Reforming the Medical Professional Liability Insurance System

American College of Physicians

A Position Paper

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A Position Paper of the American College of Physicians

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Executive Summary

The American College of Physicians, representing over 115,000 internal medicine physicians and medical students, including 20,000 residents and fellows, is very much concerned about the growing crisis in the availability of medical professional liability insurance. As the largest medical specialty society and the second-largest medical society in the United States, the College is particularly concerned about rising malpractice insurance premiums and the effect on patient access to care.

The existing professional liability insurance system is in desperate need of repair. While the U.S. medical malpractice system is designed to compensate and deter medically induced injury, the current system does not deter physician negligence, provide timely compensation to injured patients, or resolve disputes fairly in favor of the injured party. Additionally, there is growing concern that physicians are defensively altering their professional practices by refusing to take certain high-risk patients and ordering medically unnecessary tests for their patients in order to protect themselves in the case of a lawsuit.

Furthermore, studies reveal that Americans are increasingly concerned about the frequency and severity of medical liability lawsuits and agree that litigation is one of the primary factors behind rising medical costs and reduced access to care. Additionally, the arbitrariness and inefficiency of the system makes physicians feel vulnerable to a lawsuit, thereby dismantling the physician–patient relationship. As a result, comprehensive changes to the medical liability system must be made.

The American College of Physicians believes that every tort reform measure should be assessed according to its capacity for lowering liability insurance premiums or reducing the frequency and severity of malpractice claims without denying injured patients appropriate redress for physician negligence. To the extent that medical professional liability reforms would result in speedier and more equitable damage awards and discourage frivolous or nonmeritorious claims, they are desirable. However, to the extent that they curtail the right to seek just and appropriate redress for medically caused injury, they hamper rather than promote a fair malpractice compensation/deterrence system (1).

Over the years, the College has published several papers on reform of the medical professional liability insurance system. This paper is a culmination of those papers, along with additional background and research to reflect the present-day environment. Unfortunately, over time, the medical professional liability insurance crisis has not improved. In fact, as this paper will show, the medical malpractice system has only gotten worse and has become a "lottery" for some attorneys who file as many suits as possible, hoping one will be their big payday.

Background

Doctors across the country are experiencing sticker shock when they open their medical malpractice insurance renewal notices—if they even get a renewal notice. After more than a decade of generally stable rates for professional liability insurance, physicians have seen costs dramatically increase in 2000 to 2002. And in some areas of the country, premiums have soared to unaffordable levels. According to the *Medical Liability Monitor*, in mid-2001, insurance companies writing in 36 states and the District of Columbia have raised rates well over 25 percent (2).

While obstetricians, general surgeons, and other high-risk specialists have been hit hard by the increase in premium rates, internists have been one of the hardest-hit specialties (see Table 1) (2). In some cases, physicians, even those without a track record of lawsuits, cannot find an insurance company willing to provide coverage. These physicians are being forced to decide whether to dig deeper and pay the steeper bill, change carriers, move out of state, or retire from the practice of medicine.

Table 1. Medical Malpractice Liability
Average Premium Increases by Specialty, 2000–2002

	July 2000	July 2001	July 2002
Internists	17%	10%	25%
General Surgeons	14%	10%	25%
Obstetricians/Gynecologists	12%	9%	20%

Source: *Medical Liability Monitor* (2). Rounded to the nearest whole percent.

Of these options, changing carriers may not even be an alternative. Finding replacement coverage won't be as easy as it was in a buyer's market. Companies writing professional liability insurance coverage are fleeing or being chased from the market. As an example, St. Paul Companies, which insures doctors in 45 states and is the second-largest medical underwriter in the country, announced late in 2001 that it no longer would write medical liability policies. It plans to phase out coverage as physicians' contracts expire over the next 18 to 24 months. Frontier and Reliance are also gone. Other commercials, such as PHICO, MIXX, CNA, and Zurich, are significantly cutting back (2). Even some provider-owned insurers, committed to this market by their founders, are pulling back from some states in which they extended sales.

At a time when the market is squeezing physician and hospital margins, the rise in professional liability insurance may be the deciding factor that contributes to whether physician offices and emergency departments keep their doors open (3). Recently, the costs of delivering health care have been driven by increased costs of new technologies; increased costs of drugs that define the standard of care acceptable for modern medicine; the rising costs of compliance under increasing state and federal regulation; the low reimbursement rate under Medicare and Medicaid; and the declining fees from managed care, which have all been contributing factors that have affected patient access to health care. For many, this scenario is the "perfect storm," and premium affordability may be the defining moment that drives physicians out of practice.

Unquestionably, there is real potential that rising insurance rates ultimately will reduce access to care for patients across the country. Indeed, press accounts on a daily basis are demonstrating exactly that from coast to coast. Physician offices and emergency departments have been closing their doors all across the country due to the exorbitant costs. Patient access to care is now seriously threatened in states such as Florida, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. In other states, such as Alabama, Arizona, Illinois, North Carolina, South Carolina, and Tennessee, a crisis is looming (4).

While some states have recently tried to address the dramatic increase in professional medical liability insurance rates, they have had little success. At best, attempts by these states to solve this problem without sufficient safeguards have resulted in only band-aid approaches to the more underlying problem: the escalation of lawsuit awards and the expense of litigation has led to the increase in professional liability premiums. This fact has resulted in patients not receiving or delaying much-needed medical care. ACP strongly believes that Congress must act to stabilize the market to avoid further damage to the health care system.

The Need for Federal Legislation

Insurance premiums for medical malpractice are increasing at a rapid rate, particularly in states that have not taken steps to make their legal systems function more predictably and effectively (5). Of the majority of states that have made reforms, the constitutionality of these medical liability reforms has been challenged. At least 12 states have passed some form of health care liability reform that was later deemed unconstitutional by their state supreme courts. Those states are Alabama, Arizona, Georgia, Illinois, Kansas, Kentucky, New Hampshire, Ohio, Oregon, Pennsylvania, Texas, and Washington (6). Caps were struck down in the majority of those states because the courts said that they infringed on an injured person's right to a trial by jury.

In 1985, Ohio's Supreme Court became one of the first to hold their state's medical liability statute unconstitutional (7). The court reasoned that the state statute violated the constitutional right of equal protection because the limitation on damages unfairly burdened those plaintiffs least able to pay their medical and legal expenses (8). Alternatively, in that same year, California's liability reform statute came under judicial scrutiny. The challenges asserted there that the California law violated the equal protection and due process clauses of the 14th Amendment. The California Supreme Court applied a rational basis test to each provision and determined that each statute was "rationally" related to the legitimate government purpose of easing the insurance crisis in California (9).

