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Medical Malpractice: An Overview

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Medical Malpractice: An Overview

Summary

The rising cost of medical malpractice insurance is of concern to Congress largely because of its potential impact on the availability of health care providers and services. As malpractice insurance becomes increasingly expensive, some physicians claim that premium increases have forced them to limit the services they provide, move their practice locations, or leave medicine altogether. This is especially the case for certain specialists who have experienced the largest premium increases. Some providers have gone on strike to publicize their plight. They cite excessive malpractice lawsuits and unreasonably large jury awards as the causes of the malpractice insurance "crisis."

Some lawyer and consumer groups counter that the insurance industry is to blame for the rapid rise in malpractice insurance premiums. These groups contend that bad investment choices, in addition to the underwriting cycle, have led to dwindling profits for insurers, who then try to recoup their losses through expensive insurance products. Abetting this, in their eyes, is an exemption from the normal federal antitrust law for insurers.

Congressional debate on these issues generally has conformed to the contrasting perspectives mentioned above. During the first session of the 109th Congress, some Members, notably both House and Senate majority leadership, attributed the rise in malpractice insurance premiums to "frivolous" lawsuits and large jury awards. Other lawmakers respond that spikes in malpractice insurance premiums are the result of the insurance underwriting cycle and sagging insurer investments. In addition, there is a third perspective, which has not generated the same level of attention or controversy, that sees the overall medical error rate as the root of the problem.

Given the malpractice insurance debates from previous sessions, proposals for legal changes (H.R. 5, which has passed the House, and S. 354, which is currently on the Senate Calendar) most likely will be high on the legislative agenda. These bills are designed to decrease the overall number of malpractice lawsuits and the payment amounts awarded in successful claims. Examples of specific reforms include establishing a federal statute of limitations, restricting attorneys' fees, and placing caps on the amount juries may award in damages. Proposals addressing the insurance side (S. 1525, H.R. 3359) include a range of strategies to constrain the cost of malpractice insurance, such as greater oversight of the insurance industry and stabilizing the reinsurer market in order to limit the liability that primary insurers face in the event of extraordinary loss. Some Members also have expressed interest in alternatives to tort and insurance reforms. Among the proposals introduced during the 109th Congress are efforts to disclose medical error data (S. 554, now P.L. 109-41), establish administrative proceedings (S. 1337), and award tax credits to physicians to help cover premium costs (H.R. 2291).

This report will be updated in the event of major legislative activity.

Contents

Medical Malpractice: An Overview

Introduction

Medical malpractice insurance has become increasingly expensive during the past several years. Some physicians claim that premium increases for malpractice insurance have forced them to limit the services they provide, move their practice locations, or leave medicine altogether. This is especially the case for certain specialists, such as obstetricians, who have experienced the largest premium increases. Some providers have gone on strike to publicize their plight. They cite excessive malpractice lawsuits and unreasonably large jury awards as the causes of a malpractice insurance "crisis." Many physicians support tort reform legislation that would, among other things, limit the amount juries could award to plaintiffs in malpractice cases.

Certain trial lawyer and consumer groups counter that the insurance industry is to blame for the rapid rise in malpractice insurance premiums. These groups contend that bad investment choices, in addition to the relatively normal underwriting cycle of higher and lower insurance rates, have led to dwindling profits for insurers, who then try to recoup their losses through expensive insurance products. Abetting this, in their eyes, is an exemption from the normal federal antitrust law for insurers. Lawyers and consumer groups generally support efforts to reform the insurance industry to address difficulties from rising premiums.

Congressional debate on these issues generally has conformed to the contrasting perspectives mentioned above. During the first session of the 109th Congress, some members, notably both House and Senate leadership, attributed the rise in malpractice insurance premiums to "frivolous" lawsuits and large jury awards. Moreover, they argued that such lawsuits and awards make physicians fearful, leading to the practice of "defensive medicine" and adding to overall health care costs.[1] Other lawmakers responded that spikes in malpractice insurance premiums are the result of the insurance underwriting cycle and sagging insurer investments. They also point out that capping malpractice awards unfairly penalizes individuals who have been injured due to medical malpractice.

Given the malpractice insurance debates from previous sessions, legal reforms seem likely to top the legislative agenda for addressing medical malpractice problems. These reforms are designed to decrease the overall number of malpractice lawsuits and the payment amounts awarded in successful claims. Examples of specific reforms include establishing a federal statute of limitations, restricting

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[1] See "Economic Report of the President," Council of Economic Advisers, Feb. 2006, p. 95, Box 4-2: Medical Liability Costs, at [http://www.whitehouse.gov/cea/erp06.pdf].

attorneys' fees, and placing caps on the amount juries may award in damages. Proposals addressing the insurance side include a range of strategies to constrain the cost of malpractice insurance, such as greater oversight of the insurance industry and stabilizing the reinsurer market in order to limit the liability that primary insurers face in the event of extraordinary loss.

Some members also have expressed interest in alternatives to tort and insurance reforms. Among the proposals introduced during the 109th Congress are efforts to disclose medical error data, establish administrative proceedings, and award tax credits for medical malpractice premiums. Medical error information could be in the form of non-identifiable data to be used for health system improvement (as enacted under the Patient Safety and Quality Improvement Act of 2005 (P.L. 109-41)), or provider-specific malpractice information included in the National Practitioner Data Bank (currently not open to the public). Administrative approaches, such as mediation and arbitration, have proven effective in isolated clinical settings and may provide a model for broader implementation. A different strategy that addresses the cost of malpractice premiums, but not the underlying causes, is to provide tax credits to physicians to help cover premium costs.

Background on Medical Malpractice Insurance[2]

The recent difficulties in the market for medical malpractice insurance constitute the third such "crisis" that has been proclaimed over the past three decades. Both the mid-1970s and mid-1980s saw similar situations where rising prices and decreased availability of insurance caused difficulties for physicians and other healthcare providers. These past events led to both public policy and market reactions to address the problems, and the crisis eventually abated. Judgments as to what "solved" the problems and what might be applied to today's difficulties can, however, be difficult to make. Since the crisis is typically seen as one of medical malpractice insurance, it may be best to begin by examining the particular nature of this market and how medical malpractice insurance works.

Prevalence of Medical Malpractice Insurance

Most physicians are covered by medical malpractice insurance. Many states require physicians to have malpractice insurance in order to practice in that state. Also, some states allow only those physicians with malpractice insurance to have access to state excess liability funds or other protections. Hospitals purchase their own malpractice insurance and typically require physicians to be insured in order to have admitting privileges. In the case of physicians who are employees of a hospital, the hospital generally buys insurance that covers both itself and its staff.

