



POLICY BRIEF

Overview of Initiatives 330 and 336 **Proposals to Reform Washington's** **Medical Liability Law**

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September 2005

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Executive Summary

In November voters will consider two ballot initiatives that deal with medical liability reform. This study summarizes both initiatives and explains how they differ. It also presents research showing that caps on non-economic damages in other states have been effective in reducing the costs malpractice lawsuits impose on the health care system. Comparative research also finds that caps improve access to health care by increasing the number of doctors per state resident. Finally, this study recommends stronger enforcement of professional medical standards by the state and greater use of mediation to settle malpractice claims before they go to court.

I. Introduction

On election day the voters of Washington will be presented with two ballot measures that propose far-reaching changes in the state's medical liability laws. Supporters of Initiative 330 say their proposal is needed because costly lawsuits are fueling the rise in insurance premiums and causing doctors to reduce or close their practices. The trend, they say, is contributing to higher health care costs and a shortage of doctors, especially in key specialties like obstetrics, neurosurgery and trauma care.

Supporters of Initiative 336 counter that the problem lies not with the size of jury awards and insurance costs, but with bad doctors who, through mistreatment or neglect, injure their patients. They say full access to the courts for injured patients is needed to

redress harm done by doctors and to keep negligent doctors from continuing to practice. They also say increased regulation of malpractice insurance rates is needed to keep premium costs in line.

Initiative 330 and Initiative 336 take sharply divergent approaches to medical liability reform. These competing measures have been placed on the November ballot by two professional groups, doctors and lawyers, with different interpretations of whether there is a medical liability “crisis” in Washington and what is the proper role of the courts in addressing wrongs committed by health care practitioners.

Their dispute is one of degree. Both groups agree that injured patients should be able to seek justice and fair compensation in the courts. Both agree that poor-performing doctors should be held legally accountable for their actions and, if necessary, barred from practicing medicine. Both agree that good doctors should not be put out of business by rising insurance costs and that malpractice premiums should be set at a reasonable level.

Their disagreement centers on a key question: Are medical liability lawsuits a significant driver of health care costs and, if so, what policy changes would best reduce this effect? Specifically, doctors and lawyers disagree about whether Washington, like other states, should adopt a cap on non-economic damage awards and a limit on the percentage of an award that can be paid to an injured patient’s attorneys. These different viewpoints are reflected in the texts of Initiatives 330 and 336.

Non-economic damages are the part of a medical malpractice settlement that compensates an injured person for pain, suffering and emotional distress. By their nature non-economic damages are difficult to measure. How a jury assesses such damages is unpredictable and the cost of non-economic awards varies widely even among cases with similar facts.

This study explains the main provisions of each initiative, and looks at whether and to what extent medical liability suits contribute to rising health care costs. This study also gives real-world examples of how Washington physicians have been affected by higher liability insurance costs, presents the findings of national studies on the effectiveness of non-economic damage caps, and examines the experience of California, Texas and other states that have adopted restrictions on medical liability awards.

The purpose of this study is to explain the issues involved, untangle the technical provisions of these competing initiatives, and clarify the confusing aspects of medical liability reform so voters can make an informed decision on election day.

II. Rising Health Care and Liability Insurance Costs

In recent years U.S. health care spending has been rising at more than three times the rate of general inflation, and today exceeds \$1.7 trillion a year, about 15% of the

gross domestic product.¹ Health care costs are increasing for a number of reasons; over-regulation, new medical technologies, greater use of preventative and diagnostic services, an aging population and market distortions created by the federal tax code.

In addition to these factors, a central cost-driver is the rising cost of medical liability lawsuits, which in turn fuel mounting insurance expenses for doctors, clinics and hospitals. In 2002, malpractice insurance cost the nation's doctors \$6.3 billion, while hospitals, nursing homes and clinics spent billions more for additional coverage.² Today, the amount U.S. health care professionals spend on medical malpractice premiums exceeds \$21 billion a year.³

Critics of limits on jury awards say there are other reasons malpractice insurance is becoming so expensive. They cite declines in investment income, the withdrawal or failure of some insurers, and changes in reinsurance rates as alternate reasons for higher malpractice premiums. While this may be true, there is no doubt that the steady upward trend in record-high jury awards is a direct contributing factor in the rising cost of medical liability coverage.

The rise of multi-million dollar jury awards

The nation has seen a sharp increase in the number of multi-million dollar jury awards in recent years. Multi-million dollar awards rose 40% in 1997-99, 53% in the following two years and a further 54% in 2002-03.⁴ The typical jury award increased between 1994 and 2001 by 176%, to around \$1 million per settlement,⁵ while insurance losses due to medical malpractice settlements rose from \$289 million in 1996 to \$3 billion in 2001, an increase of 938% over five years.⁶

During the 1990s premium rates rose an average of 8.1% a year, three times faster than the general inflation rate and twice as fast as health care inflation.⁷ Aggregate data on medical malpractice claims shows that even cases that are dropped or dismissed cost an average of about \$17,000 in legal defense costs.⁸ The legal expenses of doctors

¹ "Health Care Spending in the United States Slows for the First Time in Seven Years," press release, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, January 11, 2005, at www.cms.hhs.gov/media/?media=pressr.