Unfortunately, many states have relied on Ohio's line of reasoning in finding their state statutes unconstitutional. Reform advocates have resorted to electing state supreme court candidates who favor reform and tend to support states' rights in their decision making. Unfortunately, not all states elect their supreme court justices, making this approach difficult to achieve with any measure of success. What we are left with is a patchwork of laws throughout the country that make it difficult for insurance companies to accurately gauge rates. Therefore, in order to bring stability and predictability into the professional liability insurance market, a federal mandate is necessary—one that results in lower premiums and equitable compensation to the injured.

The Increase in Litigation Has Contributed to Spiraling Premiums

The rise in medical professional liability premiums is being driven primarily by increases in lawsuit awards and secondarily by increases in litigation expenses. According to a Jury Verdict Research study, in just a 1-year period (between 1999 and 2000), the median jury award increased 43 percent. Further, median jury awards for medical liability claims grew at seven times the rate of inflation, while settlement payouts grew at nearly three times the rate of inflation. Additionally, the proportion of jury awards topping $1 million increased from 34 percent in 1996 to 52 percent in 2000. More than half of all jury awards today top $1 million, and the average jury award has increased to about $3.5 million (10). Doctors alone spent $6.3 billion last year to obtain coverage (11).

Unfortunately, patients with very little evidence to demonstrate a physician's negligence may be entitled to unlimited compensation. To prevail, the patient need only show that the physician deviated from the medically adopted standard of care. The problem today is that, depending on the expert witnesses used and the particular specialty being reviewed, there is a potential to view any physician's conduct as a deviation.

When a patient does decide to go into the litigation system, only a very small number recover anything. One study found that only 8 to 13 percent of cases filed went to trial, and only 1.2 to 1.9 percent resulted in a decision for the plaintiff (12). Fully 70 percent of all medical malpractice actions brought against physicians result in no indemnity payment being made to the plaintiff (or his/her lawyer). In other words, the vast majority of cases brought have no merit. Unfortunately, even these cases are costly to defend. The average cost to defend these meritless claims in 2001 was $22,967 (13).

The current system imposes a tremendous financial burden that all Americans pay through higher insurance premiums, higher out-of-pocket payments, and higher taxes.

A leading study estimates that limiting unreasonable awards for non-economic damages could reduce health care costs by five to nine percent without adversely affecting the quality of care (14). This would save $60 to 108 billion in health care costs each year that would permit an additional 2.4 to 4.3 million Americans to obtain health insurance (15). The direct cost of malpractice coverage and indirect cost of defensive medicine increases the amount that the federal government pays by $28.6 to 47.5 billion a year (16). This is enough money to fund a prescription drug benefit for Medicare beneficiaries and help Americans obtain health insurance coverage.

The independent Congressional Budget Office (CBO) confirms the cost savings of medical professional liability insurance reform for physicians, hospitals, and other health care providers and organizations (17). According to a September 2002 CBO cost estimate analysis, that reduction in insurance costs would, in turn, lead to lower charges for health care services and procedures and, ultimately, to a decrease in rates for health insurance premiums.

Because employers would pay less for health insurance for employees, more of their employees' compensation would be in the form of taxable wages and fringe benefits. As a result, CBO estimates that enacting medical professional liability reform would increase federal revenues by $40 million in 2003 and by $2.4 billion over the 2003 to 2014 period (17). Additionally, reform would also reduce federal direct spending for Medicare, Medicaid, the government's share of premiums for annuitants under the Federal Employees Health Benefits Program (FEHBP), and other federal health benefits programs. The CBO estimates that direct spending would decline by $11.3 billion over the 2004 to 2012 period. For active employee FEHBP beneficiaries, reform would reduce spending by about $400 million over the same period (17).

Public Opinion Supports Medical Liability Reform

A recent nationwide poll of 1,006 adults reveals that Americans are increasingly concerned about the frequency and severity of medical liability lawsuits and agree that litigation is one of the primary factors behind rising medical costs and reduced access to care. By overwhelming margins, Americans favor reforms to limit the fees that trial lawyers can collect from medical liability claims and guarantee patients full payment for medical expenses and lost wages while placing reasonable controls on awards for noneconomic damages, such as "pain and suffering." The results of the poll reflect growing sentiment that lawsuit abuse is rampant and that the wrong party is receiving compensation:

- Nearly four out of five Americans (78 percent) express concern that skyrocketing medical liability costs could limit their access to care, as doctors in many parts of the country, particularly those providing specialized care, scale back services or abandon their practices.
- Nearly half of Americans (48 percent) believe that the number of malpractice lawsuits against health care providers is "higher than is justified," compared to just 17 percent who said that the number of claims is "lower than is justified."
- More than seven out of 10 Americans (71 percent) agree that medical liability litigation is one of the primary forces driving up health care costs.
- By a wide margin (73 percent to 26 percent), Americans favor a law that would guarantee injured patients full payment for lost wages and medical costs and place reasonable limits on awards for "pain and suffering" in medical liability cases.
- More than three-quarters of Americans (76 percent) favor a law limiting the percentage that a trial lawyer can collect in a settlement or award from a medical liability case, including an overwhelming 80 percent of Americans between the ages of 35 and 64 (18).[1]

Position

1. *Congress should immediately pass medical professional liability insurance reforms similar to those contained in the California Medical Injury Compensation Reform Act (MICRA), particularly caps on noneconomic damages, as necessary changes in a flawed system.*

In 1975, California faced a severe medical professional liability insurance crisis (19).[2] This crisis caused consumer health insurance rates to escalate and health insurance availability to decrease. In response, Governor Jerry Brown called an emergency session of the California legislature. The legislature, in an attempt to bring health insurance rates back to an affordable level, enacted the Medical Injury Compensation Reform Act (MICRA) (20). MICRA substantially modified the remedies available to plaintiffs in medical malpractice cases. Twenty-seven years later, MICRA is still the law in California.

1. The margin of error is +/–3.1 percentage points at a 95 percent confidence level.
2. In 1965, there were only 13.5 malpractice claims for every 100 physicians. By 1974, the number of claims rose 40 percent to 18 per 100. Jury awards in medical malpractice suits also increased during the period preceding the enactment of MICRA. In 1968, only one medical malpractice claimant received a jury verdict in excess of $250,000. In 1974, however, 14 malpractice damage awards in California were in excess of $250,000, totaling $3,643,000.

For nearly three decades, MICRA has proven to stabilize the medical liability insurance market in California (see Table 2). MICRA is also saving California from the current medical liability insurance crisis.[3] Premiums there have risen much more slowly than the rest of the country without any effect on the quality of care received by residents of California. Insurance premiums in California have risen by 167 percent over this period, while those in the rest of the country have increased by 505 percent (21).