However, some physicians believe that the cost of malpractice insurance is too high and have decided to practice without it ("go bare"). In addition, some hospitals

[2] For a more in-depth discussion of the economics of malpractice insurance see CRS Report RL31886, *Medical Malpractice Insurance: An Economic Introduction and Review of Historical Experience*, by Baird Webel.

choose to self-insure by setting funds aside to cover future claims, instead of buying an insurance policy. According to the American Hospital Association, 40% of its member hospitals are now self-insured.[3]

Sources of Medical Malpractice Insurance

Providers can get malpractice insurance through different types of organizations. Historically, such insurance was the domain of large, commercial carriers that offered several lines of insurance. Currently, most malpractice insurance companies are provider-owned insurance companies. For physicians who cannot find coverage, some states have established joint underwriting associations to act as insurers of last resort. In addition, some states have established excess liability or patient compensation funds which cover claim costs above a prescribed amount. (The evolution of the malpractice insurance industry is described in greater detail under the "Market Structure" section below.)

State Regulation

Regulation of malpractice insurance is the responsibility of the states. In general, states require that insurance rates be (1) adequate, (2) not excessive, and (3) not unfairly discriminatory. However, the practical implementation of these tests varies by state.

States use six types of rating laws with respect to malpractice insurance: prior approval, modified prior approval, flex rating, file and use, use and file, and no file/record maintenance.[4] Most states apply either prior approval, or file and use requirements to malpractice insurers. But even among states using the same type of insurance rating law, there are variations. For example, Oregon initiates "prior review" procedures for rate increases greater than 15%, whereas Alabama requires prior approval for any proposed rate increase starting at 10%.[5]

Malpractice Liability and Resolution of Claims

Medical malpractice liability arises when a health care professional engages in negligence or commits an intentional tort. Negligence has been described as conduct falling below standards set by law for the protection of others. In most instances it arises from a failure to exercise due care, but a defendant may have carefully

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[3] Reported in U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003. (Hereafter cited as GAO, *Medical Malpractice and Premium Rates*.)

[4] For descriptions of these rating laws, see Insurance Information Institute, "Rates and Regulation," Mar. 2006, at [http://www.iii.org/media/hottopics/insurance/ratereg]. (Hereafter cited as III, "Rates and Regulation.") Note: a 7th rating law type, State-Prescribed, does not apply to malpractice insurance.

[5] For a state-by-state table of rating rules, see III, "Rates and Regulation."

considered the possible consequences of his or her conduct and still be found to have imposed an unreasonable risk on others.[6]

Although tort law allows plaintiffs to sue defendants to recover damages, most malpractice claims do not reach this point. The vast majority of claims are settled before cases even reach the courts. Of those cases where juries reach a verdict, most are found in favor of the defendant. Thus, only a small proportion of plaintiffs actually receive jury-awarded damages in malpractice cases. Moreover, successful plaintiffs who receive a judgment from a court wait an average of four to five years from when the negligence occurred to receive payment, "with many claims taking much longer."[7]

The Underwriting Cycle — "Hard" and "Soft" Insurance Markets

Insurance can be seen as the transfer of an uncertain future risk for a current finite payment, an insurance premium. The most critical aspect of the transaction is the size of this premium. An insurer must estimate the amount and probability of future losses and charge a sufficient premium to cover these losses. Since the losses are in the future, while the premium is paid today, the insurer invests that premium until the losses occur.[8] To do otherwise would require that the purchaser pay a higher current price for the insurance coverage. Although the insurance purchaser generally benefits from the lower price due to the investment of the premium, this investment also introduces another uncertainty into the equation, namely future investment returns. If investment returns change unexpectedly, then the premiums paid will also have to change, which can mean substantial increases or decreases in premiums even if there have been few or no claims made by the insured.

Property/casualty insurance, of which medical malpractice is a part, is known for its cyclical nature. So-called "soft" markets, periods where prices are generally low and insurance is readily available, alternate with "hard" markets, periods where prices are generally high and consumers may have difficulty finding insurance. Some trace these market cycles to changes in the investment climate, although it is probably more accurate to trace them to unexpected events on either side of the insurance equation. A hard market could come about because returns unexpectedly fall, or it could happen because unexpectedly large losses were experienced. Since 2001, both events have occurred, with the fall of the stock market and interest rates as well as the September 11, 2001, terrorist attacks.

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[6] For additional discussion about the legal aspects of medical malpractice, see CRS Report RL31692, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages*, by Henry Cohen. (Hereafter cited as CRS Report RL31692.)

[7] Eric Nordman, Davin Cermak, and Kenneth McDaniel, *Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis*, White Paper presented to the National Association of Insurance Commissioners, Sept. 12, 2004, p. 10. (Hereafter cited as McDaniel, et al., *NAIC Medical Malpractice White Paper*.)

[8] Insurer investment practices are regulated by the states, with the large majority of such investment going into relatively stable investments.

Medical Malpractice Insurance Market Structure

The general market for property/casualty insurance is huge and varied. Literally thousands of companies operate in the United States, ranging from obscure small insurers that might focus on a particular area or type of insurance to large companies that are recognized names across the country. Thirty years ago, medical malpractice insurance was generally the province of large, diversified insurers; only 8% of the market was served by provider-owned insurers. Largely in response to the difficulties experienced in the marketplace in the mid-1970s and mid-1980s, the large diversified companies exited the market and were largely replaced by small companies. Many of these were mutual insurers, owned by the healthcare providers who were also the ones insured, and most focused on a particular geographical state or region, or on a particular medical speciality. Within the target geographic area or speciality, such small companies may have a very large share of the market. By 1992, provider-owned insurers had grown to 62% of the market.[9] This market share has dropped somewhat since 1992, but such insurers have remained a large part of the market, particularly in hard markets as was seen after 2001.

The market evolution from large, diversified insurers to small, focused entities has a number of possible outcomes. One of these is a greater reliance on reinsurance. A small insurer pools risk away from an individual healthcare provider, but it does not spread this risk as widely as a larger insurer. To further spread risk, many insurers rely on purchasing reinsurance from other insurance companies. Using the reinsurance market effectively allows risk to be spread across a large amount of international capital. However, it also makes an insurer vulnerable to the vagaries of international capital markets.