² "Medical Malpractice Insurance," by Robert P. Herwig, Ph.D., CPCU and Claire Wilkinson, Insurance Issues Series, Volume 1, Number 1, Insurance Information Institute, New York, June 2003, p. 3, at www.iii.org/media/hottopics/insurance/medicalmal/whitepaper.

³ Ibid.

⁴ "Tort Excess 2005: The Necessity for Reform from a Policy, Legal and Risk Management Perspective," by David Dial, Esq. et al., Insurance Information Institute, 2005, p. 2, chart: "Trends in Million Dollar Verdicts," Medical Malpractice, at www.iii.org/media/hottopics/insurance/liability/tort/.

⁵ "Liability for Medical Malpractice: Issues and Evidence," Joint Economic Committee of the United States, Washington, D.C., May 2003, at www.house.gov/jec/tort.htm.

⁶ Ibid.

⁷ Ibid.

⁸ "The Perverse Nature of the Medical Liability System," Joint Economic Committee of the United States, Research Report number 109-2, March 2005, at www.house.gov/jec/tort.htm.

charged with malpractice is almost the same regardless of whether a trial results in a guilty or not guilty verdict.⁹

Frivolous lawsuits lower the quality of health care

Higher malpractice expenses add directly to the cost of doing business. Health care providers have no choice but to pass these costs on to both individual consumers and employers who pay for employee health coverage. Frivolous lawsuits also reduce the quality of health care services. The time doctors spend preparing for trial, meeting with lawyers, giving depositions, reviewing testimony and gathering records is time they do not have for medical training or treating patients.

III. Rising Liability Costs in Washington

As indicated by the preceding discussion, the cost of medical malpractice insurance places a heavy financial burden on health care across the United States, and Washington is one state where it having the greatest impact.

Partly for that reason, paying for health care is one of the fastest-rising costs facing businesses and families in Washington state. In Washington Policy Center's statewide survey, most small business owners said reducing the cost of health care was their top recommendation to state policymakers.¹⁰

Washington is one of 21 states identified by the American Medical Association as a state in medical liability crisis, especially in certain specialties.¹¹ For example, 25% of family practitioners statewide have quit obstetrics since 2000.¹² In addition, between 1998 and 2002, the number of doctors moving out of the state increased 31%.¹³ Between 1996 and 2001 the number of doctors retiring from practice increased by 50%, while the average age of retirement fell from 63 to 58.¹⁴

⁹ Ibid.

¹⁰ "Agenda for Reform: Priority Solutions for Improving Washington's Small Business Climate," Policy Brief, Washington Policy Center, January 2004, at www.washingtonpolicy.org/SmallBusiness/PBMontagueAgendaforReform.htm.

¹¹ "Medical Liability Reform," American Medical Association, accessed August 2005, at www.ama-assn.org/ama/pub/category/7861.html. The other crisis states are Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, West Virginia and Wyoming.

¹² Dr. Jean Marshall of the Group Health Cooperative clinic and President of the Washington Academy of Family Practice, quoted in "Care cost crisis, malpractice insurance rate increases force reductions in services," by Mike Archbold, *King County Journal*, January 25, 2004.

¹³ "Premiums threaten affordable care," by Julia Anderson, *The Columbian*, February 3, 2003.

¹⁴ Ibid.

The contingency fee system

Under the current civil judicial system it costs very little to file a malpractice lawsuit against a doctor, clinic or hospital. Lawyers typically agree to take such cases on a contingency basis. If the suit succeeds, the winning attorney receives a portion of the jury award, usually one third. The patient filing the suit incurs little or no risk. If he wins, the patient receives two-thirds of the jury award. If the suit fails the patient pays nothing. Critics of the contingency fee system say it promotes so-called “jackpot justice,” in which cases with little merit are brought to court because the financial reward for winning, though remote, is so large. Defenders of contingency fees say it is the only way low-income plaintiffs can gain effective access to the courts.

Rising malpractice awards in Washington

The number of high-dollar malpractice jury awards and out-of-court settlements in Washington has risen steeply in recent years. In 1993 there were 10 malpractice cases of \$1 million or more, while in 1998 there were 27. By 2002 the number of \$1 million-plus medical liability cases had risen to 39, a nearly four-fold increase in less than ten years.¹⁵ Under current state law there is no limit on the dollar amount juries can award to injured patients for non-economic damages.

Supporters of Initiative 330 say high liability insurance costs are affecting the quality of the care state residents receive. According to a survey by the Washington State Medical Association:

- 51% of Washington doctors said they are less willing to perform high-risk operations.
- 44% said they have stopped performing certain services.
- 71% said their patients have had to travel farther to receive adequate care.
- 81% said their community has had trouble recruiting doctors for certain specialties.

Examples of the impact of liability costs on health care availability

Rising liability coverage costs affect all doctors, including model providers who have never faced a lawsuit or disciplinary action. Stories about doctors reducing or closing their practices because of rising malpractice insurance costs have become common in the news media. To list all these cases is beyond the scope of this study. Below are representative examples to illustrate the general trend as reported in Washington newspapers.