Table 2. States with High Annual Premiums in 2001 by Specialty Compared to California

	Internists	Surgeons	OB/GYN
Florida	$27K–51K	$63K–159K	$143K–203K
Michigan	$18K–40K	$67K–94K	$87K–124K
Illinois	$16K–28K	$50K–70K	$89K–110K
Ohio	$11K–16K	$33K–60K	$58K–95K
Nevada	$9K–16K	$32K–57K	$60K–95K
New York	$6K–22K	$19K–63K	$34K–115K
West Virginia	$8K–16K	$44K–56K	$63K–85K
California	**$4K–15K**	**$14K–42K**	**$23K–72K**

Source: Trends in 2001 rates for physicians' medical professional liability insurance. Medical Liability Monitor. October 2001;26.

Therefore, ACP makes the following recommendations concerning MICRA-type reforms:

Noneconomic Damages

Noneconomic damages are paid to compensate an individual for physical and emotional pain, suffering, inconvenience, mental anguish, loss of enjoyment of life, and other intangible, nonmonetary losses. The United States is the only country in the world that provides unlimited compensation for noneconomic damages (6).

Noneconomic damages are separate and distinct from, and do not include, compensation for medical costs, lost wages, loss or impairment of earning capacity, projected medical expenses, or other out-of-pocket expenses—these are economic damages. Therefore, a cap on noneconomic damages would not in any way limit the amount of money that an injured plaintiff could receive to cover his or her hospital costs, doctor bills, other medical expenses, lost wages, or future damages.

ACP Recommendation: The College favors a $250,000 cap on noneconomic damages. Additionally, the College supports a $50,000 cap on noneconomic damages for any doctor performing immediate, life-saving care. The College strongly believes that a cap on noneconomic damages is the most effective way to stabilize premiums and should be the centerpiece of any legislative proposal to reform the medical professional liability insurance system. ACP is opposed to limits on economic damages.

3. The Doctors Company reported a 93 percent difference in average rates between obstetrician/gynecologists in California (with MICRA reforms) and Nevada (with no MICRA-type reforms).

Collateral Source Rule

Under the collateral source rule, a defendant is prohibited from introducing in court any evidence to suggest payments received by the plaintiff from sources other than the defendant, which might remedy some of the plaintiff's economic loss. These sources could include health insurance reimbursement, workers' compensation, and disability insurance payments.

The result: double recovery of damages by plaintiffs, since both the defendant and another party, such as an insurance company, pay the plaintiff for the same loss. This is contrary to the decision by the jury. Eliminating this rule and allowing offsets for collateral sources would mean that the amount of collateral source payments made to the plaintiff would be subtracted from the amount of damages awarded by the court. The plaintiff still would be made whole for his or her injuries, but would not receive a windfall, and the decision of the judge or jury would be respected.

ACP Recommendation: Juries should be aware of collateral source payments and allow offsets for those payments.

Statute of Limitations

All states have statutes of limitation, or procedural laws cutting off a cause of action, applicable to medical malpractice actions. In many states, the time during which a lawsuit may be filed for malpractice actions begins only upon discovery of the injury. Since injuries caused by malpractice may be discovered several years after procedures are performed or treatment rendered, the time period for filing a cause of action may be very uncertain.

Therefore, a reasonable statute of limitation on claims is necessary. This requirement guarantees that health care lawsuits will be filed no later than 3 years after the date of injury, providing health care providers with ample access to the evidence they need to defend themselves. In some circumstances, however, it is important to guarantee patients additional time to file a claim (e.g., an extension of the statue of limitations for minors injured before age 6 years). This provision allows for a reasonable amount of time for the minor plaintiff to have discovered the injury to bring a suit.

The rationale for limiting the time in which a plaintiff can file a lawsuit is that evidence becomes stale over time. Therefore, there is a point in time where the plaintiff's right to bring a lawsuit is outweighed by the defendant's interest in not being subjected to a suit in which evidence has been destroyed or lost, witnesses have died, etc. The limitations also allow individuals and insurers to anticipate future liability from past conduct.

ACP Recommendation: A reasonable statute of limitation on claims should be required. Lawsuits should be filed no later than 3 years after the date of injury, providing health care providers with ample access to the evidence that they need to defend themselves. In some circumstances, however, patients should have additional time to file a claim for an injury that could not have been discovered through reasonable diligence.

Joint and Several Liability

This rule allows any defendant in a lawsuit to be held liable for the entire amount of the claimant's damages, regardless of that defendant's proportion of fault for the damage done. Courts have held defendants who have been judged to be responsible for only one percent of the cause of injury responsible for 100 percent of the damages paid. Joint and several liability, then, encourages trial lawyers to ignore defendants who are truly responsible and focus on any deep-pocket party that is tangentially related to a case. It separates responsibility for causing an injury from the responsibility to compensate for that injury.

ACP Recommendation: Defendants should remain jointly liable for all economic losses, such as medical bills and lost wages, but should be held liable *only* for their own portion of the noneconomic and punitive damages.

Periodic Payment of Future Damages

Future damages are the plaintiff's losses that are projected to occur in the future resulting from the injury at issue. They include future medical expenses and loss earnings. One way to help reduce the impact of large awards on insurers is to allow damages to be awarded according to a schedule of periodic payments. This provision would allow the defendant to pay for future losses with annuities or other financial instruments that have a lower "present value." It also would ensure that funds continue to be available to the plaintiff to cover these future damages as they do occur by avoiding the possibility of mismanagement of a lump sum payment. In short, periodic payment vehicles are generally better for patients and save the health care system money.

ACP Recommendation: Allow the defendant to make periodic payments of future damages over $50,000, if the court deems appropriate, instead of a single lump sum payment. The plaintiff still would receive full and immediate compensation for all out-of-pocket expenses; noneconomic damages; punitive damages, if awarded; and future damages of $50,000 or less.

Attorney-Contingent Fees

Typically, when an attorney agrees to take a case on a contingency fee basis, he or she agrees to charge the plaintiff a fixed percentage of the plaintiff's award or settlement, usually between 33 1/3 and 50 percent, leaving victims with only 66 percent or less. If the plaintiff either settles or receives a judgment, the attorney's fee would be the agreed-upon percentage of the award or settlement. If the plaintiff receives no award for his or her claim, the plaintiff's attorney does not receive a fee. This approach seeks to attract frivolous suits and discourage prompt settlements and assures an unfair distribution of awards.

