19.
82. JOINT ECON. COMM., *supra* note 15, at 20.
83. JOINT ECON. COMM., *supra* note 15, at 20; HHS, *supra* note 18, at 19.
84. JOINT ECON. COMM., *supra* note 15, at 20; HHS, *supra* note 18, at 19.
85. JOINT ECON. COMM., *supra* note 15, at 20; HHS, *supra* note 18, at 19.
86. JOINT ECON. COMM., *supra* note 15, at 20; HHS, *supra* note 18, at 19.
87. JOINT ECON. COMM., *supra* note 15, at 20; HHS, *supra* note 18, at 19.

After the first two medical liability crises in the 1970s and the 1980s, several states passed various tort reform measures in an effort to cool down the crises.[88] However, there is no conclusive answer to the question of whether those measures yielded the intended effects of decreasing the frequency and severity of claims.[89] For example, Professor Furrow noted that in Indiana, where caps were instituted, plaintiffs' awards actually grew. Similarly, a study in Wyoming revealed that the tort reforms instituted there had a negligible effect on both the frequency of malpractice claims and award amounts.[90]

Nonetheless, states are continuing to explore the possibility of further tort reform.[91] Many states are proposing similar provisions to the ones in the pending federal bill discussed above. Among the different measures considered are caps on non-economic damages, sovereign immunity caps for public hospitals and public healthcare employees, abolition of the collateral source rule which bans multiple recoveries for the same injury, tightening expert witness rules, elimination of joint and several liability, limiting attorney contingency fees, and shortening statute of limitations periods.[92] Therefore, those states that are concerned with the tort system and the medical malpractice litigation process itself have a host of options from which to choose in designing a plan of recourse to the malpractice problem.

B. Insurance Market Stabilization

Another set of measures proposed by Professor Furrow targets the insurance industry in an effort to stabilize it. One such measure is creating Joint Underwriting Associations which serve as a temporary patch when the insurance cycle hits its bottom.[93] Joint Underwriting Associations are conglomerates of insurance carriers, sponsored by individual states, which offer insurance in times of insurance coverage shortages.[94] The benefits of such a measure are that the risk is spread among all the insurance companies in the association and it provides otherwise unobtainable coverage.[95] The downside, however, is that such coverage may be more

88. MARCHEV, *supra* note 18, at 12.
89. *Id.*
90. *Id.*
91. John Hillman, *Medical Liability Reform Stalls*, BEST'S REV., Jan. 1, 2004.
92. NGA CTR. FOR BEST PRACTICES, ADDRESSING THE MEDICAL MALPRACTICE INSURANCE CRISIS 4-6 (2002).
93. *Id.* at 3-4.
94. *Id.*
95. *Id.* at 4.

costly than a traditional medical malpractice policy because it is only available in emergent situations.[96]

Another measure suggested by Professor Furrow is heightened regulation of the insurance industry. Currently, the federal government does not oversee nor regulate the insurance industry in any way.[97] Moreover, the individual states' regulatory efforts have proved to be insufficient and virtually no requirements for data disclosure are in place.[98] Therefore, Professor Furrow called for provisions mandating the disclosure of risk data and imposing sanctions for noncompliance. Further, he stressed the need for insurance rate regulation to prevent future cyclical downturns.[99] Finally, Professor Furrow proposed provisions which would require insurers to notify their insureds about renewal rates and non-renewal decisions in order to give physicians the opportunity to secure alternative coverage.

There are, of course, other measures aimed at stabilizing the insurance industry.[100] States can offer stop-gap coverage in which they create their own insurance funds to provide physicians with coverage in times of insurance shortage.[101] Although such a measure tends to be expensive and may potentially put a state into the position of being the only provider of coverage, it helps alleviate the crisis in the short-term.[102] Also, states can establish patient compensation funds which subsidize the portion of a plaintiff's award exceeding a certain amount, for example, $200,000 per occurrence and $600,000 per year.[103] Financing of such a fund would come through a yearly surcharge on participating healthcare providers.[104] Another possible strategy is for states to subsidize physicians' insurance premiums during times of crisis.[105] Even though subsidies do not solve the underlying problem of rising premiums, they pose little challenges in the legislative process and are easy to administer.[106] Thus, there are several remedies to which states can turn in an attempt to better control the insurance industry and ensure the availability and affordability of insurance coverage to the healthcare community, thereby eliminating the prospects of another malpractice liability crisis.