- On the first day of 2004, obstetrician John Lenihan of Tacoma announced he was restricting his practice to gynecology; he would no longer deliver babies. He

¹⁵ “American’s Medical Liability Crisis Backgrounder - Washington,” American Medical Association, accessed August 2005, at www.ama-assn.org/ama/pub/category/print/12398.html.

reports his liability insurance increased from about \$10,000 annually ten years ago to \$63,000 in 2003. He indicated his premium was scheduled to increase to \$74,000 in 2004, prompting his decision to reduce his practice.¹⁶

- In early 2004, Valley Women’s Healthcare, an obstetric and gynecology clinic in south King County, cut back on services to patients. Also, Swedish Physicians, which operates 11 clinics in the Puget Sound region, reduced the number of its family physicians who deliver babies from 21 to seven.¹⁷
- Doctors Michael Kappleman and Gary Koch of the Vashon Health Center announced in January 2004 that they would no longer deliver babies “because of the rising costs of malpractice insurance and the toll it took at the Health Center.”¹⁸ Vashon Island doctor Sjardo Steneker also said he no longer delivers babies “because of the cost of malpractice insurance.”¹⁹ These were the last of Vashon’s obstetricians; women must now leave the island to give birth.
- Dr. Charles Pilcher, head of the Emergency Department at Evergreen Hospital Medical Center in Kirkland reports his medical malpractice insurance premium increased by more than 300% over three years.²⁰
- In Okanogan County, orthopedic surgeon Dr. Lisa Lamoreaux left the state, reporting her malpractice insurance was approaching \$300,000 a year.²¹
- Dr. Mark A. Snyder reports that in Yakima 19 doctors have left the area in recent years, that specialists are not available to treat accident victims, and that “family practitioners are cutting back on obstetrical patients because of malpractice premiums.”²²

Recent legislative action in the states

Medical liability is largely governed by state law. The issue has garnered a great deal of interest among state lawmakers in Washington and around the country. Forty-eight states considered over 400 separate bills dealing with medical malpractice in their 2005 legislative session. This year 29 states passed over 50 bills dealing with some aspect of medical liability reform.²³

¹⁶ “Vanishing physicians; As care for high-risk conditions becomes harder to find, patients pay the price,” by Pat O’Callahan, *Tacoma News Tribune*, January 11, 2004.

¹⁷ “Care cost crisis – Malpractice insurance rate increases force reductions in services,” by Mike Archbold, *King County Journal*, January 25, 2004.

¹⁸ “Island doctors no longer will deliver babies,” by Susan Riemer, *The Beachcomber*, January 14, 2004.

¹⁹ *Ibid.*

²⁰ “Second Opinion: Don’t blame doctors for soaring insurance,” by Charles A. Pilcher, *King County Journal*, January 14, 2004.

²¹ *The Chronicle*, letter to the editor, March 5, 2004.

²² *Yakima Herald Republic*, letter to the editor, February 9, 2004.

²³ “Medical Malpractice Tort Reform,” State and Federal Issues, National Conference of State Legislatures, July 25, 2005, at www.ncsl.org/standcomm/sclaw/medmaloverview.htm.

IV. Summary of Initiative 330

The main sponsor of Initiative 330, the “Health Care Access Initiative,” is the Washington State Medical Association, representing the state’s licensed physicians. Supporters have formed an advocacy group, Doctors, Nurses and Patients for a Healthy Washington, to push for passage. Their website is www.yesoni330.org.

Supporters of Initiative 330 had earlier directed their efforts to Olympia. The text of Initiative 330 was introduced as an initiative to the Legislature and was included in House Bill 1686, introduced on February 2, 2005 with 18 cosponsors.²⁴ The bill included a number of other reforms and was referred to the House Health Care Committee. No further action was taken on the bill before the Legislature adjourned for the year on April 24th.

*Ballot Title and Ballot Summary*²⁵

The official Ballot Title for Initiative 330 reads – “This measure would change laws governing claims for negligent healthcare, including restricting non-economic damages to \$350,000 (with exception),²⁶ shortening time limits for filing cases, limiting repayments to insurers and limiting claimants’ attorney fees.”

The official summary as it will appear on the ballot reads – “This measure would change healthcare liability laws by: limiting recovery for non-economic damages; limiting attorney fees; requiring advance notice of lawsuits; shortening time for filing cases; expanding evidence of payment from other sources and eliminating subrogation for those sources; authorizing mandatory arbitration without trial; authorizing periodic payments of future damages and terminating those payments under certain circumstances; eliminating liability for other persons or entities in some cases; and limiting damage recovery from multiple healthcare providers.”

Following is a short explanation of Initiative 330’s main provisions.

- Limiting recovery for non-economic damages. The initiative would limit total non-economic damages in medical malpractice lawsuits to \$350,000 per claimant. Only one damage award for each wrongful bodily injury or death would be allowed.

²⁴ State of Washington, 59th Legislature, 2005 Regular Session, HB 1686, “Implementing health coverage cost reduction and consumer choice,” text available at www.washingtonvotes.org.

²⁵ In this section the source for all references to the contents of Initiative 330 come from the initiative text, available at the Office of the Secretary of State, Olympia, Washington, at www.secstate.wa.gov/elections/initiatives/text/i330.pdf.

²⁶ The exception is provided in Section 2 (3) of the initiative; a total combined limit of \$700,000 on non-economic damages for hospitals that are found liable for the actions of their non-health care employees.