This provision places limits on attorneys' fees and will reduce lawyers' incentives to bring frivolous lawsuits, while allowing more money to go directly to injured patients. Limited resources can either fund lawyers or fund patients in our health care system. Under this approach, the larger a victim's demonstrable, real-life economic damages are, the more he or she will receive, because lawyers will be allowed to take only 15 percent of awards over $600,000. This proposal would allow victims to keep roughly 75 percent of awards under $600,000 and 85 percent of awards over $600,000. Simply, victims who demonstrate large losses get more and lawyers get less, but not so much less that the lawyers won't take on claims. In fact, in California, where limitations on attorneys' fees as part of tort reform have been in place since 1975, a plaintiff's attorney still receives more than $220,000 of a $1 million award—and plaintiffs receive 17 percent more than under traditional contingency arrangements (22).

ACP Recommendation: Establish a sliding scale for attorneys' fees. This provision would place plaintiff attorneys on the following scale:

- **Forty percent (40%) of the first $50,000 recovered**
- **Thirty-three and one-third percent (33 1/3%) of the next $50,000 recovered**
- **Twenty-five percent (25%) of the next $500,000 recovered**
- **Fifteen percent (15%) of any amount recovered in excess of $600,000**

Punitive Damages

Punitive damages are awarded in addition to any awards for economic or noneconomic losses. They are aimed at punishing the defendant for egregious, malicious, or intentional misconduct, not as compensating the plaintiff. Every state has its own standard for determining when punitive damages are appropriate. A plaintiff who proves that his or her injuries were caused by the defendant's negligence will receive full compensation for his or her injuries, regardless of whether punitive damages are limited or not awarded at all.

Although punitive damages are rarely awarded in medical liability cases, plaintiff's attorneys routinely include punitive damage claims in their complaints. This has the effect of hampering settlements. Where there are no reasonable guidelines to aid juries in determining the appropriate level of punitive damages, such awards potentially could be limitless. This "lottery" atmosphere—where suits are filed at the hint of negligence—makes settlement negotiations difficult, since the parties are unable to make an accurate assessment of the value of the particular case.

ACP Recommendation: Punitive damages should be awarded only if there is "clear and convincing evidence" that the injury meets the standard set by each jurisdiction. In those cases, damages should be limited to $250,000 or twice compensatory damages (the total of economic damages plus noneconomic losses), whichever is greater.

Alternative Dispute Resolution

The principal objective of Alternative Dispute Resolution (ADR) is to promote quicker and less costly resolution of claims. Because our civil justice system has exceptionally high administrative costs (attorney fees, expert witness fees, outlays for medical reports, second opinions, insurance company overhead), most of the business community has adopted ADR. Health care and personal injury litigation has slowly lagged behind the trend.

ADR can take many forms, such as mediation. Arbitration, mini-trials, summary jury trials, and moderated settlement conferences are all hybrid forms of these categories. Some ADR programs are voluntary (whereas both parties agree to try to resolve their differences before going to court), while others are mandatory (the parties have no choice; they are required by statute or contract to participate in the ADR process). If participation is voluntary, the ADR decision is more likely to be binding on the parties. If participation is mandatory, the ADR decision is often but not always nonbinding in effect.

ACP Recommendation: The Secretary of Health and Human Services would be authorized to make grants to states for the development and implementation of ADR programs. States would have flexibility in devising their ADR programs as long as federal standards were met. Federal standards should require ADR systems to incorporate some sort of disincentive to proceeding through the court system so that the ADR would not simply be a costly "add-on" rather than a cost-effective and faster way of resolving claims. Additionally, the ADR decision should be admissible in court if the parties proceed to litigation.

Effect on State Law

ACP Recommendation: Nothing that Congress passes should preempt or supersede any state law: 1) on any statutory limit on the amount of compensatory or punitive damages that may be awarded in a health care lawsuit; 2) on any defense available to a party in a health care lawsuit; and 3) that imposes greater protections for health care providers and health care organizations from liability, loss, or damages.

Any law that Congress passes should preempt state law if it differs with the federal law to the extent that it: 1) provides for the greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages; and 2) prohibits the introduction of evidence regarding collateral source benefits or mandates or permits subrogation or a lien on collateral source benefits.

These recommendations are prescribed in H.R. 4600/S. 2793, the Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002, and must be the centerpiece of any reform initiative. These prescribed reforms are not part of some untested theory—they work. Therefore, the American College of Physicians strongly supports this legislation and urges its immediate passage in Congress.

Position

2. *Congress should examine the insurance industry's financing operations, with a view toward identifying the sources of industry difficulty with predicting loss and setting actuarially appropriate rates. However, an examination of industry practices is not an adequate substitute for MICRA-type reforms.*

Because of disagreement amongst the commercial insurance industry as to whether the proposed medical malpractice reforms will lead to a reduction in medical liability premiums or just stabilize the current market, the College favors further examination of malpractice reforms in addition to the MICRA-type proposals. It has been suggested on Capitol Hill that the availability and affordability crisis in malpractice insurance may be related to actuarially unsound underwriting practices on the part of commercial insurance carriers (23). Therefore, the College endorses a thorough collection and analysis of information detailing the rate-setting practices, claims-reserving practices, and investment activities of all medical malpractice carriers.

Data illuminating commercial insurance company practices, including the number and amount of premiums collected, the standard used to assess risk of exposure, the number and amount of claims paid out per unit of exposure, the amount of reserves per unit of exposure, and the amount of investment income earned, should be documented by carriers and available to public policymakers (1). Evaluation of commercial insurance industry operations data—particularly data that sheds light on the relationship between the legal aspects of the compensation system and insurance rates—will enable fair conclusions to be drawn about the relative merit of liability reform versus insurance regulation approaches to resolving the medical liability crisis.

There is a growing perception that the recent premium rate increases reflect excessive profiteering rather than appropriate estimates of future liabilities (24). While this argument is made among the commercials, the doctor-owned and/or -operated insurers routinely return excess payments to policyholders and should be distinguished among other carriers. Insurance industry critics also argue that profit motive has induced carriers to set premium rates artificially high (12). Liability insurers counter that premium increases are necessary to meet anticipated losses from the high volume of lawsuits in the pipeline (25). Evaluation of insurance industry operations will provide greater insight into the source and scope of industry profits and enable fair conclusions to be drawn about the need for industry-wide reform.

An affordable and stable medical professional liability insurance market is fundamental to the proper functioning of the health care delivery system. When insurance is unavailable or becomes prohibitively expensive to obtain, physicians may begin to alter traditional practice patterns by refusing to perform inherently risky medical procedures, ordering additional or costly tests to avoid liability, or even declining to practice medicine in certain high-risk specialty areas (26).[4] The ACP supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category (27).

