

IN THE SUPREME COURT OF OHIO

MELISA ARBINO,

Petitioner,

v.

JOHNSON & JOHNSON, et al.,

Respondents.

: Case No. 2006-1212  
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:  
: On Questions Certified by the  
: United States District Court for  
: Northern District of Ohio,  
: Western Division  
:  
: U.S. District Court Case No.  
: 3:06 CV 40010  
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BRIEF OF *AMICI CURIAE*, THE OHIO HOSPITAL ASSOCIATION,  
THE OHIO STATE MEDICAL ASSOCIATION,  
AND THE OHIO OSTEOPATHIC ASSOCIATION,  
IN SUPPORT OF THE RESPONDENTS

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Janet G. Abaray (0002943)  
(COUNSEL OF RECORD)  
Calvin S. Tregre, Jr. (0073454)  
Melanie S. Bailey (0075821)  
Burg Simpson Eldridge Hersh & Jardine  
312 Walnut St., Suite 2090  
Cincinnati, OH 45202-4028  
Phone: (513) 852-5600  
Fax: (513) 852-5611

Robert S. Peck  
Stephen B. Pershing  
Center For Constitutional Litigation, P.C.  
1050 31<sup>st</sup> Street N.W.  
Washington D.C. 20007  
Phone: (202) 944-2874  
Fax: (202) 965-0920

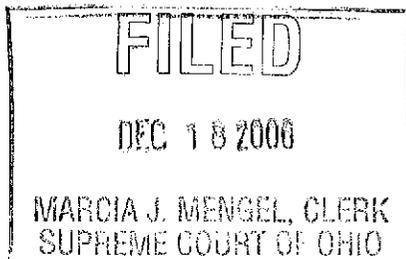
Counsel for Petitioner, Melisa Arbino

Catherine Ballard (0030731)  
(COUNSEL OF RECORD)  
Lana Knox (0080651)  
Bricker & Eckler LLP  
100 South Third Street  
Columbus, OH 43215-4291  
Phone: (614) 227-2300  
Fax: (614) 227-2390  
E-mail: [cballard@bricker.com](mailto:cballard@bricker.com)  
[lknox@bricker.com](mailto:lknox@bricker.com)

Counsel for *Amici Curiae*, Ohio Hospital  
Association, Ohio State Medical Association,  
and Ohio Osteopathic Association

Irene C. Keyse-Walker (0013143)  
(COUNSEL OF RECORD)  
Benjamin C. Sasse (0072856)  
Julie A. Callsen (0062287)  
Tucker Ellis & West LLP  
1150 Huntington Bldg.  
925 Euclid Ave.  
Cleveland, OH 4415-1475  
Phone: (216) 696-2286  
Fax: (216) 592-5009

Counsel for Respondents, Johnson & Johnson,  
*et al.*



Jim Petro, Attorney General (0022096)  
Stephen P. Carney, State Solicitor (0063460)  
(COUNSEL OF RECORD)  
Sharon Jennings (0055501)  
Holly Hunt (0075069)  
Frank Strigari (0078377)  
Office of the Ohio Attorney General  
30 E. Broad Street, 17<sup>th</sup> Floor  
Columbus, OH 43215  
Phone: (614) 466-4320  
Fax: (614) 466-5087

Counsel for Plaintiff-Intervenor (Respondent)  
State of Ohio

**TABLE OF CONTENTS**

	<u>Page</u>
TABLE OF CONTENTS.....	i
TABLE OF AUTHORITIES .....	iii
STATEMENT OF FACTS .....	1
STATEMENT OF INTEREST OF <i>AMICI CURIAE</i> .....	1
ARGUMENT.....	3
A.    Ohio’s Recent Tort Reform Efforts Bring Ohio In Line With Other States That Have Similarly Found The Need to Limit Noneconomic Damages To Reduce Escalating And Unpredictable Noneconomic Damage Awards. ....	4
B.    Since the Noneconomic Damage Caps Contained in S.B. 281 Have Been In Effect, Ohio’s Medical Liability Insurance Market Appears to be Showing Initial Signs of Recovery. ....	8
1.    S.B. 281 Was Enacted In Response To A Growing Medical Liability Insurance Crisis In Ohio.....	8
2.    S.B. 281’s Noneconomic Damage Caps Have Contributed To The Stabilization Of Medical Liability Insurance Rates In Ohio And Have Had A Positive Impact On Access To Health Care Services In Ohio. ....	11
C.    Other Jurisdictions Have Enacted Noneconomic Damage Caps As Effective Tort Reform Measures. ....	13
D.    Petitioner’s Constitutional Challenges Have Been Rejected In Other States With Similar Noneconomic Damage Caps.....	15
1.    Limitations On Noneconomic Damages Do Not Violate The Right To Trial By Jury.....	16
2.    Limitations On Noneconomic Damages Do Not Violate Separation Of Powers Principles.....	18
3.    Limitations On Noneconomic Damages Do Not Violate Equal Protection Guarantees. ....	20
4.    Limitations On Noneconomic Damages Do Not Violate Due Process Guarantees. ....	23

5.	Limitations On Noneconomic Damages Do Not Violate The Right To A Remedy.....	24
	CONCLUSION.....	25
	CERTIFICATE OF SERVICE.....	27
<u>APPENDIX</u>		
	Ohio Medical Malpractice Commission's Final Report .....	Exhibit A
	Executive Summary of the Ohio Department of Insurance's "Physician Medical Malpractice Insurance Survey" .....	Exhibit B
	Shannon Mortland, <i>Docs Find Relief at Last; Tort Reform Helps Apply Brakes to Steep Malpractice Insurance Hikes; More Physicians Staying in Ohio</i> , CRAIN'S CLEVELAND BUSINESS, Sept. 11, 2006.....	Exhibit C
	Ohio Department of Insurance Table, "Med Mal Rate Changes 2000 to 2006" .....	Exhibit D
	<i>Medical Mal Insurance Rates Fall, ODI Reports</i> , GONGWER, vol. 75, Nov. 8, 2006 .....	Exhibit E
	Chris Grier, <i>New AMA Study Says Jury Award Caps Stem Losses</i> , BEST'S INSURANCE NEWS, Oct. 5, 2006 .....	Exhibit F
	"The Texas Success in Brief: Texas Proves that Medical Liability Reform Works" .....	Exhibit G

**TABLE OF AUTHORITIES**

Page

**CASES**

*Arrington v. ER Physicians Group, APMC* (La. App. 3 Cir. Sept. 27, 2006),  
La. App. No. 04-1235, 2006 La. App. LEXIS 2164..... 16

*Austintown Twp. Bd. of Trustees v. Tracy* (1996), 76 Ohio St.3d 353,  
667 N.E.2d 1174 ..... 19, 20

*Beatty v. Akron City Hosp.* (1981), 67 Ohio St.2d 483, 424 N.E.2d 586 ..... 20

*Best v. Taylor Machine Works* (1997), 179 Ill.2d 367, 689 N.E.2d 1057 ..... 16

*Brannigan v. Usitalo* (1991), 134 N.H. 50, 587 A.2d 1232..... 16

*Direct Plumbing Supply Co. v. Dayton* (1941), 138 Ohio St. 540, 38 N.E.2d 70 ..... 23

*Estate of Hood v. Rose*, 2003-Ohio-3268, 153 Ohio App.3d 199 ..... 18

*Etheridge v. Medical Center Hospitals* (1989), 237 Va. 87, 376 S.E.2d 525..... 16, 17, 22

*Evans v. State* (Alaska 2002), 56 P.3d 1046 ..... passim

*Fassig v. State ex rel. Turner* (1917), 95 Ohio St. 232, 116 N.E. 104..... 18

*Fein v. Permanente Medical Group* (1985), 38 Cal.3d 137, 695 P.2d 665 ..... 15

*Ferdon v. Wisc. Patients Comp. Fund* (2005), 284 Wis.2d 573, 701 N.W.2d 440 ..... 16

*Gourley v Nebraska. Methodist Health Sys.* (2003), 265 Neb. 918, 633 N.W.2d 43 ..... passim

*Judd ex rel. Montgomery v. Drezga* (Utah 2004), 103 P.3d 135 ..... 15, 17, 19, 24

*Kinney v. Kaiser Aluminum & Chemical Corp.* (1975), 41 Ohio St.2d 120,  
322 N.E.2d 880 ..... 20

*Kirkland v. Blaine County Med. Ctr.* (2000), 134 Idaho 464, 4 P.3d 1115 ..... passim

*Knowles v. United States* (1996), 544 N.W.2d 183, 1996-SD-10 ..... 16

*Lakin v. Senco Products, Inc.* (1999), 329 Ore. 62, 987 P.2d 463..... 16

*Morris v. Savoy* (1991), 61 Ohio St.3d 688, 576 N.E.2d 765..... 24

*Murphy v. Edmonds* (Md. 1992), 325 Md. 342, 601 A.2d 102..... 15, 16, 21

<i>Pulliam v. Coastal Emergency Services of Richmond, Inc.</i> (1999), 257 Va. 1, 509 S.E.2d 307 .....	16, 19
<i>Robinson v. Charleston Area Medical Center, Inc.</i> (1991), 186 W. Va. 720, 414 S.E.2d 877 .....	16, 22
<i>Scholz v. Metro. Pathologists P.C.</i> (Colo. 1993), 851 P.2d 901 .....	15, 21
<i>Schwan v. Riverside Methodist Hosp.</i> (1983), 6 Ohio St.3d 300, 452 N.E.2d 1337 .....	24
<i>Smith v. Botsford General Hosp.</i> (C.A. 6, 2005), 419 F.3d 513 .....	15, 21
<i>Sofie v. Fibreboard Corp.</i> (1991), 112 Wn.2d 636, 771 P.2d 711 .....	16
<i>State ex rel. Adams v. Aluchem, Inc.</i> , 104 Ohio St.3d 640, 2004-Ohio-6891 .....	18
<i>State v. Thompson</i> , 95 Ohio St.3d 264, 2002-Ohio-2124 .....	21
<i>Strock v. Presnell</i> (1988), 38 Ohio St.3d 207, 527 N.E.2d 1235 .....	18
<i>United States v. Playboy Ent. Group, Inc.</i> (2000), 529 U.S. 803 .....	21
<i>Van Der Veer v. Ohio Dept. of Transp.</i> (1996), 113 Ohio App.3d 60, 680 N.E.2d 230 .....	23
<i>Vance v. Bradley</i> (1979), 440 U.S. 93 .....	22
<i>Verba v. Ghaphery</i> (2001), 210 W. Va. 30, 552 S.E.2d 406 .....	16, 20

**STATUTES**

R.C. 2315.18 .....	passim
R.C. 2315.18(A)(4) .....	5
R.C. 2315.18(B)(2) .....	6
R.C. 2315.18(B)(3) .....	6
R.C. 2323.43 .....	1, 3, 4, 5
R.C. 2323.43(A)(2) .....	5
R.C. 2323.43(A)(3) .....	5
R.C. 2323.43(H)(3) .....	5

**CONSTITUTIONAL PROVISIONS**

Article I, Section 16, Ohio Constitution ..... 23, 24  
Article I, Section 2, Ohio Constitution ..... 20  
Article II, Section 1, Ohio Constitution ..... 19

**OTHER AUTHORITIES**

Behrens and Silverman, Now Open for Business: The Transformation of Mississippi’s  
Legal Climate (2005), 24 Miss. C. L. Rev. 393 ..... 14  
Kinney, Indiana’s Medical Malpractice Reform Revisited: A Limited Constitutional  
Challenge (1998), 31 Ind. L. Rev. 1043, 1047 ..... 13

## **STATEMENT OF FACTS**

The relevant facts are set forth in Respondents' merit brief. Those facts are adopted by reference and incorporated herein.

## **STATEMENT OF INTEREST OF *AMICI CURIAE***

*Amici curiae* -- the Ohio Hospital Association, the Ohio State Medical Association, and the Ohio Osteopathic Association -- strongly support the General Assembly's enactment of Senate Bill 80 ("S.B. 80"). Specifically, *amici curiae* believe that limitations on noneconomic damages in tort actions are an essential element of tort reform measures. S.B. 80's limitations on noneconomic damages in general tort actions (R.C. 2315.18) are similar to those contained in Senate Bill 281 ("S.B. 281"), which limit noneconomic damages in the context of medical claims (R.C. 2323.43).

The purpose of this brief is to address the critical role noneconomic damage limitations play in tort reform efforts in Ohio and across the country. Although S.B. 281 became effective in April 2003, information recently released from the Ohio Department of Insurance shows that Ohio is only now beginning to see the positive impact of S.B. 281's noneconomic damage caps on both medical liability insurance rates and access to quality health care. At least thirty other states have included a statutory limitation on noneconomic damages as part their tort reform efforts. Courts in several of these states have considered the constitutionality of noneconomic damage caps and have rejected arguments similar to those raised by the Petitioner. For the reasons contained herein, *amici curiae* respectfully urge this Court to find that the General Assembly's enactment of R.C. 2315.18 is a constitutionally valid exercise of legislative authority and to uphold the noneconomic damage cap at issue.

The OHA is a private nonprofit trade association established in 1915 as the first state-level hospital association in the United States. From its first major legislative undertaking involving the federal Harrison Narcotic Act, the OHA has provided a mechanism for Ohio's hospitals to come together and develop health care legislation and policy in the best interest of hospitals and their communities. The OHA is comprised of more than one hundred seventy (170) private, state and federal government hospitals and more than forty (40) health systems, all located within the state of Ohio; these hospitals and health systems employ nearly 240,000 employees. The total number of people working in Ohio hospitals, including physicians and volunteers is 303,000. The OHA's mission is to be a membership-driven organization that provides proactive leadership to create an environment in which Ohio hospitals are successful in serving their communities.

The Ohio State Medical Association ("OSMA") is a non-profit professional association established in 1835 and is comprised of approximately 16,000 physicians, medical residents, and medical students in the State of Ohio. The OSMA's membership includes most Ohio physicians engaged in the private practice of medicine, in all specialties. The OSMA strives to improve public health through education, to encourage interchange of ideas among members, and to maintain and advance the standards of practice by requiring members to adhere to the concepts of professional ethics.

The Ohio Osteopathic Association ("OOA") is a non-profit professional association, founded in 1898, which represents Ohio's 3,300 osteopathic physicians, thirteen member health care facilities accredited by the American Osteopathic Association's Healthcare Facilities Accreditation Program, and the Ohio University College of Osteopathic Medicine in Athens, Ohio. Osteopathic physicians make up eleven percent of all licensed physicians in Ohio and

twenty-six percent of the family physicians in the state. The OOA's objectives include the promotion of Ohio's public health and maintenance of high standards at all osteopathic institutions within the state.

The OHA, the OSMA, and the OOA are strong advocates of a comprehensive solution to the significant issues facing Ohio's health care system. In this regard, *amici curiae* actively support patient safety initiatives, insurance industry reform, and tort reform measures. *Amici curiae* were involved in the formation of the Ohio Patient Safety Institute,<sup>1</sup> which is dedicated to improving patient safety in the State of Ohio, and the OHA created OHA Insurance Solutions, Inc.,<sup>2</sup> which seeks to restore stability and predictability to Ohio's medical liability insurance market. Additionally, *amici curiae* have been proponents of Ohio's tort reform measures in S.B. 281 and S.B. 80.

### **ARGUMENT**

This Court has accepted for review three questions regarding the constitutionality of S.B. 80. Although all three issues are important to Ohio's medical community, this brief focuses only on the noneconomic damages limitation codified R.C. 2315.18. While not dispositive regarding S.B. 281's noneconomic damage limitations, the Court's decision in this case with respect to the constitutionality of noneconomic damage caps in the general tort context (R.C. 2315.18) may impact how the lower courts apply noneconomic damage caps in the context of medical claims (R.C. 2323.43). *Amici curiae* believe both statutes are constitutional and, accordingly, urge the Court to reject Petitioner's constitutional challenges to R.C. 2315.18.

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<sup>1</sup> <http://www.ohiopatientsafety.org/>

<sup>2</sup> <http://www.ohainsurance.com/>

**A. Ohio's Recent Tort Reform Efforts Bring Ohio In Line With Other States That Have Similarly Found The Need to Limit Noneconomic Damages To Reduce Escalating And Unpredictable Noneconomic Damage Awards.**

In recent years, Ohio has enacted two separate tort reform measures which include limitations on noneconomic damages -- the first applies to medical negligence actions (see R.C. 2323.43, included in S.B. 281) and the second applies to general tort actions (see R.C. 2315.18, included in S.B. 80). Ohio is not unique in enacting statutes that limit noneconomic damage awards in tort actions. More than twenty-five states have enacted statutes limiting noneconomic damages<sup>3</sup>, and an additional five states have enacted statutes limiting total damages (both economic and noneconomic damages).<sup>4</sup> The Ohio General Assembly was aware that many other states had laws limiting noneconomic damages at the time it enacted Ohio's noneconomic damage limitation statutes in S.B. 281 and S.B. 80. The adoption of these statutes brought Ohio into the mainstream of tort law throughout the country.

In April 2003, S.B. 281, which applies to medical claims, became effective. The General Assembly enacted S.B. 281 in response to increasing concerns that medical liability insurance premiums "were driving away health care providers and compromising the ability of Ohio consumers to receive the health care they need."<sup>5</sup> S.B. 281, contains a set of tort reform measures directed towards stabilizing Ohio's medical malpractice insurance market and decreasing both health care and litigation costs in an effort to ensure access to quality health care

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<sup>3</sup> States with caps on noneconomic damages include: Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Kansas, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Utah, West Virginia, and Wisconsin. See American Medical Association, Medical Liability Reform – NOW! July 19, 2006, at 27, available at: <http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnw.pdf>.

<sup>4</sup> Indiana, Louisiana, Nebraska, New Mexico, and Virginia. *Id.*

<sup>5</sup> Final Report and Recommendations of the Ohio Medical Malpractice Commission, April 2005, at 2 ("Ohio Medical Malpractice Commission's Final Report"), attached hereto as Exhibit A (without the exhibits).

to Ohioans.<sup>6</sup> An essential component of S.B. 281 is R.C. 2323.43, which limits noneconomic damages.

