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THE WHITE HOUSE OFFICE OF CABINET AFFAIRS

STAFFING MEMORANDUM

Date: December 11, 1990

Due by: _____

Subject: Domestic Policy Council Meeting WITH THE PRESIDENT, Thursday, December 13, 1990 at 2:00 P.M. in the Cabinet Room (FOR PRINCIPALS ONLY).

From: Richard W. Porter
Executive Secretary, Domestic Policy Council

	Action	FYI		Action	FYI
ALL CABINET MEMBERS	☐	☐	CIA	☒	☐
Vice President	☒	☐	CEA	☒	☐
Agriculture	☒	☐	CEQ	☐	☐
Commerce	☒	☐	EPA	☒	☐
Defense	☒	☐	GSA	☐	☐
Education	☒	☐	NASA	☐	☐
Energy	☒	☐	National Science Foundation	☐	☐
HHS	☒	☐	ONDCP	☒	☐
HUD	☒	☐	OPM	☐	☐
Interior	☒	☐	OSTP	☒	☐
Justice	☒	☐	SBA	☒	☐
Labor	☒	☐	UN	☐	☐
OMB	☒	☐	Cicconi (For WH Staffing)	☒	☐
State	☒	☐	_____	☐	☐
Transportation	☒	☐	_____	☐	☐
Treasury	☒	☐	_____	☐	☐
USTR	☒	☐	_____	☐	☐
Veterans	☒	☐	_____	☐	☐

COMMENTS: The Domestic Policy Council will hold a meeting WITH THE PRESIDENT on Thursday, December 13, 1990 from 2:00 to 3:00 P.M. in the Cabinet Room to discuss the third National Drug Control Strategy (Strategy III).

Attached is an agenda for the meeting and a revised version of the options paper entitled, "The Third National Drug Control Strategy (Strategy III): Issues for Domestic Policy Council Consideration."

Please confirm your attendance with Honor Willson Ingersoll (456-2800) by noon, Wednesday, December 12.

THE WHITE HOUSE
WASHINGTON

December 11, 1990

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: RICHARD W. PORTER *RWP*
Executive Secretary

SUBJECT: Domestic Policy Council Meeting with the
President, Thursday, December 13, 1990 at 2:00
P.M. in the Cabinet Room

The Domestic Policy Council will hold a meeting with the President for principals only on Thursday, December 13, 1990 from 2:00 to 3:00 P.M. in the Cabinet Room. The purpose of this meeting is to discuss the third National Drug Control Strategy. John Walters, Acting Director of the Office of National Drug Control Policy, will make the presentation.

Attached is an agenda for the meeting and a revised version of the options paper entitled, "The Third National Drug Control Strategy (Strategy III): Issues for Domestic Policy Council Consideration." The paper has been revised to reflect the discussion in Monday's DPC meeting. You have also previously received a full draft text of Strategy III.

Please confirm your attendance with Honor Willson Ingersoll (456-2800) by noon, Wednesday, December 12.

Attachment

THE WHITE HOUSE
WASHINGTON

MEETING OF THE DOMESTIC POLICY COUNCIL
WITH THE PRESIDENT

2:00 P.M., Thursday, December 13, 1990
The Cabinet Room

Third National Drug Control Strategy

AGENDA

1. Opening.....The President
(1 minute)
2. Introduction.....Attorney General Thornburgh
(3 minutes)
3. Presentation.....John Walters, Acting Director
Ofc. of National Drug Control
Policy (10 minutes)
4. Discussion.....All Participants
(45 minutes)
5. Conclusion.....Attorney General Thornburgh
(2 minutes)

CLOSE HOLD

December 11, 1990

THE THIRD NATIONAL DRUG CONTROL STRATEGY (STRATEGY III): ISSUES FOR DOMESTIC POLICY COUNCIL CONSIDERATION -- REVISED

Background:

The Anti-Drug Abuse Act of 1988 (P.L. 100-690) requires that a National Drug Control Strategy be transmitted to Congress not later than February 1 each year. Accordingly, the Office of National Drug Control Policy (ONDCP) has drafted for Domestic Policy Council consideration the third National Drug Control Strategy (Strategy III).

The President announced the first National Drug Control Strategy (Strategy I) on September 5, 1989. The second National Drug Control Strategy (Strategy II) was transmitted to Congress on January 25, 1990. Strategy III will be transmitted to Congress concurrently with the President's Fiscal Year 1992 Budget. (This schedule conforms to statutory requirements.)

Strategy III stays the course charted in Strategies I and II. It further refines the blueprint laid out in Strategy II with respect to the activities and responsibilities of Federal departments and agencies; specific initiatives to begin in this fiscal year; and the funding and legislation necessary to carry out the Administration's policy.

In summary, the approach laid out in the two previous Strategies seems to be the right one and seems to be working; none of the major policy directions in Strategies I and II is reversed in Strategy III.

The structure of Strategy III maintains that of Strategies I and II. Following the Introduction, seven chapters examine the "fronts" on which the drug war must continue to be waged: Criminal Justice; Drug Treatment; Education, Community Action, and the Workplace; International Initiatives; Border Interdiction and Security; Research; and Intelligence.

Several Appendices are included with the Strategy: High Intensity Drug Trafficking Areas (Appendix A); Resource Requirements (Appendix B); Management (Appendix C); and Recommended State Legislation (Appendix D).

Progress In the War on Drugs:

We are now turning the corner in the war on drugs. Cocaine, for example, is harder to find, more expensive, and less pure

today than it was one year ago. Drug use is down. The Federal government has provided unprecedented funding through State block grants for drug treatment, prevention, and State and local law enforcement.

Asset forfeiture collections have also been enhanced -- in FY90, collections increased 28 percent to \$460 million. An agreement between the Drug Enforcement Administration and Customs cross-designating an additional 1,000 Customs agents in the effort to investigate drug and money-laundering cases has been implemented. The U.S. signed the Document of Cartagena establishing drug control cooperation with Peru, Bolivia, and Colombia.

ONDCP released three "white papers" in 1990: 1) a paper on leading drug indicators, showing significant declines in drug use from 1988 to 1989; 2) a paper explaining how effective drug treatment works; and 3) a paper on State drug control policy and activity, including recommendations for State drug-free workplace statutes.

Working Group Consideration:

The DPC Working Group on Anti-Drug Policy reviewed early drafts of Strategy III. During Working Group consideration, numerous issues were addressed and resolved between ONDCP and the agencies. Budget levels in Strategy III (Appendix B) will be addressed in the FY92 Budget review process. The International chapter was discussed in the NSC process, and a declassified version of the International chapter is included in Strategy III.

Highlights of Strategy III:

Strategy III includes some follow-up on three major policy issues addressed in previous Strategies:

1. Tying Federal highway funds to State drivers' license revocation laws. Strategy I urged States to adopt laws revoking the drivers' licenses of convicted drug offenders. The President decided that the Administration would not propose to sanction Federal highway funds going to States that had not enacted such laws.

The FY91 Transportation appropriations bill included a provision that requires 5 percent of a State's Federal highway funds to be withheld if the State has not enacted a revocation law within two years. After four years, 10 percent of Federal highway funds will be withheld. States must revoke a driver's license for 6 months after a drug conviction. (This pertains to any drug conviction -- the offense does not have to be related to

driving.) The only exception for a State is to certify that it officially considered revocation laws and rejected them.

Strategy III does not further address this controversial issue.

2. High Intensity Drug Trafficking Areas. The law authorizes the designation of certain localities in the United States as high intensity drug trafficking areas. Strategy II designated New York City, Miami, Houston, Los Angeles, and the Southwest Border as high intensity drug trafficking areas.

In FY90, the five areas received \$25 million for use by Federal law enforcement agencies. The Administration requested \$50 million for FY91, but Congress appropriated \$82 million -- earmarking the additional \$32 million for direct State and local law enforcement funding assistance. Funding for designated high intensity drug trafficking areas was intended to be seed money to aid stepped up local efforts by an enhanced Federal presence.

Strategy III (Appendix A, p. 188) maintains the designation of the five areas as high intensity drug trafficking areas. ONDCP is required to report to Congress by March 1, 1991, on the effectiveness of and need for such designations.

The appropriate FY92 funding level for high intensity drug trafficking areas as well as the proper funding mechanism (i.e., whether to provide funding through ONDCP or through normal budget channels at the Departments of Treasury and Justice) are questions expected to be addressed in the FY92 budget review process.

3. National Drug Intelligence Center. A proposal for the National Drug Intelligence Center (NDIC) was highlighted as an Administration priority in previous Strategies. Congress rejected the Administration's proposal and instead included \$10 million in the FY91 Defense appropriations bill for a National Drug Intelligence Center to be located in Pennsylvania and operated by the Department of Defense. This was done by Rep. John Murtha (D-Pennsylvania). It is not clear that the Department of Defense has legal authority to operate such a Center. No work has begun in setting up the NDIC; the Department of Defense and ONDCP are still studying the statutory language and the conference report. Some members of Congress seem to disapprove of the \$10 million NDIC appropriation and may alter the law in the next Congress.

Moreover, in the Commerce, State, Justice appropriation bill for FY91, Congress directed that no funds be spent by the Justice Department for any activity called a National Drug Intelligence Center, yet the involvement of Justice is essential.

As the Administration seeks to resolve with Congress the question of creating a National Drug Intelligence Center, Strategy III (p. 178) calls for continued improvements in our capability to produce strategic intelligence on drug trafficking organizations. The Attorney General will create and chair a Law Enforcement Drug Intelligence Committee (LEDIC) to coordinate the development of drug intelligence collection. As one of its initial tasks, the LEDIC will explore alternate means to accomplish NDIC's primary missions, such as enhancements to or expansions of existing drug intelligence entities.

Major Policy Issues Requiring DPC Consideration:

The Working Group on Anti-Drug Policy has identified the following issues for DPC consideration. (Budgetary implications related to the following issues will be decided in the FY92 budget review process and are not addressed here.)

1. Treatment capacity. The major emphasis in Strategy III is the commitment to treatment. HHS now estimates 6 million Americans need and could benefit from drug treatment. This constitutes an increase of 2 million persons over earlier Administration estimates, due to efforts to count certain populations (e.g., prisoners, the homeless) not previously included in the total.