Insurance carriers should also collect data concerning the malpractice experience of individuals that are insured. This information should be made available to institutional health care providers for use in determining whether to grant clinical privileges to staff applicants or to extend, restrict, or renew privileges to staff members. This information should also be made available to state boards of medical examiners to assist them in identifying incompetent practitioners and developing systems for monitoring and eradicating incompetent professional behavior (1).

While the College supports an examination of the insurance industry's financing operations to ensure accuracy in setting premium rates, we strongly believe that it is important that this approach not be a substitute to enacting real MICRA-type reforms that have been proven to stabilize the medical liability insurance market in California. The ACP believes that this recommendation, and others, be considered as supplemental to MICRA-type reforms.

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4. According to a March article in the *Las Vegas Review-Journal*, many Las Vegas Valley doctors say that they will be forced to quit their practices, relocate, retire early, or limit their services if they cannot find more affordable rates of professional liability insurance by early summer.

Position

3. *The medical community should employ practices designed to reduce the incidence of malpractice, including setting standards of care based on efficacy assessment data, implementing risk management programs in all health care institutions, reviewing current and prospective medical staff members' malpractice and professional disciplinary records, and restricting or denying clinical privileges to unqualified or incompetent physicians.*

Because the litigation system does not accurately judge whether an error was committed in the course of medical care, physicians adjust their behavior to avoid being sued. A recent Harris Interactive study conducted for *Common Good* illustrates just how detrimental the litigious nature of our society is to physicians and other health care professionals (28). Three hundred physicians, 100 hospital-based nurses, and 100 hospital administrators were interviewed online using Harris Interactive's Physician Panel. The study reveals the extent to which the fear of litigation affects the practice of medicine and the delivery of health care: "From the increased ordering of tests, medications, referrals, and procedures to increased paperwork and reluctance to offer off-duty medical assistance, the impact of the fear of litigation is far-reaching and profound" (28).

The study shows that more than three-fourths (76 percent) of physicians believe that concern for medical liability litigation has hurt their ability to provide quality care in recent years and nearly all physicians and hospital administrators feel that unnecessary or excessive care is provided because of the fear of litigation. It further shows that an overwhelming majority of physicians (83 percent) and hospital administrators (72 percent) do not trust the current system of justice to achieve a reasonable result to a lawsuit (28).

A broad range of experts on improving health care quality has developed strong evidence that the best way to achieve these needed improvements in quality of care is to provide better opportunities for health professionals to work together to identify errors, or practices that may lead to errors, and correct them. Many problems in the health care system result not from one individual's failings but from complex system failings. These can only be addressed by collecting information from a broad range of doctors and hospitals and encouraging them to collaborate to identify and fix problems. Many health care systems are already beginning to make these improvements:

- Intermountain Health Care and LDS Hospital in Utah improved quality and efficiency of the intensive care unit by applying quality improvement techniques and improving collaborative efforts.

- The Pittsburgh Regional Healthcare Initiative has brought together hospitals, health plans, physicians, and purchasers of health care in a collaborative effort to identify better ways to provide care. It has reduced blood infections in intensive care units by 20 percent in just 2 years, and it is encouraging reporting to reduce medication errors.

- The Baylor Medical Center in Dallas, Texas, has recently initiated an error-reporting system and integrated it into care delivery to reduce medication and other errors (29).

However, these efforts and other efforts are impeded and discouraged by the lack of clear and comprehensive protection for collaborative quality efforts. Doctors are reluctant to collect quality-related information and work together to act on it for fear that it will be used against them or their colleagues in a lawsuit. Perhaps as many as 95 percent of adverse events are believed to go unreported (29). To make quality improvements, doctors must be able to exchange information about patient care and how it can be improved—what is the effect of care not just in one particular institution or of the care provided by one doctor, but how the patient fares in the system across all providers. These quality efforts require enhancements to information and reporting systems.

In its recent report, "To Err is Human," the Institute of Medicine (IOM) observed that, "[R]eporting systems are an important part of improving patient safety and should be encouraged. These voluntary reporting systems [should] periodically assess whether additional efforts are needed to address gaps in information to improve patient safety and to encourage health care organizations to participate in . . . reporting, and track the development of new reporting systems as they form (30)."

However, as the IOM emphasized, fear that information from these reporting systems will be used to prepare a lawsuit against them, even if they are not negligent, deters doctors and hospitals from making reports. This fear, which is understandable in the current litigation climate, impedes quality improvement efforts. According to many experts, the "#1 barrier" to more effective quality improvement systems in health care organizations is fear of creating new avenues of liability by conducting earnest analyses of how health care can be improved. Without protection, quality discussions to improve health care provide fodder for litigants to find ways to assert that the status quo is deficient. Doctors will be reluctant to engage in health care improvement efforts if they think that reports and recommendations that they make will be thrown back at them or others in litigation. Quality improvement efforts must be protected if we are to obtain the full benefit of doctors' experience in improving the quality of health care.

The IOM Report emphasized the importance of shifting the inquiry from individuals to the systems in which they work: "The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system" (30). But the litigation system impedes this progress—not only because fear of litigation deters reporting but also because the scope of the litigation system's view is restricted. The litigation system looks at the past, not the future, and focuses on the individual in an effort to assess blame rather than considering how improvements can be made in the system.

Researchers have found that most errors are system failures rather than individual faults. Doctors could do their job correctly and most errors would still occur. In addition, since human error inevitably occurs, built-in systems should automatically prevent, detect, and/or correct errors before they occur. Continuous quality improvement processes, which have been effective in many other "high-risk" sectors, focus on finding ways to design work processes so that better results and fewer errors can be achieved. This requires measurement and analysis of the ways that health care is provided and the results of care for patients. By encouraging the experts to work both inside their own organization and with outside groups to share information on how medical errors or "near misses" occur and ways to prevent them, health care organizations have begun to develop tools to prevent injury and increase knowledge of how errors occur.

A principal obstacle to taking these steps is the fear of doctors, hospitals, and nurses that reports on adverse events and efforts to improve care will be subject to discovery in lawsuits. As several distinguished physicians recently wrote, "for reasons that include liability issues and a medical culture that has discouraged open discussion of mistakes, the power of individual case presentation, so important in the physician's clinical medicine education, has not been harnessed to educate providers about medical errors" (31).

The College encourages continued development of existing efforts within the profession to examine the diagnostic and therapeutic procedures that constitute the physician's art, and to develop guidelines for their use, based on solid data and expert opinion. The formulation and dissemination of such guidelines can aid practitioners in making more medically effective clinical decisions and can provide them with the assurance of meeting a professional standard of practice—an assurance that will prevent resort to inappropriate defensive practices.