Another result of the recent market evolution has been a high concentration of market share by particular insurers. This seems initially counterintuitive: one might expect a greater number of small companies to result in less market concentration. The key, however, is the geographic concentration of the companies. For example, in 2003, PIC of Wisconsin may have held a 0.7% market share nationwide, but in the state of Wisconsin, its market share was nearly 40%. The Copic Group had a 0.7% nationwide market share, but in Colorado, its share was 52%. Even the big insurers are not evenly distributed across the country. MLMIC Group was the largest insurer with 9.4% market share across the country, but its share in New York was 51.4%, in New Jersey, 45.9%, and Wyoming, 44.3%. The only other state where it was one of the two largest insurers was Massachusetts, where it had only 10% of the state's market.[10]

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[9] Conning and Company, *Medical Malpractice Insurance: A Prescription for Chaos*, 2001, p. 86.

[10] "Medical Malpractice, Top Writers by State — 2003," *AM Best*, Nov. 15, 2004, p. 1; and "Medical Malpractice, Top Writers — 2003," *AM Best*, Nov. 15, 2004, p. 1-2.

Premium Data

A recurring theme in past examinations of medical malpractice insurance is the lack of solid data with which to make judgments.[11] This uncertainty extends even as far as a seemingly simple question such as, "How much have medical malpractice premiums increased?" The insurance rating firm A.M. Best reports that total medical malpractice premiums increased 15.6 % in 2001,[12] 22.5% in 2002,[13] 13.5% in 2003,[14] and 5.5% in 2004,[15] with no data yet on 2005. The 2002 National Association of Insurance Commissioners' white paper, working from slightly different data, found a 28% rise in 2002, the most recent year listed, and a 13.2% rise in 2001. Regardless of data differences, it is clear that aggregate premiums rose substantially from 2001 to 2003.

The experience of individual healthcare providers, however, has been much more variable than the aggregate numbers indicate. Different specialities and different areas have experienced dramatically different rates for malpractice insurance, and this impact on individual physicians and particular areas is usually what drives public concern. It offers little solace to a small town losing a physician to note that the average rise in premiums may not have been that bad.

The most often cited source for specific area and speciality data on medical malpractice premium rates is the *Medical Liability Monitor* (MLM), which has published a yearly survey of medical malpractice insurance companies for the past 14 years. The MLM survey tracks three specialities: internal medicine, general surgery, and OB/Gyn. It reports premiums for each speciality by company within each state. By their own estimate, the MLM survey captures 65-75% of the market. The surveys of the past few years certainly seem to track the aggregate numbers indicating that rates have gone up significantly since 2000.[16] For example, from 1999 to 2004, an OB/Gyn in Philadelphia might have seen rates go from $32,236 to $161,211 and a general surgeon in Florida, from $99,652 to $277,241. In 2004 alone, an OB/Gyn in Maryland might have seen an increase of 132.8% from $44,063 to $102,587. There are, however, experiences on the other end of the scale as well. Rates reported by one company for an internist in northern California actually

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[11] For example, see McDaniel, et al., *NAIC Medical Malpractice White Paper*, and U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836, Aug. 2003. (Hereafter cited as GAO, *Medical Malpractice and Access*.)

[12] "Medical Malpractice, Top Writers — 2001," *AM Best*, Aug. 5, 2002, p. 1.

[13] "Medical Malpractice, Top Writers — 2002," *AM Best*, Nov. 17, 2003, p. 1.

[14] "Medical Malpractice, Top Writers — 2003," *AM Best*, Nov. 15, 2004, p. 1.

[15] "Medical Malpractice, Top Writers — 2004," *AM Best*, Aug. 22, 2005, p. 1.

[16] Various MLM headlines: "1999 Survey Finds No Widespread Rush by Medical Malpractice Writers to Raise Rates," vol. 24, no. 9, Sept. 1999; "2002 rate survey finds malpractice premiums are soaring...," vol. 27, no. 10, Oct. 2002; "2004 rate survey indicates rate increases may be leveling, but triple-digit hikes not over," vol. 29, no. 10, Oct. 2004.

dropped from $7,526 in 1999 to $6,869 in 2004,[17] and an internist in Nebraska might pay only $3,212 in 2004, unchanged from 2003.

Impact on Consumers and Providers

Concern about rising premiums for medical malpractice insurance extends beyond the affordability of coverage to include the potential impact on access to health services, quality of care provided, and health spending overall. As mentioned previously, some physicians claim that rising malpractice insurance rates force them to reduce, relocate, or end their medical practices, affecting consumer access to health care. Some also argue that the fear of liability (and the potential cost and professional harm a malpractice lawsuit could entail) leads physicians to practice defensive medicine. That is, "physicians' ordering of tests and procedures, or avoidance of high-risk patients or procedures, primarily (but not necessarily solely) to reduce their exposure to malpractice risk."[18] Detractors of the limited consumer access and defensive medicine arguments contend that other factors, such as the type and cost of insurance coverage that a patient might have, exert more influence over health care access or spending than does the malpractice system. Research on these issues has led to mixed or incomplete findings with ambiguous policy implications.

Consumer Access to Services and Providers

Over the past several years, stories of physicians going on strike or moving their business in response to growing malpractice insurance premiums have populated mainstream media.[19] Doctors and their supporters cite multiple examples of providers curtailing high-risk services or shutting down practices altogether, because malpractice insurance has gotten too expensive. They claim that "large jury awards and the burgeoning costs of defending against lawsuits" are the causes for "skyrocketing" liability premiums, and they see tort reform — especially limiting damages awarded in malpractice lawsuits — as the solution.[20]

Researchers have tested this theory by monitoring physician actions (e.g., moving medical practices) either in direct response to premium growth or in response to state tort reforms, such as caps on award damages. Overall, studies have found evidence of fewer physician services in response to rising premiums and increased physician supply in states that have passed tort reforms. However, access problems

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[17] Rates for Norcal Mutual in San Mateo, Santa Clara, Santa Cruz, Fresno, and Monterey Counties in 2004, and Northern California as a whole in 1999.

[18] U.S. Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs*, OTA-BP-H-1 19, Oct. 1993, p. 6.

[19] Selected examples include David Eisenberg and Maggie Sieger, "The Doctor Won't See You Now," *Time*, June 9, 2003; Rita Rubin, "Doctors Act Against Malpractice Premiums," *USA Today*, Jan. 19, 2004; and Marketplace Public Radio, "Medical Malpractice," Aug. 19, 2002, at [http://marketplace.publicradio.org/features/health_desk/].

[20] "Medical Malpractice," *CQ Researcher*, Feb. 14, 2003, vol. 13, no. 6, p. 135.

were not experienced uniformly, so the overall impact on consumer access to health care is unclear.

