



POLICY BRIEF

Health Care Lawsuit Reform in Washington State

by Roger Stark, MD, FACS
Health Care Policy Analyst

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Key Findings

1. Estimates of the added cost of lawsuits and the threat of lawsuits to health care in the United States range from 2.4% to as high as 27%.
2. After the number of malpractice claims and the size of jury awards sharply increased in the mid-1980s, insurance premiums increased 15–60% in 1985 and an additional 35–60% in 1986.
3. In many states, health care lawsuit reform has helped hold costs down and provided a stable physician pool while still allowing injured patients to have their “day in court.”
4. In Washington state, lawmakers can help reduce the cost of health care lawsuits, slow the rise in overall health care costs and increase patient access to high-quality, affordable care by adopting reasonable limits on the noneconomic costs of malpractice awards.
5. The public policy goals of health care lawsuit reform are to lower health care costs for all patients, provide a stable physician supply and allow injured patients access to the legal system.

Introduction

Everyone agrees the rising cost of health care in the United States is unsustainable. Last year the country spent \$2.4 trillion, or nearly 18% of our gross domestic product (GDP), on health care. Frivolous lawsuits against doctors and hospitals contribute significantly to these rising costs. Unlike other western countries, the United States has a very active legal system and hospitals, doctors and other providers must constantly manage the impending threat of costly medical lawsuits.

In many states, health care lawsuit reform, that is, reasonable limits placed on the cost of lawsuits, has helped hold costs down and provided a stable physician pool, while still allowing injured patients to have their “day in court.” Medical malpractice reform was the number-one health care reform recommended by Washington state small business owners at the Washington Policy Center’s 2011 Small Business Conference.¹ This paper examines the experience of other states, assesses which real-world reforms have been successful and draws practical lessons about how policymakers can implement effective lawsuit reform and legal cost controls in Washington state.

Background

The number of medical malpractice lawsuits has occurred in waves in the past 50 years. Three crises in soaring medical malpractice costs occurred in the 1970s, the mid-1980s and the late 1990s into the mid-2000s. Malpractice insurance premiums for doctors fluctuate over time, but they predictably increase dramatically during these times of crisis.

For example, in 2006, 21 states experienced a medical malpractice crisis and premiums rose, on average, 80% that year.² Unfortunately, in times of crisis malpractice insurance premiums tend to increase for all doctors regardless of their individual litigation history. In addition, malpractice insurance companies reassess their viability in the market and often leave a state that is experiencing a high rate of malpractice claims.³

¹ “7 Steps on the Road to Economic Recovery, Key Recommendations to Improve Washington Small Business Climate,” by Paul Guppy and Caitlin Kincaid, Policy Brief, Washington Policy Center, January 2012, at www.washingtonpolicy.org/publications/brief/7-steps-road-economic-recovery.

² “Another state added to liability crisis list,” American Medical Association, March 6, 2006, at www.ama-assn.org/amednews/2006/03/06/prca0306.htm.

³ “The New Medical Malpractice Crisis,” by Michelle M. Mello, David M. Studdert and Troyen A. Brennan, *New England Journal of Medicine*, 2003; 348 (23): 2281–2284.

The great majority of injured patients do not sue their doctor, and only one in six of those who do sue receives compensation. In 40% of medical malpractice cases there is no evidence of medical error or even that an injury has occurred. Yet these unquestionably frivolous lawsuits account for fully 16% of medical liability costs.⁴

Jury awards also trend upward at these times. During the last severe crisis, the national average jury award increased almost 60%, from \$3.9 million in 2001 to \$6.2 million in 2002.⁵ Unfortunately, the patient is not the biggest winner in the dispersal of the award. Patients, on average, receive only 46% of the money they are awarded by juries. The remainder goes to lawyers, expert witnesses and court fees. The average time an injured patient waits to receive compensation is five years.⁶

Medical malpractice insurance premiums are usually set by an outside actuarial firm that examines an insurance company's historical losses. Projections for future losses are estimated and insurance price changes are based on these estimates. The unpredictable and potentially catastrophic loss for the insurance company is a single multimillion-dollar jury award for one winning plaintiff. Even the costs of out-of-court settlements are high and these add to the rise in insurance costs.⁷

Changes in a company's investment portfolio also influence insurance price changes. Virtually all insurance companies invest heavily in high-grade bonds, with very little exposure to shifting equities and market risk. Fluctuations in the stock market have almost no impact on an insurance company's investment portfolio.⁸

Insurance premium rates vary depending on the medical specialty covered and claims experience of individual doctors. Physicians in high risk specialties, such as obstetrics and neurosurgery, pay more for malpractice insurance than do family doctors or pediatricians. A physician with multiple legal claims filed against him will pay more for malpractice insurance than a doctor in the same specialty with no claims history.