In any given year, about half of this group -- or 3 million people -- will be induced into treatment. Because the number of Americans using drugs continues to decline, the 3 million persons who could be induced into treatment is expected to drop to 2.5 million in the next few years. The current treatment system (public and private) can absorb up to 1.7 million people.

HHS data also show that while the number of treatment slots in certain urban areas is inadequate, treatment capacity in other geographical areas goes unused. Thus, despite the perception of a national shortage of treatment capacity in all regions, only 80 percent of the slots are used. This geographical mismatch between the supply of and demand for treatment slots is but one example of how the way treatment is currently funded fails to reach everyone in need. The lack of State treatment action plans, well-trained staff, and new sites for program expansions has also frustrated plans for growth in treatment.

Strategy III (p. 65) proposes to expand or redirect treatment capacity so that by 1994 treatment is available to all those who need treatment and could benefit from it (i.e., 2.5 million people). Strategy III proposes to increase the size of the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant to achieve this goal. Depending on budgetary decisions made in the FY92 budget review process, this may not be possible.

However, a variety of other funding alternatives are possible, such as (among others): 1) altering the allocation formula to direct treatment funds to States with greater need or to greater areas of need within States; and 2) targeting discretionary grants to areas with particular treatment needs.

It must be emphasized that any approach chosen (such as those mentioned above) will entail costs -- both political and fiscal. For instance, altering the allocation formula to direct treatment funds to States with greater need involves shifting funds from rural, primarily western States to more urban States. Targeting may involve recreating categorical programs that at the Reagan Administration's request were combined to form the block grant in 1981.

To better analyze and rationalize the implications of a decision to expand treatment, the Director of OMB has agreed to convene the affected agencies (HHS, ONDCP, OMB, OPD) to explore options.

Question: Should Strategy III have as one of its primary objectives the expansion of treatment availability to all those who need treatment and could benefit from it -- by 1994 (provided offsets, if necessary, can be found to support the proposal)?

Pros:

- o A plan to make treatment available within three years to all those who could benefit visibly demonstrates the Administration's commitment to treatment.
- o Some Democrats have attempted to criticize the Administration in previous Strategies for emphasizing law enforcement at the expense of treatment.

Cons:

- o The goal of making treatment available to all those who could benefit by 1994 may be unachievable for both programmatic and budgetary reasons. Five years instead of three may be more reasonable.
- o A Federal commitment to make treatment available to all who could benefit is largely meaningless because States will have to bear the larger responsibility in funding treatment expansion.
- o The funding alternatives mentioned above, such as changing the allocation formula for the block grant, might have political disadvantages. Intense Congressional opposition, especially in the Senate, can be expected to any proposal that would reduce block grant funds going to rural States or

that would direct new funds to populous States.

2. Numerical objectives. The law requires two-year and ten-year numerical goals in each Strategy. Strategy I first laid out a set of nine quantified goals that were subsequently revised in Strategy II. Most of the goals are based on National Household Survey data from the National Institute on Drug Abuse (NIDA) and are directly related to drug use. Various data indicate some success in the drug war (cocaine prices and purity, cocaine-related deaths, etc.) and many of the two-year goals specified in previous Strategies have already been met.

Strategy III (p. 4) again revises the two-year and ten-year numerical objectives, making them more ambitious in light of recent progress in the war on drugs. For example, Strategy III sets a goal of a 20 percent reduction (from the 1988 level) for current overall drug use by 1993 and a 60 percent reduction by 2001. Some of the goals are even more ambitious: Strategy III aims at a 60 percent reduction (from the 1988 level) in the number of adolescents reporting past month cocaine use by 1993 and a 75 percent reduction by 2001.

Question: Does the DPC approve the more ambitious numerical two- and ten-year objectives included in Strategy III?

Pros:

- o More ambitious goals highlight that progress in the war on drugs is being made.
- o Unless we revise some of the goals, we will establish goals that are below what we have already achieved.
- o Holding ourselves to more stringent goals is consistent with the accountability theme that pervades other Administration policies, such as the National Education Goals.
- o The Administration risks looking insincere if it maintains that progress is being made, but insists on a relatively less stringent set of goals for itself.

Cons:

- o Reductions in drug use indicators as measured by the Household Survey might be reflecting the hardening of social attitudes; respondents could be simply less likely to admit drug use than they were in past surveys.
- o After initial precipitous reductions in reported drug use, subsequent marginal reductions become much more difficult to achieve.

3. National standards for drug testing labs: Drug testing in the workplace is becoming more and more a common practice. In fact, a growing number of employers have begun to institute testing for broader categories of employees. Public support for drug testing programs depends in large part on high standards of accuracy of the tests. False-positive results from any single poor quality lab can endanger the credibility of drug testing programs generally.

Strategy III (p. 106) calls for the development of national drug testing legislation for lab certification only, thus separating the narrower question of lab certification from the broad range of employer needs and employee rights. Strategy III otherwise maintains current policy of encouraging States to adopt their own drug-free workplace policies.

Question: Should Strategy III call for development of national drug testing legislation for lab certification that would preempt State legislation?

Pros:

- o Preemption of State law for certification of drug testing laboratories would not be as significant a departure from general Administration policy as would overall national drug testing legislation.
- o National legislation will promote consistently high-quality drug testing programs, thus minimizing the credibility damage resulting from a few isolated labs producing poor results.
- o There are problems with varying degrees of quality among laboratories. National legislation would remove the problem of conflicting quality standards for companies operating in more than one State.
- o Business groups would likely support legislation providing consistency across State lines.
- o HHS currently certifies some medical laboratories for certain purposes. The approach would be consistent with 1988 legislation regarding clinical laboratories.

Cons:

- o National drug testing legislation would preempt State legislation and private testing practices, thus running counter to the principle of Federalism and opening the door

to preemption in other areas. Administration policy has generally been not to preempt State laws.

- o States are better suited to judge what particular adjustments must be made to address the needs of their populations.
- o "Federalizing" drug testing legislation could make the Federal government liable to a new round of costly litigation.
- o ONDCP has already released a "white paper" recommending model State legislation for building a drug-free workforce.
- o Administration-sponsored legislation preempting States in the relatively narrow area of lab certification will give Congress an opportunity to expand the scope of the legislation and more broadly preempt State laws.

THE WHITE HOUSE

WASHINGTON

DOMESTIC POLICY COUNCIL

Wednesday, July 25, 1990

3:30 P.M.

Roosevelt Room

AGENDA

1. Low Income Opportunity Strategy

THE WHITE HOUSE OFFICE OF CABINET AFFAIRS STAFFING MEMORANDUM

Date: July 20, 1990

Due by: _____

Subject: Domestic Policy Council Meeting, Wednesday, July 25, 1990 from 3:30 to 4:30 PM in the Roosevelt Room (for PRINCIPALS ONLY).

From: Kenneth P. Yale, Executive Secretary
Domestic Policy Council

	Action	FYI		Action	FYI
ALL CABINET MEMBERS	☐	☐	CIA	☐	☐
Vice President	☒	☐	CEA	☒	☐
Agriculture	☒	☐	CEQ	☐	☐
Commerce	☐	☐	EPA	☒	☐
Defense	☐	☐	GSA	☐	☐
Education	☒	☐	NASA	☐	☐
Energy	☒	☐	National Science Foundation	☐	☐
HHS	☒	☐	ONDCP	☐	☐
HUD	☒	☐	OPM	☐	☐
Interior	☒	☐	OSTP	☒	☐
Justice	☒	☐	SBA	☐	☐
Labor	☒	☐	UN	☐	☐
OMB	☒	☐	Cicconi (For WH Staffing)	☒	☐
State	☐	☐	_____	☐	☐
Transportation	☐	☐	_____	☐	☐
Treasury	☒	☐	_____	☐	☐
USTR	☐	☐	_____	☐	☐
Veterans	☒	☐	_____	☐	☐

COMMENTS: The Domestic Policy Council will hold a meeting for PRINCIPALS ONLY on Wednesday, July 25, 1990 from 3:30 to 4:30 PM in the Roosevelt Room. The subject of this meeting is Low Income Opportunity Strategy. Attached are (1) an agenda and (2) a final draft options paper on the subject of Low Income. This paper is extremely sensitive in nature and should be treated as very close hold. Please refrain from making any additional copies.

Please inform Honor Willson (456-2800) by C.O.B. Tuesday, July 24, 1990 as to whether or not you plan to attend this meeting.

*7/20 accepted
to Caroline*

THE WHITE HOUSE

WASHINGTON

July 20, 1990

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: KENNETH P. YALE *Ky*
Executive Secretary

SUBJECT: Meeting of the Domestic Policy Council, Wednesday,
July 25, 1990 at 3:30 P.M. in the Roosevelt Room

The Domestic Policy Council will hold a meeting for principals only, on Wednesday, July 25, 1990 from 3:30 to 4:30 P.M. in the Roosevelt Room. The subject of this meeting is the Administration's Low Income Opportunity Strategy. Charles Kolb, Chairman of the Low Income Opportunity Board, will make the presentation.

Attached for your review prior to Wednesday's meeting is a final draft options paper on the low income opportunity strategy. It should be noted that this paper is sensitive in nature and should be treated as a close hold document. Please refrain from making any additional copies.

Please inform Honor Willson (456-2800) by C.O.B. Tuesday, July 24, as to whether or not you plan to attend this meeting.

Attachment

THE WHITE HOUSE
WASHINGTON

DOMESTIC POLICY COUNCIL

Wednesday, July 25, 1990

3:30 P.M.

Roosevelt Room

AGENDA

1. Low Income Opportunity Strategy

CLOSE HOLD

July 20, 1990

MEMORANDUM

SUBJECT: An Administration Low Income Opportunity Strategy

BACKGROUND:

Since July 1989, the Domestic Policy Council (DPC) has met seven times on the subject of low income opportunity. On September 14, 1989, the President approved a DPC memorandum in part directing the Low Income Opportunity Board (LIOB) to develop, within 90 days, the principles of a conservative anti-poverty agenda. The DPC then decided to ask the LIOB to take additional time to provide some original thinking on a broad, comprehensive low income opportunity strategy.