For example, the then-General Accounting Office (GAO) examined the implications of premium growth on availability of physician services. GAO interviewed physicians and physician associations in nine states that included a "range of malpractice premium pricing and tort reform environments."[21] They found instances of health care access problems such as gaps in speciality surgical care and lack of obstetric services. However, these problems were not found in every area studied, sometimes involved relatively few physicians, and oftentimes occurred in rural areas where "providers identified long-standing factors in addition to malpractice pressures that affected the availability of services."[22]

With respect to the impact of tort reforms on physician supply, a number of studies have found a positive relationship. For example, a study published in the Journal of the American Medical Association (JAMA) found that state adoption of "direct" tort reforms[23] led to more growth in the physician supply. From 1985-2001, the physician supply grew 2.4% more in direct-reform states than in non-reform states. The researchers found a similar impact for certain physician specialities associated with high premiums for malpractice insurance. For example, the supply of obstetricians and gynecologists in solo practice grew 2.3% more in direct-reform states than in non-reform states. For emergency physicians, the difference was 11.5%.[24] Such findings comport with studies published in *Health Affairs* and by the American Enterprise Institute (AEI) that also found a positive correlation between malpractice tort reforms and physician supply.[25]

However, a slight increase in physician supply does not necessarily translate to more consumer access and better health outcomes, nor may the increase be attributed solely to tort reform. For instance, the JAMA study looked only at the change in physician supply, but did not measure total number of hours worked. Moreover, the researchers concede that the increase in physician supply in reform states may be a

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[21] GAO, *Medical Malpractice and Access*, pp. 2-3. GAO is now the Government Accountability Office.

[22] GAO, *Medical Malpractice and Access*, p. 13.

[23] "Direct" reforms include caps on damage awards, abolition of punitive damages, no mandatory prejudgement interest, and reform of the collateral source rule. For a discussion about these and other malpractice tort reforms, see CRS Report RL31692.

[24] Daniel Kessler, William Sage, and David Becker, "Impact of Malpractice Reforms on the Supply of Physician Services," *Journal of the American Medical Association*, June 1, 2005, vol. 293, no. 21. (Hereafter cited as Kessler, et al., *Journal of the AMA*.)

[25] See William Encinosa and Fred Hellinger, "Have State Caps on Malpractice Awards Increased The Supply of Physicians?" *Health Affairs*, May 31, 2005; and Jonathan Klick and Thomas Stratmann, *Does Medical Malpractice Reform Help States Retain Physicians and Does It Matter?* American Enterprise Institute, Sept. 11, 2003. (Hereafter cited as Klick and Stratmann, *Does Medical Malpractice Reform Help States Retain Physicians*.)

"consequence of those states having more room for growth,"[26] and admit that their evaluation did not assess the impact of malpractice on cost, access, or quality. Studies that have looked at the impact of tort reform on quality of care have reached mixed findings. One study analyzed the impact of tort reforms on hospital expenditures for Medicare patients with heart conditions. The researchers found that hospital spending decreased, with no significant impact on health outcomes. However, the authors of the aforementioned AEI study found that the reforms "lower[ed] the standard of care provided" and had an adverse impact on infant mortality under certain circumstances.[27]

Defensive Medicine

Statements linking malpractice concern with reduced physician services are reflected in the discussions regarding the role of malpractice in encouraging the practice of defensive medicine. The premise underpinning defensive medicine is that the fear of liability and the potential negative outcomes associated with malpractice claims lead physicians to administer additional health care treatments or avoid high-risk services primarily to reduce their liability risk. The implication is that defensive medicine results in either an increase in overall spending for health care that may not be medically necessary, or a decrease in access to certain services or for certain patients. Multiple studies have found evidence of defensive medicine, but the policy implications remain ambiguous.

One study compared the rate of Caesarean sections at hospitals that experienced high malpractice claims and had high malpractice insurance premiums with the C-section rate at hospitals with low claims frequency and premiums. The researchers found that hospitals with high claims and premiums had a higher C-section rate, even when controlling for patient, physician, and hospital characteristics.[28] However, it is doubtful that such results are generalizable to all physician specialties. Due to the heightened risk associated with obstetrics, this specialty generally experiences greater-than-average malpractice claims and greater premium increases for malpractice insurance. It stands to reason that such an environment would make obstetricians more sensitive to changes in the malpractice environment, compared with physicians in non-high-risk fields.

The aforementioned study of Medicare hospital spending is another example cited as providing evidence of defensive physician behavior. The study analyzed the impact of tort reforms adopted between 1984 and 1990. As previously mentioned, the researchers found that spending decreased — between 5% and 9% within five years after reform implementation — with no significant impact on mortality or severe complications. The authors attributed the decrease in spending to behavior

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[26] Kessler, et al., *Journal of the AMA*, p. 2624.

[27] Klick and Stratmann, *Does Medical Malpractice Reform Help States Retain Physicians*, p. 17.

[28] A. Russell Localio, et al., "Relationship Between Malpractice Claims and Cesarean Delivery," *Journal of the American Medical Association*, Jan. 20, 1993, vol. 269, no. 3.

change prompted by tort reforms that directly limited physician liability.[29] Like the previous study, the question of generalizability is relevant. Given the narrow population studied, these results could not be generalized to all health care consumers. Moreover, CBO later applied the same methodology used in the Medicare study to a broader set of medical conditions and found no evidence of reduced medical spending attributable to malpractice tort reforms.[30]

Multiple physician surveys have found that doctors practice defensive medicine regarding referrals, treatments, patient mix, and business practices.[31] For instance, nine out of 10 of respondents to a survey conducted in Pennsylvania reported that they practiced defensive medicine at least some of the time. Five out of 10 respondents said that they often provided unnecessary referrals, and four out of 10 reported that they avoided treating high-risk patients. However, self-reports about physician behavior should be treated cautiously. Many physician surveys have low response rates. Generally, physicians who are more likely to respond to a survey focusing on malpractice concerns will be doctors who are more sensitive to the issue due to personal or professional concerns. The Pennsylvania insurance study specifically surveyed only physicians in six high-risk specialty fields.[32] The researchers note that the state had been "hit particularly hard by the latest malpractice 'crisis.'"[33] Factors such as these can bias the survey response and cast doubt on generalizability to all physician specialties in all malpractice environments.