Therefore, the American College of Physicians supports the voluntary reporting of incidents that do not result in fatalities or major errors, but that could indicate systemic problems. Protection of the confidentiality of data is essential to ensure that incidents adversely effecting patient safety are reported. The College strongly suggests that a voluntary reporting system must be primarily educational rather than punitive. Any potential increased exposure to lawsuits, losses of hospital privileges, or loss of medical licensure will discourage physicians from voluntarily reporting "near misses" and other adverse incidents (32).

The College supports legislation introduced in both Houses and Congress that would provide protection from discovery in lawsuits for reports made to patient safety organizations and for their collaborative efforts to improve care. H.R. 4889/S. 2590, the Patient Safety and Quality Improvement Act, will ensure that patient safety and quality reports are given the protection that they deserve. Information developed or used through these reporting mechanisms would be protected and would not be available for trial lawyers to exploit in order to find new opportunities for litigation.

Additionally, the College believes that hospitals can limit their exposure to malpractice by continually assuring the high quality of their medical staffs. All health care institutions should keep updated records of malpractice and professional disciplinary experience of their staff. They should also seek to obtain a complete malpractice and disciplinary history of staff applicants, denying privileges to any physician whose record reflects incompetence. No physicians should ever be granted privileges by an institution to perform procedures for which he or she is not qualified. Staff privileges should be structured so that proof of ability to competently perform select procedures should be a condition precedent to being granted the privilege to do so (1).

Position

4. *Demonstration projects should be authorized and funded to test no-fault system(s), enterprise liability, and the bifurcation of jury trials and to study raising the burden of proof.*

No-Fault Systems

The most discussed alternative to reforming the medical professional liability system is the no-fault system. The central premise behind the no-fault model is that patients need not prove negligence to access compensation. They must only prove that they have suffered an injury, that it was caused by medical care, and that it meets whatever severity criteria applies (33). Precedent from no-fault automobile insurance and Workers' Compensation supports this system. Additionally, Virginia and Florida became the first states to introduce no-fault for medical injuries (34). Although narrowly focused, the programs in Virginia and Florida are significant because they are the only operating examples in the United States of no-fault for medical injuries.

During the 1980s, the medical professional liability insurance market became unsettled, largely due to the unpredictable awards of severely brain-damaged newborns. The solution was to "carve out" from tort the most costly obstetrical liability. By eliminating a narrow portion of physicians' liability, the result was a smaller and more predictable tort system for the states of Virginia and Florida in obstetrics.

The goal of the no-fault concept is to improve upon the injury resolution of liability. No-fault advocates point to improved *compensation*, *deterrence*, and *justice* in the liability system (35).

No-fault improves *compensation* in several ways: 1) More people collect benefits because (a) coverage extends to medical injuries caused by medical acts or omissions that are not demonstrably negligent, and (b) the costs of bringing a claim in time, dollars, and adversarial tension is reduced; 2) Payment of benefits should occur at a faster rate through insurance claims as opposed to litigation. No-fault is meant to encourage prompt filing because the costs are so low, and the need for attorney representation is minimized; 3) More benefits should be paid relative to premiums because the administrative share of spending will decline without the litigation process. As a result, claimants would not be forced to compromise; 4) Benefits should be better tailored to the individual needs because payments are made as needs arise; and 5) Compensation should be improved through no-fault because periodic payment of benefits provides a form of insurance protection against unanticipated changes in needs (35).

No-fault improves *deterrence* of injury and promotion of quality in the following ways: 1) covering more cases internalizes a greater share of medical injury costs into premiums, which should motivate premium payers to investigate the causes of injury and take cost-effective precautions; 2) larger scale operations and greater expertise should allow an administrative agency or insurer to develop epidemiologic data about medical injuries and about what practices tend to reduce such injuries; 3) greater medical credibility among affected medical practitioners who ensure that causative instrumentalities should result from administrative dispute resolution by an expert agency or use of preset lists of avoidable events in place of a trial by jury or attorney negotiations; and 4) deterrence of injury due to the reduction in the likelihood for defensive medicine (35).

No-fault improves *justice* for the claimant because more patients will be served. Injured parties and families feel attended to, even though they never set foot in a courtroom. Justice is also advanced because of the consistency in payments, achieving equal reimbursement for patients suffering similar harm, a feat that the current malpractice system has struggled to accomplish.

Opponents of the no-fault system argue that the greatest shortcoming of this system is the foregoing of benefits received under tort. The no-fault system also leads to a lower payout for attorney's fees, which critics argue may result in poorer representation.

Nevertheless, obstetrical liability premiums in Virginia and Florida declined much more rapidly after no-fault than the rest of the nation. This success was largely achieved by taking many of the more expensive obstetrical cases out of the court system. These programs, albeit on a very narrow and limited focus, demonstrate the technical feasibility of running a medical injury program successfully. Given the benefits achieved, together with the significant possibility of a broader no-fault system to improve compensation, deterrence, and justice, demonstration projects seem warranted.

Early Offers

Early Offers is an innovative hybrid of the no-fault system (36).[5] Under this model, physicians and other health care providers can offer an injured person payment for all future economic losses. In return, the plaintiff gives up his or her right to sue in court. This approach would provide a new set of balanced incentives to encourage doctors to make offers quickly after an injury and to compensate the patient for economic loss and encourage patients to accept this compensation.

Further, Early Offers would make it possible for injured patients to receive fair compensation quickly, and over time if any further losses were incurred, without having to enter into a courtroom. Additionally, because doctors and hospitals would have an incentive to discover adverse events quickly in order to make a qualifying offer, they would work in tandem leading to prompt identification of quality issues.

Opponents of the Early Offers system argue that it is unduly coercive on patients. Moreover, they claim, the immediate payment version of the idea relies on provider willingness to accept responsibility in more cases. In addition, like other alternatives in the tort reform system, it might work "too well," and large numbers of cases would have to be paid.

Given the potential for success, demonstration projects should be funded and tested to see if Early Offers can reduce premiums. Therefore, ACP expresses support for demonstration projects to test the feasibility of no-fault liability system(s).

5. A bill to implement this approach was first introduced by Reps. Henson Moore and Richard Gephardt in 1987, H.R. 5400, 98th Congress.

Enterprise Liability

In 1993, the Clinton Administration's health care reform proposal included enterprise liability as a demonstration project for improving the medical malpractice reform system (37). While term enterprise liability was first envisioned to encompass liability for hospitals, many have attempted to apply the concept to health plans. Just as hospitals would be responsible for malpractice committed within their walls, so, too, would health plans be liable for malpractice committed by a physician in their network.