S.B. 281 limits noneconomic damages<sup>7</sup> in medical negligence actions to the greater of \$250,000 or three times the plaintiff's economic loss, up to a maximum of \$350,000 per plaintiff or \$500,000 per occurrence. R.C. 2323.43(A)(2). These limitations increase to \$500,000 per plaintiff and \$1,000,000 per occurrence for injuries involving permanent and substantial physical deformity, loss of a limb or bodily organ system, or for an injury that deprives a person of independently caring for himself and performing life-sustaining activities. R.C. 2323.43(A)(3)(a)-(b). In support of the cap, the Ohio General Assembly noted that Indiana, Colorado, California, Nebraska, Utah and Montana had adopted a \$250,000 limitation on noneconomic damages. S.B. 281, § 3(A)(4)(d). The General Assembly further found that “[t]hese states, as well as others that have imposed meaningful caps on noneconomic damages, report significantly lower increases in average premium rates than those states without caps.” *Id.*

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<sup>6</sup> Senate Bill 281, §§ 3(B)(1) and (2):

[T]he General Assembly declares its intent to accomplish all of the following by the enactment of this act: (1) To stem the exodus of medical malpractice insurers from the Ohio market; [and] (2) To increase the availability of medical malpractice insurance to Ohio's hospitals, physicians, and other health care practitioners, thus ensuring the availability of quality health care for the citizens of this state...

<sup>7</sup> The term “noneconomic damages” is used herein to refer to damages for noneconomic loss. R.C. 2323.43(H)(3) defines “noneconomic loss” in the context of a “medical, dental, optometric, or chiropractic claim” as:

nonpecuniary harm that results from an injury or loss to person or property that is a subject of a tort action, including, but not limited to, pain and suffering, loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, disfigurement, mental anguish, and any other intangible loss.

R.C. 2315.18(A)(4) similarly defines “noneconomic loss” in the context of tort claims.

Recognizing the impact that caps were having in other states to achieve similar legislative goals, the Ohio General Assembly made a policy decision to enact a limitation on noneconomic damages in an effort to stabilize health care costs and to ensure access to necessary medical services for Ohioans. *Id.* at § 3(A)(3) (“The overall cost of health care to the consumer has been driven up by the fact that malpractice litigation causes health care providers to over prescribe, over treat, and over test their patients.”).

More recently, in April 2005, S.B. 80, which applies to general tort claims, became effective. S.B. 80 includes a noneconomic damages cap at R.C. 2315.18. The noneconomic damage cap contained in S.B. 80 follows a similar pattern to that set forth in S.B. 281. Specifically in S.B. 80, the General Assembly limited noneconomic damages in tort actions to the greater of \$250,000 or an amount equal to three times the economic loss, up to \$350,000 per plaintiff or \$500,000 per occurrence. R.C. 2315.18(B)(2). However, unlike S.B. 281, S.B. 80 contains no limitations for certain catastrophic injuries. Therefore, under S.B. 80, a plaintiff demonstrating a permanent and substantial physical deformity, loss of use of a limb, loss of a bodily organ system, or a functional injury that prevents him from performing life-sustaining activities, has no limitation on noneconomic damages. R.C. 2315.18(B)(3).

In enacting S.B. 80, the General Assembly made several specific findings and recognized, *inter alia*:

- Ohio’s civil litigation system (for general torts) presented a challenge to Ohio’s economic well-being (S.B. 80, § 3(A)(1));
- Ohio was in need of a “fair system of civil justice” that balanced the rights of tort claimants with “the rights of those who have been unfairly sued” (S.B. 80, § 3(A)(2));
- noneconomic damages have been unfairly inflated in the civil tort system by, among other factors, “the improper consideration of evidence of wrongdoing” (S.B. 80, § 3(A)(6)(d));

- “inflated damage awards” for intangible loss have the effect of increasing the cost of litigation, resulting in a rise in insurance premiums and that these costs are ultimately borne by the general public “through higher prices for products and services” (S.B. 80, § 3(A)(6)(e));
- nationally, 24% of tort costs are attributable to noneconomic damages ((S.B. 80, § 3(A)(3)(d));
- these tort/litigation costs have a negative impact on economic development in Ohio because they “threaten Ohio jobs, drive up costs to consumers, and may stifle innovation” ((S.B. 80, § 3(A)(3)(f)).

Thus, in adopting tort reform measures, including limitations on noneconomic damages in S.B. 281 and S.B. 80, the Ohio General Assembly sought to bring Ohio in line with the majority of states that have sought to curtail unpredictable and unlimited noneconomic damage awards.<sup>8</sup>

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<sup>8</sup> While limitations on noneconomic damages are widely-used in the medical malpractice context, several states have enacted caps on noneconomic damages that are applicable to non-medical claims. See Alaska Stat. 09.17.010 (limiting noneconomic damages in personal injury or wrongful death claims to the greater of \$400,000 or the injured person’s life expectancy in years multiplied by \$8,000 and capping noneconomic damages for personal injuries involving “permanent physical impairment or sever disfigurement” to the greater of \$1,000,000 or the person’s life expectancy in years multiplied by \$25,000); Colo. Rev. Stat. 13-21-102.5 (limiting noneconomic damages in “any civil action other than medical malpractice actions” to \$250,000 “unless the court finds justification by clear and convincing evidence” for a larger award, not to exceed \$500,000); Haw. Rev. Stat. 663-8.7 (capping noneconomic damages for physical pain and suffering to \$375,000 with specifically delineated exceptions for certain types of torts); Idaho Code Ann. 6-1603 (limiting noneconomic damages in personal injury cases to \$250,000); Kan. Stat. Ann. 60-19a01 (capping noneconomic damages in personal injury actions at \$250,000); Md. Code Ann., Cts. & Jud. Proc. 11-108 (capping noneconomic damages at \$350,000 for personal injury actions arising on or after July 1, 1986 and at \$500,000 for personal injury actions arising on or after October 1, 1994; the cap increases by \$15,000 on October 1 of each year starting with October 1, 1995); Mich. Comp. Laws 600.2946a (limiting noneconomic damages in product liability cases to \$280,000, “unless the defect in the product caused either the person’s death or permanent loss of a vital bodily function” in which case the cap increases to \$500,000).

**B. Since the Noneconomic Damage Caps Contained in S.B. 281 Have Been In Effect, Ohio's Medical Liability Insurance Market Appears to be Showing Initial Signs of Recovery.**

As previously indicated, S.B. 80's noneconomic damage provision at issue in this case (i.e., the \$350,000/\$500,000 cap) is substantially similar to its counterpart included in S.B. 281. The constitutionality of the noneconomic damage limitations contained in S.B. 281 has not yet been tested. Therefore, the Court's decision in the present case may provide support for the validity of S.B. 281's noneconomic damage cap. On the other hand, if limitations on S.B. 80's noneconomic damages are held unconstitutional, such a determination (although not controlling with respect to S.B. 281) may have significant implications on hospitals, health care providers, and medical professionals in general and would likely result in increased insurance premiums for purchasers of liability insurance throughout Ohio.

**1. S.B. 281 Was Enacted In Response To A Growing Medical Liability Insurance Crisis In Ohio.**

S.B. 281 was enacted to address concerns that medical liability insurance in Ohio had become increasingly unaffordable and to ensure access to quality health care in Ohio. Specifically, the Ohio General Assembly was concerned that: 1) insurance premiums were rapidly increasing; 2) insurers were leaving the market; and 3) physicians were either retiring early or being forced out of state due to the inability to obtain insurance coverage. See S.B. 281, § 3(B)(1)-(2). The General Assembly noted that several medical malpractice insurers fled the Ohio market due to unbridled compensatory damage awards in medical malpractice cases. *Id.* at § 3(A)(3)(b). Once insurance carriers began leaving the state, health care providers had a difficult time finding affordable insurance coverage. *Id.* at § 3(A)(3)(c).<sup>9</sup> Health care costs

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<sup>9</sup> "Some health care practitioners, including a large number of specialists, have been forced out of the practice of medicine altogether as a consequence. The Ohio State Medical Association

skyrocketed, not only due to the increase in medical malpractice insurance rates, but also as a result of an increasing focus on practicing defensive medicine. The General Assembly specifically noted that “malpractice litigation causes health care providers to over prescribe, over treat, and over test their patients.” *Id.* at § 3(A)(3). For example, a 2005 survey conducted by the Ohio Department of Insurance (“ODI”) found that nearly seventy-five percent of physicians have increased the number of tests that they order for patients in an attempt to reduce their exposure to malpractice liability.<sup>10</sup>

In response to increasing insurance premiums, physicians were leaving Ohio “and closing or limiting their practices because they no longer could afford Ohio’s malpractice rates. Cuyahoga County was especially hard hit, as local hospitals lost specialists such as obstetrician-gynecologists, neurosurgeons and cardiologists.”<sup>11</sup> In the previously mentioned 2005 survey, the ODI found that nearly forty percent of the 1,359 doctors who responded had either retired or planned to retire in the next three years due to rising insurance costs. (Only nine percent of respondents were over age sixty-four.) See Executive Summary of the Ohio Department of Insurance’s “Physician Medical Malpractice Insurance Survey,” attached hereto as Exhibit B. Specifically, physicians in high-risk fields such as neurology and specialty surgery, which are associated with the highest rates of malpractice insurance, were especially likely to retire. *Id.* ODI found that many physicians have “decided to drop their private practice, reduce or eliminate

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reports 15 percent of Ohio’s physicians are considering or have already relocated their practices due to rising medical malpractice insurance costs.” S.B. 281, § 3(A)(3)(c).

<sup>10</sup> See Ohio Department of Insurance, “Physician Medical Malpractice Insurance Survey,” February 2005, at 25, available at: [http://www.ohioinsurance.gov/documents/ODI\\_MD\\_Report\\_v6-1\\_2.pdf](http://www.ohioinsurance.gov/documents/ODI_MD_Report_v6-1_2.pdf); See Executive Summary of the Ohio Department of Insurance’s “Physician Medical Malpractice Insurance Survey,” attached hereto as Exhibit B.

<sup>11</sup> Shannon Mortland, *Docs Find Relief at Last; Tort Reform Helps Apply Brakes to Steep Malpractice Insurance Hikes; More Physicians Staying in Ohio*, CRAIN’S CLEVELAND BUSINESS, Sept. 11, 2006, attached hereto as Exhibit C.

high-risk procedures, or otherwise change the service they provide.” See Ohio Medical Malpractice Commission’s Report, at 4, attached hereto as Exhibit A. Rising premiums have contributed to reduced access to certain patient services and have had a significant impact on Ohio’s patient population.<sup>12</sup> See *id.* According to the Ohio Medical Malpractice Commission:

Sixty-six percent of doctors surveyed indicated that they have turned down high-risk procedure patients or have referred those patients elsewhere. The situation is critical in southeast Ohio, where 95 percent of doctors surveyed have declined or referred high-risk patients. In northeast Ohio, 48 percent of OB/GYN and family practice physicians reported they have stopped delivering babies due to high medical liability insurance costs. Over half of the osteopathic doctors who responded indicated that they are no longer delivering babies.

*Id.* at 5. Therefore, high medical malpractice premiums not only increase health care costs but additionally affect both the availability and quality of health care services in Ohio.

One of the Ohio General Assembly’s goals in enacting S.B. 281 was to alleviate the adverse effects escalating noneconomic damage awards were having on insurance premiums. The legislature was also concerned about the detrimental affect increases in medical malpractice insurance rates have on patient access to health care. See S.B. 281, § 3(A)(1) (finding that “[m]edical malpractice litigation represents an increasing danger to the availability and quality of health care in Ohio”). The General Assembly made a policy decision to curb noneconomic

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<sup>12</sup> Outside of Ohio, other states are similarly experiencing the negative implications that rising medical malpractice premiums have on patient access to health care. In a 2003 report of the General Accounting Office (“GAO”), five states (Florida, Mississippi, Nevada, Pennsylvania, and West Virginia), were experiencing reduced patient access, especially in rural areas. See General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, August 2003, GAO-03-836, at 12, available at: <http://www.gao.gov/new.items/d03836.pdf>. The report found that patient access problems, specifically the reduction in ER on-call surgical coverage and newborn delivery services, were prevalent in rural locations where patients were required to travel long distances to receive care. *Id.* at 13. In Mississippi, for example, a hospital representative from a rural county noted that “it closed its obstetrics unit after five family practitioners who attended deliveries stopped providing newborn delivery services in order to avoid a more than 65 percent increase in their annual premium rates. Pregnant women in the area now must travel about 65 miles to the nearest obstetrics ward to deliver.” *Id.* at 14.

damage awards in an attempt to retain qualified physicians and protect the public interest in affordable, quality health care. This decision was in line with several other state legislatures which enacted limitations on noneconomic damages as part of their tort reform measures. See, *supra* p. 4.

**2. S.B. 281's Noneconomic Damage Caps Have Contributed To The Stabilization Of Medical Liability Insurance Rates In Ohio And Have Had A Positive Impact On Access To Health Care Services In Ohio.**

While it is still too early to know the long-term impact of S.B. 281, Ohio's medical liability insurance market has shown initial signs of stabilizing since the noneconomic damage caps have been in place. In 2004, medical malpractice insurance rates for the top five insurers in Ohio increased an average of 20%. See Ohio Department of Insurance Table, "Med Mal Rate Changes 2000 to 2006," attached hereto as Exhibit D. In 2005, the same top five companies increased their rates by an average of 6.7%. *Id.* Thus far in 2006, the top five Ohio medical insurance companies have *decreased* their rates an average of 1.7%. *Id.* Of the top five insurance companies, American Physicians Assurance Corporation reduced their insurance rate by 3.6% and The Medical Protective Company filed a 5% rate reduction. *Id.* In regard to these rate reductions, the Ohio Department of Insurance "credited a handful of actions – *including capping certain damages on medical malpractice awards . . .* for helping to stabilize the market." *Medical Mal Insurance Rates Fall, ODI Reports, GONGWER, vol. 75, Nov. 8, 2006, at 7, attached hereto as Exhibit E (emphasis added).*

In addition to these insurance rate reductions new insurers have recently entered Ohio's medical insurance market. Although in previous years several medical insurers fled the Ohio market, two new insurers, OHA Insurance Solutions, Inc. and Healthcare Underwriters Group of Ohio, recently were licensed in Ohio. See Ohio Medical Malpractice Commission's Final Report, at 5, attached hereto as Exhibit A.

The Ohio Medical Malpractice Commission has indicated that, “[w]hile the Ohio medical liability market is beginning to recover, it is still in a state of crisis.” *Id.* at 6. In fact, as recently as January 2006, the American Medical Association (“AMA”) classified Ohio as being “in crisis.”

Although medical liability insurance rates in Ohio are stabilizing, premiums are still at high levels. For example, over the period from 2000 to 2006, Ohio’s five largest medical malpractice insurers, which account for approximately 60% of the malpractice coverage in Ohio, experienced an increase in physician and surgeon malpractice insurance rates of 189.6%. See Ohio Department of Insurance Table, “Med Mal Rate Changes 2000 to 2006,” attached hereto as Exhibit D. In other words, even though the insurance market shows initial steps toward stabilization, affordability of insurance is still a major issue for the typical health care provider. High premiums continue to have a substantial affect on the cost of health care, patient access to health care services, the recruitment and retention of physicians, and the costly practice of defensive medicine.

*Amici curiae* acknowledge that the noneconomic damage caps applicable to general tort actions differ from the caps applicable to medical claims. Nonetheless, these statutes follow a similar pattern for non-catastrophic injuries. Therefore, the Court’s decision in the present case may provide an indication as to the validity of the noneconomic damage caps set forth in S.B. 281. *Amici curiae* urge this Court to uphold the constitutionality of S.B. 80’s noneconomic damage caps. A finding to the contrary would likely raise insurance premiums for purchasers of liability insurance, and may have a particularly devastating effect on the health care industry and those it serves. Upholding the constitutionality of noneconomic damage caps will continue the

stabilization of the medical malpractice insurance market, advance the recent movement toward more affordable insurance rates, and improve patient access to quality, affordable health care.

**C. Other Jurisdictions Have Enacted Noneconomic Damage Caps As Effective Tort Reform Measures.**

As previously indicated, tort reform measures similar to those contained in S.B. 281 and S.B. 80 have been enacted in other states, and some have been in effect for many years.<sup>13</sup> In enacting S.B. 281, the Ohio General Assembly recognized that noneconomic damage caps were successfully reducing insurance premiums in other jurisdictions and cited to a 2002 U.S. Department of Health and Human Services publication which found that “health care practitioners in states with effective caps [were] experiencing premium increases in the twelve to fifteen per cent range, as compared to an average forty-four per cent increase in states that do not cap noneconomic damage awards.” S.B. 281 § 3(A)(3)(e).

The AMA recently conducted a study focusing on the impact of noneconomic damage limitations and concluded that caps on noneconomic damages “keep doctors from quitting or moving to states with lower liability insurance premiums.” Chris Grier, *New AMA Study Says Jury Award Caps Stem Losses*, BEST’S INSURANCE NEWS, Oct. 5, 2006, attached hereto as Exhibit F. The report further indicated that “states with caps on noneconomic ‘pain and suffering’ awards had losses 17% lower than those of insurers in other states. Earned premiums also were 6% lower.” *Id.* With respect to physician retention, the AMA report “found that caps

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<sup>13</sup> Both California and Indiana provide examples of states with meaningful medical liability reforms which have been consistently upheld since their inception in 1975. See Cal. Civ. Code 3333.2 (the Medical Injury Compensation Reform Act (“MICRA”) contains a provision capping noneconomic damages in medical malpractice actions at \$250,000) and Ind. Code. Ann. 34-18-14-3. In response to Indiana’s Medical Malpractice Reform Act, “medical malpractice premiums in Indiana dropped and insurance became readily obtainable again, and Indiana has enjoyed relatively low malpractice premiums since.” Kinney, *Indiana’s Medical Malpractice Reform Revisited: A Limited Constitutional Challenge* (1998), 31 Ind. L. Rev. 1043, 1047.

and other medical tort reforms increased the number of physicians by 2.4%, compared with states without caps or tort reforms.” *Id.*

The Ohio General Assembly noted that several states were utilizing caps on noneconomic damages to combat increasing insurance premiums and litigation costs. A number of states that have enacted limitations on noneconomic damages have experienced considerable success in terms of reducing insurance premiums, increasing patient access to affordable health care, and decreasing the number of lawsuits filed.<sup>14</sup> Based on these documented successes, many other states continue to express an interest in adopting tort reform measures.<sup>15</sup>

Outside of the context of medical claims, at least one state that passed comprehensive tort reform measures in 2004, including noneconomic damage caps applicable to general tort actions, has begun to see that effective tort reform measures create a more attractive environment for business and economic development. See Behrens and Silverman, *Now Open for Business: The Transformation of Mississippi’s Legal Climate* (2005), 24 *Miss. C. L. Rev.* 393. In Mississippi, among other developments attributable to the more-balanced legal environment created by tort

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<sup>14</sup> Texas’ experience demonstrates that medical liability reforms – including caps on noneconomic damages – can successfully reduce insurance premiums, improve patient access to health care, and create a stable health care system. In Texas, voters approved Proposition 12 which amended the state constitution to specifically permit the legislature to enact laws that place limitations on noneconomic damages in medical cases. Currently, Texas caps noneconomic damage awards in medical liability cases at \$250,000. *Tex. Civ. Prac. & Rem. § 74.301*. Since the noneconomic damage cap went into place, medical liability insurance premiums have decreased and patients have experienced improved access to affordable health care. See Health Coalition on Liability and Access, “The Texas Success in Brief: Texas Proves that Medical Liability Reform Works,” at 4, attached hereto as Exhibit G. Specifically, in response to the limitation on noneconomic damages, “rate cuts by the five largest physician insurance carriers in Texas have produced \$48.6 million in annualized premium reductions, there has been a 50% reduction in the number of lawsuits filed in most Texas counties, and 3,000 more physicians have come to the state.” See *Medical Liability Reform – NOW!* at 36.