Although gross negligence does occur in health care, just as often doctors get sued merely for bad patient outcomes. Patient expectations can often be unreasonably high, or the physician has not spent enough time discussing the severity of the patient's condition and the chances of recovery. When dealing with the human body, a less than ideal outcome often results, despite the best care modern medicine can provide.

Unfortunately, the Washington State Supreme Court has ruled that "loss of a chance of a better outcome" confirms medical negligence. Doctors and medical malpractice insurance companies currently must live with this "bad outcome" ruling.

⁴ "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," by David M. Studdert, et. al., *New England Journal of Medicine*, 2006; 354(19): 2024–2033.

⁵ "Medical Liability Reform Crisis 2008," by Stuart L. Weinstein, *Clinical Orthopaedics and Related Research*, 2009; 467: 392–401.

⁶ *Ibid.* See Note 3.

⁷ "Defense Costs of Medical Malpractice Claims," by Seth Seabury, et. al., *New England Journal of Medicine*, 2012; 366:1354–1356.

⁸ "The Impact of Medical Malpractice Insurance and Tort Law on Washington's Health Care Delivery System," Report from the Washington State Medical Education and Research Foundation, September 2002, at www.wsma.org/files/download/wsmef/Tort_reform.pdf.

Court cases are usually determined by the testimony of expert witnesses. An entire industry of professional experts has grown up, although qualifications for experts continue to evolve. Today, experts can be hired to argue virtually any side in a pending lawsuit.

Ideally, irresponsible doctors are sanctioned with practice limitations imposed by their medical peers. Ironically, it is lawyers, working on behalf of and protecting bad doctors, who make it difficult for medical associations to police chronically bad physicians. Hospital and community medical review committees continually face the threat of civil lawsuits over defamation of character or restraint of trade when they try to weed out bad doctors.

Critics of medical lawsuit reform claim that without the potential of punitive lawsuits, doctors would become sloppy and careless in their practices.⁹ However, there is no objective evidence that the threat of malpractice lawsuits improves the quality of health care. It is clear, though, that increasing malpractice insurance prices and the fear of being sued are causing many skilled physicians to retire early, leave Washington state, or reduce patient access to care by limiting their practices to less risky procedure.

The Cost of Medical Malpractice Lawsuits

Estimates of the added cost of lawsuits and the threat of lawsuits to health care in the United States range from 2.4%¹⁰ to as high as 27%.¹¹ These costs include jury awards, out-of-court settlements, court and attorneys' fees and, most importantly, the practice of defensive medicine.

Defensive medicine is defined as “an effort to pre-empt litigation by ordering laboratory tests, exploratory procedures, costly high tech equipment and other items as a protective measure against medical malpractice suits.”¹² Defensive medicine is not practiced on behalf of the patient; it is motivated by fear of hostile legal action in the future. Defensive medicine is designed to prevent lawsuits, not cure human diseases.

The true cost of defensive medicine is impossible to know. However, physician surveys show that 93% of specialists alter their clinical practices due to malpractice concerns and 43% order clinically unnecessary tests to protect themselves against legal threats. In addition, 42% of all doctors, and 70% of specialists in high risk specialties, say they restrict their practices to decrease their exposure to possible lawsuits.¹³ These surveys suggest the cost of defensive medicine is currently underestimated and that actual costs are much higher.

⁹ “Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?,” by Shirley Svooney, Policy Analysis number 685, Cato Institute, October 20, 2011, at www.cato.org/publications/policy-analysis/could-mandatory-caps-medical-malpractice-damages-harm-consumers.

¹⁰ “National Costs of the Medical Liability System,” by Michelle M. Mello, et. al., *Health Affairs*, 2010; 29(9): 1569–1577, at www.content.healthaffairs.org/content/29/9/1569.abstract.