- Limiting attorney fees. Current law provides no limit on attorney fees. Under Initiative 330 the portion of a malpractice award that could go to the claimant's lawyers would be limited to 40% of the first \$50,000, 33.3% of the next \$50,000, 25% of the next \$500,000 and 15% of any amount over \$600,000. Under these limits, the maximum attorney fee for a \$1 million malpractice award would be \$221,500, or 22%.
- Requiring advance notice of lawsuits. Injured patients would have to give 90 days notice before filing a lawsuit.
- Shortening time for filing cases. The time for filing a malpractice lawsuit would be three years from the time of the injury. The time allowed for lawsuits filed for injuries to children under six years of age would be limited to the child's eighth birthday. Under current law such suits can be filed until the child's 21st birthday.
- Expanding evidence of payment from other sources and eliminating subrogation for those sources. Juries would be allowed to hear about payments injured patients received from other sources. Those sources would not be relieved of their financial responsibilities because of any award the injured person might receive from the lawsuit.
- Authorizing mandatory arbitration without trial. Contracts for medical services would contain a provision requiring malpractice disputes to be submitted to arbitration rather than go to trial.
- Authorizing periodic payments of future damages and terminating those payments under certain circumstances. Malpractice awards of \$50,000 or more could be paid out over time, rather than as a lump sum. At the death of the injured patient, payments for medical treatment and continuing care would stop. Payments for loss of earnings and other economic damages would go to the patient's estate.
- Eliminating liability for other persons or entities in some cases. Initiative 330 would end the so-called "ostensible agency" doctrine in Washington. That is, hospitals could not be sued for the negligent acts of a doctor unless the doctor was actually a hospital employee and under the direction of the hospital's rules and procedures.
- Limiting damage recovery from multiple health care providers. Doctors and other health care providers could not be sued for the negligent acts of another provider, as they can under current law, unless they had direct control or supervision over the actions of the offending provider.

In important respects, such as changes in the time for filing cases and ending the "ostensible agency" doctrine, Initiative 330 would bring Washington medical liability

law closer to that of Idaho and Oregon. For a description of how current Washington law compares with state law in Oregon and Idaho, see “Medical Liability Reform, A Three State Comparison,” published this year by Washington Policy Center and the Spokane Regional Chamber of Commerce.²⁷

Important Definitions in Initiative 330

In the initiative “economic damages” means objectively verifiable financial losses, including such things as the cost of medical care, rehabilitation equipment, lost property, loss of earnings, burial costs and lost of employment opportunities.

“Non-economic damages” means subjective, non-financial losses, such as pain and suffering, emotional distress, disfigurement, loss of society and companionship, loss of reputation, and lost or damaged personal relationships.

“Claimant” means an injured person or a deceased person’s estate seeking recovery of damages for injury or death occurring as a result of health care or related services.

“Health care professional” and “health care institution” mean any person or entity that is licensed, registered or certified by the state to provide health care or related services, or to arrange for such services.

What would not change.

In order to understand how Initiative 330 would work, it is important to know what aspects of the Washington law would *not* change if it is enacted.

Non-economic awards would be capped at \$350,000, but there would be no limit on economic and other measurable losses, such as medical bills, rehabilitation costs, medical equipment and specially-modified vehicles, prescription drug costs, lost wages and other financial losses, in-home care and childcare expenses.

Initiative 330 would change state law regarding civil suits, but the rules determining who can be sued and the legal standards for establishing fault would not be affected. Also, the criminal code and all enforcement actions initiated by prosecutors against doctors or other health care providers would not be changed.

Health training requirements, hospital certification, medical qualifications, professional licensing, and the medical regulatory structure for maintaining public safety would remain unchanged.

²⁷ “Medical Liability Reform, A Three State Comparison,” by Amy Johnson, Policy Analyst, joint publication of Washington Policy Center and the Spokane Regional Chamber of Commerce, April 2005, at www.washingtonpolicy.org/Misc/PB_MedicalLiabilityReform.

Is Initiative 330 unconstitutional?

Opponents of Initiative 330 say parts of the measure are unconstitutional. They point out that the state supreme court has ruled a cap on non-economic damages violates the state constitution's right to a trial by jury.²⁸

In an effort to allay this criticism, Initiative 330's sponsors have included a section which provides that if a court strikes down this part of the initiative, non-economic caps will take effect only if the state constitution is amended or Congress passes a federal law allowing such caps. Either course would be difficult to achieve.

There is a strong possibility, though, that Initiative 330 backers may not have to face this contingency, since virtually identical caps have survived extensive legal challenges in other states. Also, Congress and state legislatures routinely set standards for minimum and maximum punishments allowed for criminal offenses, without depriving citizens of their right to trial by jury. The same legal reasoning could apply to setting legal standards in civil cases.

V. Summary of Initiative 336

The main sponsor of Initiative 336, "Making Health Care Better for Washington," is the Washington State Trial Lawyers Association. Supporters have formed Citizens for Better Safer Health Care to urge passage of their initiative. Their website is www.bettersafecare.org.

Initiative 336 was apparently filed as a response to Initiative 330, since there were no proposals based on this initiative's policy approach to liability reform until it seemed likely Initiative 330 would qualify for the ballot. Initiative 330 opponents may have felt that simply urging a no vote would not be sufficient, and that instead voters should be given a choice of which approach to medical liability reform would be best for Washington.