Taken together, studies quantifying the extent to which defensive medicine is practiced have shown that it exists to some degree. But even physician and other provider groups concede that "it is difficult to measure."[34] Like the experience with rapidly rising premiums, the extent to which defensive medicine is practiced also seems to vary based on physician specialty and practice location. Moreover, defensive medicine can have both negative and positive aspects for consumers. For example, liability concerns may discourage physicians from treating certain medical cases, but such concerns may also encourage physicians to spend more time with patients.[35]

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[29] Daniel Kessler and Mark McClellan, *Do Doctors Practice Defensive Medicine?*, NBER Working Paper 5466, Feb. 1996.

[30] U.S. Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice*, Jan. 8, 2004, at [http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf].

[31] For example, see David Studdert, "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment," *Journal of the American Medical Association*, June 1, 2005, vol. 293, no. 21. (Hereafter cited as Studdert, *Defensive Medicine*.); Stephen Zuckerman, "Medical Malpractice: Claims, Legal Costs, and the Practice of Defensive Medicine," *Health Affairs*, fall, 1984 (Hereafter cited as Zuckerman, *Medical Malpractice*.); and GAO, *Medical Malpractice and Access*.

[32] The specialities are emergency medicine, general surgery, orthopedic surgery, neurosurgery, obstetrics/gynecology, and radiology.

[33] Studdert, *Defensive Medicine*, p. 2610.

[34] GAO, *Medical Malpractice and Access*, p. 27.

[35] For more information about the range of defensive practices, see Zuckerman, *Medical*

(continued...)

Causes of the Problem

Although the extent of the impact of higher medical malpractice insurance premiums may be unclear, both state legislatures and Congress have considered various proposals to address the discontent caused by higher premiums. The wide variety of cures for the problems in medical malpractice insurance are largely a result of three differing diagnoses of the underlying cause of these problems: the tort system, the insurance system, or the healthcare system.

Tort System: "Frivolous" Lawsuits and High Damage Awards

The focus in Congress, particularly of the bills that have seen floor action in the past several years, has been on the tort system as the root of the problem in medical malpractice insurance. Many argue that the incentives under the current tort system have led to increases in both the frequency of malpractice claims and severity (size) of awards. In theory, the tort system can work very efficiently to both deter wrongdoing and compensate those who are injured by this wrongdoing. In the current system, many argue, this model has become a caricature of itself: a sort of lottery situation where frivolous lawsuits clog the courts, the plaintiffs hoping to either settle before trial or find a jury to award high damages out of sympathy to the injured patient. With insurance claims from settlements and awards skyrocketing, the insurance premiums increase as a matter of course.

The Joint Economic Committee (JEC) issued a study in 2003[36] that strongly supported this argument for the tort system as the root of the problem. Citing a wider variety of influences than the JEC, GAO also found in 2003 that "Increased Losses on Claims Are the Primary Contributor to Higher Medical Malpractice Premium Rates."[37] The Congressional Budget Office (CBO) cites increased payments of claims as a major factor in driving medical malpractice insurance costs, though they cite other market forces as well.[38] CBO's cost estimates for bills that would institute limits on the tort system for medical malpractice have predicted significant savings in insurance costs. The latest of these was for H.R. 5 in the 108th Congress. CBO concluded that this bill's limits on tort damages and lawyers' fees would reduce medical malpractice premiums by 25%-30%.[39]

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[35] (...continued)
Malpractice, Exhibit 3.

[36] U.S. Congress, Joint Economic Committee, *Liability for Medical Malpractice: Issues and Evidence*, May 2003.

[37] GAO, *Medical Malpractice and Premium Rates*, p. 15.

[38] U.S. Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice*, Jan. 8, 2004, pp. 3-4.

[39] U.S. Congressional Budget Office, *Cost Estimate: H.R. 5 Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003 as ordered reported by the House Committee on the Judiciary on March 5, 2003*, Mar. 10, 2003, p. 4.

These conclusions have been disputed by many, and definite conclusions are difficult to draw because of a lack of underlying data.[40] For example, many of the arguments on increased medical malpractice claims draw their information for the size of damage awards from Jury Verdicts Research. These numbers, however, have been criticized as incomplete and "skewed significantly upward"[41] as compared to statistics from the National Practitioners Data Bank (NPDB). The NPDB, however, has been strongly criticized as a data source as well.[42] Another study casting doubt on increasing claims as an explanation for high premiums came from a review of the closed claims information in the state of Texas. This study found that from 1988-2002, the number of large paid claims was roughly constant, the number of small claims declined, and the real total cost per large paid claim rose by only 0.8%-1.2% per year.[43] These conclusions, however, have been disputed as well.[44]

Insurance System: Regulation and Antitrust Exemption

Another cause for the large increases in medical malpractice premiums that is frequently cited is the working of the insurance industry itself and the regulation, or lack thereof, of the industry. As was noted above, pricing for insurance seems to go in cycles of hard and soft markets that are at least somewhat based on investment returns earned by insurers. Some see the large price increases in medical malpractice insurance as an attempt by insurers to make up for stock market losses due to overly risky investment decisions. Others attribute the problem of increasing premiums to the limited exemption from the federal antitrust laws for the "business of insurance" that was granted by the McCarran-Ferguson Act of 1945.[45] This exemption, it is argued, allows insurers to engage in certain anti-competitive behavior that pushes insurance prices higher than those that would prevail under a free market.[46]

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[40] Both GAO and the NAIC cited limitations on currently available data as a significant problem in researching the issue.

[41] "Medical Malpractice Award Trends: Believe Government Sources, Not Doctors," on the Public Citizen website at [http://www.citizen.org/congress/civjus/medmal/articles.cfm?ID=8798].

[42] For more information about the NPDB, see U.S. General Accounting Office, *National Practitioner Data Bank: Major Improvements Needed to Enhance Data Bank's Reliability*, GAO-01-130, Nov. 2000.

[43] Bernard S. Black, et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, University of Texas Law & Economics Research Paper No. 30, p. 1. Available at [http://ssrn.com/abstract=678601].

[44] See [http://www.aei.org/events/filter.all,eventID.1037/summary.asp] for a discussion of this paper.

[45] 15 U.S.C. 1011-1014, P.L. 79-15.

[46] See, for example, the Statement of Robert Hunter, in U.S. Congress, Senate Committee on Government Affairs, *Oversight Hearing on Insurance Brokerage Practices, Including Potential Conflicts of Interest and the Adequacy of the Current Regulatory Framework*, 108th Cong., 2nd sess., Nov. 14, 2004, pp.8-9. Available at [http://hsgac.senate.gov/_files/Huntertestimony0.pdf].