Under enterprise liability, a hospital (or health plan) would bear the exclusive responsibility for medical malpractice committed by affiliated providers. The only exception would be for an injury resulting from gross negligence or intentional misconduct on the part of the physician. A system of enterprise liability for health plans should have the following principal features:

- Each health plan would be liable for negligent injury to its enrollees caused by the health plan's affiliated practitioners and providers.
- Physicians and other health professionals practicing as employees of or under contract to health plans would be immune from suit.
- Health plans would be prohibited from requiring practitioners to indemnify them for malpractice losses or to purchase insurance but would be allowed to pass along a portion of their total liability costs as overhead affecting compensation.
- Institutional providers (such as hospitals) that can monitor and improve the quality of care within their organizations would be allowed to negotiate indemnification or risk-sharing agreements with health plans.
- Alternatives to litigation, such as arbitration or limited no-fault arrangements, would be encouraged to allow health plans to compensate fairly and rapidly a greater percentage of injured patients.
- Limits on noneconomic damages (a $250,000 cap would be instituted to eliminate the threat of unreasonably large awards against corporate defendants).

Many integrated heath care enterprises, including academic and nonprofit hospital systems, such as the Federation of Jewish Philanthropies in New York City and the Harvard Medical Institutions in Boston, currently purchase malpractice insurance for their affiliated, as well as employed, physicians (38). In these arrangements, affiliated physicians do not carry individual insurance polices but are covered under the policy of the hospital or health systems of primary affiliation. Physicians pay a portion of the enterprise's premium, which is considerably less than individual liability coverage. When a suit arises, the individual physician still stands as a defendant, but one insurer covers both the institution and the physician, with claims defended jointly by one attorney. Kaiser Permanente and government-run delivery systems, such as the Department of Defense, the Veterans Administration, the Indian Health Service, the Public Health Service, and the Bureau of Prisons, assume similar liability structures (39).

Many believe that enterprise liability is designed to improve the quality of care and reduce burdens on individual practitioners by placing incentives for providing good medical care and efficiently resolving disputes on entities that can best respond—the health plan or hospital. The theory is that if these entities assume responsibility for the clinical, as well as the cost, consequences of their care management decisions, physicians would feel less pressure to practice defensive-

ly and the entities would pay more attention to avoiding injury. Under the enterprise liability system, health plans and hospitals would select high-quality providers, promote improvements in practice through better information and communication, seek out evidence of patient (dis)satisfaction, and move rapidly to investigate, redress, and avoid patient injury.

Unfortunately, there are some unknowns with the enterprise liability system. For enterprise liability to be effective, physicians would have to be employees of the organization or there has to be sufficient integration for the health plan (or hospital) and physicians to work together on the necessary quality assurance and injury prevention programs. Additionally, practitioners belonging to many health plans with privileges at many hospitals pose a problem, as do solo practitioners. Further, the health plan or hospital may be discriminated against in a jury trial because it may be seen as an unsympathetic defendant, thereby erasing any savings from this arrangement.

Despite the potential for drawbacks, the opportunity exists for potential benefit to result from the enterprise liability concept that should be further explored. Thus, ACP expresses support for demonstration projects to determine the feasibility of enterprise liability.

Bifurcation of Jury Trials

Jurors deciding cases of physician negligence are required to determine whether the defendant performed in an appropriate manner at the time of the original decision or treatment prior to the negligent acts. Unfortunately, this decision is made from the perspective of hindsight. There is a presumption that jurors can somehow separate their knowledge of the outcome and return to the perspective of the defendant who, at the time, could not have known the outcome. Unfortunately, people tend to exaggerate when retrospectively considering an event that could have been correctly predicted beforehand (40). This tendency is known as "hindsight bias" (41). Insurance companies routinely settle cases for fear that, in hindsight, the physician appears to be negligent, even though in foresight no such determination is warranted. Awards in jury trials may be granted for similar reasons.

To remedy this notion of "hindsight bias," ACP recommends that medical malpractice trials should be divided into two phases. The first phase of the trial addresses the issue of whether the physician exercised reasonable care in light of the facts available at the time of diagnosis. The purpose of the first phase is only to render judgment, without knowledge of the outcome. Only if the jury finds that the physician deviated from this appropriate standard of care does the second phase, known as the penalty phase, occur. Because the issue of physician care is the only issue decided in the first phase, the jury does not hear complaints associated with noneconomic damages. Thus, no knowledge of the severity of the outcome would minimize the effects of "hindsight bias."

Studies have shown that the bifurcation of trial was favored by a 10 to 1 ratio among federal judges, and by a 13 to 1 ratio among state judges, as having a positive impact on the fairness of the outcome (42). In both the federal and state samples, 84 percent of the judges thought that bifurcation had helped the process (42). A total of 82 percent of the federal judges and 77 percent of the state judges thought that the bifurcation procedure accelerated the trial process (42). Thus, the potential for a second hearing actually expedited rather than delayed the process according to the judges.

The bifurcation of a jury trial is not new to the judicial system. Rule 42(b) of the Federal Rules of Civil Procedure provides for separate trials in furtherance of

convenience to avoid prejudice or when conducive to expedition and economy.

There are, however, a couple of reasons why the bifurcated trial procedure may not be the solution to "hindsight bias." For one thing, while jurors may not be aware of any particular negative outcome, they will assume that a bad outcome occurred, or else the case wouldn't be brought forth. Secondly, the plaintiff's lawyer may attempt to introduce evidence about damages during the liability phase of trial. Therefore, it will be crucial that adequate rules of civil procedure be developed to prohibit the inappropriate introduction of damage evidence into the liability phase of the trial.

Given the studies that indicate that the bifurcation of jury trials has a positive impact on the fairness of the outcome, and given that "hindsight bias" tends to exaggerate the outcome of jury trials, the bifurcation of medical malpractice cases is appealing and should be further explored. Thus, ACP expresses support for demonstration projects to determine the feasibility and effectiveness of the bifurcation of jury trials as one component to reform the medical professional liability system.

Study Raising the Burden of Proof

Current law provides that a plaintiff only has to prove a medical liability claim by a "preponderance of the evidence." Essentially, this level of proof only requires that something is more likely true than not. Given the low level of proof that is required, and the fact that very little evidence is necessary to achieve this low standard, the American College of Physicians believes that there is merit in obtaining further data on the feasibility of raising the burden of proof to a higher standard as a possible model for federal and state tort reform legislation.

The "clear and convincing evidence" standard is a higher level of proof for the plaintiff to meet that simply means that the trier of fact must be persuaded by the evidence that it is *highly probable* that the claim or affirmative defense is true. Given the fact that medicine is not an exact science, and that jurors are typically not experienced in the appropriate standard of care, raising the burden of proof should be further studied in the hopes of achieving a more equitable judicial system. Potentially, this change could result in fewer frivolous claims being filed and only encourages those claims with merit being brought forward, making this a favorable outcome.