¹¹ “Alternative Solutions to Florida’s Medical Malpractice System,” by Beth Ann Fiedler, Ph.D., Adjunct Scholar, Background, The James Madison Institute, No. 69, November, 2011, at www.patientsforfaircompensation.org/media/3927/white_paper_jmi_medmalpracticereform_nov11.pdf.

¹² Ibid.

¹³ “Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment,” by David M. Studdert, et. al., *Journal of the American Medical Association (JAMA)*, June 1, 2005; 293(21): 2609–2617, at www.jama.jamanetwork.com/article.aspx?articleid=200994.

History of Medical Lawsuit Reform in Washington State

The first national spike in medical malpractice claims occurred in the 1970s. Traditional commercial insurance companies left the marketplace because of overwhelming losses. Nearly 100 physician-owned insurance companies started up during this period to fill the void. Doctors in Washington state, along with the Washington State Medical Association, formed a company, Physicians Insurance, in 1982.

The Washington state legislature responded to the malpractice crisis and in the late 1970s passed several important pieces of legislation. Lawmakers:

- Legally defined medical negligence and informed consent (what a physician must explain to a patient before a procedure)
- Passed an eight-year statute of limitation (which was later overturned by the courts)
- Allowed providers to pay the medical bills of injured patients without admitting fault or liability
- Prohibited the dollar amount of damages to be publicized
- Allowed evidence of other source payments (money from other parties being sued) that plaintiffs received to be reported in court¹⁴

The second malpractice crisis in Washington state occurred in the mid-1980s. Not only did the number of claims sharply increase, so did the size of jury awards. Insurance premiums increased 15–60% in 1985 and an additional 35–60% in 1986.

In response to this second malpractice crisis, Washington's Legislature passed The Liability Reform Act of 1986. The provisions of this law were:

- A sliding scale cap on non-economic damages or “pain and suffering” (based on average wages and life expectancy of the patient)
- A new statute of limitations
- Modified joint and several liability, protecting doctors with minor responsibility for a patient's injury from having to pay the entire jury award
- Payment-over-time on settlements
- Stronger requirements for patients to prove doctor negligence

However, in 1989 the Washington State Supreme Court ruled the cap on non-economic damages unconstitutional and other courts subsequently ruled against the statute of limitation.¹⁵

During the 1990s, malpractice claims increased at an annual compounded rate of 6.9%, compared with general inflation of only 2.6%. From 2001 to 2002, however, the average claim paid by Physicians Insurance rose 48.5%. In response, malpractice insurance premiums rates increased 8.6% in 2002, 16.7% in 2003 and 19.0% in 2004.¹⁶

The last major lawsuit reform effort in Washington state was an initiative campaign in 2005. Initiative 330 was sponsored by the Washington State Medical Association and had the following provisions:

¹⁴ Ibid. See Note 7.

¹⁵ Ibid.

¹⁶ Ibid.

- A cap on non-economic damages of \$350,000 to \$1,050,000
- Change of the statute of limitation for filing a claim on a child from 21 years of age to eight years of age
- A limit on attorneys' fees
- Modified joint and several liabilities

The Washington State Trial Lawyers Association sponsored a competing initiative (Initiative 336) the same year. Its provisions were:

- “Three strikes, you’re out” on providers
- Create a government-run malpractice insurance program
- Add patient advocates to the state Medical Quality Assurance Commission
- Report any verdict or settlement over \$100,000 to the state Department of Health
- Doctors must disclose their expenses
- Allow patients and families access to all medical records
- Require insurance companies to explain rate increases
- Limit the number of expert witnesses in a court case to two
- Expand the legal definition of an adverse medical incident that results in patient injury¹⁷

A bitter and confusing public campaign resulted, and both initiatives were defeated by voters. Throughout the campaign, though, research showed that voters made the connection between the current medical tort system and their ability to access needed medical services.

Lawsuit Reform in California and Other States

The public policy goals of health care lawsuit reform are to lower health care costs for all patients, provide a stable physician supply and allow injured patients access to the legal system. States that have enacted caps on non-economic damage awards have experienced a 3–4% decrease in health care costs¹⁸ and an increase in physician supply of more than 3%.¹⁹ Injured patients in these states continue to have access to attorneys, courts and juries for all their medical bills and for full economic losses, and to pain-and-suffering awards up to the level of the legal cap.