<sup>15</sup> For example, the National Conference of State Legislatures reports that limitations on noneconomic damages are one of several medical malpractice reforms that “continue[s] to appear in the 2006 legislation.” See National Conference of State Legislatures, “Medical Malpractice Tort Reform,” available at <http://www.ncsl.org/standcomm/sclaw/medmaloverview.htm>

reform measures, three property and casualty insurers (St. Paul Travelers, World Insurance Co. and Equitable Life Insurance Co.) have re-entered the market “because of the recent tort reform laws.” *Id.* at 422-23.

Therefore, the Ohio General Assembly is not alone in its recognition that noneconomic damage caps are an important element of tort reform measures.

**D. Petitioner’s Constitutional Challenges Have Been Rejected In Other States With Similar Noneconomic Damage Caps.**

Petitioner has challenged the constitutionality of S.B. 80 on the grounds that it violates the following provisions of the Ohio Constitution: 1) right to a jury trial; 2) separation of powers; 3) due process and equal protection guarantees; and 4) right to a remedy. See Merit Brief of Petitioner, at pp. 5-6. The highest courts of several states have upheld statutory limitations on noneconomic damages as a reasonable and valid exercise of legislative authority. Specifically, several well-reasoned decisions from other jurisdictions have rejected constitutional challenges substantially similar to those raised by Petitioner in the present case.<sup>16</sup> *Amici curiae* urge this

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<sup>16</sup> See e.g. *Evans v. State* (Alaska 2002), 56 P.3d 1046 (upholding a cap on noneconomic damages awarded in personal injury actions against several constitutional challenges); *Smith v. Botsford* (C.A. 6, 2005), 419 F.3d 513, 519-20 (upholding Michigan’s noneconomic damage cap of \$280,000 which changes based on yearly adjustments); *Fein v. Permanente Medical Group* (1985), 38 Cal.3d 137, 164, 695 P.2d 665 (\$250,000 cap on noneconomic damages held constitutional); *Scholz v. Metro. Pathologists P.C.* (Colo. 1993), 851 P.2d 901, 911 (upholding the \$250,000 limit on noneconomic damages against challenges based on the right to trial by jury, equal protection, and due process); *Kirkland v. Blaine County Med. Ctr.* (2000), 134 Idaho 464, 471, 4 P.3d 1115, 1122 (finding the \$400,000 cap on noneconomic damages constitutional); *Murphy v. Edmonds* (Md. 1992), 325 Md. 342, 370, 375, 601 A.2d 102 (\$350,000 cap on noneconomic damages in personal injury actions does not violate equal protection or right to trial by jury); *Gourley v. Nebraska. Methodist Health Sys.* (2003), 265 Neb. 918, 957, 633 N.W.2d 43 (finding that the limit on noneconomic damages did not violate the right to jury trial, equal protection, separation of powers, or open courts provision of the Nebraska Constitution); *Judd ex rel. Montgomery v. Drezga* (Utah 2004), 103 P.3d 135, at ¶40 (upholding statutory limitation on noneconomic damages which caps at \$250,000 for actions arising prior to July 1, 2002, \$400,000 for actions arising between July 1, 2001 and July 2, 2002, adjusted for inflation thereafter); *Pulliam v. Coastal Emergency Services of Richmond, Inc.* (1999), 257 Va. 1, 7, 509 S.E.2d 307 (affirming *Etheridge v. Medical Center Hospitals* (1989), 237 Va. 87, 376 S.E.2d 525); *Verba v.*

Court to reject Petitioner's constitutional challenges and uphold the noneconomic damage cap contained in S.B. 80.

**1. Limitations On Noneconomic Damages Do Not Violate The Right To Trial By Jury.**

Petitioner contends that the noneconomic damage cap provided in R.C. 2315.18 violates her right to trial by jury. Several other jurisdictions have addressed whether noneconomic damage caps infringe on the constitutional right to a jury trial. The majority of these courts have found that limitations on noneconomic damages do not violate the right to trial by jury. See *Smith v. Botsford General Hosp.* (C.A. 6, 2005), 419 F.3d 513, 519 (upholding Michigan's noneconomic damage cap as non-violative of the right to trial by jury); *Kirkland v. Blaine County Med. Ctr.* (2000), 134 Idaho 464, 469, 4 P.3d 1115 (finding that the cap on noneconomic damages "does not infringe upon the jury's right to decide cases"); *Murphy v. Edmonds* (Md. App. 1992), 325 Md. 342, 373-74, 601 A.2d 102 (finding no violation of the right to a jury trial); *Etheridge v. Medical Center Hospitals* (1989), 237 Va. 87, 96-97, 376 S.E.2d 525 (holding that the cap on damages "does not infringe upon the right to a jury trial because [it] does not apply until after a jury has completed its assigned function"); *Evans v. State* (Alaska 2002), 56 P.3d 1046, 1051 (finding that the damage cap does not violate the jury trial right because the "decision to place a cap on damages awarded is a policy choice and not a re-examination of the

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*Ghaphery* (2001), 210 W. Va. 30, 37, 552 S.E.2d 406 (affirming *Robinson v. Charleston Area Medical Center, Inc.* (1991), 186 W. Va. 720, 414 S.E.2d 877) upholding the constitutionality of the \$1,000,000 cap on noneconomic damages).

While the majority of states that have enacted noneconomic damage caps in some form have had the legislation upheld in the courts, a few states have declared their damage caps unconstitutional. See e.g. *Ferdon v. Wisc. Patients Comp. Fund* (2005), 284 Wis.2d 573, 701 N.W.2d 440; *Lakin v. Senco Products, Inc.* (1999), 329 Ore. 62, 987 P.2d 463; *Best v. Taylor Machine Works* (1997), 179 Ill.2d 367, 689 N.E.2d 1057; *Knowles v. United States* (1996), 544 N.W.2d 183, 1996-SD-10; *Sofie v. Fibreboard Corp.* (1991), 112 Wn.2d 636, 771 P.2d 711; *Brannigan v. Usitalo* (1991), 134 N.H. 50, 587 A.2d 1232; *Arrington v. ER Physicians Group, APMC* (La. App. 3 Cir. Sept. 27, 2006), La. App. No. 04-1235, 2006 La. App. LEXIS 2164.

factual question of damages”); *Judd v. Drezga*, 2004-UT-91, 103 P.3d 135, at ¶35 (finding that Utah’s damage cap does not violate the right to trial by jury “because it allows the jury to determine facts in the first instance, before requiring the court to apply relevant law to the jury’s verdict”); *Gourley v. Nebraska Methodist Health System, Inc.* (2003), 265 Neb. 918, 954, 663 N.W.2d 43 (holding that the cap on noneconomic damages does not violate the right to jury trial because the legislature “has the power to limit recovery in a cause of action”).

Courts from other jurisdictions employ similar reasoning to reach the conclusion that noneconomic damage caps do not violate the right to trial by jury. These courts begin with the general proposition that the primary role of the jury is factfinding, “which includes a determination of a plaintiff’s damages.” *Gourley*, 265 Neb. at 954; *Judd* at ¶34; *Etheridge*, 237 Va. at 96. While the jury ascertains the facts and assesses damages, the court must apply the law to the facts as determined by the jury. *Gourley*, 265 Neb. at 954; *Kirkland*, 134 Idaho at 469. Limitations on noneconomic damages “represent[] law, similar to an element of a claim to which the trial court must comport the jury’s factual determinations.” *Judd* at ¶34. In this way, the court applies the noneconomic damage limitation only *after* the jury has fulfilled its crucial factfinding role. See *Judd* at ¶35; *Gourley*, 265 Neb. at 954; *Etheridge*, 237 Va. at 96.

Although factfinding is the exclusive function of the jury, courts must apply the law, which is established by the legislature, to the jury’s factual determinations. *Kirkland*, 134 Idaho at 469. In *Kirkland*, the Idaho Supreme Court noted that the right to jury trial entitles a plaintiff to present evidence to the jury and have the jury render a verdict based on such evidence. *Id.* at 469. Once the verdict is rendered, the “legal consequences and effect of a jury’s verdict are a matter for the legislature (by passing laws) and the courts (by applying those laws to the facts as found by the jury).” *Id.* Likewise, in *Evans*, the Supreme Court of Alaska found that the

“decision to place a cap on damages awarded is a policy choice and not a re-examination of the factual question of damages determined by the jury.” *Evans*, 56 P.3d at 1051.

The noneconomic damage cap set forth in R.C. 2325.18 does not burden the jury’s ability to carry out its factfinding function. Once the jury makes its factual determinations courts apply the substantive law to such factual findings, including the limitation on noneconomic damages. As well-reasoned decisions from other jurisdictions have indicated, a limitation on noneconomic damages represents a valid legislative policy decision, which applies *after* the jury determines the facts. See *Kirkland*, 134 Idaho at 469; *Evans*, 56 P.3d at 1051; *Gourley*, 265 Neb. at 954.

*Amici curiae* urge this Court to follow the well-reasoned decisions on this issue from other states, including Michigan, Virginia, Idaho, Alaska, Utah, Nebraska, and Maryland, and hold that the noneconomic damage caps set forth in R.C. 2315.18 do not violate the right to trial by jury.

## **2. Limitations On Noneconomic Damages Do Not Violate Separation Of Powers Principles.**

The General Assembly, as “the final arbiter of public policy,” has the authority to enact laws which reflect the public policy of Ohio. See *Estate of Hood v. Rose*, 2003-Ohio-3268, 153 Ohio App.3d 199, at ¶18; see also *State ex rel. Adams v. Aluchem, Inc.*, 104 Ohio St.3d 640, 2004-Ohio-6891, at ¶51. The authority to adopt substantive rules of law includes the ability to establish or modify remedies available. See *Strock v. Presnell* (1988), 38 Ohio St.3d 207, 214, 527 N.E.2d 1235; *Fassig v. State ex rel. Turner* (1917), 95 Ohio St. 232, 248, 116 N.E. 104. Accordingly, the General Assembly has the authority to create tort law remedies in response to Ohio’s changing social and economic needs.

Petitioner argues that the legislatively-imposed cap on noneconomic damages violates separation of powers principles embodied in the Ohio Constitution. Article II, § 1 of the Ohio

Constitution provides that “[t]he legislative power of the state shall be vested in a General Assembly consisting of a senate and a house of representatives. . . .” Article IV sets forth the parameters of judicial authority vested in Ohio courts. As this Court has indicated, “it is not the function of a reviewing court to assess the wisdom or policy of a statute, but rather, to determine whether the General Assembly acted within its legislative power.” *Austintown Twp. Bd. of Trustees v. Tracy* (1996), 76 Ohio St.3d 353, 356, 667 N.E.2d 1174. When assessing the constitutionality of a statute, “courts presume legislation enacted by the General Assembly to be constitutional, and will not declare it to be unconstitutional unless it ‘appears beyond a reasonable doubt that the legislation and constitutional provisions are clearly incompatible.’” *Id.*

Courts in several other jurisdictions have held that statutory limitations on noneconomic damages do not violate the separation of powers doctrine. See *Judd* at ¶38 (“The damage cap represents law to be applied, not an improper usurpation of jury prerogatives. Consequently, it does not violate the separation of powers provision of the constitution.”); *Evans*, 56 P.3d at 1056 (upholding the noneconomic damage caps as not violating the separation of powers provision because the legislature has the authority to alter common law remedies); *Kirkland*, 134 Idaho at 470-71 (holding that noneconomic damages cap did not violate separation of powers because the legislature has the ability to “modify or abolish common law causes of action”); *Gourley*, 265 Neb. at 956 (holding that “the ability to cap damages in a cause of action is a proper legislative function”); *Pulliam v. Coastal Emergency Servs. of Richmond, Inc.* (1999), 257 Va. 1, 21-22, 509 S.E.2d 307 (upholding noneconomic damage cap against separation of powers challenge because the legislature “has the power to provide, modify, or repeal a remedy”); *Verba v. Ghaphery* (2001), 210 W. Va. 30, 35, 552 S.E.2d 406 (finding that a medical malpractice

damages cap did not violate separation of powers because the legislature has the power to alter common law remedies).

The Ohio General Assembly made a policy decision to limit noneconomic damages in certain general tort actions. As this Court has recognized, such legislative policy choices should not be second-guessed by the courts. See *Austintown Twp. Bd. of Trustees*, 76 Ohio St.3d at 356. Accordingly, *amici curiae* respectfully urge this Court to defer to the legislature's reasonable policy decision to limit noneconomic damages. Furthermore, this Court should adopt the reasoning of other jurisdictions which have determined that a legislature can limit noneconomic damages without violating separation of powers principles.

### **3. Limitations On Noneconomic Damages Do Not Violate Equal Protection Guarantees.**

Petitioner claims that the noneconomic damage cap constitutes a violation of equal protection because it divides tort plaintiffs into two separate categories: 1) those who have damages in excess of S.B. 80's caps; and 2) those whose damages are below the caps. See Petitioner's Merit Brief, p. 27. Article I, Section 2 of the Ohio Constitution provides in pertinent part that: "[a]ll political power is inherent in the people. Government is instituted for their equal protection and benefit." Ohio Const. art. I, § 2 (1851).

This Court has recognized that the Equal Protection Clauses of the Ohio and United States Constitutions are substantively identical. See *Beatty v. Akron City Hosp.* (1981), 67 Ohio St.2d 483, 491, 424 N.E.2d 586 (quoting *Kinney v. Kaiser Aluminum & Chemical Corp.* (1975), 41 Ohio St.2d 120, 123, 322 N.E.2d 880). Consequently, under either constitution, when a fundamental right or suspect classification based on race or national origin is involved, the court applies strict scrutiny to determine whether the statute is narrowly tailored to serve a compelling state interest. *United States v. Playboy Ent. Group, Inc.* (2000), 529 U.S. 803, 813; *State v.*

*Thompson*, 95 Ohio St.3d 264, 2002-Ohio-2124, at ¶13. If a statute does not implicate a fundamental right or suspect class, the applicable standard of review is the rational basis test. *Id.* Under rational basis review, a court will uphold a statute against equal protection challenges as long as the statute is “rationally related to a legitimate government purpose.” *Id.*

Petitioner argues that the cap violates the fundamental right to trial by jury and requests that the Court apply strict scrutiny. See Petitioner’s Merit Brief, p. 26. This argument must fail because, contrary to Petitioner’s assertions, R.C. 2315.18 neither discriminates against a suspect class nor implicates a fundamental right. See *Thompson* at ¶13. As previously indicated, R.C. 2315.18 does not interfere with the right to trial by jury. Accordingly, the appropriate level of scrutiny is rational basis review. See *id.*

Most courts that have considered equal protection challenges to noneconomic damage caps have applied a rational basis test and have found that these limitations do not violate constitutional equal protection guarantees. See e.g., *Evans*, 56 P.3d at 1052-53 (applying rational basis review to Alaska’s cap on noneconomic damages because “plaintiffs’ interests in unlimited damages are merely economic”); *Botsford*, 419 F.3d at 520 (applying rational basis review to uphold Michigan’s noneconomic damage cap against an equal protection challenge); *Gourley*, 265 Neb. at 947-48 (finding that the cap on noneconomic damages was enacted to further the legitimate legislative goal of reducing health care costs); *Scholz v. Metropolitan Pathologists P.C.* (Colo. 1993), 851 P.2d 901, 906-907 (en banc) (finding that the cap satisfies the rational basis test); *Murphy*, 325 Md. at 363-64 (“the great majority of cases which have considered equal protection attacks upon classifications created by legislative caps upon recoverable tort damages have utilized a traditional rational basis test”); *Robinson v. Charleston Area Med. Center* (1991), 186 W. Va. 720, 729-30, 414 S.E.2d 877 (applying rational basis review “we

cannot say that [the cap] is not rationally related to a legitimate state interest”); *Etheridge*, 237 Va. at 103-104 (finding that Virginia’s cap satisfies the rational basis test).

In *Evans v. State*, the Alaska Supreme Court upheld a cap on noneconomic damages in personal injury cases against an equal protection challenge. *Evans*, 56 P.3d at 1052-54. In its analysis, the court weighed the “the relative importance of the plaintiff’s interest and the State’s interest.” *Id.* at 1052. The court classified plaintiffs’ “interest in unlimited damages” as being purely economic in nature. *Id.* Because mere economic interests are not considered “important” for purposes of equal protection review, the state’s objectives were only required to be “legitimate.” *Id.* at 1053. The Alaska legislature enacted the noneconomic damage caps in response to “problems with tort litigation that needed to be solved, including frivolous litigation, excessive damages awards, and increased costs for malpractice and other liability insurance.” *Id.* The *Evans* court, refusing to engage in policy analysis, deferred to the legislature’s stated objectives and “decline[d] the plaintiffs’ invitation to second-guess the legislature’s factual findings.” *Id.* Specifically, the *Evans* court indicated that “it is not a court’s role to decide whether a particular statute or ordinance is a wise one; the choice between competing notions of public policy is to be made by elected representatives of the people.” *Id.* at 1054.

Petitioner’s interest in unlimited damages is purely economic in nature and therefore is subject to rational basis review, not strict scrutiny. See *Evans*, 56 P.3d at 1052. Applying a rational basis test, courts must uphold a statute against constitutional challenge if the statute is “rationally related to furthering a legitimate state interest.” *Vance v. Bradley* (1979), 440 U.S. 93, 97. Utilizing this highly deferential test, the noneconomic damage cap contained in R.C. 2315.18 easily withstands Petitioner’s equal protection challenge. Similar to the legislative objectives that led to Alaska’s noneconomic damage cap, the Ohio General Assembly enacted

S.B. 80 for the legitimate purpose of “curbing the number of frivolous lawsuits” which “threatens Ohio jobs, drives up costs to consumers, and may stifle innovation.” S.B. 80, § 3(A)(3).