*Ballot Title and Ballot Summary*²⁹

The official Ballot Title for Initiative 330 reads – "This measure would: require notices and hearings on insurance rate increases; establish a supplemental malpractice insurance program; require license revocation proceedings after three malpractice incidents; and limit numbers of expert witnesses in lawsuits."

²⁸ Ruling in *Sofie v. Fibreboard Corporation*, 112 Wn.2nd 636, 771 P.2nd 711, 780 P.2nd 260, April 27, 1989, based on the Court's interpretation of Article 1, Section 21 of the Washington Constitution that "The right of trial by jury shall remain inviolate..."

²⁹ In this section the source for all references to the contents of Initiative 336 come from the initiative text, available at the Office of the Secretary of State, Olympia, Washington, at www.secstate.wa.gov/elections/initiatives/text/i336.pdf.

The official summary as it will appear on the ballot reads: “This measure would establish a supplemental malpractice insurance program for liability exceeding private insurance, overseen by an appointed board and the insurance commissioner. Healthcare facilities and providers would pay for coverage; the legislature could add state funds. Public notice and hearings on malpractice rate increases would be required. In lawsuits, experts would be limited and plaintiffs required to certify merit of cases. Medical doctors’ licenses could be revoked for three malpractice incidents absent mitigating circumstances.”

Not all of Initiative 336’s main provisions are cited in the ballot summary. The initiative’s provisions fall into three broad categories: health care reforms, insurance reforms and legal reforms. Following is a short description of the provisions in each of these categories.

Health care reforms

- Revokes a medical license for three malpractice convictions. Under Initiative 336 the medical license of doctors who receive three malpractice convictions within a ten year period would be revoked. An exception is allowed for mitigating circumstances if “there is a strong potential that remedial education and training will prevent future harm to the public.”
- Increases the number of citizen members of the Washington State Medical Quality Assurance Commission from four to six. The current commission has 19 members, each appointed to four-year terms; 13 health care providers, two physicians assistants and four citizen members.³⁰
- Bars private individuals from reaching confidential out-of-court settlements over malpractice disputes.
- Requires health care providers to disclose within 15 working days all information relating to “any adverse medical incident,” including unproven accusations of malpractice, upon the request of a patient or patient’s family.

Insurance Reforms

- Public notice and hearings on malpractice rate increases. The insurance commissioner would be required to hold a public hearing before any proposed malpractice insurance rate increase of 15% or more could be approved.
- All medical malpractice verdicts or settlements over \$100,000 would be reported to the Department of Health.

³⁰ Revised Code of Washington 18.71.015, “Commission established – Membership – Qualifications – Duties and Powers – Compensation – Order of removal – Vacancies.”

- Requires insurance companies to open their financial records and all related material regarding medical malpractice rate filings to the public.
- State-run malpractice insurance program. Creates a new government program administered by the insurance commissioner to provide supplemental malpractice insurance for clinics, hospitals and doctors. Authorizes the use of tax money to pay for the program.
- New reporting requirement. All insurers would have to report to the insurance commissioner every month any claim related to medical practice, regardless of the validity of the claim. Any insurer who fails to report a claim would be subject to a fine of \$250 a day.
- Each year the Insurance Commissioner would issue a report containing statistical information about all malpractice claims made in the state.

Legal Reforms

- Certificate of merit. Lawyers filing malpractice lawsuits would have to submit to the court within 120 days a certificate of merit from a qualified medical expert. An extension of a further 60 days would be allowed. Lawyers who failed to submit the certificate on time could be required to pay the defendant's legal costs.
- The number of expert witnesses allowed at a medical malpractice trial would be limited to two for each side, unless a judge rules that more expert witnesses are allowed "as the court deems appropriate."

Supporters of Initiative 336 say their proposal "brings accountability to the health care system, the insurance industry and the legal system for better safer health care." Initiative 336, they say, punishes bad doctors, not bad outcomes, prevents rising insurance rate hikes that limit access to health care, stops frivolous lawsuits and lowers litigation costs for doctors and patients.³¹

What happens if both initiatives pass?

If both Initiative 330 and 336 pass both measures would become law. Because they take very different approaches to medical liability reform, the main provisions of the two initiatives do not contradict each other. Initiative 330 places certain limits on jury awards and sets a sliding scale for attorneys fees. Initiative 336 creates new reporting requirements, increases state regulation of insurance, establishes a new public insurance program, and sets up a "three strikes you're out" rule for doctors found guilty of malpractice.

³¹ "Why I-336 Is Needed," Citizens for Better Safer Health Care, accessed August 20, 2005, at www.bettersafecare.org/index.php.

Disputes over the interpretation or implementation of the two initiatives would be settled by the courts, as is the process with other state laws. Also, after two years the Legislature would have the option of amending or repealing either or both initiatives to resolve any contradictions.

VI. Medical Liability Reform in Other States

Proposals to limit medical malpractice costs in Washington reflect a broader trend across the country. In 2004, the Mississippi and Oklahoma legislatures passed bills to abolish or limit joint and several liability. Similar legislation was passed earlier this year in Georgia, Missouri and South Carolina.³² In the same period, bills to limit non-economic damages passed in Colorado, Georgia, Mississippi, Missouri and Oklahoma.³³ In all, twenty-seven states have adopted some form of limitation on non-economic damages, with caps ranging from \$250,000 to \$1.5 million. Five states have enacted caps of \$250,000.