As a matter of economics, investment returns will play a role in pricing for insurance because of the difference in time between when premiums are paid by the insured and when claims are paid by the insurer. Whether the investments currently undertaken by insurers are "too risky," however, is inherently a value judgment that likely cannot be proven. The individual states do currently have regulations outlining what investments may be undertaken, and historically, approximately 75% of general property/casualty investments have been in bonds or cash equivalents, which tend to be more stable than stocks.[47] For medical malpractice insurers, the ratio is even higher: approximately 86% is in bonds or cash equivalents.[48] States also regulate to various degrees the rates that companies can charge and usually require that rates be set on a prospective basis (current rates should cover the expected future claims), not a retrospective basis (current rates covering past claims). Whether or not the state regulation is adequate, however, has been questioned in the past, and stronger regulation has been cited as a way to address higher insurance prices.[49]

Consideration of the effect of the limited antitrust exemption is complicated by the intricacies of both the law itself and judicial interpretations of it, *and* by the way in which insurance companies set rates. The legal question concerns the precise actions that courts have found permissible under current law, as well as interpretation of any amendment that might be passed by Congress in the future. Courts have found under McCarran-Ferguson's exemption from the antitrust laws for "the business of insurance" that information sharing and joint rate making are permissible. The definition of "the business of insurance," however, has been narrowed over the years.[50] It is not implausible, for example, that some cases of insurer rate setting might be found by future courts to fall outside of the current antitrust exemption as impermissible price fixing; nor is it implausible that, even in the event of a complete repeal of the McCarran-Ferguson exemption, some collective action and data sharing might be found to be permissible under the antitrust laws — although anything determined to be price fixing would not qualify for such treatment.[51] Some collective action, even including joint rate making, might also be judged permissible if states authorize such action. Proponents of even a limited antitrust exemption argue that any repeal of the current exemption, even if collective action might eventually be judged permissible, would result in costly litigation and raise, rather than lower or stabilize, insurance prices.

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[47] Insurance Information Institute, *Insurance Fact Book 2005* (New York), p. 25.

[48] NAIC, *Medical Malpractice White Paper*, p. 1.

[49] See, for example, the Testimony of Jay Angoff in U.S. Congress, Joint Hearing of the Senate Committee on the Judiciary and the Senate Committee on Health, Education, Labor and Pensions, *Patient Access Crisis: The Role of Medical Litigation*, 108th Cong. 1st sess., Feb. 11, 2003. Available at [http://judiciary.senate.gov/hearing.cfm?id=600].

[50] For a discussion of court interpretations of the McCarran-Ferguson Act, see CRS Report RS22118, *Courts Narrow McCarran-Ferguson Antitrust Exemption for "Business of Insurance"*, by Janice Rubin.

[51] Under the Rule of Reason doctrine in antitrust law, courts balance the anticompetitiveness of some actions against any procompetitive effects that might be produced by those actions. *Per se* violations (those that are automatically unlawful, and may never be justified), however, are not eligible for Rule of Reason analysis.

However, given that the limited antitrust exemption is ultimately defined by the courts, the effect of such an exemption on the economics of insurer rate setting is uncertain and possibly unknowable given the current state of economic research. It is clear from economic theory that the more information available to an insurer, the more accurate and efficient the resulting insurance rates will be. While some information sharing certainly lowers rates overall, as more collective action occurs between insurers, it seems more likely that anti-competitive collusive action would occur. The policy judgment that must be made is where exactly to draw the line between collective action that enhances efficiency and drives down prices versus collective action that becomes anti-competitive and drives up prices.

Health Care System: Medical Errors

Among the cacophony of voices attributing the growth of medical liability premiums to high jury awards or poor investment choices by insurers, is a third group, which points to medical errors as a source of the problem and patient safety as a solution.[52] Supporters of this view argue that efforts to reduce medical errors will decrease the possibility of medical injury and subsequent malpractice lawsuits. Since death is the most frequently cited injury in lawsuits that are found in favor of the plaintiffs (23% of all such cases),[53] they reason that patient safety efforts will prevent some of these deaths, as well as other medical injuries, which should lead to reductions in malpractice claims and costly jury verdicts.

Anesthesiologists make up one physician group that is routinely cited as a model for patient safety and malpractice reform efforts. As a medical specialty, "anesthesiology is an example of a local, but complex, high-risk, dynamic patient care system in which there has been notably reduced error."[54] Through a combination of technological advancements, committed leadership, research focused on patient safety, and informed decision making, anesthesiologists have produced a dramatic reduction in anesthesia-related deaths. As a result, the proportion of total medical liability suits filed against anesthesiologists has dropped, and the median payment made in malpractice cases against anesthesiologists has been cut in half over the

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[52] Patient safety refers to the panoply of rules, practices, and systems related to the prevention of patient injury, also known as "adverse events." Intrinsic to patient safety efforts are strategies to prevent medical errors (i.e., the use of an incorrect medical treatment or the failure of a specific treatment to achieve the intended result). For more information about these issues, see CRS Report RL32092, *Medical Malpractice: The Role of Patient Safety Initiatives*, by Bernadette Fernandez.

[53] The remaining 77% is comprised of many other medical cases, such as injuries to the brain, genitals, spinal nerves, and other body parts, plus conditions such as cancer, paralysis, and emotional distress, among others. Brooke Doran, ed., *Medical Malpractice: Verdicts, Settlements and Statistical Analysis, Updated Edition*, (Horsham, PA: Jury Verdict Research, 2005).

[54] U.S. Institute of Medicine, *To Err is Human: Building a Safer Health System*, 1999, p. 164, [http://www.nap.edu/books/0309068371/html/].

course of 20 years. Moreover, the premiums anesthesiologists pay for malpractice insurance are lower today than the rates they paid 20 years ago.[55]

The link between medical errors and malpractice liability is not universally accepted. Multiple studies have found that the majority of malpractice claims filed do *not* involve negligent medical care.[56] In other words, the majority of patients who file malpractice claims have suffered medical injuries, but not of the type that would be "legally compensable" on the grounds of provider negligence.[57] At the same time, only a small proportion of patients whose injuries are caused by negligence actually end up filing a malpractice claim. In one study, only 3% of patients who experienced a negligent injury sued for malpractice.[58] Although these studies speak more to the misalignment of incentives under the current tort system than the relationship between medical negligence and provider liability, the findings are cited in arguments that the relationship between negligence and malpractice claims is a tenuous one.