DPC interest in the issue has been extremely strong. The Attorney General and several other DPC members regard the low income discussions as related to current civil rights concerns. The first war on poverty was intimately linked with the civil rights movement in the 1960's. Political enfranchisement was supposed to go hand in hand with economic enfranchisement. The political goals of the civil rights movement were largely achieved, but since economic empowerment does not come from government handouts, the war on poverty essentially bogged down. Although it alleviated some of the worst symptoms of poverty, the war on poverty could not succeed in reducing poverty because it was based on a philosophy of redistributionism and promoted dependency.

It is time now for phase two of the war on poverty -- economic empowerment -- the logical next step for true civil rights enfranchisement. Economic empowerment comes from wealth expansion; a strong social fabric; and access to education, jobs, and opportunity. That is why a conservative war on poverty has every chance of succeeding where its predecessor failed. Our anti-poverty efforts must be redirected with that overarching principle in mind.

This paper outlines a comprehensive, long-term anti-poverty strategy for the Administration. It begins with a description of what an effective anti-poverty policy would achieve, presents the successes and failures of current anti-poverty efforts, provides a set of principles to guide future policy decisions, and

presents a set of strategic options for consideration. The DPC recommends an approach that builds on current efforts through enhanced targeting of resources and better integration of services to make government work better in promoting economic independence and self-sufficiency.

I. What would an effective anti-poverty strategy do?

The principal goal of an effective anti-poverty system should be to assist families in taking responsibility for their own lives and to provide economic empowerment for American families that enables them to participate fully in the mainstream of the economy. An effective welfare system consistent with this goal would operate not merely as a safety net, but rather as a trampoline. It would help the poor achieve the dignity and self-respect that flow from economic self-sufficiency, and it would function as a long-term safety net only for those unable to achieve self-sufficiency. The outcomes of such a system might include:

- o Low unemployment; few working poor. Those who are willing and able to work can find employment that does not leave their families poor.
- o Few disadvantaged children. All children receive good health care, attend well-functioning schools, and have a sense of being part of society and responsible to it.
- o Communities that work. Cities and neighborhoods are healthy, both economically and socially. Local institutions -- including schools, public service providers, and the health care and criminal justice systems -- operate effectively.
- o Families function effectively. Family members recognize and carry out their responsibilities to provide economic and personal support to each other; children receive support from both parents, even if those parents live apart.
- o Little welfare dependence. Public assistance mainly provides short-term aid to those who are poor and gives people the tools to escape poverty. But individuals who are unable to achieve economic self-sufficiency, such as the elderly or the permanently and severely disabled, have the resources necessary to live adequately.
- o Private sector efforts complement government efforts to reduce dependency and promote self-sufficiency. Many for-profit and nonprofit organizations, as well as individual citizens, work together to help disadvantaged Americans.

II. Where are we now?

A. Problems with current anti-poverty efforts.

Our present anti-poverty system often does not function effectively -- certainly not effectively enough to produce the outcomes described above. The focus of most existing programs has been to provide income supplements (either in cash or in-kind), not to foster economic self-sufficiency. Additionally, many non-working individuals often face disincentives to work. The current system of anti-poverty programs is fragmented, inefficient, and often includes disincentives to self-sufficiency. Programs are poorly coordinated; eligibility rules are occasionally conflicting, generally confusing, and not standardized.

B. The current face of poverty.

Poverty among children was sharply higher in the 1980s than in the previous decade. In 1988, almost one child in five lived in a poor family. This problem is closely related to the growth of single-parent families, who are less likely to work, often have only low-wage jobs, and cannot rely on a spouse for additional earnings. More than half of all poor children live in such families.

A significant portion of the poor actually work full-time but remain poor. Sixteen percent of all poor families have at least one full-time, year-round worker. Long-term poverty and long-term dependence on government assistance also continue. Poor people in some areas suffer from the breakdown of the entire range of social institutions, from family and schools, to the overcrowded criminal justice system.

C. Poverty in the midst of a growing economy.

Despite eight years of sustained economic growth, poverty rates have not fallen as rapidly as historical experience would have predicted. This is partially due to slower growth in the demand for less-skilled workers as well as to the changing composition of the poor, especially the growth in female-headed households. Slower labor force growth in the 1990s as the baby boom ages means that the greater challenge will not be to create jobs, but to assure that workers have the needed skills to fill the jobs available.

III. How do we get there from here?

The DPC proposes the following strategic principles to guide the development of the Administration's economic empowerment policies:

1. The government must maintain a healthy, growing economy. Economic growth has done more to reduce poverty and economic need over the past century than any specifically designed anti-poverty policy.
2. Employment should be the central objective of an economic empowerment strategy. Employment is the best way to reduce poverty and welfare dependence among families with an able-bodied, non-elderly adult. Getting a job -- even a low-skilled job -- provides work experience and encourages good work habits.
3. The design, implementation, and evaluation of the entire range of programs and policies that affect low income Americans should be better targeted and better coordinated. Coordination across Departments and levels of government is essential, so that schools, public assistance programs, the criminal justice system, drug abuse programs, the health care system, housing programs, and economic development policies all work together. Program coordination requires administrative leadership from Federal, State, and local officials. Given scarce resources, we also need to review whether existing programs are targeted on those who need them most. Thus, a national low income opportunity strategy is required, one that pays close attention to how programs work together.
4. Anti-poverty programs should enforce the mutual obligations and responsibilities of individuals and public institutions. Governments are responsible for operating schools that work, maintaining a healthy economy, preventing crime, and assisting those who find themselves in need. An individual should be expected to take advantage of available opportunities for education and employment, to obey the law, and to nurture his or her children so that they too can become responsible citizens. An effective anti-poverty system must acknowledge and enforce these obligations, and hold both institutions and individuals accountable.
5. Social programs and institutions should empower individuals and communities. Public programs should seek to give individuals greater control over their lives, enhancing personal autonomy and dignity. A strong emphasis on choice and responsibility can foster the values that are central to economic self-sufficiency.
6. Financing and decision-making need to be appropriately shared between local, State and Federal entities. Decisions that are more appropriately made by local and State communities should not be usurped by the Federal government. But the Federal government must hold State and local institutions accountable for effective delivery of services and programs, particularly those supported by Federal funds.

7. The private sector is an essential partner with government in economic empowerment efforts. Because of a shrinking pool of entry-level workers, employers will have incentives to invest in training low-skilled workers. These efforts need to be encouraged and the partnership between the public and private sectors strengthened, with each sector doing what it does best.

8. The public system of anti-poverty programs should encourage innovation and experimentation, particularly among State and local governments that want to design programs to fit their populations.

ISSUES FOR PRESIDENTIAL DECISION:

In outlining an Administration low income opportunity strategy, the DPC presents five issues for consideration: 1) articulating our current activities in terms of an overall high-profile strategy; 2) expanding the role of the Low Income Opportunity Board; 3) building on current innovative efforts; 4) analyzing the distributional effects of current programs; and 5) integrating services.

1. Through a high-profile effort, clearly articulate and announce the Administration's anti-poverty strategy, principles, and agenda. A "kinder, gentler America" must include a concern for the economic difficulties low income persons experience in trying to achieve the American dream. The Administration has already begun to address this concern through a series of initiatives from Head Start expansion and new literacy and job-training initiatives to new homeownership and housing strategies, from undertaking a comprehensive look at health care to developing a new agenda to end homelessness and articulating the National Education Goals. The public, however, is only dimly aware of many of these initiatives, and is certainly not aware of them as part of a comprehensive low income opportunity strategy.

Cabinet members will be charged with the responsibility of articulating the eight principles outlined above and focusing attention on current Administration anti-poverty efforts -- some new, some incremental. Wherever possible, the Administration's commitment should be made clear through specific, quantifiable goals, such as: the 90 percent high school graduation rate by the year 2000; a million new homeowners; ending homelessness in the 1990's; a half-million new minority and low income area entrepreneurs; and other appropriate goals as determined by the Cabinet Secretaries.

Pros:

- o Having a clearly defined rationale for a particular anti-poverty agenda makes it easier to oppose proposals the Administration thinks are misdirected.
- o A major Administration anti-poverty emphasis is consistent with other efforts to increase investment in America's future.
- o Polls consistently show that the public is very sympathetic to helping the poor but unsympathetic to welfare and welfare recipients. An economic empowerment strategy of promoting jobs and opportunity rather than welfare takes the moral high ground of reducing poverty rather than maintaining a permanently poor welfare population.

Cons:

- o Administration statements that articulate an anti-poverty strategy may be viewed as purely rhetorical and may not be given serious public attention.
- o Adopting a major public commitment to economic empowerment may create significant pressure to increase spending and to demonstrate concrete success by 1992.

2.a. Expand the Low Income Opportunity Board. The chairperson of the LIOB would be given primary responsibility, under the continued direct oversight of the Domestic Policy Council, for coordinating Federal efforts to eliminate poverty. This could include responsibility for implementing the principles that underlie the anti-poverty strategy; ensuring coordination in the array of public assistance programs; and developing an evaluation strategy to measure the performance of the entire welfare system.

In its expanded role, the LIOB will include other representatives (e.g., tax experts from Treasury) outside of the traditional Federal welfare agencies that comprise the Board. The LIOB staff may have to be increased from its current level (one staff member) to 2 - 3 staff members in order to handle all the work associated with the expanded LIOB role proposed in this option, especially if option 4 below is also approved. It is expected that these additional assignments would be handled by detailing employees from agencies represented on the LIOB and by drawing upon agency expertise under LIOB coordination.

Pros:

- o A strong LIOB could provide the leadership necessary to coordinate anti-poverty activities crossing the jurisdictions of several Federal agencies.
- o Some coordinating entity outside of the agencies is required to avoid "capture" by particular programmatic interests.
- o The Administration would be seen by Congress and the public to be speaking with one coherent voice on this issue.

Cons:

- o Providing leadership and several staff positions for the LIOB might require an increase in current resources, especially if detailees were not feasible.
- o Giving poverty-related problems greater visibility may encourage Congress to develop initiatives the Administration considers counter-productive or too expensive.
- o Some may criticize an expanded LIOB as inadequate, citing the need for a full-fledged "poverty czar" with sufficient stature to compel cooperation among Federal agencies.