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96. *Id.*
97. CTR. FOR JUSTICE & DEMOCRACY, *supra* note 37, at 4.
98. *Id.*
99. *Id.*
100. NGA CTR. FOR BEST PRACTICES, *supra* note 92, at 3-4.
101. *Id.* at 3.
102. *Id.*
103. *Id.*
104. *Id.*
105. *Id.*
106. NGA CTR. FOR BEST PRACTICES, *supra* note 92, at 3.

C. Patient Safety

The last possible solution to the medical malpractice insurance crisis is increased attention to patient safety, as recommended by both Professors Furrow and Hyman. At a time when death and injury due to medical error are alarmingly high, certain safeguards should be put into place in an effort to put a halt to them.[107] By enacting measures aimed at improving the quality and safety of patient care, incidences of medical error will decline, decreasing the number of lawsuits, and subsequently, lowering malpractice insurance premiums.[108]

To further patient safety, Professor Furrow recommended that states promulgate error disclosure mandates, requiring healthcare providers to disclose all medical errors and near misses, offering whistleblower protection, and administering sanctions for noncompliance. At the moment, approximately twenty states mandate error reporting.[109] These states have discovered that the increase in reporting has resulted in the better identification and solution of problems, which eventually translate into higher quality of care.[110]

Both Professors Furrow and Hyman proposed another innovative approach to achieving higher levels of patient safety—structuring compensation of healthcare providers based on the quality of care they provide to their patients. Professor Hyman indicated that the healthcare industry, in its present state, provides the same amount of compensation to healthcare providers, regardless of the quality of their care. In comparison, all other industries reward their workers based on the quality of their end product. Therefore, the Professors proposed a tiered compensation system based on healthcare providers' performance, which would arguably give incentive to providers to administer the best care possible.

States may also consider a host of other possible patient safety measures in their quest for better healthcare quality.[111] For instance, they can enact provisions empowering their state medical and licensing boards to regulate healthcare professionals more closely, requiring a higher level of quality.[112] Unfortunately, under the current state structures, these boards maintain that "they can only perform their mission if they are properly organized, effectively empowered, and adequately funded."[113] Furthermore, states can

107. MARCHEV, *supra* note 18, at 17.
108. NGA CTR. FOR BEST PRACTICES, *supra* note 92, at 9.
109. *Id.*
110. HHS, *supra* note 18, at 22.
111. NGA CTR. FOR BEST PRACTICES, *supra* note 92, at 9–11.
112. *Id.* at 9.
113. *Id.*

encourage further disclosure of adverse events, licensure issues, and medical malpractice insurance payment history to the National Practitioner Data Bank, created by Congress in an effort to facilitate the hiring and licensing process of healthcare providers.[114] Another tactic is for states to provide healthcare providers, particularly those practicing in high-risk specialties such as obstetrics and gynecology, emergency medicine, or anesthesia, with current medical guidelines outlining practice and risk management protocols.[115] If providers follow such guidelines, they will be afforded an affirmative defense against negligence claims.[116] Finally, states can establish patient safety centers for the collection of medical error data, the development of strategic solutions to the problem, dissemination of information to patients, and the provision of training and educational materials to healthcare providers.[117] Therefore, at a time when medical error has climbed to alarmingly high numbers, states can implement various measures to improve the quality of medical care, which will simultaneously aid in extinguishing the current medical malpractice insurance crisis by generating less negligence claims and judgments.

V. CONCLUSION

In summary, there is no question that the nation is undergoing another medical malpractice insurance crisis. Coping with losses, insurance companies have been radically raising their insurance premiums, dropping their medical malpractice insurance lines, or simply going out of business altogether. In turn, high premiums and lack of coverage have driven several doctors to relocate to different states, retire prematurely, or cut back on much needed services. According to Professor Furrow, the three major catalysts of the current crisis are high incidences of medical error, the insurance industry cycle, and healthcare cost inflation. As for alleviating the problem, Professor Furrow stresses enacting measures to promote patient safety, further regulating the insurance industry, and of course, looking at tort reform. Professor Hyman highlights the importance of quality and safe medical care and proposes a compensation system based on the quality of care administered to the patient.

At this point, we have heard most of the clamor, debate and disagreement. The time is now ripe to look forward and find long-term solutions to this devastating problem so as not to revisit this topic again in the next ten years.

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114. *Id.* at 10.
115. *Id.*
116. *Id.*
117. NGA CTR. FOR BEST PRACTICES, *supra* note 92, at 11.