California

California was hit particularly hard by the first health care malpractice crisis of the 1970s. Jury awards skyrocketed. Many physicians could not find malpractice insurance at any price and consequently restricted their medical practices or left the state. Patient access to health care suffered as doctors scaled back or left the health care market.

¹⁷ “Medical Liability Reform: A Three State Comparison,” by Amy Johnson, Policy Brief, Washington Policy Center, April 2005, at www.washingtonpolicy.org/publications/brief/medical-liability-reform-three-state-comparison.

¹⁸ “The Impact of State Laws Limiting Malpractice Damage Awards on Health Care Expenditures,” by Fred J. Hellinger and William E. Encinosa, *Journal of Public Health*, August 2006; 98(8): 1375–1381, at www.ncbi.nlm.nih.gov/pmc/articles/PMC1522105/.

¹⁹ “Impact of Malpractice Reforms on the Supply of Physician Services,” by Daniel P. Kessler, et. al., *Journal of the American Medical Association*, June 2005, 293(21): 2618–2625, at www.jama.jamanetwork.com/article.aspx?articleid=200996.

In 1975 California passed the Medical Injury Compensation Reform Act (MICRA). The key provision of the reform law was a cap on non-economic (pain and suffering) damages. The amount of awards for medical bills and actual economic losses for the patient remained unlimited. The non-economic cap has been upheld as constitutional by the California courts. It is estimated that MICRA saves Californians \$6 billion annually in reduced health care costs. Although California doctors have experienced a 283% increase in medical malpractice premiums since 1975, this compares to an average of 925% increase in the rest of the country.²⁰

It is also important to note that the \$250,000 cap was in 1975 dollars and was not indexed to inflation. Consequently, in real dollars, the California cap has gotten smaller each year.

Other States

At present, 35 states have non-economic caps ranging from \$250,000 in California to \$1.75 million in Nevada. A cap higher than \$500,000 may not be effective in controlling rising health care costs caused by the threat of lawsuits. Courts have upheld non-economic caps in 16 states and have overturned caps in 11 states.²¹

Constitutions specifically prohibit non-economic caps in four states (Arizona, Kentucky, Pennsylvania and Wyoming) in addition to Washington state.²²

In 2011, nine more states passed health care lawsuit reform legislation. North Carolina and Tennessee adopted non-economic caps for the first time, and Oklahoma and South Carolina made their existing caps more stringent, resulting in increased savings for patients.²³

Federal Medical Lawsuit Reform

Lawsuit reform has been a long-standing states' rights issue. However, at various times over the past 40 years, Congress has taken up the matter. In 2011 and again in March 2012, the House of Representatives passed the Help Efficient, Accessible, Low-cost, Timely Healthcare Act, or HEALTH.²⁴ This is a comprehensive lawsuit reform bill that includes:

- A \$250,000 cap on non-economic damages
- A three-year statute of limitations
- Joint and several liability
- Limits on attorneys' contingency fees
- A collateral source rule, where injured patients must disclose all sources of potential money in a lawsuit

²⁰ "Medical liability reform and the states," by Alexis Walters, *American College of Surgeons Bulletin*, 2010; 95(3): 29–30.

²¹ "Medical liability reform: Evidence for legislative and alternative approaches," by Ian S. Metzler and John G. Meara, *American College of Surgeons*, 2012; 97(1): 6–11.

²² "Caps on Damages, 2011," American Medical Association, 2011, at www.ama-assn.org/resources/doc/arc/capsdamages.pdf.

²³ "State Tort Reform in 2011," by John F. Kuppens and Jay T. Thompson, *Law360*, September 16, 2011, at www.nelsonmullins.com/articles/state-tort-reform-in-2011.

²⁴ H.R. 5, "Protecting Access to Health Care Act," 112th Congress, 2011–2012, sponsor Rep. John "Phil" Gingery, R-Ga., at www.govtrack.us/congress/bills/112/hr5.