2.b. Expand the Low Income Opportunity Board, with a Cabinet Secretary as the Chair. Even with increased resources, the LIOB may not have sufficient "clout" to pursue a high-profile anti-poverty strategy outside the Administration. One way to ensure that a leader of sufficient stature and authority heads the effort is to appoint a Cabinet Secretary to coordinate the low income opportunity strategy, with the strengthened LIOB operating as a staff-level interagency coordinator.

Pros:

- o An effort led by a Cabinet Secretary ensures high-level visibility, interagency cooperation, and commitment.
- o Placing a Cabinet Secretary in the lead role provides a recognized spokesperson for anti-poverty strategy and will help to persuade critics of the importance of this issue within the Administration.

Cons:

- o Visible Cabinet-level leadership raises public expectations of success.

- o A Cabinet Secretary may become a target/lightning rod for Congressional and media criticism of Administration policy toward the poor.

3. Direct Cabinet Secretaries to review current innovative program efforts within their purview, and frame them within the economic empowerment strategy. Current Administration efforts, rather than new categorical initiatives, should form the foundation of the low income opportunity strategy. Several major new initiatives (such as joint HHS-HUD efforts on homeless programs or job training and public housing linkages currently being developed by HUD and Labor) could be announced and implemented almost immediately. This could also include modifications which build upon current efforts, subject to budgetary constraints and policy review, such as:

- Expand the Earned Income Tax Credit (EITC). The EITC could be adjusted by number of children, expanded to workers without children, or the dollar amount could be increased.
- Propose health care initiatives based on the current HHS review of alternatives relating to improved access to health care, with particular attention to the need for adequate insurance for the uninsured.
- Expand the Administration's current housing initiatives, including HOPE and enterprise zones, designed to help many low income families move toward self-sufficiency.
- Continue to expand Head Start and use Head Start as a means to influence low income families with young children. Head Start should also be better coordinated with Even Start and Chapter 1 administered by the Department of Education.
- Improve health services for infants and pregnant women. This may include expansion of WIC and other nutrition programs, drug abuse initiatives targeted at pregnant women and mothers, and immunization programs for children.
- Find ways to promote volunteerism and individual giving. For instance, HHS' Administration on Aging could expand programs that promote intergenerational volunteer efforts to bring needy children together with older adults.
- Emphasize educational results, not resources, as a way to improve our education deficit. Empowerment programs such as choice could be promoted as a key strategy for helping achieve the six education goals.

Pros:

- o Builds upon efforts the Administration has already recognized as effective.
- o Targets problems widely recognized among the public as important (health insurance, infant health, housing affordability).

Cons:

- o With deficit-reduction still a high priority, there is a budgetary risk to encouraging expansionary pressures.
- o Proposed directive may focus public and Congressional debate on dollars rather than on the underlying effort to promote self-sufficiency and reduce poverty.
- o Only addresses those problems that are targeted by existing initiatives; does not by itself promote comprehensive reformation or systemic renovation.

4. Analyzing the distributional effects of existing programs.

The LIOB (assuming expansion of current LIOB staff to 2 - 3 staff persons) and the agencies would be instructed to conduct a full-scale analysis of all Federal programs (not just welfare programs) to examine the effectiveness of programs in reaching the poor.

The ultimate aim would be to develop a legislative and administrative package to retarget program dollars to the most disadvantaged populations and areas. This may involve reconsidering Federal matching formulas and reallocating Federal moneys to the most needy areas, as the Administration has proposed in the Community Development Block Grant. In addition, it may require reallocation in traditional welfare and other programs, including housing, agriculture, entitlements, and certain tax expenditures.

Pros:

- o Allows the Administration to take the high ground by asserting that it is trying to target funds to the most needy.
- o Information produced from such an analysis would be extremely useful; current data regarding the recipients of funds from some Federal programs are incomplete.
- o Limiting tax expenditures can reduce tax-induced distortions in the market.

Cons:

- o Cutting benefits to any group or area is politically difficult. Thus, even conducting the analysis is likely to be strongly opposed by those who may ultimately lose Federal funding.
- o May prove futile; historical attempts to retarget funds have rarely been successful.
- o Altering Federal policies may adversely affect those who made long-term plans based on current law.

5. Integrating services. Provide Federally-funded social and welfare services in a "client-centered" approach. This could include: 1) unifying eligibility requirements and streamlining application procedures across programs; 2) establishing "one-stop shopping" in one location; 3) encouraging effective case management; 4) designating single "lead" Federal agencies to deal with State agencies; 5) scrubbing existing programs to identify and eliminate disincentives to self-sufficiency; and 6) developing client participation and feedback mechanisms, such as beneficiaries councils, to empower and involve clients in effective program operation.

Pros:

- o Should significantly decrease administrative costs by reducing the duplication and complexity of program administration.
- o Provides better and less degrading services to clients by promoting greater communication, cooperation, and coordination among agencies responsible for providing different services to the same population.
- o May reduce welfare costs if integration of welfare services with employment and education services results in more welfare clients becoming self-sufficient.

Cons:

- o Program unification alone will not get at any of the underlying causes of poverty; it simply makes the welfare system run more efficiently.
- o May be strongly opposed by congressional committees as well as by those who view this as a serious threat to employment and "turf" among existing program bureaucracies.

- o Simplifying and unifying welfare services may increase participation, thereby increasing costs and possibly increasing welfare dependency.
- o Where current eligibility requirements are inconsistent, Congress is likely to avoid reducing eligibility or benefits and may select the most expansive definition. This would increase costs.

RECOMMENDATION:

The Domestic Policy Council recommends approval of an outline of a low income opportunity strategy for the Administration with the following features: 1) articulation of principles in a high-profile effort; 2) an expanded role for the Low Income Opportunity Board; 3) current efforts as the foundation; 4) a comprehensive distributional analysis of Federal programs; and 5) an emphasis on integrating services.

It should be emphasized that options 4 and 5 are not ends in themselves, but rather means to help us achieve the ends of our overall strategy, namely, equal opportunity through economic empowerment of all Americans.

If this comprehensive approach is approved, the efforts associated with options 1, 2, and 3 will begin immediately. If options 4 and 5 are also approved, it would be appropriate to direct the Domestic Policy Council to oversee the LIOB's efforts and to report back within six months on the efforts underway to integrate services among Departments, and within one year on the results of the comprehensive distributional analyses of Federal programs. The distributional analyses could result in several legislative proposals to alter existing formula grant programs to permit improved targeting. These proposals could be considered in the context of the Fiscal Year 1993 budget development process.

THE WHITE HOUSE

WASHINGTON

DOMESTIC POLICY COUNCIL

Friday, June 22, 1990

10:00 A.M.

Cabinet Room

AGENDA

1. Violent Crime and Savings and
Loan Enforcement Briefing --
The Attorney General
2. Status Report on Implementation of
the National Drug Control Strategy --
Director Bennett

FACT SHEET

UPDATE ON THE FIGHT AGAINST FINANCIAL INSTITUTION FRAUD

This Administration has aggressively pursued financial institution fraud. In February 1989, during the first month of the Administration, the Attorney General identified fraud against financial institutions as one of the Department of Justice's highest enforcement priorities. That same month, the President proposed a major financial fraud legislative initiative which included stronger civil and criminal tools and major increases in penalties. The following month, March 1989, the President submitted a \$36.8 million supplemental budget request for FY 1989 to meet the escalating problem of financial institution fraud. Congress twice denied the extra funding.

Prosecution Efforts Against Financial Institution Fraud

Even without new resources, the Department of Justice has aggressively pursued financial institution fraud achieving impressive results:

- ° 791 major fraud (losses over \$100,000) convictions for financial institutions fraud in 1989, including both banks and savings and loans.
- ° 530 active FBI investigations of failed financial institutions in 1990, an increase of 88% from 1987.

In 1987, the Department had established the Dallas Task Force, using existing Criminal Division resources and the resources of other agencies to supplement the work of the U.S. Attorney's Office. Today, the Task Force consists of 22 Assistant U.S. Attorneys and Fraud Section attorneys, 3 Tax Division lawyers, 36 FBI agents, 16 IRS Special Agents, and 3 Office of Thrift Supervision examiners.

In three years, the Task Force has achieved substantial results. It has:

- ° brought criminal charges against 77 persons
- ° obtained 52 convictions, 40 of which relate to savings and loan institutions.

It currently has 42 separate savings and loan associations and 560 persons under investigation. Based on the success of the

Dallas Task Force, the Attorney General is expanding the task force concept to a total of 27 cities.

In late November, 1989, the Congress appropriated almost \$50 million, which the President had sought earlier that year. As the Department has received these additional resources, it has increased its enforcement efforts and worked to ensure that sufficient resources are focused on the most important cases -- those involving high losses, the weakening or failure of an institution or potential insider fraud. These funds will support:

- ° 153 FBI agents.
- ° 118 Assistant U.S. Attorneys.
- ° 24 Fraud Section attorneys.
- ° 100 accounting technicians.

In addition, the FBI has already shifted 49 agents to augment the FIRREA financial institution effort and 18 more agents are in the process of being shifted. Thus, a total of 220 agents are being added to the fight against financial institution fraud.

Additional Administrative Efforts Against Financial Institution Fraud

The Attorney General has taken additional administrative steps to address this important problem. He has established the position of Special Counsel for Financial Institutions, reporting to the Deputy Attorney General. The Special Counsel's sole responsibility is to coordinate all matters concerning the investigation and prosecution of financial institution fraud. Additionally, the Special Counsel will ensure that the resources are properly allocated to the most significant financial institution fraud cases. The Attorney General directed the creation of a Financial Fraud Coordinating Unit within the Deputy Attorney General's Office to support the work of the Special Counsel.

The Attorney General and Secretary of the Treasury have formed an interagency group of senior officials from the Department of Justice, Department of Treasury, Federal Bureau of Investigation, Office of Thrift Supervision, Federal Deposit Insurance Corporation, Comptroller of the Currency, Board of Governors of the Federal Reserve System, Resolution Trust Corporation, the National Credit Union Administration, and the Attorney General's Advisory Committee of U.S. Attorneys. This group will prioritize the significant savings and loan cases to

be investigated and prosecuted. Chaired by the Special Counsel, this group will enhance interagency coordination and assist in accelerating the investigation and prosecution of these financial institution fraud cases.