National studies on the effectiveness of non-economic caps

Several national studies have examined the effectiveness of non-economic caps on the number of doctors in a given state. A recent study by the Agency for Healthcare Research and Quality, part of the U.S. Department of Health and Human Services, shows that the number of doctors per 100,000 residents increased faster between 1975 and 2000 in states with caps compared to states having no caps. Specifically, the study found that the number of doctors increased by more than 100% in states that had caps in place by the 1980s, while in non-cap states the number of doctors rose by only 83%, resulting in fewer physicians available per resident.³⁴

The same study found non-economic caps associated with greater access to specialists. The median number of surgical specialists increased by 41% in states with caps of \$250,000, compared to a 31% increase in states with higher caps. Similarly, the number of OB/GYN specialists per 100,000 women age 15 to 44 increased 61% in states with caps of \$250,000 compared to states with higher caps.³⁵

The study also examined the effect of malpractice caps on the supply of doctors who are willing to practice in rural areas, since these areas often have difficulty maintaining adequate access to medical services. The study found that rural counties in states with caps on non-economic damages had more doctors per person than states

³² “Tort Excess 2005: The Necessity for Reform from a Policy, Legal and Risk Management Perspective,” by David Dial, Esq. et al., Insurance Information Institute, 2005, p. 13, at www.iii.org/media/hottopics/insurance/liability/tort/.

³³ Ibid.

³⁴ “Have State Caps on Malpractice Awards Increased the Supply of Physicians?” William E. Encinosa and Fred J. Hellinger, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, published in *Health Affairs, The Journal of the Health Sphere*, May 31, 2005, at www.healthaffairs.org.

³⁵ Ibid.

without such caps. Results showed that the presence or absence of caps had more influence on the decision of obstetricians and surgeons than on other doctors about whether to continue to accept patients.³⁶ These specialties are particularly vulnerable to malpractice lawsuits.

Another national study, using different methodology, similarly found a greater growth in the overall supply of doctors in states with medical malpractice caps than in other states. The study found that from 1985 to 2001 the number of doctors in all states increased, but states that had adopted caps on non-economic damages experienced an increased physician supply of 3.3% more than other states. Study data was controlled for differences in population, states' health care systems and malpractice law. The results showed the effect of direct malpractice reforms was even greater in increasing the number of specialists, compared to the overall number of doctors.³⁷

One commentator called this effect "relatively modest," but limits on damage awards were clearly associated with more doctors entering the field of medicine or continuing to practice in certain states rather than in others.³⁸ A study co-author said, "It is clear that both physicians and patients are victims of a seriously flawed malpractice system," and that the dynamics of malpractice "drive premiums into crisis cycles with pernicious consequences."³⁹ The study's basic conclusion: "Tort reform increased physician supply."⁴⁰

Example of liability limits in another business sector

Legislation to limit liability has been successful in other sectors of the economy. For example, by the early 1990s lawsuits and high-cost jury awards had put most manufacturers of light aircraft in the United States out of business, resulting in a 95% decline in business activity, shuttered factories and the loss of more than 100,000 jobs.

In 1994, Congress passed the General Aviation Revitalization Act, which placed clear, reasonable limits on the liability of aircraft manufacturers. Within a few years the sector had revived, more than doubling production as new airplane manufacturing plants opened.⁴¹ Today the industry employs thousands of skilled workers, supplies a thriving

³⁶ Ibid.

³⁷ "Impact of Malpractice Reforms on the Supply of Physician Services," by Daniel P. Kessler, PhD, JD; William M. Sage, MD, JD; David J. Becker, BA, *Journal of the American Medical Association (JAMA)*, Vol. 293, No. 21, June 1, 2005, at www.jama.ama-assn.org.

³⁸ "Effect of Damage Caps in Medical Malpractice Suits, Health Affairs, JAMA Studies Examine," *Medical News Today*, June 2, 2005, at www.medicalnewstoday.com. The quote is from Peter Budetti, professor at the University of Oklahoma College of Public Health.

³⁹ Ibid, quote of William Sage, professor of law at Columbia University and director of Pew Charitable Trust Project on Medical Liability.

⁴⁰ "Impact of Malpractice Reforms on the Supply of Physician Services," by Daniel P. Kessler, PhD, JD; William M. Sage, MD, JD; David J. Becker, BA, *Journal of the American Medical Association (JAMA)*, Vol. 293, No. 21, June 1, 2005, at www.jama.ama-assn.org.

⁴¹ "A Report to the President and Congress on the General Aviation Revitalization Act, Five Year Results," General Aviation Manufacturers Association, Washington, D.C., 1996, available at www.gama.aero/pubs/getFile.php?catalogID=11.

domestic market in U.S.-built light aircraft, and exports about a third of its annual production to the world market.⁴²

California and MICRA

The California legislature passed the Medical Injury Compensation Reform Act (MICRA) in 1975, a time when the cost of medical liability insurance was soaring and many health care specialists were having difficulty finding coverage. The law limits jury awards for non-economic damages to \$250,000 per claimant and sets a sliding scale that determines how much of an award the plaintiff's lawyers can receive for their services. Lawyers' fees are limited to 40% of the first \$50,000 of a jury award, 33% of the next \$50,000, 25% of the next \$500,000 and 15% of any amount over \$600,000.⁴³ These same limits are proposed in Initiative 330.