Given that medical error can lead to injury and that injury (whether or not resulting from negligence) is the medical basis on which a malpractice claim is made, analyzing the relationship between medical errors and malpractice claims may prove insightful in developing strategies to reduce both. Congress has already set the foundation for such work. In 2005, Congress passed S. 544, the Patient Safety and Quality Improvement Act of 2005, which became P.L. 109-41. Once implemented, this law will establish legal protections for medical errors information and develop procedures to encourage the voluntary reporting and analysis of such data. The expectation is that analysis of the data will lead to recommendations for the prevention of medical errors and, as a consequence, enhancement of patient safety.

Legislative Proposals in the 109th Congress

Given the complexity of the malpractice insurance debate, it is no wonder that legislative proposals vary in terms of the approaches they employ to address these issues. Proposals may focus on the problem itself, or attempt to mitigate its adverse effects. In addition, legislative approaches will reflect logistical and political considerations.

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[55] Joseph Hallinan, "Heal Thyself: Once Seen as Risky, One Group of Doctors Changes Its Ways," *Wall Street Journal*, June 21, 2005, p. 1.

[56] For example, see David Studdert, et al., "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care*, Mar. 2000. (Hereafter cited as Studdert, *Negligent Care*); Paul Weiler, et al., *A Measure of Malpractice*, 1993; and Troy Brennan, et al., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I," *New England Journal of Medicine*, vol. 324, issue 6, Feb. 7, 1991.

[57] Gerald Hickson, et al., "Development of an Early Identification and Response Model of Malpractice Prevention," *Law and Contemporary Problems*, winter, 1997, p. 9.

[58] Studdert, *Negligent Care*.

Legislative proposals differ on the problem each proposal is attempting to address and the presumed cause of the problem. Is the problem rapid growth in malpractice insurance costs caused by unreasonable jury awards? Or is it insurance companies' attempts to counter dwindling investment returns by raising premiums? Or a health system that does not do enough to prevent medical errors? And how are these issues related to the twin goals of the liability tort system: fair and timely compensation to those injured, and deterrence of negligent medical care?

What then are the objectives of these legislative proposals? Is it to reduce the growth of malpractice insurance premiums (e.g., through damage caps or insurance market reforms), or make insurance more affordable (e.g., through a tax credit to physicians)? Or is it broader — aligning medical, health insurance, and tort incentives to equitably treat patients and providers? These proposals also raise questions about the appropriate role for government, as well as the appropriate level (state vs. federal) for any intervention.

Given the diversity of issues discussed above, bills introduced in the 109th Congress employ a variety of strategies in addressing those issues. The bills include provisions that target the legal system (e.g., tort reforms), the insurance industry (e.g., prohibition of anti-competitive behavior), and the health care system (e.g., medical error reporting). Many bills also include provisions that use both public- and private-based solutions (e.g., grants to states to develop administrative procedures for resolving malpractice claims). The next section of this report summarizes current proposals, using different legislative approaches: tort reform, patient safety and medical error reporting, administrative approach and research, tax credit, antitrust prohibition, and comprehensive reform.

Tort Reform

H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2005, would preempt state tort law regarding certain aspects of medical malpractice liability and liability for medical products. It would not preempt state laws that provide greater substantive or procedural protections to health care providers and organizations. The act would establish a federal statute of limitations concerning malpractice lawsuits, limit noneconomic damages to $250,000, make each party liable for damages in proportion to their responsibility for the patient's harm, allow the court to restrict attorneys' fees to a percentage based on the amount awarded to the claimant, allow any party to introduce evidence of collateral source benefits, limit punitive damages to the greater of $250,000 or twice the amount of economic damages, and provide for periodic payments for damages over $50,000.

S. 354 is the companion bill to H.R. 5. The bills are identical except for four nontrivial differences.[59] H.R. 5 was passed by the House on July 28, 2005. It was referred to the Senate Judiciary Committee on July 29. S. 354 was referred to the Health, Education, Labor, and Pensions Committee on February 10, 2005.

[59] The differences are discussed in the CRS Report RS22075, *Medical Malpractice Liability Reform: S. 354, 109th Congress*, by Henry Cohen.

Patient Safety and Medical Error Reporting

S. 544, the Patient Safety and Quality Improvement Act of 2005, would amend the Public Health Service Act to establish legal protections for medical errors information and develop procedures to encourage the voluntary reporting and analysis of such data. The act would protect medical error data from being used in administrative, civil, or criminal proceedings, or from being disclosed under Freedom of Information Act requests, with certain exceptions, such as for public health or law enforcement purposes. Certified patient safety organizations (PSOs) would collect the data, analyze it, and disseminate patient safety recommendations based on those analyses. The act would also require the Secretary of Health and Human Services to submit a report to Congress regarding approaches to reducing medical errors and improving patient safety. S. 544 became **Public Law 109-41** (P.L. 109-41) on July 29, 2005.

Administrative Approach and Research

S. 1337, the Fair and Reliable Medical Justice Act, would amend the Public Health Service Act to authorize the Secretary of Health and Human Services to award grants to states to develop, implement, and evaluate alternatives to tort litigation for the purpose of resolving medical malpractice claims. The Secretary may award up to 10 grants, with each grant not exceeding five years in duration. Each state desiring a grant must develop an alternative approach to resolve malpractice claims and allow for the collection and analysis of patient safety data. Each state must demonstrate how the alternative approach encourages prompt and fair resolution of malpractice claims, promotes disclosure of medical errors, increases patient safety, and preserves access to medical malpractice insurance. The alternatives developed may be based on three models described in the bill: "early disclosure and compensation model," "administrative determination of compensation model," or "special health care court model." The bill was referred to the Senate Health, Education, Labor, and Pensions Committee on June 29, 2005.

H.R. 2399, the Improved Medical Malpractice Information Reporting and Competition Act of 2005, would establish the Office of Health Care Competition Policy within the Department of Health and Human Services (HHS) for the purpose of conducting the Secretary's activities related to the National Practitioner Data Bank. The Director is appointed by the HHS Secretary. The bill requires additional information to be submitted to the existing database. Any entity that "underwrites a policy of insurance for medical malpractice actions or claims" must submit information related to the insurer's premiums, income, claims, reserves, expenses, underwriting gains/losses, operational gains/losses, and any other topic the Secretary deems necessary for "appropriate interpretation." The Secretary will make certain database information available online to the public for free, provided that the information does not include "individually identifiable information." The bill was referred to the House Energy and Commerce Committee, Health Subcommittee, on June 3, 2005.