To further assist in this effort, the Attorney General and Secretary of the Treasury have directed the creation of a "flying squad" of specialized attorneys and auditors drawn from the Department's Civil and Criminal Divisions, the Office of Thrift Supervision, the Office of the Comptroller of the Currency, the FDIC, and the RTC to concentrate immediate and joint enforcement efforts on selected financial institutions victimized by potentially criminal activity. Upon short notification, this squad will take all appropriate action to preserve assets of an institution, protect the vital documents and records, and undertake an immediate investigation.

The resources of other agencies will also be brought to bear on this problem. The Resolution Trust Corporation has established an Office of Investigations and a national network of investigative teams. Approximately 300 new investigative staff will be added by the end of this year. The IRS will continue to prosecute aggressively individuals who commit tax fraud involving failed financial institutions. The Office of Thrift Supervision has recently opened a new regional enforcement office sited in its Jersey City, New Jersey, office to enhance its enforcement capabilities. OTS intends to open at least two additional regional enforcement offices before the end of 1990.

Additional Legislative Efforts Against Financial Institution Fraud

The Administration supports the package of legislative proposals that provide important additional enforcement tools to attack, civilly and criminally, financial institution fraud. The Departments of Justice and Treasury worked closely with the legislative sponsors in the development of these measures. The proposals will mobilize government-wide resources by allowing the Department of Justice to use, without reimbursement, attorneys, investigators, accountants, and other personnel from appropriate agencies. Also included is a provision to allow law enforcement agencies to request court-authorized wiretaps to investigate bank fraud, false statements to financial institutions, bribery of bank officials, and related offenses for which wiretap authority is not presently available.

The legislative package contains other significant measures. Cases brought by the FDIC and the RTC will receive priority consideration by the courts. Also, procedures for expedited appeals of these cases will be established. The Department of Justice, the FDIC, the RTC and Office of Thrift Supervision will

be authorized to seek court orders to freeze the corporate and personal debts of defendants in civil financial institution fraud cases. In addition, the claims of the Federal Government will receive priority over those of creditors in bankruptcy and other claimants in suits against parties responsible for losses due to financial institution fraud.

Victims of financial institution fraud will receive enhanced protections when the legislation is enacted. The legislation authorizes courts to order payment of restitution to all victims of financial institution fraud schemes even where they were not identified in the charges underlying the conviction. Perpetrators of financial institution fraud will be prohibited from using the bankruptcy laws to avoid payment of damages, penalties and forfeitures that are used to reimburse victims.

These new measures will be especially effective when combined with the authority granted in FIRREA. Enacted in August 1989, FIRREA authorized a number of expanded enforcement powers, increased penalties, and procedural improvements to facilitate financial institution investigations and prosecutions. The new law provided (a) increased and expanded civil penalties of up to \$1 million (with \$5 million for continuing violations) and criminal penalties of up to 20 years' imprisonment; (b) extended forfeiture authority to 18 financial institution related offenses; (c) amended grand jury secrecy protections to facilitate the use of grand jury information in seeking civil actions related to financial institution offenses; (d) made bank fraud a RICO predicate offense; and (e) amended the Right to Financial Privacy Act to prohibit financial institutions from disclosing that records were being sought pursuant to a grand jury subpoena related to financial institution offenses.

June 22, 1990

FACT SHEET

COMBATTING VIOLENT CRIME

The President has articulated the four fundamental principles which guide all of our efforts to combat violent crime.

- ° A primary purpose of government is to protect citizens and their property. Americans deserve to live in a society in which they are safe and feel secure.
- ° Those who commit criminal offenses should, and must, be held accountable for their actions.
- ° Our criminal justice system must have as its objective the swift and certain apprehension, prosecution, and incarceration of those who break the law.
- ° Success in accomplishing our criminal justice system goals requires a sustained, cooperative effort by federal, state and local law enforcement authorities.

The President's program includes legislative proposals and other initiatives to strengthen federal, state, and local laws; enhance cooperative law enforcement efforts; increase prison capacity; and reform the nation's criminal justice system to ensure both the certainty and severity of punishment for violent criminals.

Violent Crime in America

The chance of being a violent crime victim in the United States continues to be greater than that of being injured in a traffic accident. Approximately 6 million Americans were victims of violent crime in 1989.

The violent crime situation in general has improved significantly since its peak in 1981, and remained relatively stable since 1988. Although, the number of murders rose from 1988 to 1989, it remains well below the 1980 figure. In short, we are keeping the lid on violent crime, but the situation is a highly volatile one, and the nation's criminal justice system is being stressed to its limits and in need of fundamental reforms.

Administration Action

The Attorney General, Treasury Secretary Brady, and other Administration officials have taken action to implement each step of the President's plan which was not dependent upon legislative action.

The President's Proposals Passed by Congress

The Administration convinced Congress to fund:

Significant Increases for Enforcement

- ° 300 **FBI** positions to implement their violent crime and repeat offender program;
- ° 150 positions to enhance the **U.S. Marshals Service's** fugitive apprehension efforts;
- ° 109 positions to **INS** and 38 new Immigration Judges to expedite deportation of criminal aliens.

Significant Increases for Prosecution

- ° 1,375 new positions for **U.S. Attorneys Offices**;
- ° \$45.9 million for the **Judiciary** for pre-trial services, probation, juror fees, court security and court administration.

Significant Increases for Federal Prisons

- ° \$1.4 billion for 24,500 new bed spaces -- a 77% increase. Federal prison capacity is being more than doubled at President Bush's initiative.

Footdragging by Congress

The Congress has failed to adopt other parts of the President's Comprehensive Violent Crime Control bill including key provisions to:

- o **restore an enforceable death penalty** for the most aggravated Federal crimes and extend capital punishment to a number of new offenses, such as murder for hire;
- o **reform Habeas Corpus** to curb abuse and eliminate the seemingly endless process of repetitive appeals and reviews which serve no purpose but to delay justice;
- o **reform the Exclusionary Rule** to assure that legal technicalities do not prevent the truth from being heard in court or to allow the guilty to go unpunished;
- o **make drug testing a mandatory condition** of Federal probation, parole or supervised release;

- o **enhance Federal penalties for firearms violations** and provide a bonus to states for doing the same; restrict gun magazines of over 15 rounds; and limit access to firearms by criminals by closing loopholes in current laws.

What Needs to be Done

Every effort should be made to push aggressively for the enactment of the fundamental criminal justice reforms embodied in the President's own violent crime and drug control proposals. "Sound-alikes" or quick fixes won't suffice.

Because violent crime is primarily a state and local responsibility, attention must be focused on the need for adopting comparable reforms and making adequate resource commitments at the state and local levels. Federal efforts to combat violent crime should continue to be directed primarily on its interstate and international aspects; improving law enforcement cooperation and coordination, training and technical assistance; data collection and intelligence sharing; and leadership.

DRUG POLICY UPDATE

I. WHAT'S BEEN ACCOMPLISHED IN 16 MONTHS

A. Formulated first National Strategy, September 1989

- * First nationally--televised speech by the President. One of his highest priorities. ("This scourge will end" -- A quote from the inaugural.)**
- * Our Strategy brought together the efforts of Federal, State and local governments, and those of the private sector, schools, communities, and volunteers, into the first truly national strategy.**
- * Brought together nearly 50 Federal agencies and State and local governments into a working relationship based on a common set of goals and objectives.**
- * We've raised awareness among the American people that drugs are a major problem in our schools and communities requiring their involvement.**

B. Developed and Published second National Strategy, January 1990

- * Built on the first. No strong criticism from the Hill Democrats. The issue is ours.**

C. Begun implementing Strategies I and II.

D. Increased Federal funding for drugs

- * \$10.6 billion proposed drug budget for FY 91.**
- * The FY 91 request is a 69 percent increase since Bush took office.**
- * Largest growth of any major Federal program. Examples:**
 - Law Enforcement: up 60 percent**
 - Treatment: up 68 percent**
 - Education/Prevention: up 83 percent**
 - International Programs: up 127 percent**
 - Research: up 66 percent**
 - Drug Intelligence: up 225 percent**

- * More funding for State & local drug initiatives.
 - Requested over \$2.6 billion for State and local drug grant programs for FY 1991, a \$1.4 billion, 109 percent, increase over the FY 1989 level. Most of this is for "demand-side" programs.

II. KEY PRINCIPLES OF THE STRATEGIES

A. User Accountability

- * People must be held accountable for their own drug use. Drug users are not "victims". They are law violators.

B. Strong Law Enforcement

- * Increase the risk of punishment; broaden the array of sanctions.

C. Effective Treatment -- Treatment that works

- * We'll help people who need help kicking the drug habit. But our help is going to be tough and demanding. We're not interested in coddling drug users. Make treatment accountable. We want treatment that works.
- * We're asking Congress for approximately \$350 million in FY 91 for programs to help pregnant women and babies affected by drugs.

D. Innovative Prevention

- * We'll do all we can to mobilize our schools, communities, and workplaces to work together to make drug use unacceptable, unattractive, and uncommon.

E. Broader Involvement of the States

- * We're working with the States to increase and improve their efforts, and better coordinate their efforts with ours. Example: State and local Drug Czar Conference, May 1990.

F. International Cooperation

- * We're working to win the full cooperation and participation of other countries in the drug war. The United States cannot win it alone. Examples of U.S. activity: Andean Strategy, Cartagena Summit and seven bilateral side agreements, and the linkage of U.S economic assistance to Andean drug control efforts.

III. WHAT ADDITIONAL TOOLS ARE NEEDED -- OUR LEGISLATIVE PROPOSALS

A. Proposals Congress approved last year:

*** Drug Free Schools.**

- Congress approved our proposal last fall to require drug free policies in all primary and secondary schools, colleges and universities.**
- Congress also approved our proposal for emergency grants to urban and rural schools in areas hardest hit by the drug problem.**

B. Additional proposals we're seeking this year:

*** Accountability.**

-- Drug Testing.