The General Assembly acted reasonably in enacting the statutory parameters of noneconomic damages. The legislature made a policy decision to cap noneconomic damages in an attempt to make “certain that Ohio has a fair, predictable system of civil justice.” *Id.* Recognizing that it is the role of the legislature, not the courts, to formulate policy, this Court should defer to the Ohio General Assembly’s attempt to reduce excessive tort litigation costs. *Amici curiae* urge this Court to join the majority of jurisdictions that have applied rational basis review to uphold statutory caps on noneconomic damages against equal protection challenges.

#### **4. Limitations On Noneconomic Damages Do Not Violate Due Process Guarantees.**

Petitioner challenges the noneconomic damage cap on the ground that it violates due process guarantees. Article I, Section 16 of the Ohio Constitution provides that every person who sustains an injury shall “have remedy by due course of law.” Ohio courts have construed “due course of law” as equivalent to the “due process of law” protections provided in the Fourteenth Amendment of the United States Constitution. *Direct Plumbing Supply Co. v. Dayton* (1941), 138 Ohio St. 540, 544, 38 N.E.2d 70.

Under Ohio law, due process and equal protection analyses are, “generally speaking, . . . identical, and the only substantial difference between substantive due process and equal protection is that the legislation reviewed under equal protection involves a classification.” *Van Der Veer v. Ohio Dept. of Transp.* (1996), 113 Ohio App.3d 60, 64, 680 N.E.2d 230. As

previously indicated, statutory limitations on damages are economic in nature. These noneconomic damage caps do not burden a fundamental right or suspect class and thus the rational basis test is applicable. See *Schwan v. Riverside Methodist Hosp.* (1983), 6 Ohio St.3d 300, 301, 452 N.E.2d 1337; See *Morris v. Savoy* (1991), 61 Ohio St.3d 688-89, 576 N.E.2d 765 (statute imposing \$200,000 cap on general damages in medical malpractice actions “did not involve a fundamental right or suspect class”). The legislative history of the noneconomic damage limitation explicitly states that the cap was enacted to curb frivolous lawsuits and reduce disparate, and consequently unpredictable, damage awards. See S.B. 80, § 3(A)(3). For the same reasons discussed above in the context of equal protection analysis, this Court should apply rational basis review and uphold the caps contained in S.B. 80 against Petitioner’s due process challenge.

**5. Limitations On Noneconomic Damages Do Not Violate The Right To A Remedy.**

Petitioner contends that S.B. 80’s cap on noneconomic damages denies plaintiffs their right to a remedy in violation of the Ohio Constitution. Article I, Section 16 of the Ohio Constitution provides that “[a]ll courts shall be open, and every person, for an injury done him in his land, goods, person, or reputation, shall have remedy by due course of law, and shall have justice administered without denial or delay.”

Several courts that have addressed the constitutionality of noneconomic damage caps have found that these limitations do not violate the right to remedy guarantees provided in their respective state constitutions. See *Gourley*, 265 Neb. at 951-52 (“Because the Legislature can eliminate a common-law cause of action entirely, it can also alter the remedy for a cause of action without providing a replacement remedy, or quid pro quo.”); *Judd* at ¶10-18 (applying a

two-part test, the court found that the statutory cap was a reasonable, nonarbitrary means of controlling the evil of rising health care costs and thus the right to remedy<sup>17</sup> and open courts provisions were not violated); *Evans*, 56 P.3d at 1056-57 (finding that the noneconomic damage caps do not violate access to the courts because “they are not so drastic so as to eliminate the tort remedies that they modify”).

*Amici curiae* urge this Court to adopt the reasoning of other jurisdictions which have found that limitations on noneconomic damages do not violate the constitutionally guaranteed right to remedy.

### CONCLUSION

By enacting S.B. 80 and S.B. 281, Ohio has joined the mainstream of states which have recognized a need for tort reform measures. Noneconomic damage caps are an important element of tort reform because they bring predictability to an otherwise unquantifiable compensatory damage award. Ohio is only now beginning to see the positive impact of S.B. 281’s noneconomic damage caps within the medical context. *Amici curiae* submit that the noneconomic damage caps contained in S.B. 80 can similarly have a positive impact in achieving the legislature’s goals in the general tort context. Accordingly, *amici curiae* urge this Court to join the ranks of the several other states which have upheld noneconomic damage caps against the same constitutional challenges raised by Petitioner.

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<sup>17</sup> Utah’s open courts and right to remedy provision is similar to that contained in the Ohio Constitution: “All courts shall be open, and every person, for an injury done to him in his person, property, or reputation, shall have remedy by due course of law, which shall be administered without denial or unnecessary delay.” Utah Const. art. I, § 11.

Respectfully submitted,



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Catherine Ballard (0030731)

Lana Knox (0080651)

Bricker & Eckler LLP

100 South Third Street

Columbus, Ohio 43215

Tel: (614) 227-2300

Fax: (614) 227-2390

Counsel for *Amici Curiae*

Ohio Hospital Association, Ohio State Medical  
Association, and Ohio Osteopathic Association

**CERTIFICATE OF SERVICE**

I hereby certify that a true copy of the foregoing Brief of *Amici Curiae* Ohio Hospital Association, Ohio State Medical Association, and Ohio Osteopathic Association, was sent via regular U.S. mail, postage prepaid this 18<sup>th</sup> day of December 2006, to the following:

Janet G. Abaray (0002943)  
(COUNSEL OF RECORD)  
Calvin S. Tregre, Jr. (0073454)  
Melanie S. Bailey (0075821)  
Burg Simpson Eldridge Hersh & Jardine  
312 Walnut St., Suite 2090  
Cincinnati, OH 45202-4028

Robert S. Peck  
Stephen B. Pershing  
Center For Constitutional Litigation, P.C.  
1050 31<sup>st</sup> Street N.W.  
Washington D.C. 20007

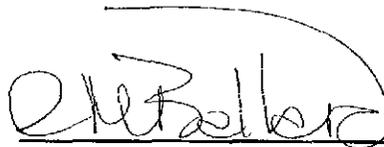
Counsel for Petitioner, Melisa Arbino

Irene C. Keyse-Walker (0013143)  
(COUNSEL OF RECORD)  
Julie A. Callsen (0062287)  
Benjamin C. Sasse (0072856)  
Tucker Ellis & West LLP  
1150 Huntington Bldg.  
925 Euclid Ave.  
Cleveland, OH 4415-1475

Counsel for Respondents, Johnson & Johnson, et al.

Jim Petro, Attorney General (0022096)  
Stephen P. Carney, State Solicitor (0063460)  
(COUNSEL OF RECORD)  
Sharon Jennings (0055501)  
Holly Hunt (0075069)  
Frank Strigari (0078377)  
Office of the Ohio Attorney General  
30 E. Broad Street, 17<sup>th</sup> Floor  
Columbus, OH 43215

Counsel for Plaintiff-Intervenor (Respondent)  
State of Ohio

  
Catherine Ballard

# **APPENDIX**

## APPENDIX

Ohio Medical Malpractice Commission's Final Report.....	Exhibit A
Executive Summary of the Ohio Department of Insurance's "Physician Medical Malpractice Insurance Survey" .....	Exhibit B
Shannon Mortland, <i>Docs Find Relief at Last; Tort Reform Helps Apply Brakes to Steep Malpractice Insurance Hikes; More Physicians Staying in Ohio</i> , CRAIN'S CLEVELAND BUSINESS, Sept. 11, 2006 .....	Exhibit C
Ohio Department of Insurance Table, "Med Mal Rate Changes 2000 to 2006" .....	Exhibit D
<i>Medical Mal Insurance Rates Fall, ODI Reports</i> , GONGWER, vol. 75, Nov. 8, 2006.....	Exhibit E
Chris Grier, <i>New AMA Study Says Jury Award Caps Stem Losses</i> , BEST'S INSURANCE NEWS, Oct. 5, 2006.....	Exhibit F
"The Texas Success in Brief: Texas Proves that Medical Liability Reform Works" .....	Exhibit G

**FINAL REPORT AND RECOMMENDATIONS**  
**OF THE**  
**OHIO MEDICAL MALPRACTICE COMMISSION**

**APRIL 2005**

**Commission Members**

Ann Womer Benjamin, Esq.  
Director  
Ohio Department of Insurance  
Columbus, Ohio  
Chairman of the Commission

Steve Collier, Esq.  
Connelly, Jackson & Collier LLP  
Toledo, Ohio

George F. Dunigan II  
Director of Government Relations  
Ohio University COM/OOA  
Columbus, Ohio

Ray Mazzotta  
President & CEO  
OHIC Insurance Co.  
Columbus, Ohio

Frank Pandora II, Esq.  
Sr. VP & General Counsel  
Ohio Health  
Columbus, Ohio

Wayne Wheeler, MD  
Portsmouth, Ohio

Gerald Draper, Esq.  
Roetzel & Andress LPA  
Columbus, Ohio  
(Member from inception of  
Commission through June 2004.)

William Kose, MD  
Rawson, Ohio

D. Brent Mulgrew  
Executive Director  
Ohio State Medical Association  
Hilliard, Ohio

Hans Scherner, Esq.  
Scherner Hanson & Cornwell LLC  
Columbus, Ohio  
(Member from July 2004 until  
conclusion of Commission)

## I. INTRODUCTION

### Overview

The Ohio Medical Malpractice Commission was created in 2003 in legislation to address the medical liability crisis in Ohio. That legislation, Senate Bill ("S.B.") 281 (R-Goodman), was enacted in response to concerns that rapidly rising medical malpractice insurance premiums were driving away health care providers and compromising the ability of Ohio consumers to receive the health care they need.<sup>1</sup> The bill contained a comprehensive set of tort reforms aimed at addressing litigation costs and stabilizing the Ohio medical malpractice market. Governor Bob Taft signed S.B. 281 on January 10, 2003. The bill became effective on April 11, 2003.

In order to further analyze the causes of the current medical liability crisis, and to explore possible solutions in addition to tort reform, S.B. 281 created the Ohio Medical Malpractice Commission ("Commission"). The Commission is composed of nine members, including representatives of the insurance industry, health care providers, and the legal system. (Exhibit A). The Commission's first meeting was held in May 2003 and at the June meeting Commission members adopted the following mission statement:

*"Provide available, affordable, and stable medical liability coverage for the Ohio Medical Community while providing for patient safety and redress for those who are negligently harmed."*

The Commission's statutory requirements and mission statement indicate a desire among all members to conduct a thorough analysis of the causes of the current crisis. All Commission members are united in their intent to avert another crisis in which the health care of Ohio consumers could be compromised, and to mitigate the current crisis as possible. The Commission does note that many members voiced concern with the overall health system, including reimbursement rates for Ohio providers. Although reimbursement may be relevant to the affordability of medical liability coverage, the Commission has not examined that issue.

The enactment of S.B. 281 in Ohio was intended to respond to concerns raised by providers that Ohio medical liability insurance had become unaffordable, thereby creating a situation where medical liability insurance was no longer available to certain physicians.<sup>2</sup> Ohio's tort reform efforts were preceded by enactment of similar laws in other states. Among the states already with medical malpractice tort reform are Colorado, Indiana, Wisconsin, Louisiana, California, and New Mexico. These states are commonly referred to as "non-crisis" states as defined by the American Medical Association. A primary feature of such tort reform, including Ohio's, is caps on non-economic damages in medical malpractice lawsuits. While caps in some states include caps on economic damages (Colorado, Virginia, and Indiana) and lower caps than Ohio implemented, Ohio established caps on non-economic damages generally at \$500,000, with a \$1,000,000 cap for catastrophic injuries involving permanent and substantial physical deformity, loss of a limb or bodily organ system, or for an injury that deprives a person of independently caring for himself and performing life-sustaining activities.

Senate Bill 281 also changed the statute of repose to generally bar claims initiated more than four years after the occurrence of the act or omission constituting the basis of the claim, required a plaintiff's attorney whose contingency fees exceed the applicable amount of the limits on damages to file an application in the probate court for approval of the fees, and mandated lawsuit data reporting to the Department of Insurance.

### **Charge of Commission**

As provided by S.B. 281, the Commission has two charges. First, the Commission is required to study the effects of the tort reforms contained in S.B. 281 on the medical malpractice marketplace. Second, the Commission is required to investigate the problems posed by, and the issues surrounding, medical malpractice. The Commission is required to submit a report of its findings to the Ohio General Assembly in April 2005.

Another piece of legislation impacting the Commission, Senate Bill 86 (R-Stivers), became effective on April 13, 2004. (Exhibit B). Senate Bill 86 added several additional charges to the Commission's mission. Those new charges require the Commission to

- Study the affordability and availability of medical malpractice insurance for health care professionals and other workers who are volunteers and for nonprofit health care referral organizations;
- Study whether the state should provide catastrophic claims coverage, or an insurance pool of any kind, for health care professionals and workers to utilize as volunteers in providing health-related diagnoses, care, or treatment to indigent and uninsured persons;
- Study whether the state should create a fund to provide compensation to indigent and uninsured persons who are injured as a result of the negligence or misconduct by volunteer health care professionals and workers; and
- Study whether the Good Samaritan laws of other states offer approaches that are materially different from the Ohio Good Samaritan Law.

### **Onset of the Ohio Medical Liability Crisis**

In the late 1990's, the Ohio medical liability insurance market began to slip into what we now recognize as a crisis. Rapidly rising costs caused the profitability for insurers doing business in Ohio to plummet. In 1999, Ohio's medical liability insurers reported underwriting costs that were 50.2 percent higher than the premium they collected. In 2000, underwriting costs exceeded premium by 67.9 percent. (Exhibit C). Underwriting costs are those directly related to providing insurance, including claim investigation and payment, defense of policyholders and operating expenses. By 2000, companies were forced to react to the increasing costs and began to raise rates dramatically. By late 2001, insurers were leaving the market and rates were rapidly rising.

Since 2000, nine insurers have left the Ohio medical liability market. St. Paul, First Professionals, Professionals Advocate, Lawrenceville, Phico, Clarendon, CNA, Farmers, and Frontier all withdrew from Ohio and other states due to the difficulties faced in this line of business. The surplus lines market, where providers turn when admitted insurance carriers turn away business, grew significantly.

Health care providers faced increasing difficulty finding affordable medical liability insurance coverage since rates were rising rapidly. The five major medical liability insurance companies in the state, Medical Protective, ProAssurance, OHIC Insurance Company, American Physicians, and The Doctors Company, which collectively cover nearly 72 percent of the Ohio market, raised their rates dramatically. The attached exhibit shows the average rate change for Ohio "Physicians and Surgeons" since 2000. (Exhibit D). The average change in 2002 was the highest at 31.2 percent. Some areas of Ohio, such as the counties in the northeast and along the eastern border, experienced even higher increases. Medical specialties such as OB/GYNs, neurosurgeons, radiologists, and emergency/trauma providers were hit particularly hard.

Despite the rate increases, the premiums collected by medical liability insurers in Ohio have not been sufficient to cover the costs of providing insurance, such as the cost of investigation, defense and payment of claims and operating expenses. Financial reports by Ohio medical liability insurers have not shown a profit since the mid-1990's, with insurers reporting underwriting losses in each of the last five years. (Exhibit C). All five of the top insurers received downgrades from rating agencies over the last five years, and today only two have high "A-" ratings and one is unrated.

Another fact illustrating the crisis is the number of inquiries by Ohio providers and requests for help made to the Ohio Department of Insurance. Since late 2002, the Department has assisted 223 doctors regarding their medical liability insurance coverage. Many of the calls demonstrated that certain specialties such as obstetrics were particularly impacted by rate increases. Another 17 doctors asked the Medical Coverage Assistance Program (MCAP) to help them secure medical liability insurance coverage. Additionally, the Department has documented that 228 doctors have retired, reduced or eliminated high-risk procedures, or moved to another state. Of those doctors, 97 decided to drop their private practice, reduce or eliminate high-risk procedures, or otherwise change the service they provide; 68 decided to retire and 63 have moved to another state. As a result of these ongoing dialogues and concerns about the availability of physicians, the Department conducted a survey of Ohio providers to ascertain their concerns about the current crisis.

### **Impact of the Crisis on Doctors and Their Patients**

In the summer of 2004, the Ohio Department of Insurance commissioned a survey of 8,000 doctors to understand how rising premiums affected the doctors' practices and their patients. (Exhibit E). The results demonstrated that the rising medical liability insurance costs have significantly affected physician behavior. Nearly 40 percent of the 1,359 doctors who responded to the survey indicated that they have retired or plan to retire in the next three years due to rising insurance costs, yet only 9 percent of the respondents were over age 64.

Northeast Ohio can anticipate the highest number of those retirements, with more than 40 percent of the local physicians planning to leave in the next three years.

Ohio's patient population is being impacted, with a significant reduction in patient services already having occurred. Sixty-six percent of doctors surveyed indicated that they have turned down high-risk procedure patients or have referred those patients elsewhere. The situation is critical in southeast Ohio, where 95 percent of doctors surveyed have declined or referred high-risk patients. In northeast Ohio, 48 percent of OB/GYN and family practice physicians reported they have stopped delivering babies due to high medical liability insurance costs. Over half of the osteopathic doctors who responded indicated that they are no longer delivering babies.

Rising insurance costs also have affected where doctors see patients. Doctors have reduced the number of patients they see in nursing homes and in home care and hospice settings. Southeast and northeast Ohio have been hit particularly hard with 60 percent of responding southeast Ohio doctors having cut their in-home visits, and 54 percent of responding northeast Ohio doctors reporting that they have done the same. Responding doctors also indicated that, as a result of these high medical liability premium costs, they are being forced to see more patients to remain financially viable and many are cutting staff. In short, the survey reported that high medical liability premiums are having an effect on health care services in Ohio, and that Ohio could soon face a crisis of access to care.

### **Initial Signs of Recovery**

The Ohio medical liability market is beginning to show signs of recovery. Two new medical liability companies, OHA Insurance Solutions, Inc. and Healthcare Underwriters Group Mutual of Ohio, have been licensed in Ohio in the last year and a half. The five major medical liability insurers in the Ohio market have stayed in Ohio throughout these difficult times. These companies indicated to the Commission during a joint legislative hearing on April 19, 2004 that among other factors, Ohio's enactment of medical malpractice tort reform legislation made them more confident about the future of Ohio's medical liability marketplace.