ACP recognizes that a study raising the burden of proof from a "preponderance of the evidence" to "clear and convincing evidence" will not be without its fair share of criticism. It will be claimed that some cases will not be brought forth because there is not enough evidence to meet the higher standard. Additionally, others may charge that legitimate claims will be discouraged from being filed, something that may disproportionately impact the poorest population. All of these are concerns that will need to be addressed by policymakers. Unfortunately, there is no experiential evidence to suggest that such a change will have a positive or negative impact on the judicial system. ACP strongly believes and reiterates in this paper that those individuals who have been injured due to medical negligence deserve fair and just compensation. We also believe in the promotion of a fair malpractice and deterrence system. ACP believes these two notions can work in tandem.

Therefore, although ACP does not currently believe that there is sufficient experiential evidence to advocate as a national organization in favor of raising the burden of proof from a "preponderance of the evidence" to a "clear and convincing evidence" standard, we believe that there is a strong potential that such a change would result in fewer frivolous claims being filed, leading to lower premiums without compromising injured patients' right to fair and just compensation. Therefore, ACP urges that additional data be obtained on the potential impact of raising the burden of proof through demonstration projects at the state level.

Conclusion

For several years, the American College of Physicians has strongly advocated for MICRA-type reforms to provide immediate relief to physicians and to help provide more compensation to patients in a timely fashion. We affirm our strong support for these concepts and believe that the proven California MICRA law must remain the centerpiece of any reform. Moreover, we restate our belief that every tort reform measure should be assessed toward its ability to lower professional liability insurance premiums or reduce the severity and frequency of malpractice claims without denying injured patients fair and appropriate redress for negligence.

It is clear the current tort reform system is broke and must be reformed to eliminate its inherent flaws. The new structure should have the capacity to accomplish the goals of preventing and detecting medical errors, compensating patients in a timely fashion, and reducing the costs associated with defensive medicine. Alternative approaches, such as enterprise liability and no-fault liability, are also necessary because the current system does not adequately protect physicians or fairly distribute compensation to the injured.

Still another aspect that has received much attention from Congress involves an examination of the insurance industry's financing and operations. This approach should be simultaneous with other recommendations of reforming the medical professional liability insurance system with a view toward better predicting loss and setting rates within the industry. Further oversight of the business practices of the insurance industry would reveal any existing alleged improper management or excessive profiteering that might explain the premium affordability issue.

Furthermore, the College encourages continued development of existing efforts within the profession to examine medical procedures that constitute the physician's art, and to develop guidelines for their use, based on solid data and expert opinion. The formulation and dissemination of such guidelines can aid practitioners in making more medically effective clinical decisions and can provide them with the assurance of meeting a professional standard of practice—an assurance that will prevent resort to inappropriate defensive practices.

Therefore, the American College of Physicians supports the voluntary reporting of incidents that do not result in fatalities or major errors, but could indicate systemic problems. Protection of the confidentiality of data is essential to ensure that incidents adversely effecting patient safety are reported. The College strongly suggests that a voluntary reporting system must be primarily educational rather than punitive. Any potential increased exposure to lawsuits, losses of hospital privileges, or loss of medical licensure will discourage physicians from voluntarily reporting "near misses" and other adverse incidents.

Another innovative approach to reforming the medical professional liability system is through enterprise liability. Enterprise liability recognizes the current trend in the health care market moving toward a more integrated delivery system. This approach demands further study as to its feasibility in the health care arena. If an entity—a hospital or health plan—can show that it can develop injury prevention programs and effectively monitor the quality of care, and its affiliated physicians agree to participate, it should be allowed to develop an enterprise liability system.

The College also believes that theories within the no-fault approach should be further tested. Similar to what Virginia and Florida have experienced in obstetric care, like models should be authorized and funded to demonstrate whether similar successes can be achieved to bring down the cost of premiums among other high-risk specialties. Under this equitable approach, patients

would receive equal reimbursement for suffering similar harm and awards for noneconomic damages would be prohibited.

Therefore, we urge Congress to pass legislation authorizing the Secretary of the Department of Health and Human Services to provide grants to develop no-fault and enterprise liability projects. To be eligible to receive federal money, a grantee would have to show that its system meets the following criteria:

- It resolves disputes quickly and fairly.
- It is voluntary. Patients would give consent and have the ability to opt-out.
- It provides timely compensation to injured persons.
- It improves the quality of care.
- It is supported by participating physicians. This will ensure that physicians are involved in all phases of the project's development and implementation, including development of risk management systems, quality monitoring, and injury prevention.
- It has policies in place guaranteeing certain "due process" protections for physicians.
- It has physician advisory panels to oversee liability claims management for health plans and organizations so that physicians are protected from undue micromanagement (43).

Additionally, to address "hindsight bias," ACP recommends demonstration projects to establish the effectiveness of the bifurcation of jury trials into two phases. The first phase of the trial should address the issue of judgment, and whether the physician deviated from the standard of care, without knowledge of the outcome. The second phase, known as the penalty phase, only occurs if the jury finds the physician deviated from this appropriate standard of care. Because the issue of physician care is the only issue decided in the first phase, the jury does not hear complaints associated with noneconomic damages. Thus, no knowledge of the severity of the outcome would minimize the effects of "hindsight bias."

Finally, ACP requests further research and analysis on raising the burden of proof from a "preponderance of the evidence" to "clear and convincing evidence" for all medical malpractice claims. This approach, should it be determined equitable, could result in fewer frivolous claims from being filed and only encourages those claims with merit to be brought forth, without negatively impacting those individuals who have been injured and deserve just compensation. In turn, we believe that this approach, if successful, will lead to lower premiums. But because there is no research or data available to suggest whether such an approach would be successful, ACP supports further information gathering to prove that raising the burden of proof will result in a more fair and equitable judicial system.

In summary, the medical professional liability insurance system imposes substantial costs on the health care system that every American ends up paying. While the medical malpractice system was designed to adequately compensate the injured and deter future injury, the current system does not deter negligence, provide timely compensation to the injured, or resolve disputes in favor of the injured. Until the U.S. Congress decides to act, professional liability insurance premiums will continue to spiral out of control to unaffordable levels and patients will see their access to care reduced. If reasonable limits were placed on noneconomic damages, the savings would permit more Americans to obtain health insurance, more children to be immunized, and more Medicare beneficiaries to obtain prescription drug coverage. Therefore, it is our belief that comprehensive changes to the medical liability system must be made immediately.

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