- * Require States to establish a drug testing policy in their Criminal Justice Systems as a condition of receiving Federal BJA grants. (Originally submitted following Strategy I.)**
- * Establish a nationwide program of drug testing for Federal offenders on post-conviction release.**

-- Statewide Treatment Plans.

- * Require States to develop a Statewide Treatment Plan as a condition of receiving the drug portion of Federal ADAMHA grants. (Originally submitted following Strategy I.)**
- * The Plan must describe ways to expand capacity, assess need, improve client referrals, provide in-service staff training, coordinate with other services, and expand and improve services for pregnant women and drug-affected newborns.**
- * It must also include a drug testing component.**

-- Maintenance of Effort.

- * Prohibit States from using Federal ADAMHA grants to reduce their own expenditures for drug activities.**

- * **Death Penalty for Drug Kingpins.**
 - **Permit the sanction of death:**
 - * **For major drug kingpins,**
 - * **For drug kingpins who attempt a killing to obstruct an investigation or prosecution of a drug offense, and**
 - * **For traffickers who engage in a federal drug felony that results in a death.**
- * **International Programs.**
 - **Provide certain waivers to facilitate the provision of assistance critical to the implementation of the Andean Initiative. (Some of these were originally submitted following Strategy I.)**
 - **Provide the Secretary of State the discretion to order the extradition of a U.S. citizen to a foreign country even if the terms of the applicable treaty do not obligate the U.S to extradite.**
- * **Criminal Justice System Improvements.**
 - **Immigration System Improvements.**
 - * **Provide INS agents and officers authority to make arrests for non-immigration offenses committed in their presence.**
 - * **Expedite the procedures to exclude or deport criminal aliens and restrict the appeal rights of such individuals.**
 - **Protection of Judges, Jurors and Witnesses.**

Provide stronger penalties for obstruction of justice offenses against court officers and jurors. Penalties would be similar to those that exist for obstruction of justice offenses against witnesses, victims and informants.
 - **Drug-Related Public Corruption.**

Punish drug-related public corruption with up to 25 years imprisonment.

-- **Drug Paraphernalia.**

Allow forfeiture of assets and add civil penalties for violations of the drug paraphernalia statute.

-- **Sanctions for Failure to Land or Bring To.**

- * **Make it a criminal offense to fail to obey the order of an authorized Federal law enforcement officer to land an aircraft or bring-to a vessel,**
- * **Provide for revocation of operator's licenses for failure to obey the order, and**
- * **Provide Coast Guard specific authority to engage in air interdiction over U.S. waters and the high seas.**

-- **Asset Forfeiture and Money Laundering Amendments.**

Provide for quarterly (instead of annual) transfer of funds from the DOJ Forfeiture Fund to ONDCP's Forfeiture Fund, allow for forfeiture of vehicles with concealed compartments, and make other conforming amendments.

IV. KEY INDICATORS

A. Casual use is down sharply

- * **High School Senior Survey.**
 - **Prior year use of illicit drugs by high school seniors has declined from 38.5 percent in 1988 to 35.4 percent in 1989, continuing a decline that began in 1985. Disapproval of drug use by high school seniors is very high and increasing.**
- * **Household Survey.**
 - **Current (30 day) users of illicit drugs decreased from 23 million in 1985 to 14.5 million in 1988.**
 - **Current cocaine users declined from 5.8 million in 1985 to 2.9 million in 1988.**
 - **Current use of marijuana decreased from 18 million in 1985 to 11.6 million in 1988.**

- We need to keep these trends heading south. We expect the data from the next Household Survey in December.

B. Hard-core use may be declining

*** Drug Abuse Warning Network (DAWN).**

- Since such information has been collected, huge yearly increases in the number of emergency room mentions of cocaine, heroin, and marijuana have been the norm.

- * 1989 is the first break in that sharp increase, the last quarter of 1989 actually showed a decline -- the first major decline since 1985.

- Although still preliminary for 1989, it looks like medical examiner mentions of illegal drugs will follow the pattern seen in emergency rooms.

- Although it is too early to declare a downward trend, the initial report is encouraging.

C. Drug availability may also be declining

- * Cocaine purity is down. In 1988, the average purity for a "street" gram was 70 percent. Average purity fell to 66 percent in 1989, and in the first four months of 1990, it dropped even further to 55 percent.

- * U.S. cocaine prices are going up. Nationwide, the average wholesale price for a kilogram of cocaine remains within the \$11,000 to \$35,000 range. But in most cities, prices are moving toward the higher end of the range.

- In New York, for example, the average price increased from \$19,000 in the second quarter of 1989 to \$24,000 in the first quarter of 1990. In Los Angeles, average kilo prices have risen from \$13,500 to \$17,000.

- * Coca leaf prices are down. In Bolivia, a major source country, the break-even point for coca farmers is about \$30 per 100 pounds of coca leaf. Last year, they were able to get as much as \$90 per 100 pounds. This year, prices range from \$10 to \$80.

THE WHITE HOUSE OFFICE OF CABINET AFFAIRS STAFFING MEMORANDUM

Date: June 20, 1990

Due by: _____

Meeting of the Domestic Policy Council with the President, Friday
Subject: June 22, 1990 at 10:00 A.M. in the Cabinet Room.

Kenneth P. Yale
From: Executive Secretary, Domestic Policy Council

	Action	FYI		Action	FYI
ALL CABINET MEMBERS	☐	☐			
Vice President	☒	☐	CIA	☐	☐
Agriculture	☒	☐	CEA	☒	☐
Commerce	☒	☐	CEQ	☐	☐
Defense	☒	☐	EPA	☒	☐
Education	☒	☐	GSA	☐	☐
Energy	☒	☐	NASA	☐	☐
HHS	☒	☐	National Science Foundation	☐	☐
HUD	☒	☐	ONDCP	☒	☐
Interior	☒	☐	OPM	☐	☐
Justice	☒	☐	OSTP	☒	☐
Labor	☒	☐	SBA	☐	☐
OMB	☒	☐	UN	☐	☐
State	☒	☐	Cicconi (For WH Staffing)	☒	☐
Transportation	☒	☐	_____	☐	☐
Treasury	☒	☐	_____	☐	☐
USTR	☒	☐	_____	☐	☐
Veterans	☒	☐	_____	☐	☐

COMMENTS: The Domestic Policy Council will hold a meeting for principals only on Friday, June 22, 1990 from 10:00 to 11:00 A.M. in the Cabinet Room. The President will chair this meeting of the Council. Attached for your information is an agenda. The briefings will be on (1) Crime Statistics; and (2) a Status Report on Implementation of the National Drug Control Strategy.

Please inform Honor Willson (456-2800) by C.O.B. Thursday, June 21 regarding your attendance at this meeting.

THE WHITE HOUSE

WASHINGTON

June 20, 1990

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: KENNETH P. YALE *KY*
Executive Secretary

SUBJECT: Meeting of the Domestic Policy Council with the
President, Friday, June 22, 1990 at 10:00 A.M. in
the Cabinet Room

The Domestic Policy Council will hold a meeting for principals only on Friday, June 22, 1990 from 10:00 to 11:00 A.M. in the Cabinet Room. The President will chair this meeting of the Council.

There will be two topics for Friday's meeting: (1) a briefing by the Attorney General on violent crime and savings and loan enforcement; and (2) a status report on the implementation of the National Drug Control Strategy given by Director Bennett of the Office of National Drug Control Policy.

Please inform Honor Willson (456-2800) by C.O.B. Thursday, June 21 regarding your attendance at this meeting.

Attachments

THE WHITE HOUSE
WASHINGTON

DOMESTIC POLICY COUNCIL

Friday, June 22, 1990

10:00 A.M.

Cabinet Room

AGENDA

1. Violent Crime and Savings and
Loan Enforcement Briefing --
The Attorney General
2. Status Report on Implementation of
the National Drug Control Strategy --
Director Bennett

THE WHITE HOUSE
WASHINGTON

CABINET AFFAIRS STAFFING MEMORANDUM

Date: April 19, 1990 Number: _____ Due By: _____

Subject: Meeting of the Domestic Policy Council, Tuesday, April 24, 1990 from
10:30 AM to 12:00 Noon in the Roosevelt Room. (PRINCIPALS ONLY PLEASE)

	Action	FYI		Action	FYI
ALL CABINET MEMBERS	☐	☐	CEA	☒	☐
Vice President	☒	☐	CEQ	☒	☐
State	☐	☐	OSTP	☐	☐
Treasury	☐	☐	_____	☐	☐
Defense	☒	☐	_____	☐	☐
Justice	☒	☐	_____	☐	☐
Interior	☒	☐	_____	☐	☐
Agriculture	☐	☐	Scowcroft	☐	☐
Commerce	☐	☒	Porter	☐	☐
Labor	☐	☒	Breiden	☐	☐
HHS	☒	☐	Cicconi (For WH Staffing)	☒	☐
HUD	☒	☐	_____	☐	☐
Transportation	☐	☐	_____	☐	☐
Energy	☒	☐	_____	☐	☐
Education	☒	☐	_____	☐	☐
Veterans	☒	☐	_____	☐	☐
OMB	☒	☐	_____	☐	☐
USTR	☐	☐	Executive Secretary for:	☐	☐
Chief of Staff	☐	☐	DPC	☒	☒
UN	☐	☐	EPC	☐	☐
CIA	☐	☐	_____	☐	☐
National Drug Policy	☐	☐	_____	☐	☐
EPA	☒	☐	_____	☐	☐
GSA	☐	☐	_____	☐	☐
NASA	☐	☐	_____	☐	☐
OPM	☒	☐	_____	☐	☐
National Science Foundation	☐	☐	_____	☐	☐
SBA	☒	☐			

REMARKS: The Domestic Policy Council will hold a meeting for principals only on Tuesday, April 24, 1990 from 10:30 AM to 12:00 Noon in the Roosevelt Room. Attached are an agenda, as well as discussion papers on Volunteer Liability and Medical Professional Liability. Please note that these documents are sensitive in nature and should be treated as close hold documents. Please refrain from making copies.

Please inform Honor Willson (456-2800) by COB, Monday, April 23, as to whether or not you plan to attend this meeting.