Medical liability rates appear to be slowly stabilizing. In 2004, rates for the top five companies increased an average of 20 percent. The average increase, while still high, is smaller than that of the two previous years. So far in 2005, two of the top five insurers, Medical Protective and The Doctors Company, have filed and implemented rate changes averaging 12 percent. Moreover, in the past year, some of these insurers have filed decreases for some regions of the state. The Doctors Company lowered rates for General Practice by 1 percent in northwest and in southeast Ohio, and by 9 percent in central and southwest Ohio. Medical Protective filed a decrease of 3 percent for General Practice in northeast Ohio. By the end of 2005, Ohio may see average rate changes below 10 percent.

Ohio medical liability insurers are also slowly moving toward profitability, which helps ensure that the medical liability companies will remain in the market and will fulfill their financial obligations to their policyholders. Underwriting losses have steadily

decreased since 2000. (Exhibit C). While the latest year's results are not yet available, continued movement toward profitability is expected and the industry could report an operating profit for 2004 in Ohio. If that occurs, this will be the first year since 1997 that Ohio's medical liability insurance industry has reported a profit.<sup>3</sup>

### **Still in Crisis**

While the Ohio medical liability market is beginning to recover, it is still in a state of crisis. Positive signs in the marketplace do not mean that doctors are no longer facing extremely high premiums. Although rate increases are stabilizing, doctors in Ohio are still suffering from the effects of rising rates. Premiums are overall much higher than they were just five years ago. For example, rates for OB/GYNs in Cuyahoga County for the top five companies averaged \$60,000 in 2000. Now the average is \$145,000. In Athens County, the average rate for neurosurgeons was \$54,000 in 2000. Today the average is \$125,000. General surgeons in Franklin County paid an average of \$33,000 in 2000, and now face an average premium of \$68,000.<sup>4</sup>

The continuing difficulties in finding affordable medical liability insurance coverage raise concerns that health care providers, particularly those in high-risk specialties, will further limit care, leave Ohio, or leave the profession entirely. Ohio health care consumers may experience increasing difficulty seeing the provider of their choice. Costs to consumers may also rise if providers defensively over-prescribe, over-treat, and over-test their patients to avoid potential lawsuits.

## **II. FINDINGS AND RECOMMENDATIONS OF THE COMMISSION**

In this environment, the Commission held 26 meetings over a two-year period in order to meet its statutory charges. Speakers with expertise on particular medical malpractice-related topics were invited to testify before the Commission. The Commission heard testimony from actuaries, doctors, state regulators and other experts. A list of the Commission's meetings, the topics covered, and the witnesses who testified before the Commission is attached. (Exhibit F). Based upon a review of the testimony, the Ohio Medical Malpractice Commission makes the following findings and recommendations.<sup>5</sup>

### **A. Effects of Senate Bill 281**

The Commission concludes that because of the nature of ratemaking - primarily relying on loss experience over a period of time - and the fact that most medical malpractice cases now being heard in Ohio courts are not subject to S.B. 281 because they were brought and/or arose before its effective date, the Commission cannot conclusively evaluate the effects of the new law on the Ohio market, or on medical malpractice cases in Ohio.

However, based on testimony and data from states that do have tort reform in place, the Commission fully expects tort reform to have a stabilizing impact on the medical malpractice market in Ohio over time. Insurance department representatives from Indiana, Wisconsin, and New Mexico testified about the positive impact damage caps and patient

compensation funds have had on their respective markets and statistics from those states and Louisiana show their relative market stability compared to Ohio's. (Exhibit G). In addition, the Texas commissioner testified that an in-house, peer reviewed study of their recent tort reform, which included a \$250,000 cap on non-economic damages, estimated a 12 percent reduction in medical malpractice rates. Countrywide, those states with longstanding tort reform have more stable markets than Ohio's, and the American Medical Association's designation of non-crisis states also reflects this fact. (Exhibit H).

In addition, at the Commission's joint meeting with members of the House and Senate Insurance Committees on April 19, 2004, representatives of the five major medical liability insurers in Ohio (which hold about 70 percent of the market share) testified. Several indicated their increased confidence in operating in Ohio in light of the passage of medical malpractice tort reform, notwithstanding the fact that the industry has been losing money in Ohio since 1998. (Exhibit C). The Director of Insurance also has reported to the Commission that Department conversations with these insurers over the last two years indicate that a major reason they are still operating in Ohio is the passage of tort reform, since they are not compelled to remain in the market but are more optimistic the market will improve with tort reform.

#### **RECOMMENDATION:**

The Commission strongly recommends that S.B. 281 remain in effect in Ohio with the expectation that it will help to stabilize the medical malpractice market over time.

#### **B. Ratemaking**

The Commission heard testimony about ratemaking. Testimony included discussion of the ratemaking process, Department review of medical malpractice rate filings, various rate review standards such as "prior approval" and "file and use," and the role of investment income on ratemaking.

The Commission acknowledges and agrees with the testimony of most witnesses, including insurance actuaries, that the primary driver of medical malpractice rates is the costs associated with losses and defense of claims. For the three most recent years of financial reports, these costs have exceeded premiums collected by the top five medical malpractice insurance companies in Ohio by an average of 23.7 percent and have increased by 57 percent (241,488,088 to 378,313,587). (Exhibit I). In the last five years, rates for those insurers have increased more than 100 percent. (Exhibit D). The entire medical liability insurance industry has lost money in Ohio since 1998. (Exhibit C). Profit figures in Ohio for 2002 and 2003 show that the costs to provide this insurance exceeded premium by 46 percent in 2002 and by 30 percent in 2003.

Allegations that investment losses have caused the rapid rise in medical malpractice premiums in Ohio in the last several years are without basis. Returns on investments have been about 4 percent to 5 percent since 1999. Ohio law and regulation prohibit the recoupment of investment losses in prospective rates, and the Department ensures through

its rate review that this does not occur. ORC §3937.02 (D). Further, investment income primarily plays a part in ratemaking with respect to the estimated return on funds placed in reserves, to determine whether sufficient reserves, including investment earnings, will be available to pay claims. The Department reviews companies' estimates used in these calculations carefully.

Ohio's regulatory system for property and casualty rates is known as "file and use," meaning that while companies must file their rates with the Department, they may use them immediately. The Department can reject rates if after review the Department determines the rates are unfairly discriminatory, inadequate or excessive. Other states have different systems, such as "use and file" (no prior review) and "prior approval" (requiring insurance department approval before use). None of these systems appears to be distinctive in improving rates or insurance markets. In fact, according to some companies, prior approval often results in delays and political bickering before rate changes can be implemented, potentially impacting a company's financial condition. This concerns insurance regulators who also oversee the financial condition of insurance companies to protect consumers.

No legal requirement exists to compel companies to file their rate changes on a regular basis, although the practice in Ohio's volatile medical liability market has been for companies to file rate changes at least annually, and usually before a change has become effective to allow the Department time to review it beforehand. The Department has implemented procedures in the last two years to intensify scrutiny of rates and to hold companies accountable for proposed increases.

In addition, no legal requirement exists to compel companies to remain in Ohio. Despite the hard Ohio market and lack of profits in medical liability coverage, five major companies have remained in Ohio, two more have been licensed in the last year, and 32 additional companies continue to write at least \$1 million in coverage each. This is a more positive trend following the departure of nine companies from Ohio between 2000 and 2002.

#### **RECOMMENDATIONS:**

- 1.) The Commission does not recommend a change in the rate review system in Ohio since rates are well regulated.
- 2.) The Commission recommends that the Department require medical malpractice companies to file and justify their rates, even if no change is requested, at least once every year.

#### **C. Data Collection**

Senate Bill 281, the tort reform bill, required clerks of court to report medical malpractice lawsuit data to the Department, which developed a system for collecting the data. However, testimony of the Department and county clerks indicated the insufficiency and unreliability of the data collected under that system. As a result, the Commission

recommended in its Interim Report the passage of legislation requiring more comprehensive data reporting.

Subsequently, House Bill 215 (R-Schmidt) was enacted September 13, 2004, requiring detailed data reporting to the Department by insurance companies and self-insureds. The Department recently promulgated O.A.C. 3901-1-64, effective January 2, 2005, implementing H.B. 215 and requiring medical malpractice insurers and others who assume liability to pay medical, dental, optometric, and chiropractic claims to report judgment, settlement and other closed case data to the Department. Further, H.B. 425 (R-Stewart, effective April 27, 2005) contained uncodified language requesting the Ohio Supreme Court to adopt a rule requiring attorneys to report fee expense information to the Department.

The Commission concludes that the new data reporting and collection requirements appear to be comprehensive and sufficient at the present time but should be evaluated after being fully implemented to determine whether additional changes are warranted.

Confidentiality of data continues to be an issue, however. The Commission agrees that the data should remain confidential, except in the aggregate. Members expressed concern that if specific individual case data were released, insurers might not be as forthcoming with accurate data and individual medical providers could be put at some risk. Two members believe that raw data should be available so that the public can draw its own conclusions.

#### **RECOMMENDATIONS:**

- 1.) The new data collection provisions of H.B. 215, O.A.C. 3901-1-64, and H.B. 425 should be evaluated annually after each annual cycle of data has been collected. The annual report by the Department required by H.B. 215 should provide the basis for this evaluation.
- 2.) Data collected should remain confidential as required by current law.

#### **D. Medical Error Reduction**

While long known to members of the medical and legal profession, errors in the delivery of health care occur. The Institute of Medicine report issued in 2000 entitled *To Err is Human: Building a Safer Health System* focused attention on this issue. In addition, although redundancies and checks within the health care delivery system help reduce error, medical errors do occur. Whether or not most errors result in lawsuits is not clear, although a 1991 New England Journal of Medicine article evaluating a 1984 New York study indicated that only 7.7 percent of actual cases of error result in lawsuits. In addition, a 2003 GAO report estimates that 70 to 86 percent of all medical malpractice verdicts result in no payment, suggesting that not all cases are deemed meritorious.

The Commission heard testimony regarding several initiatives occurring in Ohio to address medical error. A major initiative in this area jointly sponsored by the Ohio State Medical Association, the Ohio Osteopathic Association, and the Ohio Hospital Association is the Ohio Patient Safety Institute. This organization, formed in 2000, has investigated the development of a statewide system for reporting medical errors and has undertaken a variety of initiatives to raise the awareness of participants in healthcare delivery throughout the state to patient safety and the need for improvement. Another initiative was presented to the Commission by the Ohio University College of Osteopathic Medicine, which has developed a Patient Safety Committee to research the causes of error and promote a culture of safety. Commission member Frank Pandora pointed out that most large hospitals and hospital systems have initiatives to reduce error in health care delivery underway. The Ohio State Medical Board also has an interest in reducing medical error and a responsibility to investigate medical error brought to it in the form of complaints received. The Medical Board testified that it lacks sufficient resources to investigate all complaints received in a timely fashion.

The Commission heard testimony that much of the work in the area of patient safety is based on a "systems" approach to the reduction of medical error. The approach recognizes that the occurrence of an error in the delivery of health care may involve the failure of a system to perform appropriately rather than the failure of a single or small number of members of the health care delivery team. Such an approach does not necessarily de-emphasize individual responsibility but recognizes that systems should be designed to reduce the opportunity for error to occur, and in order to improve must go beyond the emphasis on individual blame.

In addition, the Commission heard testimony that improving the structure of the health care delivery system to improve safety will require extensive capital investment in the near future. Improving data systems and investment in technology to improve safety will need capital resources currently unavailable to many participants in the system. The Commission encourages the exploration of creative ways for state government to assist in the capital investment in the health care delivery system to make it the safest possible system.

Ohio lacks a statewide uniform medical error reporting protocol, requirement or system. Although the Joint Commission on Accreditation of Health Care Organizations imposes reporting requirements of so-called sentinel events on its accredited hospitals, these requirements do not extend to the outpatient environment and do not cover the entire scope of "medical errors."

The Commission also finds that, in spite of efforts by organizations described above, the state does not have an adequately funded, centralized system for the evaluation and dissemination of best practices in the area of patient safety. Six states have established "patient safety centers" with varying oversight and funding but all with a general mission of educating health care providers on best practices. The intended goals of such a center in Ohio would be to coordinate patient safety efforts at institutions across the state, work to identify best practices in patient safety, educate health care providers about best practices,

identify funding sources for the implementation of best practice strategies, develop data collection systems and protocols for error reporting and make appropriate recommendations to the legislature concerning the funding of such activities. Such a center should be structured as a partnership among appropriate state government units and appropriate private institutions, organizations and associations.

The Commission strongly believes there is a need for a coordinated and directed effort in medical error reduction. An important step would be the development of a medical error reporting system to allow the systematic study of the errors occurring to develop appropriate response to them. Confidentiality of data needs to be addressed. Members expressed concern that if specific individual patient, physician and hospital data were released, as opposed to aggregate data, such release may weaken the reporting of medical errors. The improvement of patient safety in Ohio is an important and appropriate goal and will require governmental support and partnerships with components of the health care delivery system.

The Commission believes that cooperative ventures among the Department of Health, the Ohio State Medical Board, other agencies, private institutions and organizations may be fostered to develop and implement a statewide protocol for medical error reporting and a statewide repository for such information. This would require legislation mandating and funding such an initiative, which would add legitimacy to this effort.

#### **RECOMMENDATION:**

The Commission strongly recommends the creation of a "patient safety center" as described above which would include the development of a medical error disclosure to patients protocol and a statewide uniform medical error reporting system.

#### **E. Health Care Access, Recruitment, and Retention**

The Commission heard specific testimony from leaders at medical education institutions in Ohio that recruitment of new doctors and retention of experienced doctors, particularly in certain specialties like surgery and obstetrics, have been impacted by the medical malpractice crisis. In addition to anecdotal evidence from doctors and hospitals across the state, the Doctors' Survey commissioned by the Department in the summer of 2004 reflected the alarming response from almost 40 percent of doctors responding to the survey that they have retired or plan to retire in the next three years due to rising insurance expenses. The Doctors' Survey also indicated an impact on health care access because of doctors' increasing unwillingness to conduct certain high-risk procedures or to see patients in certain locations (such as nursing homes) and doctors' increasing practice of ordering more tests to defend their medical decisions.

The State Medical Board testified that the number of licensed doctors in Ohio is increasing, but it does not keep track of the number of licensed doctors who are retired, who moved their practices to another state, or who have otherwise limited their practice by curtailing high-risk procedures.

The Commission concludes that a correlation exists between the medical malpractice crisis and access to health care and recruitment and retention of doctors. The efforts of the Department and legislature to stabilize the medical malpractice market should help Ohio retain physicians in the long-term. Various institutions are exploring their own initiatives to retain and recruit physicians, including providing coverage through captives and risk retention groups.

**RECOMMENDATIONS:**

- 1.) The Commission recommends the investigation of programs to forgive educational loans and other incentives for doctors in certain specialties and for those doctors who agree to stay in Ohio for a specified period of time.
- 2.) The State and the Department should continue to monitor patient access to health care and doctor departures, and advise appropriate parties and agencies of such issues.

**F. Patient Compensation and Other Compensation Funds**

The Department conducted a feasibility study of patient compensation funds in 2003 (Pinnacle Report) pursuant to the directive in S.B. 281, and hired another consultant in 2004 to develop specific models for a patient compensation fund (PCF) in Ohio (Milliman Report). Milliman recommended that an Ohio PCF provide coverage over a primary layer of \$500,000, up to \$1 million in coverage, and require participation by all health care providers, including self-insured providers, which would pay premiums to fund the PCF. The Milliman report concluded that the anticipated change in overall premium based on the recommended model would be about a 5 percent reduction. The Department's position is that the long-term stabilizing impact of a PCF warrants its serious consideration, but other Commission members were not persuaded by this argument. However, Commission members did recognize the thorough research of the Department and Commission on PCFs. Members do not believe that a PCF with only a 5 percent possible reduction in premiums would be beneficial. Ohio healthcare providers indicated they sought a more significant impact on premiums for them to support implementation of a PCF.

The Commission also heard testimony on two specialized funds in Virginia and Florida for birth-related injuries. No information appears to be available in Ohio on the extent of these types of cases.

**RECOMMENDATION:**

The Commission recommends that no further action on a PCF, funded solely by health care providers, be taken at this time.

## **G. Captive Initiative**

The Department has developed legislation that would permit the formation of and provide for the regulation of captive insurers in Ohio. The Commission heard testimony about the advantages of captives - among other benefits, cheaper rates because of lower administrative costs - but discussed the need for financial standards and oversight in Ohio to protect doctors and patients. The Commission believes that such legislation could increase insurance capacity in Ohio, particularly needed in the medical liability market.

States like Vermont and South Carolina have captive statutes which allow captives to write a wide range of commercial coverage, not just medical liability. These states have attracted more companies to form captive insurers in their states rather than in offshore jurisdictions.

### **RECOMMENDATION:**

The Commission recommends that the Department continue to investigate captive formation in Ohio, which could result in related legislation.

## **H. Non-Meritorious Lawsuits**

The Commission recognizes that claims, settlements and lawsuits generate costs for insurance companies, whether or not any money is paid out to the claimant. The Commission heard considerable testimony that these cost factors drive premium increases. The failure to mitigate these costs will impact a provider's liability premium regardless of the underlying merits of the lawsuits involved.

Consistent with these concerns and recommendations made in the Commission's Interim Report, the General Assembly enacted H.B. 215 (effective September 13, 2004) which requested the Ohio Supreme Court's implementation of a rule of civil procedure requiring an affidavit of merit for the plaintiff at the initial filing of a medical malpractice case. The Supreme Court has finalized amended Civil Rule 10, which will be effective July 1, 2005. In addition, H.B. 215 provided for the filing of affidavits of non-involvement to excuse certain named parties, with the goal of dismissing certain inappropriate parties earlier in the process, thereby reducing associated costs. This provision became effective September 13, 2004.

Finally, H.B. 215 gives the Ohio State Medical Board disciplinary authority over out-of-state medical experts who come into the state to testify. This provision allows the Medical Board to monitor the caliber and veracity of medical experts in an effort to curtail unqualified "experts" from lending ostensible credibility to non-meritorious lawsuits.

The Commission also heard testimony on the viability of binding arbitration, pretrial screening panels, and medical review boards. The Commission research indicates many issues still need to be resolved regarding these proposals, including whether they are constitutionally feasible, reduce costs or save time. Evidence from states which currently

employ such measures was not conclusive on these issues. A pilot program for a less formal mediation alternative could avoid many of the constitutional issues which surfaced in the debate over pretrial screening panels and could be tested through the pilot program to evaluate its effectiveness.