Research indicates MICRA was successful in reviving medical malpractice coverage for California doctors after the crisis of the mid-1970s, and today the law is one of the most-cited examples in the debate over capping non-economic damage awards. Critics of MICRA point out that it has not been successful in preventing higher medical liability insurance rates, which have actually increased since the law's passage. When compared to other states, however, the numbers show that medical liability reform has held California's malpractice rate increases to a lower level than they would have been otherwise.

MICRA slowed the rate of premium increase

A study by the RAND Corporation's Institute for Civil Justice of 257 California medical malpractice trials found that in 45% of cases MICRA had the effect of lowering the final cost of jury awards, with the median reduction being \$366,000. The original jury verdicts studied totaled \$421 million, but when MICRA rules were applied this figure fell to \$295 million, a reduction of 30%. The study also showed that the cost of attorney fees was reduced 60%, from \$140 million to \$56 million, and that MICRA's limit on attorney fees actually had a greater effect in lowering the cost of awards than the law's cap on non-economic damages.⁴⁴

A study by Congress' Joint Economic Committee (JEC) found that from 1976 to 2000 malpractice premiums in California increased 167%, while premiums in the rest of

⁴² Ibid.

⁴³ "Medical Injury Compensation Reform Act of 1975," California Civil Code, Sections 3333.1 and 3333.2, and California Business and Professional Code, Section 6146. See www.assembly.ca.gov/clerk/archive, and Californians Allied for Patient Protection (CAPP) at www.micra.org.

⁴⁴ "Capping Non-Economic Awards in Medical Malpractice Trials – California Jury Verdicts Under MICRA," by Nicholas M. Pace, Daniela Golinelli and Laura Zakaras, study of 257 medical malpractice trials between 1995 and 1999, The RAND Institute for Civil Justice, released July 12, 2004, at www.rand.org/publications/MG/MG234/.

the nation rose 505%.⁴⁵ In examining the experience of the states with a view to possible federal legislation, the JEC found that "...some of the key reforms proposed at the federal level, including a cap on pain and suffering [i.e. non-economic] damages, have proven successful at producing savings when implemented."⁴⁶

Settling disputes faster

Caps on non-economic damages have other effects on reducing the cost of medical practice lawsuits. Under MICRA, malpractice claims in California are settled in one-third less time than the national average of more than five years, securing quicker resolution for injured patients, freeing the time of doctors and other health care professionals, and reducing the burden liability claims place on the health care system. The result of MICRA is a system that better serves the needs of patients by reducing the cost of litigation and speeding the payout of compensation.

Lower caps are more effective

Other comparisons among the states indicate that caps on non-economic damages are less effective when they are set too high. One study found that between 1991 and 2002, states that enacted caps of \$500,000 or higher saw insurance premiums increase an average of 47.7%. States that enacted caps closer to \$250,000, including California, Colorado, Indiana and Kansas, saw malpractice premiums increase an average of only 28%.⁴⁷ The experience of states with caps on non-economic awards indicates that caps alone do not prevent malpractice premiums from rising over time, but they do slow the rate of premium increase, and demonstrate that the lower the cap, the more the rate of increase is slowed.

California's well-documented experience with MICRA indicates that limits on the size of non-economic damage awards and controls on the fees collected by plaintiff's attorneys work well in moderating the cost of malpractice insurance. Long-term studies show MICRA has helped restore balance to that state's malpractice system, reducing costs for both patients and doctors, while maintaining judicial protections against doctor negligence and patient harm.

Non-economic caps in Texas

In 2003, Texas adopted a \$250,000 cap on non-economic damages in medical liability cases.⁴⁸ In a medical malpractice wrongful death suit the limit is \$500,000.⁴⁹

⁴⁵ "Liability for Medical Malpractice: Issues and Evidence," Joint Economic Committee of the United States, Washington, D.C., May 2003, at www.house.gov/jec/tort.htm.

⁴⁶ Ibid.

⁴⁷ "The Weiss Rating Report on Medical Malpractice Caps; Propagating the Myth That Non-Economic Damage Caps Don't Work," report by the Physician Insurers Association of America, July 8, 2003, at http://www.thepiaa.org/text_files/WEISS070903.htm.

⁴⁸ Texas Statutes, Civil Practice and Remedies Code, Chapter 74, Section 301, "Limitation on Noneconomic Damages," at www.capitol.state.tx.us/statutes/cp.toc.htm.

⁴⁹ Ibid.

Within a year, 15 new insurance companies had entered the state's medical malpractice market and the largest insurer, Texas Medical Liability Trust, had lowered its malpractice rates by 12%.⁵⁰ The largest hospital insurer, Health Care Indemnity, reduced its rates by 15%.⁵¹

Over the same period the number of doctors practicing in the state increased by five percent overall, with the largest rise occurring among obstetricians (62%), gynecologists (38%) and oncologists (32%).⁵² The growing supply of doctors reversed a declining trend in some specialties. In the year previous to the enactment of the cap, for example, Texas experienced a 13% *decrease* in the number of obstetricians per resident.⁵³

VII. Current Medical Licensing Rules

The role of malpractice lawsuits in assuring the quality of practicing doctors can only be assessed in light of what the state is already doing to maintain professional standards in health care, and whether the state's enforcement of medical standards is adequate to protect patients from harm.