RETURN TO:

☐ David Q. Bates
Cabinet Secretary
456-2174
(1st Floor, West Wing)

☐ Associate Director
Office of Cabinet Affairs
456-2800
(Room 235, OEOB)

THE WHITE HOUSE

WASHINGTON

April 20, 1990

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: KENNETH P. YALE *KY*
Executive Secretary

SUBJECT: Meeting of the Domestic Policy Council, Tuesday,
April 24, 1990 at 10:30 A.M. in the Roosevelt Room

The Domestic Policy Council will hold a meeting, for principals only, on Tuesday, April 24, 1990 from 10:30 A.M. to 12:00 Noon in the Roosevelt Room. The topics for discussion will be Volunteer Liability and Medical Professional Liability.

Attached for your review prior to the meeting are an agenda, as well as discussion papers on Volunteer Liability and Medical Professional Liability. Please note that these documents are sensitive in nature and should be treated as close hold documents. Please refrain from making additional copies.

Presentation of the papers on Volunteer Liability and Medical Professional Liability will be made by Stuart M. Gerson, Assistant Attorney General of the Civil Division at the Department of Justice.

Please inform Honor Willson (456-2800) by C.O.B. Monday, April 23, as to whether or not you plan to attend this meeting.

Attachments - 3

DOMESTIC POLICY COUNCIL

Tuesday, April 24, 1990

10:30 A.M.

Roosevelt Room

AGENDA

1. Volunteer Liability
2. Medical Professional Liability



U.S. Department of Justice

Civil Division

Office of the Assistant Attorney General

Washington, D.C. 20530

April 17, 1990

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: The Tort Law Reform Working Group
Domestic Policy Council *Smelick*

SUBJECT: Tort Liability and Volunteers

ISSUE: What actions should be taken to implement the three recommendations of the Working Group for an Administration initiative to assist volunteerism activities?

BACKGROUND

At its meeting held December 21, 1989, the Domestic Policy Council (DPC) directed the Tort Law Reform Working Group to suggest specific actions to implement the following recommendations for an Administration initiative to assist volunteerism activities:

Establish a National Volunteerism Center to serve as focus for nonprofits to work together in anticipating and solving their liability and insurance problems;

Promulgate a model state statute aimed at diminishing volunteers' liability; and

Amend the federal Risk Retention Act to allow easier access by volunteer organizations to insurance coverage.

Based upon its subsequent activities and study, the working group now suggests to the DPC the following:

A. National Volunteerism Center

I. Structure of Center

On January 19, 1990 the President approved further development of a concept to establish a privately funded National Volunteerism Center to address the concerns of volunteer organizations about tort liability and other issues affecting incentives to volunteer.

The following were possible structures for a National Volunteerism Center to be proposed to the President by the DPC:

1. A federally chartered private organization;
2. A coalition of nonprofits (informally endorsed by the President);
3. A national trust;
4. A federal corporation.

The working group now recommends that the National Volunteerism Center be established by a federal charter and be a private corporation.

PROS AND CONS FOR A FEDERAL CHARTER

- Pros:
- ° A federal charter will demonstrate the national importance of the Center.
 - ° Establishment of the Center by federal charter would permit the bringing together of broad based private support of volunteerism activities that presently exists.
 - ° Use of a federal charter will enable the Center to include provisions in its charter that may be of value as a model, e.g., programs regarding insurance for member organizations.
- Cons:
- ° Legislation takes time to enact. This may delay the starting date for the Center's operations (though the momentum that this approach already has gained suggests that the Center can begin before legislation is passed).
 - ° Congress may amend the legislation to include undesirable provisions.

II. Activities

1. Charterers/First Board of Directors.

An original charterer from each state would be named by the President to serve as the Center's first Board of Directors. The Board would determine how successor Directors would be selected. We recommend, however, that each state should have one (and only one) director.

2. Executive Committee.

The Board of Directors would appoint an Executive Committee to carry out its policies. The President would not be involved in the selection of the Executive Committee or in the ongoing activities of this private but federally chartered organization.

3. Membership.

The statutory charter should be broadly written. Precise membership criteria should be left for the directors to determine. The membership should include a broad spectrum of volunteer organizations and volunteers.

4. Limitation of Liability.

The charter could include provisions limiting the liability of Officers and Directors and volunteers serving the Center, in accordance with the proposed model state statute described below.

5. Powers.

The powers of the Center would include, inter alia,

- a. Providing quality assurance and standards as to the activities of volunteers;
- b. Offering informational services and coordination in sharing liability-related information among volunteer organizations;
- c. Initiating insurance programs.

6. Start of operations.

An Executive Director should be appointed with authority to ensure the proper commencement of operations. All possible sources of funding from private organizations should be examined in order to obtain sufficient resources to commence operations immediately.

III. Funding.

Funding would come from private sources and from federal grants for which the Center would be eligible on a competitive basis. This proposal would require no new appropriations of federal funds.

PROS AND CONS

- Pros:
- Funding from private sources would instill confidence in the private sector that this was not just another federal give-away program.
 - This approach is consistent with the concept of volunteerism, i.e., the Center is a private activity not a government program.
- Cons:
- Not having federal seed money could slow the Center's start-up activities.
 - Failure to provide federal seed money could be taken as lack of Administration support.

B. PROMULGATE A MODEL STATE STATUTE

I. Review of State Legislation

The proposed model state volunteer legislation would encourage states to grant specific immunities from or limits on liability for individual volunteers. Research revealed that no model statute had been drafted.

II. State Statutes

1. Delaware Act

The Delaware statute, enacted in 1986, provides volunteers of 501(c) organizations with almost absolute immunity from liability for ordinary negligence (except in the operation of motor vehicles, in which case the volunteer is liable up to the amount of his insurance coverage). Under the Delaware statute a "volunteer" is defined as any "trustee, director, officer, agent or worker who is engaged in any activity without compensation." Excluded from "compensation" are reimbursement for actual costs incurred as well as "prerequisites in the form of access to services of the organization at no or reduced cost."

Delaware, however, does not immunize the volunteer organization. The statute expressly attributes the otherwise immunized actions of the volunteer to the volunteer organization under the doctrine of respondeat superior.¹

¹ This approach would require liability insurance to be carried by the volunteer organization. Actions to assist volunteer organizations to obtain insurance at affordable cost are objectives of the proposed amendments to the Federal Risk Retention Act and of the National Volunteerism Center.

2. South Dakota Act

The South Dakota statute establishes the same immunity provisions of the Delaware Act for volunteers of 501 (c) organizations with almost absolute immunity from liability for ordinary negligence (except in the operation of a motor vehicle, wherein liability for the volunteer is covered up to the amount of his insurance) while it also creates immunity for "governmental entities." Under the South Dakota Act a "governmental entity" is defined as "any county, municipality, township, school district, chartered governmental units or other special districts, or any association, authority, board, commission, division, office, officer, task force or other agency of the state of South Dakota."

As in Delaware the "volunteer" in South Dakota is similarly defined as an individual performing services "without compensation, other than reimbursement for actual expenses incurred."

PROS AND CONS OF THE DELAWARE AND SOUTH DAKOTA MODELS

- Pros:
- Promulgation of the Delaware and South Dakota approaches as a model act would provide clear leadership and is congruent with federalism principles.
 - The statutes are simple. (Note, there are no reported cases interpreting them.)
- Cons:
- The statutes might be viewed as insufficient, inasmuch as they still leaves volunteer organizations open to litigation.
 - The Delaware model leaves governmental volunteers unprotected.

3. Texas Act

The Texas statute was enacted in 1987. It applies to charitable organizations as defined under section 501(a) of the Internal Revenue Code. Volunteers are defined as persons rendering services for a charitable organization without compensation except for reimbursement of expenses. It excludes from coverage organizations formed to dispose of hazardous waste. It does not apply to a government unit. It establishes a ceiling on the liabilities of both charities and employees, provided the charity obtains liability insurance up to the maximum amount of potential liability.

PROS AND CONS OF THE TEXAS MODEL

- Pros:
- ° The Texas model established limits of recovery against a charitable organization to the extent liability insurance is required under the Act.
 - ° It provides immunity for volunteer liability, shifting liability claims to the organization.
- Cons:
- ° The Act is complex.
 - ° It ties in immunity for volunteer organizations to insurance coverage, which might not be available.

IV. Delaware/South Dakota Model Preferred

The Working Group concluded that the model volunteer statute should be based on the Delaware and South Dakota laws because of their simplicity and reasonableness.

C. AMEND THE FEDERAL RISK RETENTION ACT

The Liability Risk Retention Act provides an alternative means by which entities -- both for-profit and nonprofit -- can obtain liability insurance. Reports that nonprofits have been inhibited by some states from forming groups led the DPC to request a report on the reasons the Risk Retention Act might need amendment.

I. Background of the Act

The Liability Risk Retention Act was enacted in 1986 in response to the "crisis" in the availability of liability insurance. The Act permits entities with similar liabilities to self-insure as a group by forming so-called risk retention groups. The Act also permits the formation of purchasing groups for the purchase of liability insurance.

II. The Efficacy of the Act

Over 60 risk retention and 300 purchasing groups have been formed since 1986. Risk retention groups have over 11,000 insured and about \$269 million in premiums. Purchasing groups have over 315,000 insured with \$575 million in premiums.

Some nonprofit groups are already using the Act to obtain liability coverage. According to the Risk Retention Reporter, a resource publication, both risk retention groups and purchasing groups have been formed by nonprofit organizations.

III. Problems in the Operation of the Act Which Inhibit Group Formation

The federal Act creates an alternative method of obtaining liability insurance that is otherwise unavailable or unaffordable to what are considered more volatile risks. The Act reserves to the states the regulation of the risk retention groups, purchasing groups and insurers and there has been a great deal of resistance on the part of many regulators, particularly to the operations of insurers of purchasing groups. Furthermore, inattention on the part of the regulators has sometimes led to instances of undercapitalized, badly managed insurers creating, marketing and insuring large numbers of purchasing groups.

To address these problems the Department of Commerce has recommended that the Act be amended to ensure that members of purchasing groups and risk retention groups maintain control over their organizations. It calls for the users of the Act to establish an accreditation program to be established to ensure the solidity of the insurance written and to build the confidence of members, regulators, reinsurers, and the public with regard to groups operating under the Act.