The nonpartisan Congressional Budget Office estimates that if enacted the HEALTH Act would reduce federal deficits by \$45.5 billion from 2013 to 2022 and would save the Medicare program almost \$50 billion over the same period.²⁵ The same legislation has been introduced in the United States Senate, but is not expected to pass.²⁶

Theoretically, federal law would take precedence over state law. However, it is uncertain whether federal law would override a state constitution.

Policy Solutions

The goal of any health care lawsuit reform should be to decrease health care costs, provide a stable physician supply and allow injured patients open access to the legal system. Multiple studies have examined reform ideas and correlated their specific effects:^{27, 28, 29}

Reform	Effect
Caps on non-economic damages	Decrease defensive medicine Improve doctor supply Decrease non-economic payments to patients Constrain med-mal premium increase No change in claims frequency No change in quality of care
Statute of limitations	Lowers medical malpractice insurance premiums
Screening panels pre-trial	Decrease defensive medicine
Limit on attorneys' fees	No effect
Joint and Several Liabilities	No effect
Periodic claims payments	No effect
Trial loser pays all costs	Unknown effect
Workers' comp-like fund	Unknown effect
Screening of expert witnesses	Unknown effect

Conclusion

The experience of other states shows that a meaningful legal cap on non-economic damages is the most effective element of successful lawsuit reform legislation. This is confirmed both by California's legislation in practice and by a number of independent academic studies. To a lesser extent, a statute of limitations on lawsuits and pre-trial screening are often effective in reducing the cost of specific medical malpractice lawsuits.

²⁵ "Reducing the Deficit: Spending and Revenue Options," Congressional Budget Office, March 10, 2011, at www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf.

²⁶ S. 218, Help Efficient, Accessible, Low-cost, Timely Health Care (HEALTH), 112th Congress, 2011–2012, sponsor Senator John Ensign, R-Nev., at www.govtrack.us/congress/bills/112/s218.

²⁷ "New Directions in Medical Liability Reform," Allen Kachalia and Michelle M. Mello, *New England Journal of Medicine*, 2011; 364(16): 1564–1572.

²⁸ *Ibid.*, see note 20.

²⁹ "Evaluating the Medical Malpractice System and Options for Reform," Daniel P. Kessler at *The Journal of Economic Perspectives*, 2011; 25(2): 93–110.

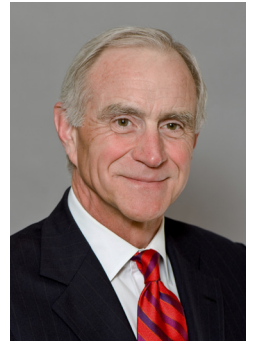
The barriers to enacting non-economic caps are provisions in some state constitutions, the active political opposition of powerful state trial lawyer associations and the question of whether the states or the federal government should pass such legislation. To control the rise in medical lawsuit costs, Washington state would need to amend its constitution. This would require a supermajority of legislative votes as well as supermajority support of voters. This must be done to avoid the next medical malpractice crisis in our state.

In Washington state, lawmakers can most effectively reduce the cost of health care lawsuits, slow the rise in overall health care costs and increase patient access to high-quality affordable care by adopting reasonable limits on the non-economic costs of malpractice awards.

In addition, meaningful caps on non-economic damages would encourage more doctors to stay in practice in Washington, would promote greater expertise in key medical specialties like delivering healthy babies and treating severe neurological injuries, and would make the state a more attractive place for University of Washington Medical School graduates and doctors from other states to open their practices. This reform would improve the affordability and quality of health care for all Washington residents.

About the Author

Dr. Roger Stark is a health care policy analyst at Washington Policy Center. He is the author of the book *The Patient-Centered Solution: Our Health Care Crisis, How It Happened, and How We Can Fix It*. He is also the author of numerous studies on state and national health care policy. Dr. Stark graduated from the University of Nebraska College of Medicine and completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. After practicing in Tacoma he moved to Bellevue and was one of the co-founders of the open heart surgery program at Overlake Hospital. He retired from private practice in 2001 and became actively involved in the hospital's foundation, serving as Board Chair and Executive Director. Dr. Stark has been a member of many local and national professional societies. He is a past member of the Governing Board of Overlake Hospital, currently serves on the Board of the Washington Liability Reform Coalition, and is an active member of the Woodinville Rotary.



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