#### **RECOMMENDATIONS:**

- 1.) The Commission recommends a pilot project of a less formal mediation alternative in conjunction with the Supreme Court.
- 2.) Although cost is a factor (typically a specialized court costs \$100,000 per year per county), the Commission recommends a pilot project in one or more counties that establishes medical malpractice courts or dockets, which may provide increased efficiency and competency.
- 3.) The Commission recommends that the process reforms enacted in H.B. 215 be evaluated by the Supreme Court after they have been in effect for two years to determine their impact on medical malpractice cases. This evaluation should be reported to the Governor, legislative leadership, and the Department.

#### **I. Charitable Immunity**

The Commission was given a new task in Senate Bill 86 of the 125th General Assembly, which extended the charitable immunity law to volunteer health care professionals regardless of where they provide the service. The Commission was directed to review the following and finds accordingly with respect to each issue:

(1) The affordability and availability of medical malpractice insurance for health care volunteers and nonprofit health care referral organizations: According to testimony before the Commission, 87 percent of the members of the Ohio Association of Free Clinics find it difficult to access affordable professional liability coverage despite both the existence of Ohio's charitable immunity law and no lawsuits filed against Ohio free clinics. At least one Ohio medical liability insurance carrier is offering coverage for free clinic staff.

(2) The feasibility of state-provided catastrophic claims coverage to health care workers providing care to the indigent and uninsured: The Commission heard testimony from Virginia and Iowa, states that indemnify or provide state coverage for charitable providers. Ohio currently only indemnifies its state employees and does not have a statutory mechanism to indemnify others. To provide indemnification or to pay premiums would be a significant funding issue in Ohio.

(3) The feasibility of a state fund to provide compensation to persons injured as a result of the negligence of health care volunteers: Providing a state fund to compensate injured persons would also face funding hurdles. Further, since no claims have been made against Ohio free clinics, the Commission does not believe that a state fund to provide

compensation to persons injured as a result of the negligence of health care volunteers is currently warranted.

(4) Other states' Good Samaritan laws: The Commission also learned that Ohio's approach to charitable immunity is comparable to a majority of other states' approaches.

The Commission finds that S.B. 86 is a good step toward encouraging charitable care in Ohio. However, free clinics still have difficulty obtaining affordable medical liability coverage, even though no claims have been made against Ohio free clinics.

#### **RECOMMENDATIONS:**

- 1.) The Commission recommends the issuance of guidelines by the Ohio Department of Insurance which would require medical liability insurance carriers to incorporate into their underwriting and pricing of policies for free clinics appropriate modifications to reflect past and prospective claim experience in Ohio.
- 2.) The Commission recommends the inclusion of free clinics in a statewide medical error reporting system in order to ensure that patients are receiving the best care possible.

#### **J. Medical Liability Underwriting Association**

House Bill 282 (R-Flowers, enacted April 4, 2004) provided for the transfer of the \$12 million previously held by the 1975 Ohio Joint Underwriting Association into a new fund that could be used to create a new medical liability company or to fund other medical malpractice initiatives as approved by the Ohio General Assembly. The legislation also gave the Director of Insurance authority to create a Medical Liability Underwriting Association ("MLUA") if the current medical malpractice market were to further deteriorate. The MLUA would write primary insurance coverage for doctors unable to find coverage.

#### **RECOMMENDATION:**

Due to the unpredictable and volatile nature of the medical malpractice market, and the Department's recent testimony on stabilizing but still uncertain market conditions, the Commission strongly urges the legislature to retain the current funding set aside for the potential enactment of the MLUA and for future medical malpractice initiatives.

#### **K. Miscellaneous Recommendations**

- 1.) During the hearings, several physician witnesses testified on the difficulty of affording the current premiums for professional liability coverage. Even more troublesome than the current pricing is the necessity of purchasing prior acts or "tail" coverage to protect and maintain existing coverage limits after retirement or changing companies. Under previous custom a company would grant a deceased,

disabled or retiring practitioner continuing coverage for any events/claims occurring during the existence of the policy's terms at no additional cost. Medical liability insurers traditionally provided tail coverage as a prepaid component of prior premiums. Companies require an amount equal to 1-2 years of mature premium prior to the physician retiring before the end of the five-year vesting period, or changing from one company to another. Additionally, market conditions have forced some physicians to switch professional liability companies several times, creating the necessity of purchasing of multiple tail policies.

According to comments by Texas Insurance Commissioner Jose Montemayor, the state of Texas has a mechanism to address part of this problem. When a company that sold policies in Texas leaves and refuses to offer a tail policy for a physician's liability coverage, the existing Texas Joint Underwriting Authority ("JUA") is authorized to provide that tail policy coverage to the physician when he or she purchases primary coverage from the JUA.

As stated earlier in this report, nine companies left Ohio between 2000 and 2002, forcing their policyholders to find tail liability policies from those companies even if the companies' financial conditions were questionable or the companies were no longer doing business in the state. Ohio has already recognized the importance of maintaining the availability of medical professional liability insurance by creating the statutory authority to establish the MLUA. The MLUA would provide primary coverage in case the remaining carriers were to decide to leave Ohio or limit their participation in the market.

The Commission recommends that the Department of Insurance investigate the economic implications of the MLUA or another state insurance entity providing prior acts or tail coverage if the original insurer has become insolvent or stopped doing business in the state. The results of this investigation could provide the basis for legislation.

- 2.) The Commission recommends that if the Department determines that the long-term medical malpractice market has stabilized and the future funding of an MLUA is unnecessary, then the current MLUA funding should be directed to fund other medical malpractice initiatives.
- 3.) The Commission recommends that the Department continue to monitor the medical liability market in Ohio, and recommends that biennially, beginning two years after issuance of this report, the Department provide a market analysis of the medical liability market to the Governor and the legislature.

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<sup>1</sup> Senate Bill 281 (124th General Assembly, enacted April 11, 2003), section 3(B)(1) and (2): "[T]he General Assembly declares its intent to accomplish all of the following by the enactment of this act: (1) To stem the exodus of medical malpractice insurers from the Ohio market; [and] (2) To increase the availability of medical malpractice insurance to Ohio's hospitals, physicians, and other health care practitioners, thus ensuring the availability of quality health care for the citizens of this state. . . ."

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<sup>2</sup> Senate Bill 281 (124th General Assembly, enacted April 11, 2003), section 3(A)(3)(c): "As insurers have left the market, physicians, hospitals, and other health care practitioners have had an increasingly difficult time finding affordable medical malpractice insurance. Some health care practitioners, including a large number of specialists, have been forced out of the practice of medicine altogether as a consequence. The Ohio State Medical Association reports 15 percent of Ohio's physicians are considering or have already relocated their practices due to rising medical malpractice insurance costs."

<sup>3</sup> "State of the Medical Malpractice Market," Ohio Department of Insurance Director before the Ohio Medical Malpractice Commission, February 28, 2005.

<sup>4</sup> Top five companies' medical malpractice 2000-2004 rate filings submitted to the Ohio Department of Insurance.

<sup>5</sup> Minority views will be expressed separately.



**Bob Taft, Governor**  
**Ann Womer Benjamin, Director**

2100 Stella Court, Columbus, OH 43215-1067  
(614) 644-2658 [www.ohioinsurance.gov](http://www.ohioinsurance.gov)

## ***Ohio Department of Insurance*** **Physician Medical Malpractice Insurance Survey**

### **Executive Summary**

The rising cost of malpractice insurance has significantly impacted Ohio physician behavior. Nearly 40 percent of the 1,359 respondents to the Ohio Department of Insurance survey said they have retired or plan to retire in the next three years due to rising insurance expenses. Only 9 percent of the respondents were over age 64.

Northeast Ohio can anticipate the highest number of those retirements, with more than 40 percent of the local physicians planning to leave in the next three years.

Ninety-six percent of the respondents had malpractice rate increases in 2004. The average annual premium for personal medical malpractice insurance paid by these Ohio physicians in 2004 was \$40,385, a 39 percent increase compared with 2003 expenses. On average, physician respondents paid 18 percent of their gross annual income in premiums.

Rates for insurance, however, vary from state to state and are very different within each state based on the specialty practice of the physician.

The Ohio Department of Insurance commissioned this survey of doctors to focus on how professional liability insurance rate increases have changed the way doctors practice medicine in Ohio and to learn doctors' preferences for solutions.

Anecdotal evidence has been presented in Ohio and across the country that a crisis has been developing due to the rapid premium increases. This study quantified the impact on physicians and patients and was large enough to show how Ohioans in different regions of the state and with varying medical needs are being affected.

The rising costs of malpractice insurance have significantly impacted physician behavior and doctors have closed their practices or are planning to do so.

More than 50 percent of the state's neurology and specialty surgeons responding to the survey are planning to retire in the next three years due to insurance rate increases. These specialties, along with obstetrics, are considered higher insurance risks and are charged the highest rates among physicians.

Ohio's patient population is already being impacted. In addition to the anticipated reduction in the number of physicians, the survey results show there has been a significant reduction in the services offered to Ohio patients. Sixty-six percent of physicians surveyed have turned down or referred high-risk procedure patients elsewhere.

The situation is critical in Southeast Ohio, where 95 percent of the survey respondents have turned down or referred patients who required high-risk procedures to other practitioners.



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Forty-eight percent of OB/Gyn and family practice physicians in Northeast Ohio surveyed have stopped delivering babies due to insurance costs, and more than 50 percent of the osteopathic doctors in the state no longer deliver babies.

Insurance concerns have also affected where physicians will see patients. Physicians responding to the survey have reduced the number of patients they see in nursing homes (55 percent have cut back), home care settings (46 percent have cut back), and hospice settings (30 percent have cut back).

Northeast and Southeast Ohio have been hit particularly hard. Sixty percent of the survey group from Southeast Ohio report having cut their in-home visits, while 54 percent of physicians surveyed in Northeast Ohio say they have cut in-home care.

Physicians recognize a need for patients to have recourse when malpractice occurs. In the survey, they recommend the state of Ohio pursue remedies that focus first on determining the merits of a claim before it is filed in court.

## **Methodology**

- This is the largest study of the impact of malpractice insurance rates conducted to date in the State of Ohio.
- 8,000 surveys were mailed to a random sample of Ohio physicians.
- 1,359 surveys were returned, for a 17 percent response rate.
- Comparisons among physicians' specialties, region of the state, age, and number of liability claims were conducted on every question.

## **Objectives**

- To understand how medical malpractice insurance has impacted Ohio physicians' revenue, as well as physicians' willingness to perform certain procedures, invest in their practices, and continue to practice medicine in Ohio.
- To learn how medical malpractice insurance has impacted overall physician care, patient access to care and the patient experience.
- To determine physician interest in various proposed measures to stabilize medical malpractice insurance premiums.

## Conclusions

**1. The first conclusion is that the rising costs of malpractice insurance have significantly impacted physician behavior and doctors have closed or are planning to close their practices.**

- We learned that nearly four out of 10 respondents said they have retired or plan to retire in the next three years due to rising insurance expenses. This finding is all the more sobering since just 9% of the respondents were over age 64.
- More specifically:
  - The percentage of doctor retirements is even higher in Northeast Ohio.
  - More than half of Ohio's neurologists and specialty surgeons responding to the survey plan to retire because of malpractice insurance rates. These specialties, along with obstetrics, are considered higher insurance risks and are charged the highest rates.

**2. Second, rising premiums and the exodus of doctors have already negatively affected Ohio's patient population. In fact, a significant reduction in patient services has already occurred.**

- For example, 66% of physicians surveyed have turned down or referred high-risk procedure patients elsewhere.
  - The situation is critical in Southeast Ohio, where 95% of physicians surveyed have declined or referred high-risk patients.
  - In addition, 48% of OB/GYN and family practice physicians in Northeast Ohio reported they have stopped delivering babies due to insurance costs.
  - Over half of Ohio's osteopathic doctors reported they no longer do deliveries.
- Also, high malpractice insurance premiums have influenced where physicians will see patients. Respondents indicated that
  - 55% have reduced the number of patients they see at nursing homes.
  - 46% have cut back the number of patients they see in home care settings.
  - And 30% see fewer patients in hospice settings.
  - The percentages are particularly high in Northeast and Southeast Ohio.
  - Physicians are minimizing patients in these settings because they consider them high-risk in terms of medical liability.

- Patient care has been impacted in other ways as well:
  - Nearly three-quarters of physician respondents say that they order more tests to better defend their decisions.
  - Physicians also report that they need to see more patients to remain financially viable, which results in longer waits for appointments and less time with each patient.
  - Finally, many doctors have cut their staff in response to malpractice insurance increases.

**3. The third conclusion from the survey is that malpractice insurance premiums have risen dramatically and have strained office economics.**

- 2004 rates went up for 96% of survey respondents, rising by an average of 39% over 2003. Well over a quarter of Ohio physicians responding paid more than \$50,000.
- On average, almost 20% of physicians' gross annual income – one dollar in five – goes to pay malpractice premium costs.
- Rates vary widely, both among states and within medical specialties. In Ohio, for example, OB/GYN physicians responding to the survey pay an average of 30% of their annual incomes – 50% more than the average physician – to malpractice insurers.

**4. The survey's final conclusion deals with curative measures, steps we might take to remedy the current problem. Here we found that physicians, while recognizing the need for patient recourse when malpractice occurs, generally favor any proposed measure to address rising medical malpractice insurance costs.**

- They are particularly supportive of a Medical Review Panel to screen medical liability cases, prior to court filing, to determine the merits of the cases. Almost nine physicians in 10 [88%] highly favor this proposal.

- Eighty percent of survey respondents highly favor the institution of a 60-day Mandatory Notice. This would require medical liability insurance companies to notify physicians well in advance if their policy were being cancelled or not renewed, or if they were receiving a significant premium increase. The Department spearheaded legislation (S.B. 187 effective 9/13/04) last year to implement this requirement.
- Finally, more than three doctors in four [76%] highly favor what is called Expert Witness Qualification Review. This would require the plaintiff to submit a “certificate of expert review” confirming that each medical expert witness is qualified to serve in that capacity. Legislation (H.B. 215 effective 9/13/04) was passed last year with the Department’s sponsorship requiring witnesses to be pre-certified as expert witnesses in their field by the Ohio State Medical Board.

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September 11, 2006

**SECTION:** COVER STORY; Pg. 1

**LENGTH:** 944 words

**HEADLINE:** Docs find relief at last;  
Tort reform helps apply brakes to steep malpractice insurance hikes; more physicians staying in Ohio

**BYLINE:** SHANNON MORTLAND

**BODY:**

Many Ohio doctors finally can exhale. For several years, physicians have held their breath each time they renewed their medical malpractice insurance, wondering if rates would rise 20%, 30% or more. However, medical liability insurance rates in the state finally have begun to level off - and even decline slightly - after years of climbing to levels that were some of the highest in the country.

"The market really appears to be slowly stabilizing," said Ann Womer Benjamin, director of the Ohio Department of Insurance. "Rates for the five major medical liability companies in Ohio show an average decrease of 1.5%. That follows significant increases in the past six years."

Just two years ago, doctors were fleeing the state and closing or limiting their practices because they no longer could afford Ohio's malpractice rates. Cuyahoga County was especially hard hit, as local hospitals lost specialists such as obstetrician-gynecologists, neurosurgeons and cardiologists.

That's no longer the case, said Tim Maglione, senior director for government relations at the Ohio State Medical Association, the professional group for Ohio's doctors.

"We're not getting the phone calls and letters from doctors who say they've got to pick up and leave Ohio," he said.

Mr. Maglione and Ms. Womer Benjamin both credit the moderation in malpractice rates to the tort reform bill that was passed by the state Legislature in 2003. The bill limited the amount of noneconomic damages awarded in medical malpractice cases to \$250,000 or three times the plaintiff's economic loss, not to exceed \$350,000.

Ms. Womer Benjamin said the CEOs of the five medical malpractice insurers that together account for an estimated 60% of the malpractice coverage in Ohio have told her in recent weeks that the market has "greatly improved" since the bill was enacted.

"There has been a slight decrease in frequency of (malpractice) cases filed," she said. "They are seeing fewer frivolous lawsuits."

Since the tort reform bill passed, there also haven't been as many "runaway verdicts" that awarded huge sums of money to the plaintiffs in medical malpractice cases, Ms. Womer Benjamin said.

**Make way for new players**

The improved market even has prompted a sizable medical malpractice insurer to enter the Ohio market.

Ace American Insurance Co. of Philadelphia last month partnered exclusively with Toledo-based insurance broker Hylant Group to market its insurance in Ohio for physicians, said Richard Hylant, president of Hylant Group Toledo. Ace provides medical liability insurance to individual physicians, hospitals and health systems, as well as to companies in the biotechnology, pharmaceutical, research and medical device fields.

## Docs find relief at last; Tort reform helps apply brakes to steep malpra

Ace's interest in Ohio is quite a shift from a few years ago, when insurance companies were halting their medical malpractice business in the state due to high jury verdicts. Ms. Womer Benjamin said she has licensed one other company to issue medical malpractice insurance in Ohio in the last two years. Before that, new companies had not entered Ohio since the early 1990s, she said.

Still, the Ohio medical liability market isn't completely healed, said Dr. John Bastulli, an anesthesiologist at St. Vincent Charity Hospital and chairman of the legislative committee at the Academy of Medicine Cleveland/Northern Ohio Medical Association. The association represents 4,000 local physicians.

"There are a large number of (medical) residents that aren't going to stay in Ohio because of medical liability insurance," and some don't even want to train here, Dr. Bastulli said.

Even the doctors who remain are struggling to pay rates that have stabilized at their peak, Dr. Bastulli said. That's why the Ohio State Medical Association has refocused its energy on helping doctors better manage the costs of running their practices, Mr. Maglione said.

"While rates may be stabilizing, they're still very expensive," he said. "Physicians have to find ways to not only keep up with that expense, but the economics of their practice."

Mr. Maglione said the association also is focusing on medical malpractice cases that go to court. Ohio law allows defendants to recoup the money they spent defending themselves in a lawsuit if the court deems that lawsuit frivolous. The association helps those defendants bring sanctions against the attorney who brought the frivolous case to court, he said.

State keeps up the pressure

Ms. Womer Benjamin said the Ohio Department of Insurance also isn't resting.

The department has implemented more comprehensive reviews of insurance rates, and Ms. Womer Benjamin now personally reviews any property and casualty insurance rate change request that is 5% or more. This year also is the first year that each insurance company doing business in Ohio annually must justify its rates, even if the insurer isn't requesting rate increases, she said.

Meanwhile, Ohio doctors are pushing Senate Bill 88, which would establish a pilot project in Northeast Ohio under which all medical malpractice cases would go through a mandatory arbitration process before going to trial.

Under the bill, which passed the Senate in May, each side in a medical malpractice complaint would select an arbitrator, and a chairperson would choose a third person to serve on an arbitration panel. The idea is to reduce the time and money it takes to go to trial, as well as to deter frivolous lawsuits.