H.R. 2400, the Emergency Malpractice Liability Insurance Commission, would authorize the establishment of the Emergency Malpractice Liability Insurance Commission to examine the causes of medical malpractice insurance costs and

propose a strategy to counteract the "crisis" in liability insurance. The bill contains provisions related to the composition and qualification of individual commission members, as well as the duties and powers of the commission as a whole. The commission is required to submit a final report to the President and Congress containing findings related to a list of issues specified in the bill, a plan to combat the impact of growing malpractice insurance premiums, and recommendations for appropriate legislative and administrative action. The bill was referred to the House Energy and Commerce Committee, Health Subcommittee on June 3, 2005.

Tax Credit

H.R. 2291, the Medical Malpractice Relief Act of 2005, would amend the Internal Revenue Code to provide tax credits to physicians, hospitals, clinics, and long-term care providers. For each taxable year, an eligible health care provider may receive a certain percentage of the provider's "qualified medical malpractice insurance expenditures" in the form of a business tax credit. These provisions limit qualified expenditures to twice the average of costs for qualified malpractice insurance for "similarly situated eligible persons." The taxpayer may elect not to claim the credit. The bill also authorizes the HHS Secretary to award grants to eligible health care providers and facilities for the purpose of assisting credit-eligible providers in "defraying qualified medical malpractice insurance expenditures." The bill was referred to the House Ways and Means Committee on May 11, 2005, and the House Energy and Commerce Committee, Health Subcommittee on May 23, 2005.

Antitrust Prohibition

S. 1525, the Medical Malpractice Insurance Antitrust Act of 2005, prohibits anti-competitive behavior in the medical malpractice insurance market. It declares that nothing in the McCarran-Ferguson Act should be construed to allow commercial insurers to engage in price fixing (competitors collectively setting prices), bid rigging (competitors deciding who will submit the winning bid on a contract), or market allocation (competitors allocating market areas among themselves). The bill was referred to the Judiciary Committee on July 28, 2005.

Comprehensive Reform

H.R. 3359, the Medical Malpractice and Insurance Reform Act of 2005, includes provisions on medical liability tort reform, mandatory mediation, malpractice insurance reform, physician supply, a medical malpractice advisory commission, and a federal agency on medical malpractice insurance information.

The provisions regarding tort reform include imposing a three-year statute of limitations for malpractice lawsuits, requiring an affidavit to affirm the merits of any malpractice action, enforcing sanctions against "frivolous actions and pleadings," and allocating half of any punitive damages awarded towards activities to enhance patient safety.

The bill mandates mediation prior to any malpractice action going to trial and requires states to make it available. The Attorney General and HHS Secretary would

develop regulations relating to the timely and reasonable implementation of these provisions.

The insurance reform provisions include several requirements related to the pricing of medical liability insurance products. The bill requires each malpractice insurer to estimate savings resulting from the tort reform and mediation provisions, and implement a plan to dedicate at least half of those savings to the reduction of malpractice insurance premiums. Another insurance reform provision prohibits commercial insurers from engaging in "any form of price fixing, bid rigging, or market allocation" for the purpose of providing medical liability insurance. The bill also requires that states have policies in effect that allow any health care provider to challenge a proposed rate increase and require a malpractice insurer to submit, at a minimum, a description of and justification for a rate increase before such an increase can take effect. Finally, the insurance provisions require the HHS Secretary to establish an interactive website for the purpose of obtaining medical liability insurance quotes from each licensed carrier.

The physician supply provisions involve amending the Public Health Service Act to authorize the HHS Secretary to award grants to health care practitioners who agree to practice in areas experiencing health provider shortages. Such shortages must be determined, by the HHS Secretary, to result from providers' decisions to reduce or relocate their medical practices in response to rising malpractice insurance costs. The bill also authorizes appropriations to assign Public Health Service Corps providers to trauma centers in health provider shortage areas.

The section on the advisory commission authorizes the establishment of the Independent Advisory Commission on Medical Malpractice Insurance for the purpose of evaluating the causes of the recent increases in medical liability insurance costs and developing strategies to reduce premiums and avoid similar rate increases in the future. The provisions describe the membership, powers, and duties of the Commission, including submitting reports to Congress on the Commission's findings, conclusions, and proposals to address rate increases.

The section on the federal malpractice insurance agency establishes the Medical Malpractice Insurance Information Administration with the Department of Health and Human Services. The Administrator, appointed by the HHS Secretary, identifies the data elements necessary to "properly evaluate the medical malpractice insurance market." Required data elements include information related to the frequency and severity of malpractice claims paid, losses associated with malpractice claims under settlements and trial verdicts, and the proportion of losses associated with economic and noneconomic damages.

The bill was referred to the House Judiciary Committee on July 20, 2005, and the House Energy and Commerce Committee, Health Subcommittee, on July 29, 2005.

H.R. 3378, the Comprehensive Medical Malpractice Reform Act of 2005, includes provisions on medical liability reform, malpractice mediation programs, voluntary reporting of medical errors, and malpractice insurance reform.

The liability reform section includes provisions that directly involve tort actions, as well as relate to general liability issues. The tort reform provisions include a $250,000 cap on awards for noneconomic damages, a process for certifying the merit of malpractice actions, and sanctions against meritless actions. The general liability provisions concern voluntary performance standards applicable to state medical boards and establishment of an "interstate patient reporting and physician tracking database."

The mediation section authorizes the Attorney General to provide grants to states and health care organizations for the development and implementation of mediation programs. Such programs would be based on the "Rush model" — a malpractice mediation program in place at Rush University Medical Center in Chicago.

The reporting section includes provisions on the voluntary reporting of medical error information for the purpose of collecting and analyzing such information to promote patient safety efforts. To encourage reporting of medical errors, the bill establishes certain legal and administrative protections. The reported information would not be subject to a "civil or administrative subpoena or order," "discovery in connection with a civil or administrative proceeding," or disclosure under the Freedom of Information Act. It also cannot be used in an "adverse employment action" against an individual who reported the information in good faith. The HHS Secretary would provide for the development and operation of a database for the purpose of collecting voluntarily reported medical error information and prepare a report to Congress on strategies to reduce medical errors and enhance patient safety.

The insurance reform section includes provisions related to proposed rate increases and premium reductions. The bill requires states to have in effect laws or regulations regarding the process for increasing malpractice insurance rates and specifies certain elements of that process. The bill also requires each malpractice insurer to estimate savings resulting from the liability reform provisions and implement a plan to dedicate at least half of those savings to the reduction of malpractice insurance premiums.

The bill was referred to the House Judiciary Committee on July 21, 2005, and the House Energy and Commerce Committee, Health Subcommittee on August 8.