Health Professions Quality Assurance (HPQA) is an office within the Washington Department of Health responsible for protecting public health by regulating the health care professions. Through the agency the state has committed itself to "strengthen and consolidate disciplinary and licensure procedures for the licensed health and health-related professions," by providing standardized procedures and enforcing a uniform code of discipline. The purpose of the state's enforcement powers is to "assure the public of the adequacy of professional competence and conduct in the healing arts."⁵⁴

The Office works in cooperation with 12 boards, four commissions and eight advisory committees to oversee the competency and qualifications of more than 270,000 health care providers throughout the state. The state administers 57 different types of licenses to people who meet legal qualifications to practice medicine, certifies people who meet certain professional standards and maintains a registration list of names and address of practitioners in each health care profession.⁵⁵ The activities of the Office are funded by annual fees paid by licensed practitioners, ranging from \$20 for a pharmacy intern to \$1,375 for a dentist.⁵⁶

⁵⁰ "Medical Malpractice – Impact of Texas Liability Limits" by Janet L. Kaminski, Associate Legislative Attorney, OLP Research Report, December 2004, at www.cga.ct.gov/2004/rpt-R-0918.htm, based on data from the Texas Department of Insurance and the Texas State Board of Medical Examiners.

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ Revised Code of Washington 18.130.010, "Intent."

⁵⁵ "What does the Health Professions Quality Assurance Office Do?," Health Professions Quality Assurance, Washington Department of Health, August 2005, at fortress.wa.gov/doh/hpqa1/hpqamain.htm.

⁵⁶ Revised Code of Washington 43.70.250, "License fees for professions, occupations and businesses."

Supporters of Initiative 336 say the state is failing to adequately police the health care profession. In presenting reasons for why their initiative is needed, they say, “the health care providers responsible are rarely punished by the state for negligence, even in grievous cases.”⁵⁷ They also add, “Rather than sanctioning and removing dangerous health care providers from the medical system, the system protects and allows them to continue endangering lives from within.”⁵⁸

While a courtroom is the appropriate place for injured citizens to seek justice, judges are poorly equipped to enforce a statewide system of medical quality standards. Better oversight and enforcement of the medical professions by the state would reduce the need for sweeping reform measures. Fewer patients would be injured, and thus fewer lawsuits filed, if the state’s existing health care enforcement officials were more effective in preventing bad doctors from practicing in the first place.

VIII. Conclusion

Washington Policy Center research over the years has indicated a need for policymakers to address rising medical liability costs. Washington Policy Center’s *Agenda 2005* issues guide, published in the fall of 2004, proposes three specific policy recommendations for improving health care services by reforming state liability law:⁵⁹

1. Change state medical liability law to place a reasonable limit on non-economic damages.
2. Place a cap on how much of a medical liability award can be claimed by lawyers, to insure that injured patients receive just compensation.
3. Encourage the use of voluntary mediation and alternative dispute resolution processes to increase the number of medical liability claims that are settled before they go to court.

The purpose of the medical liability system is to secure fair compensation for injured patients, punish negligent or incompetent doctors, and deter future acts of negligence. The court system by itself, however, is ill equipped to police the medical profession and ensure the good conduct of doctors. The enforcement powers of the executive branch are best suited for that.

For that reason lawmakers in Olympia should strengthen enforcement of the state’s medical licensing requirements. Having accepted the task of vouching for the qualifications of practicing physicians in order to protect the public, the state’s elected

⁵⁷ “Why I-336 Is Needed,” Fact Sheet, Citizens for Better, Safer Healthcare, accessed August 10, 2005, at www.bettersafecare.org/index/php.

⁵⁸ *Ibid.*

⁵⁹ “Agenda 2005, The Guide to Public Policy Issues in Washington State,” Paul Guppy, editor, published by Washington Policy Center, available at www.washingtonpolicy.org and www.agenda2005.org.

leaders should make sure this important mission is carried out effectively. While a doctor's performance record, including patient complaints and out-of-court malpractice settlements, may not be widely known to the public, they are no secret to state medical officials. Acting on this information, which must be reported by law, the state should revoke the licenses of incompetent doctors *before* they do serious and lasting harm to patients.

Whatever fate voters choose for Initiatives 330 and 336, Washington policymakers will still have to consider important changes in health care and medical liability policy that will move the system toward lower costs, better quality and improved services for patients.

About the Author

Paul Guppy is a graduate of Seattle University and holds Masters Degrees in public policy and political science from Claremont Graduate University and the London School of Economics. He completed higher education programs at The Sorbonne, Paris and at Gonzaga University in Florence, Italy. He joined the Center in 1998 after 12 years of service in Congress, including work as a Chief of Staff and a Legislative Director. Paul is the author of Policy Center studies on civil rights, labor policy, public financing and health care reform, and is editor of the Center's comprehensive "Agenda 2005" policy book.

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