\* \* \*

#### RUNAWAY MALPRACTICE RATES REINED IN

These numbers show the average rate increases for medical malpractice insurance in Ohio since 2000:

\* 2000: 14%

\* 2001: 21%

\* 2002: 30%

\* 2003: 30%

\* 2004: 20%

\* 2005: 6.7%

\* 2006: down 1.5%

Source: Ohio Department of Insurance

**GRAPHIC:** Art Caption: info box: RUNAWAY MALPRACTICE RATES REINED IN (see end of story)

Art Credit: illustration: LISA HANEY/NEWSCOM

**LOAD-DATE:** September 14, 2006

**Ohio Medical Malpractice Insurance  
Physicians & Surgeons Rate Changes for the Top Five Insurers**

Company	2005 Direct Written Premium	2005 Market Share	2000 Rate Change	2001 Rate Change	2002 Rate Change	2003 Rate Change	2004 Rate Change	2005 Rate Change	2006 Rate Change
The Medical Assurance Company	124,001,669	22.7%	9.6%	30.0%	43.6%	19.3%	8.6%	1.7%	0.0%
The Medical Protective Company	95,625,943	17.5%	8.4%	6.3%	21.7%	27.5%	40.0%	10.2%	-5.0%
OHIC Insurance Company	39,889,825	7.3%	24.3%	28.0%	24.2%	17.0%	17.9%	12.9%	2.3%
American Physicians Assurance Corporation	35,491,844	6.5%	14.9%	29.5%	29.0%	87.6%	9.1%	2.5%	-3.6%
The Doctors Company, An Interinsurance Exchange	31,172,452	5.7%	8.4%	14.9%	49.2%	18.0%	10.0%	6.9%	
Total for Top Five Companies	326,181,733	59.8%	14.3%	20.5%	31.2%	27.4%	20.1%	6.7%	-1.7%
Total Ohio Industry	545,680,892	100.0%							
Cumulative Change for Top Five Companies			14.3%	37.7%	80.6%	130.2%	176.3%	194.7%	189.6%



## Ohio Report

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Information Pertinent to Legislative and State Department Activities Since 1906

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**Volume #75, Report #215, Article #06 --Wednesday, November 8, 2006**

[<< back](#)

### **MEDICAL MAL INSURANCE RATES FALL, ODI REPORTS**

Medical malpractice liability insurance rates have fallen an average of 1.7% over the course of the year, reversing a trend that had seen double-digit annual increases, the Ohio Department of Insurance announced Wednesday.

The overall rate reduction was enhanced with a new filing from American Physicians Assurance Corporation, which proposed a 3.6% reduction in its rates.

"Stabilizing measures taken in the last few years by the Ohio Department of Insurance and the Ohio legislature to reverse Ohio's medical liability insurance crisis continue to show positive results," ODI Director Ann Womer Benjamin said. "We are still closely monitoring the market and rates to ensure Ohio's health care delivery system remains functional."

The department noted that Medical Protective Company earlier in the year requested, and receive approval for, a 5% rate reduction. ODI said the OHIC Insurance Company increased its rates by 2.3% after six years of double-digit increases.

The department credited a handful of actions - including capping certain damages on medial malpractice awards; increasing the collection of data and enhancing the rate review process - for helping to stabilize the market.

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17 South High Street - Suite 630, Columbus, Ohio 43215  
Phone: 1.614.221.1992 Email: [gongwer@gongwer-oh.com](mailto:gongwer@gongwer-oh.com)

1 of 1 DOCUMENT

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*The Insurance Information Source*  
Best's Insurance News

October 5, 2006 Thursday

**LENGTH:** 693 words

**HEADLINE:** New AMA Study Says Jury Award Caps Stem Losses

**BODY:**

WASHINGTON (BestWire) - A report by the American Medical Association claims that caps on medical-malpractice jury awards slow losses and keep doctors from quitting or moving to states with lower liability insurance premiums.

"Clearly, the body of research on the impacts of tort reform shows that caps have resulted in lower growth in medical liability losses in states that passed caps than in states that did not," states the report.

Citing previous studies and their own work using the AMA's Physician Masterfile, which it called "the sole national, annual source of physician supply," authors Carol K. Kane and David W. Emmons also say their data show "that noneconomic caps and direct tort reforms more generally have a positive effect on the number of physicians per capita in a state."

The report looked at the average impact of caps, accounting for the amount of the award limit, how different states apply the caps and whether there were exceptions for certain types of outcomes, such as permanent disability or death.

Citing data from the National Association of Insurance Commissioner, the AMA report said insurers in states with caps on noneconomic "pain and suffering" awards had losses 17% lower than those of insurers in other states. Earned premiums also were 6% lower. Losses in states where punitive damages weren't allowed were 16% lower than in states without such prohibitions; premiums earned were 8% lower than in state that did allow punitive damages.

The report also examined the phenomenon of doctors moving to other states in response to premium increases and found that caps and other medical tort reforms increased the number of physicians by 2.4%, compared with states without caps or tort reforms. Emergency physicians, one of several high-risk specialties, increased by 11.5% in states with caps, the report said.

The nation's largest physicians lobby long has pushed for caps on malpractice awards. The AMA says 21 states are in a medical-malpractice "crisis," with rising insurance premiums threatening to drive physicians out of their home states or out of the medical profession altogether. The AMA blames jury awards for rising premiums.

## New AMA Study Says Jury Award Caps Stem Losses Best's Insurance New

In June, the AMA and several major insurance trade groups -- the American Insurance Association, America's Health Insurance Plans, the Blue Cross Blue Shield Association, the National Association of Health Underwriters, the Physician Insurers Association of America and the Property Casualty Insurers Association of America -- banded together to create the Health Coalition on Liability and Access, an organization formed to lobby Congress to enact a nationwide cap on medical-malpractice lawsuit awards (BestWire, June 13, 2006).

The findings in the AMA's report, however, are at odds with the findings of the nonpartisan Government Accountability Office, Congress's investigative arm, which examined the cause of rising liability insurance premiums during the recent hard market and found that the blame couldn't be placed on any one factor, such as jury awards or poorly performing investments (BestWire, July 29, 2003).

A report in the May/June 2006 issue of the journal Health Affairs claimed there may not even be a medical-liability crisis at all. "The conventional wisdom is that malpractice premiums have steadily risen and now constitute a crisis for medical practice. The best available data suggest otherwise," said study authors Marc A. Rodwin, Hak J. Chang and Jeffrey Clausen. The Health Affairs study, also using AMA data, found premiums rose until 1986, then declined until 1996 and rose again; they were, however, lower in 2000 than in 1986. Spending on insurance premiums as a share of a doctor's practice expenses, meanwhile, fell from 1986 to 2000, the study said.

Last month, the Physician Insurers Association of America, citing its own analysis of a 48-company sample of data from medical-malpractice writers, said medical-malpractice insurers in 2005 turned a profit for only the second time in the past eight years (BestWire, Sept, 15, 2006).

(By Chris Grier, Washington correspondent, BestWeek: Chris.Grier@ambest.com)

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**THE TEXAS SUCCESS  
IN BRIEF  
TEXAS PROVES THAT MEDICAL LIABILITY REFORM WORKS**

*When the medical liability system reaches the crisis stage, as it did in Texas, patients suffer the most because they lose access to needed medical care.*

- At the height of the crisis, Texas ranked 48<sup>th</sup> out of 50 states in terms of physician manpower.<sup>1</sup> Texas averaged just 152 doctors per 100,000 people, compared to a national average of 196.<sup>2</sup>
- In the midst of the Texas crisis, two out of every three Texas counties had no obstetrician. Half of all counties had no pediatrician.<sup>3</sup>

*Lawsuits doubled as trial lawyers flooded Texas courts with medical liability claims.*

- Between 1996 and 2000, the number of lawsuits filed per 100 Texas physicians doubled.<sup>4</sup> By 2000, about one out of every three doctors practicing in Texas could expect to be sued in a given year.<sup>5</sup>
- Between 1995 and 2002, medical liability claims against Texas doctors were being filed at twice the national average.<sup>6</sup>
- Most claims had little or no merit. A 2001 Texas Medical Association study found that six out of seven lawsuits ended with no finding of fault against the doctor.<sup>7</sup>

*Soaring awards for non-economic damages lead to soaring liability premiums*

- In 1991, non-economic damages accounted for just 35 percent of total jury verdicts.<sup>8</sup> By 1999, non-economic damages had soared to a whopping 65 percent of total awards.<sup>9</sup>
- By 1999, the average non-economic damage award for a Texas medical liability case hit \$1.3 million – four times the amount a decade earlier.<sup>10</sup>

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<sup>1</sup> Texas Tech Law Review

<sup>2</sup> Texas Tech Law Review

<sup>3</sup> Texas Alliance for Patient Access (TAPA)

<sup>4</sup> Texas Department of Insurance (TDI)

<sup>5</sup> TDI

<sup>6</sup> Texas Organization of Rural and Community Hospitals (TORCH)

<sup>7</sup> TAPA

<sup>8</sup> Texas Tech Law Review

<sup>9</sup> Texas Tech Law Review

<sup>10</sup> TAPA



## A SUCCESSFUL MODEL FOR MEDICAL LIABILITY REFORM

### *How Texas Fixed Its Medical Liability Crisis And Helped Patients Get The Care They Need*

#### **THE MEDICAL LIABILITY CRISIS IN TEXAS**

In the late 1990s, Texas faced a serious medical liability crisis, much like the one that is compromising access to health care across much of the United States today.

Trial lawyers were filing lawsuit in record numbers. Jury verdicts began escalating, propelled by huge awards for non-economic damages. Medical liability insurance premiums increased rapidly, with many insurers fleeing the state. Worst of all, patients were suffering serious problems getting access to the care they needed, when they needed it.

#### ***Patients Suffer From Lack Of Access To Needed Care***

When the medical liability system reaches the crisis stage, as it did in Texas, patients suffer the most because they begin to lose access to needed medical care. Practicing doctors decide to leave the state; new doctors decide to practice elsewhere.

At the height of the crisis, Texas ranked 48<sup>th</sup> out of 50 states in terms of physician manpower.<sup>1</sup> Texas averaged just 152 doctors per 100,000 people, compared to a national average of 196.<sup>2</sup>

But those numbers don't tell the full story. Physicians who provide highly-specialized care or perform high-risk procedures are often the first targets of medical liability lawsuits. Therefore, the most vulnerable patients often experience the hardest time getting the care they need when they need it.

In the midst of the Texas crisis, two out of every three Texas counties had no obstetrician. Half of all counties had no pediatrician.<sup>3</sup>

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<sup>1</sup> Texas Tech Law Review

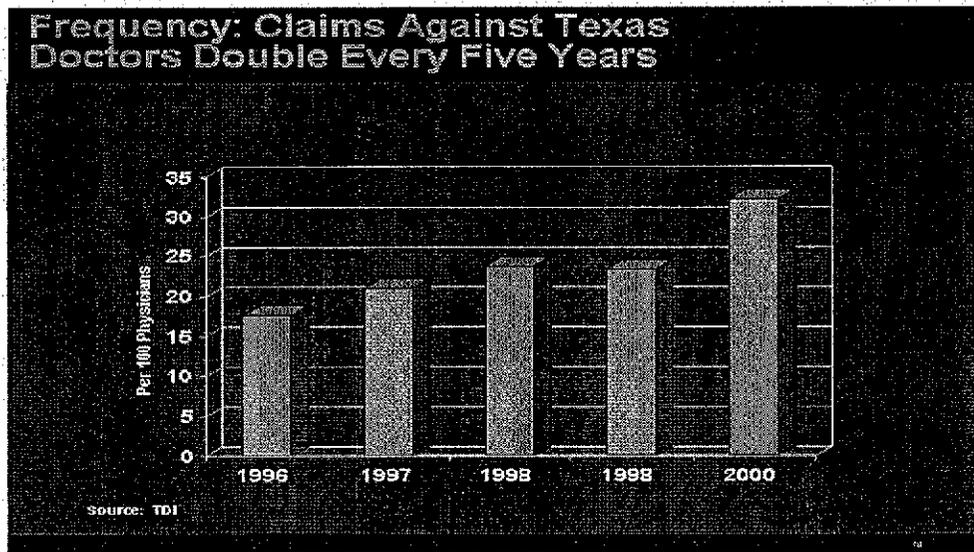
<sup>2</sup> Texas Tech Law Review

<sup>3</sup> Texas Alliance For Patient Access (TAPA) website; <http://www.tapa.info/>

How did Texas get here? The source of the crisis can be traced back to a medical liability system that put the interests of lawyers ahead of the interests of patients and their doctors.

### *Lawsuits Double In Just Five Years*

During the mid 1990s, trial lawyers began flooding Texas courts with medical liability claims. Between 1996 and 2000, the number of lawsuits filed per 100 Texas physicians doubled.<sup>4</sup>



By 2000, about one out of every three doctors practicing in Texas could expect to be sued in a given year.<sup>5</sup> Between 1995 and 2002, medical liability claims against Texas doctors were being filed at twice the national average.<sup>6</sup>

Yet most of the claims had little or no merit. According to a 2001 study by the Texas Medical Association, six out of seven lawsuits filed against doctors in Texas ended with no finding of fault against the doctor.<sup>7</sup>

### *Soaring Awards for Non-Economic Damages*

One of the major factors driving the medical liability crisis in Texas was a huge increase in awards for non-economic damages, sometimes referred to as “pain and suffering.”

<sup>4</sup> Texas Department of Insurance (TDI)

<sup>5</sup> TDI

<sup>6</sup> Texas Organization of Rural and Community Hospitals (TORCH)

<sup>7</sup> TAPA

In 1991, non-economic damages accounted for just 35 percent of total jury verdicts.<sup>8</sup> But by 1999, non-economic damages had soared to a whopping 65 percent of total awards.<sup>9</sup> In fact, by 1999, the average non-economic damage award for a medical liability case in Texas reached \$1.3 million – four times the amount a decade earlier.<sup>10</sup>

### *Medical Liability Premiums Skyrocket*

The rising tide of lawsuits combined with soaring jury awards had a predictable result: medical liability premiums began to skyrocket – if a doctor was lucky enough to find insurance at all.

- Physicians experienced insurance premium increases of between 22.5 percent and 128 percent in about four years.<sup>11</sup>
- Between 2000 and 2003, the average medical liability premium for a hospital more than doubled to \$870,000 per year.<sup>12</sup>

Many insurance companies decided that the medical liability crisis was so out of control that Texas was no longer a safe state in which to do business. Many insurance companies either went out of business or fled the state altogether.

As the crisis deepened, the number of companies providing medical liability insurance to Texas doctors fell from 17 to 4, while the number offering to insure nursing homes fell to just 1.<sup>13</sup> Insurance industry profit slumped to negative 56.6 percent.<sup>14</sup> In the five years from 1996 to 2000, the cumulative losses to Texas medical liability insurers amounted to over \$432 million.<sup>15</sup>

Soaring premiums put increased financial pressure on physicians. Two-thirds of Texas doctors reported they had to obtain bank loans, tap their retirement accounts or take a cut in salary to keep their practices going.<sup>16</sup> Many were simply unable to afford the new rates; an astounding 6,500 doctors were forced to practice without any liability coverage at all.<sup>17</sup>

In an independent study, the Texas Department of Insurance Analysis placed the blame for rising rates squarely rising lawsuits and jury awards: “Underwriting losses are the major factor affecting rates, not insurance company investment losses.”<sup>18</sup>

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<sup>8</sup> Texas Tech Law Review

<sup>9</sup> Texas Tech Law Review

<sup>10</sup> TAPA

<sup>11</sup> Texas Tech Law Review

<sup>12</sup> Texas Tech Law Review

<sup>13</sup> Texas Tech Law Review

<sup>14</sup> Texas Tech Law Review

<sup>15</sup> TDI

<sup>16</sup> TAPA

<sup>17</sup> Texas Tech Law Review

<sup>18</sup> Texas Tech Law Review

## **THE SOLUTION**

In 2003, Texas Governor Rick Perry and the Texas State Legislature took action to stem the medical liability crisis. On June 11, 2003, Governor Perry signed House Bill 4. When the legislation was challenged in court by the trial bar, Texas voters responded by passing Proposition 12, a constitutional amendment that implemented the bill's major reforms.

The most important reforms included:

- A Cap on Non-economic Damages
  - \$250,000 for all physicians per claimant
  - \$250,000 for hospital system
  - \$250,000 for a second hospital system
  - \$750,000 maximum non-economic award from all parties
- Periodic Payments for Awards Greater Than \$100,000
- Protections for Emergency Room Care Providers
- Expert Witness Reforms To Curb Frivolous Lawsuits

## **THE RESULTS ARE IN: MEDICAL LIABILITY REFORM WORKS**

The benefits of medical liability reform were immediate and dramatic. "Passage of a \$250,000 cap on non-economic damages has [been] shown to reduce medical liability insurance premiums and to keep good doctors from leaving our state, many of whom provide on-call backup to our emergency departments," said Dr. Angela Gardner of Plano, TX.<sup>19</sup>

The facts demonstrate clearly and convincingly that medical liability reform – including a \$250,000 cap on non-economic damages – can help improve access to health care for patients, reduce runaway insurance premiums, and create a stable, predictable liability system.

### ***Improved Access To Healthcare For Patients***

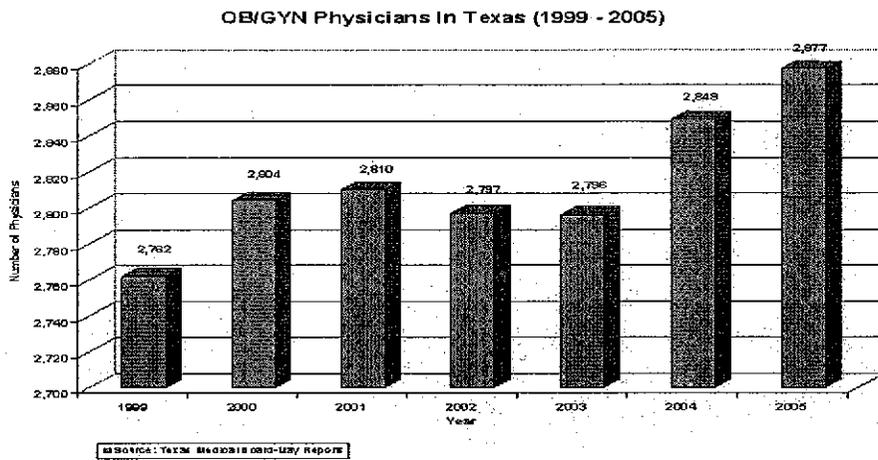
Since 2003, the year Texas adopted medical liability reform, 3,000 new physicians have moved to Texas.<sup>20</sup> The most vulnerable patients have benefiting the most from medical

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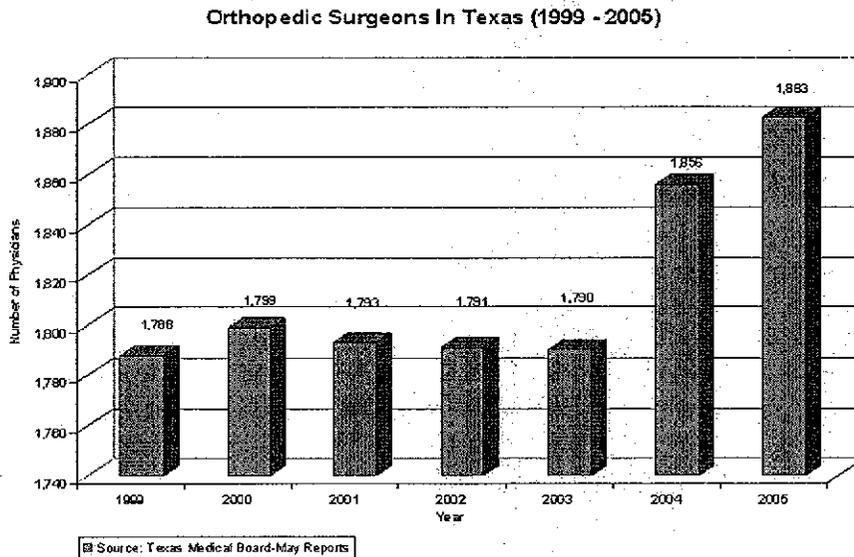
<sup>19</sup> TAPA

<sup>20</sup> Texas Medical Board

liability reform. Since the reforms were adopted, Texas has added 81 new obstetricians, compared to a net loss of 14 in the three years prior to reform.<sup>21</sup>



An additional 93 orthopedic surgeons began practicing in Texas since medical liability reform passed.<sup>22</sup>



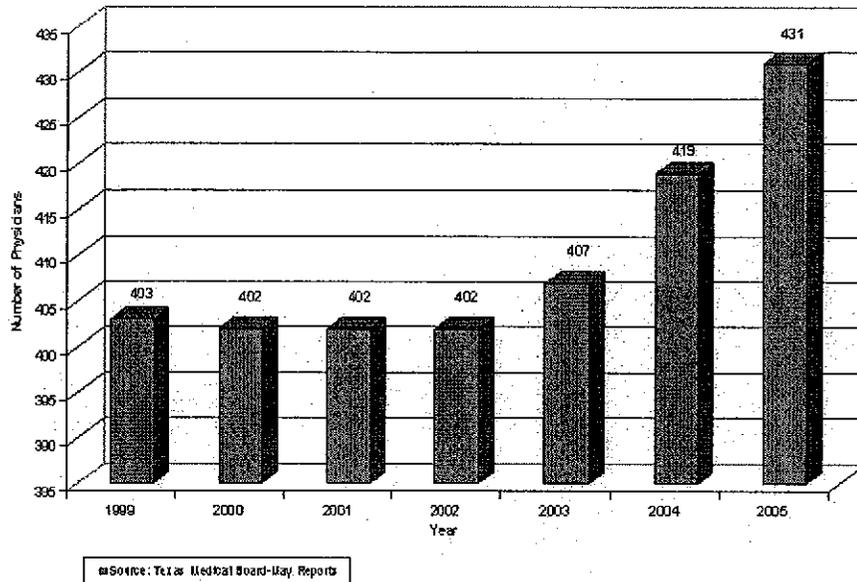
Texas also added an additional 210 new emergency room doctors since 2003 and 24 new neurosurgeons.<sup>23</sup>

<sup>21</sup> Texas Medical Board

<sup>22</sup> Texas Medical Board

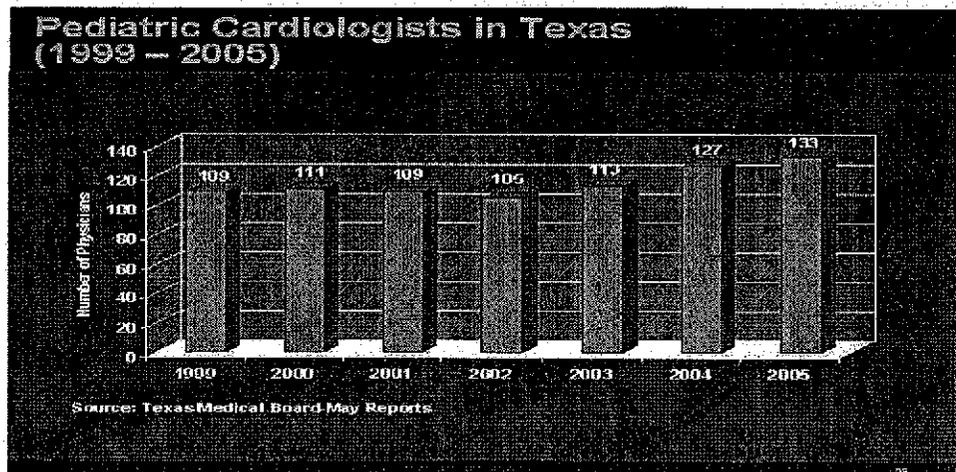
<sup>23</sup> Texas Medical Board

Neurosurgeons In Texas (1999 - 2005)



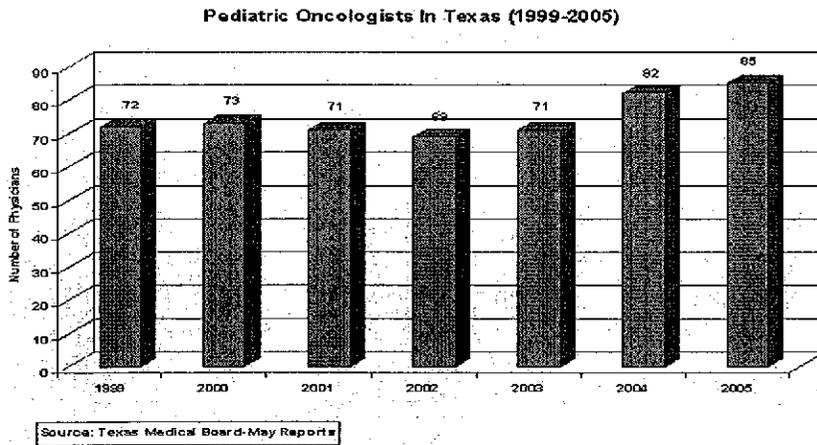
Medical liability reform has also proven to be the right decision for children. Access to pediatric care, especially for children requiring high-risk specialty care, has improved dramatically.

From a low of 105 in 2002, the number of pediatric cardiologists has increased to 133 as of 2005.<sup>24</sup>

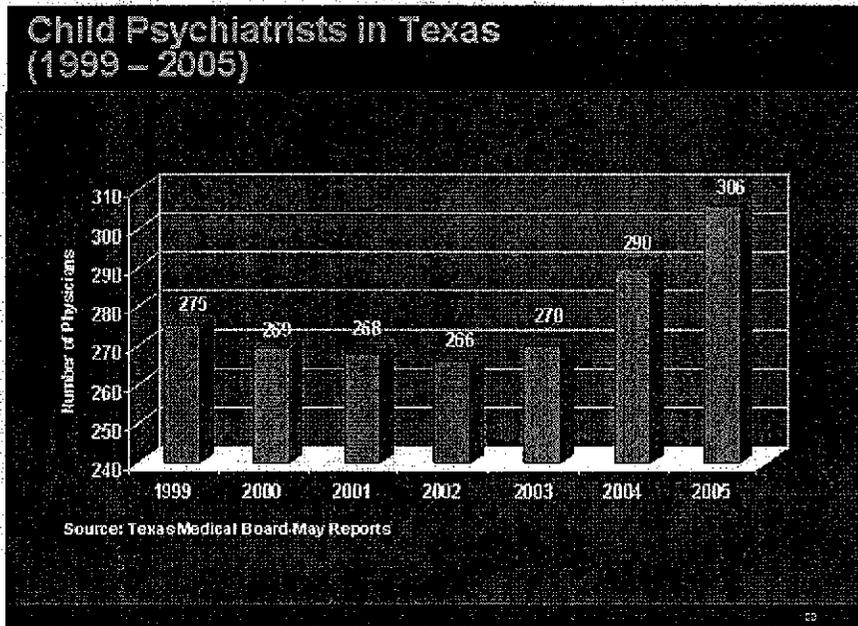


<sup>24</sup> Texas Medical Board

Fourteen new pediatric oncologists began treating Texas children between 2003 and 2005.<sup>25</sup>



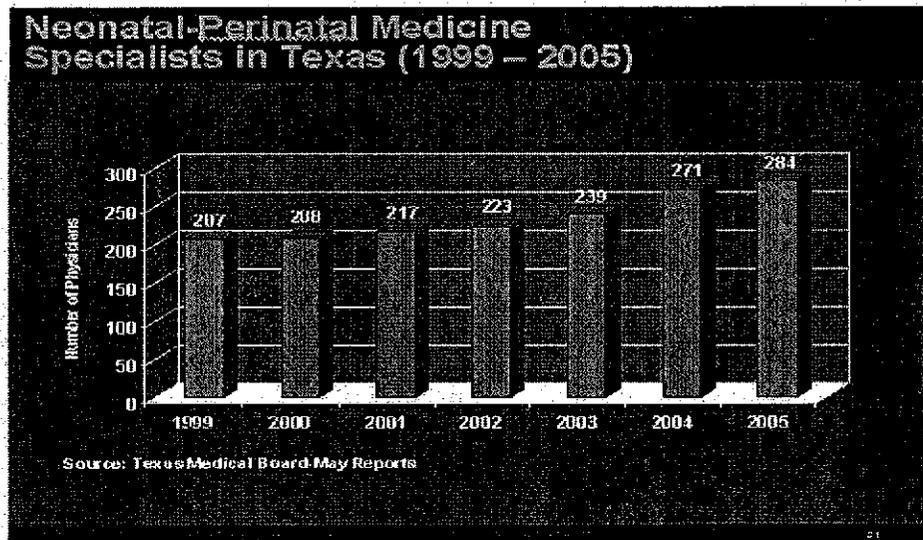
The number of child psychiatrists has increased from 266 in 2002 to 306 in 2005.<sup>26</sup>



<sup>25</sup> Texas Medical Board

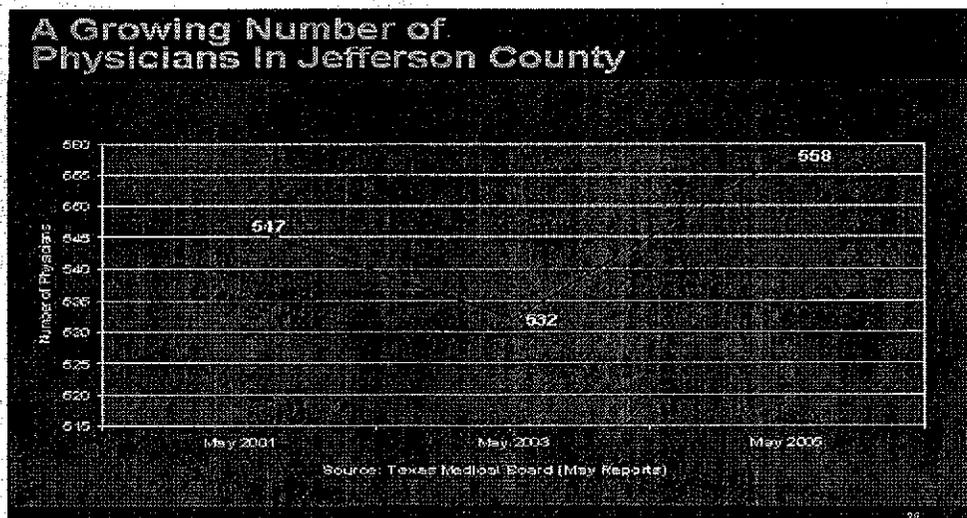
<sup>26</sup> Texas Medical Board

And the number of Neonatal-Perinatal specialists has grown from 207 in 1999 to 284 in 2005.<sup>27</sup>



Patients across Texas have benefited from improved access to medical care as a result of medical liability reform. Harris County, the state's most populous, added 762 physicians since medical liability reform was adopted, including 65 emergency room physicians and eight neonatologists.<sup>28</sup>

Between May 2003 and May 2005, the number of physicians in Jefferson County rose from 532 to 558.<sup>29</sup>

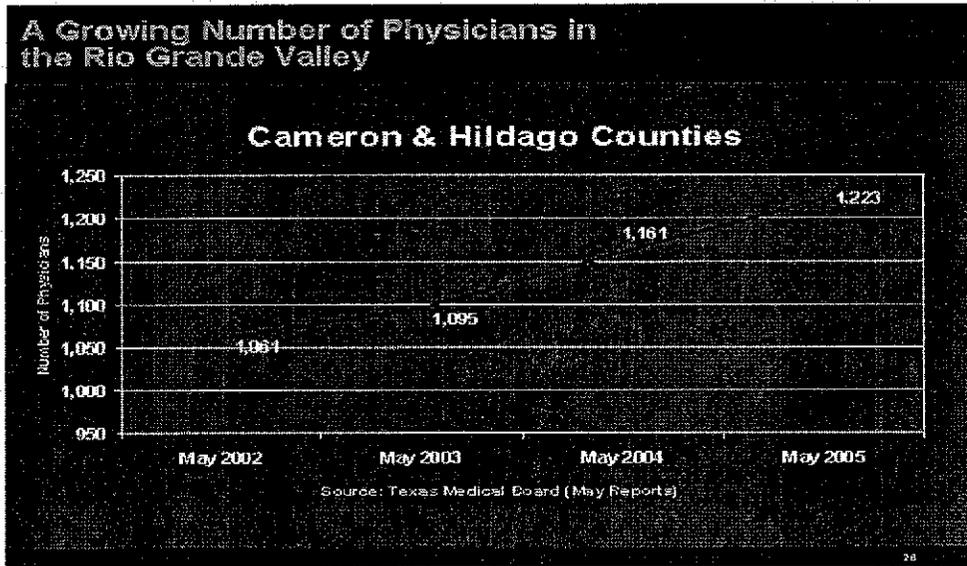


<sup>27</sup> Texas Medical Board

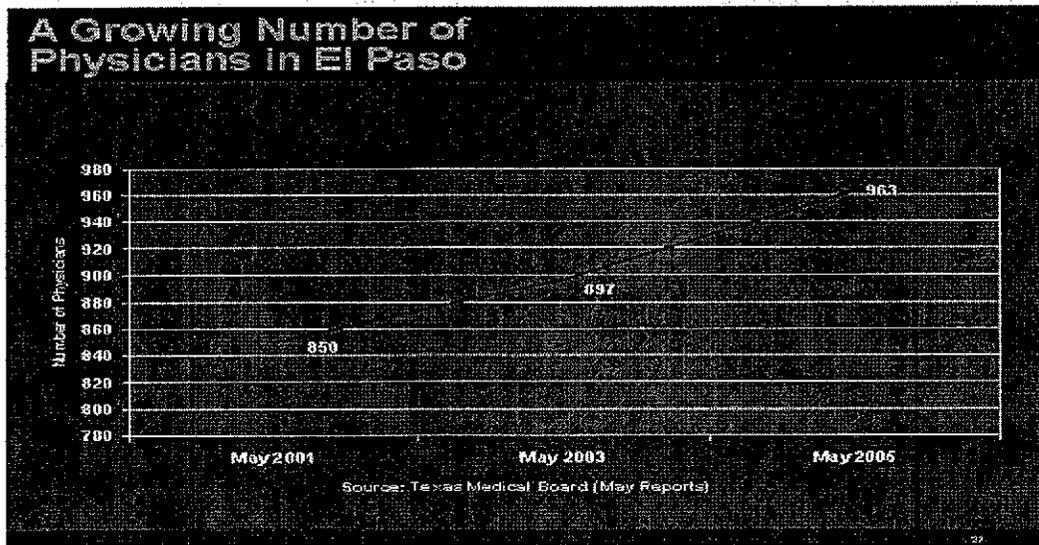
<sup>28</sup> TAPA

<sup>29</sup> Texas Medical Board

In the Rio Grande Valley, the number of physicians rose from 1,061 in May 2002 to 1,223 in May 2005.<sup>30</sup>



In El Paso, 113 new physicians began practicing, increasing the number of doctors from 850 in May 2001 to 963 in May 2005.<sup>31</sup>



<sup>30</sup> Texas Medical Board

<sup>31</sup> Texas Medical Board

In the 18 months prior to the passage of medical liability reform, Beaumont lost 12 doctors. Since reform passed, Beaumont has gained 26 physicians, including 18 ER doctors.<sup>32</sup>

### ***Lower Premiums***

In 2003, medical liability rates increased 54 percent.<sup>33</sup> Since medical liability reform was passed, insurance companies have adopted 12 significant rate reductions.

This year's rate cuts by the five major Texas insurers alone will save doctors an estimated \$49 million in liability premiums.<sup>34</sup>

- In March 2006, the Doctors Company announced an 18 percent rate cut, on top of the 14 percent reduction in 2005.<sup>35</sup>
- In February 2006, Medical Protective announced a 13 percent rate cut, their third within 11 months.<sup>36</sup>
- In August 2005, American Physicians Insurance Exchange (APIE) announced their second rate cut in seven months, this one a 13 percent reduction.<sup>37</sup>
- In March 2005, the Joint Underwriting Association announced a 10 percent rate reduction, after calling for a 36 percent rate hike before medical liability reform was passed.<sup>38</sup>

In May 2005, Texas became the only state to be removed from the American Medical Association's list of crisis states.<sup>39</sup> In its most recent report, the American College of Emergency Physicians called Texas "the paragon for medical liability reform" because of its "\$250,000 cap on non-economic damages." Texas received an A+ on its Medical Liability Environment in the latest National Report Card on the State of Emergency Medicine.<sup>40</sup>

***The bottom line: Texas proves that medical liability reform works.***

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<sup>32</sup> TAPA

<sup>33</sup> TAPA

<sup>34</sup> TAPA

<sup>35</sup> Texas Medical Association

<sup>36</sup> Texas Medical Association

<sup>37</sup> Texas Medical Association

<sup>38</sup> Texas Medical Association

<sup>39</sup> Texas Medical Association

<sup>40</sup> TAPA