IV. Recommendations

The working group concludes that the Act could provide an important means of alternative liability coverage for non-profit entities if it is amended and its availability made known to nonprofit groups. The following recommendations are consistent with recommendations previously made by the Department of Commerce:

1. The Administration should seek Congressional amendment of the Act to: 1) assure that risk retention groups and purchasing groups are controlled by their members; 2) subject purchasing groups and their insurers to single-state regulation; 3) regulate the provision of insurance to purchasing groups; and 4) strengthen notice and reporting requirements for risk retention groups, purchasing groups and purchasing group insurers.
2. The Administration should encourage the enhancement of state regulatory activities through: 1) more-effective regulatory monitoring of entities created under the Act; 2) strengthened solvency regulation; and 3) establishment of a central coordinating office.
3. The Office of Private Sector Initiatives (OPSI) and The Thousand Points of Light Initiative Foundation (TPLIF) and The National Volunteerism

Liability Center should publicize the availability and applicability of the Act to nonprofit entities;

4. As part of their educational outreach campaigns, OPSI and TPLIF should also remind volunteers that many of their activities as volunteers are already covered under their own homeowners' insurance policies.

PROS AND CONS

- Pros:
- ° Amendment would permit the Act to reach its full potential to address insurance affordability and availability problems.
 - ° Amendment would help guarantee that insurance is being written by solvent insurers.
 - ° Publicizing the existence of the Act would benefit volunteers.
- Cons:
- ° The National Association of Insurance Commissioners, strong opponents of the Act, might mount an active campaign in Congress to prevent amendments from being enacted.
 - ° The Act would not help those volunteer organizations that have no resources available for insurance.

THE WHITE HOUSE
WASHINGTON

April 23, 1990

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: KENNETH P. YALE *KY*
Special Assistant to the President
and Executive Secretary

SUBJECT: Tort Liability and Volunteers

This past Friday, April 20, you were sent materials on tort liability and volunteers for a meeting of the Domestic Policy Council scheduled for Tuesday, April 24. This is to provide you with additional material that you may find useful.

At the last meeting of the Domestic Policy Council on this issue, the Tort Law Reform Working Group was asked to provide guidance on implementing the DPC recommendations to the President on Federal actions to address concerns about liability problems faced by volunteer organizations. The paper you received on Friday is the Working Group's response to that request and, except for the issue of a proposed National Center, lays out in some detail the options considered, with pros and cons for each.

With respect to the issue of a National Center, however, the full range of options were not outlined in the paper because they had been dealt with in some detail in the December 21, 1989 meeting paper on the subject. To encourage full debate on the issues, a copy of the relevant pages of the December 21 paper is enclosed.

OPTIONS

The Working Group considered many approaches to alleviate the chilling effect on volunteerism caused by excessive exposure to the threat of tort liability. Any tort reform initiative would need to address the issues of insurance coverage of volunteer organizations, as well as scope and extent of liability for volunteers and volunteer organizations. Furthermore, any initiative which includes a proposal for federal legislation would need to take federalism concerns into account. The range of potential options includes:

- I. Establishment of a National Center to assist non-profits;
- II. Promulgation of a model state statute;
- III. Review of the federal Risk Retention Act; and
- IV. Placing limits on the tort liability of individual volunteers and volunteer organizations having a federal nexus.

The Working Group believes that Options I, II and III offer the most useful responses to the problem. For the sake of completeness, we included Option IV, for which some support existed among the Working Group. Other options such as federal preemption of state tort law through grants of immunity to volunteers and limits on liability, federal regulation of the insurance industry, and federally subsidized insurance for volunteers were considered but received no support from any of the agencies represented on the Working Group. As a result, these options have been excluded from the Options list.

OPTION I: ESTABLISH A NATIONAL CENTER TO ASSIST NONPROFITS WITH LIABILITY CONCERNS

Explanation: This would entail establishment of a broad-based National Center to address the concerns of volunteer organizations. The Center's functions could include insurance cost containment, risk management and quality assurance services and a range of training and technical assistance related to the liability and insurance needs of volunteer activities. The Working Group recommends establishing the Center with private funds.

PURPOSES

- (1) To act as a national clearing house for liability-related information.
- (2) To analyze and propose means of addressing insurance needs.
- (3) To assist nonprofits in reducing their exposure to legal liability.
- (4) To promote and develop risk management programs for nonprofits.
- (5) To increase the quality, quantity and availability of centralized information on nonprofits' claims and insurance data.
- (6) To act as an advocate for nonprofits, e.g., in negotiating with the insurance industry and lobbying state legislature and Congress for reforms.
- (7) To establish insurance programs and risk retention or purchasing groups to reduce costs and increase insurance availability.

FUNDING

The National Center could be funded through a number of private sources including (a) foundation grants, (b) corporate contributions, (c) membership dues, and (d) income generated from the sale of its publications and fees for training programs.

Federal "seed" funds could be sought to help initial establishment although this approach might over federalize the concept and would have budgetary consequences.

A. PROS AND CONS FOR ESTABLISHING A NATIONAL CENTER

- Pros:
- ° The action would be highly visible.
 - ° This proposal is flexible and could focus on the main problem areas specific to volunteer liability, including incorporation of other suggestions discussed below without substantial governmental involvement.
 - ° A National Center may increase the availability of insurance coverage through pooling agreements and risk management for all volunteer organizations but particularly for new, small or other hard-to-insure organizations.

- Depending on its structure, a National Center could be viewed as a complement to the Thousand Points of Light Foundation.
- Cons:
- The National Center, depending on the structure chosen, may appear inconsistent with the President's volunteer principles since it may be viewed as a federal rather than a volunteer initiated effort.
 - Across-the-board tort reformers would see this option as a very narrowly tailored proposal and would prefer more direct, preemptive federal action.
 - Funding questions have not been clarified. The attractiveness of this option may depend on whether any federal funding is available and if so, how much. No funds are identified for this on the fiscal year 1991 budget. If the DPC decides to recommend federal funding, the initiative would have to be postponed until fiscal year 1992 and a funding source would have to be identified.
 - Some may view a separate National Center as competing against the interest and attention given to the Thousand Points of Light Foundation.

B. POSSIBLE OPTIONS AS TO STRUCTURE OF A NATIONAL CENTER

The question of an appropriate structure depends heavily upon the functions the DPC recommends for the Center. Several structure options are outlined below:

Structure 1: A Coalition of Nonprofits (Encouraged By The President: No Legislation)

Several organizations, such as United Way, have expressed an interest in participating in an umbrella coalition. This coalition would be completely private in structure as well as funding. An expression of executive support could act as a catalyst. Such an expression of support would strengthen the nonprofits' efforts to seek private funding.

- Pros:
- This approach is likely to be tailored to the organizations' own perceived needs.

- ° Federal involvement would be minimized.
 - ° The coalition would fit well with the Thousand Points of Light Foundation.
- Cons:
- ° This approach may appear not to represent a sufficiently strong Administration commitment to aiding volunteer organizations.
 - ° The umbrella organization may become a captive of larger groups to the detriment of smaller organizations.
 - ° Without legislation, the coalition may be less effective.

Structure 2: A Federally Chartered Organization

This model would require federal legislation establishing a federal charter. Although the Center would be established by a federal charter, it would remain completely private in nature. While such legislation affords a symbolic acknowledgement of the worthiness of an organization's activities, it alone confers no legal benefits.

- Pros:
- ° This initiative would create a degree of public visibility and would result in concrete action.
 - ° The organization could be tailored to serve only those purposes deemed to be worthwhile.
 - ° The new entity would be able to chart its own course within broad limits.
- Cons:
- ° Failure of the entity could embarrass the Administration.
 - ° Any insurance functions proposed would compete with insurers who do not have the advantage of a federal charter.
 - ° Once chartered the organization would not be subject to federal controls even though it would benefit from the aura of federal approval.
 - ° Under present rules, a federal charter would require a waiver of the ten year state charter requirement.

Structure 3: An Adjunct To An Existing Federal Agency

The entity's operations could be folded into the operations of another agency, under existing statutory authorities and using currently available funds. This proposal would not require new legislation. For example, if the entity functioned only as an information clearing house, it could be folded into the operations of the Commerce Department or the Small Business Administration. Folding it into the operations of ACTION might also be a possibility.

- Pros:
- ° The new entity could benefit from the agency's established methods of implementing programs.
 - ° The entity could be established without new legislation.
 - ° The entity would have a secure base within the existing structure of government.
 - ° The entity's operations could readily be monitored and controlled.
- Cons:
- ° This could over-federalize the assistance of volunteerism.
 - ° This would be a drain on the agency's budget and divert funds from other equally worthwhile activities.
 - ° Coordination of private and governmental roles within the entity would be difficult.
 - ° It is not clear that an existing agency would have the funds or the authority to accomplish these goals.

Structure 4: An Adjunct To The Thousand Points of Light Foundation.

Depending on the functions assigned to it, the Center could serve as a useful complement to the activities of the Thousand Points of Light Foundation.

- Pros:
- ° The Foundation and the Center concept could be drafted to supplement each other, at least insofar as the dissemination of information is conceived.
 - ° This structure would avoid promulgation of two separate related initiatives in the same

general issue area and thus could reduce the potential for possible confusion.

- The entity could benefit from the groundwork that has been done to establish the Foundation.

Cons:

- The purposes of the Foundation and the National Center fill different needs and do not fit well together within a single organization.
- Of the purposes suggested for the National Center, only purpose (1) would be compatible with the Foundation's goals.
- Some of the functions that the proposed National Center could carry out, such as developing a working relationship with the insurance sector, may not be appropriate for a Foundation in which the President is substantially involved.



U.S. Department of Justice

Civil Division

Office of the Assistant Attorney General

Washington, D.C. 20530

April 24, 1990

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: ^{SMG} Stuart M. Gerson, Chairman
Tort Law Reform Working Group

SUBJECT: Medical Malpractice Reform

Attached for your review is a Memorandum with attachments detailing the status of actions of the Tort Law Reform Working Group regarding Medical Malpractice Reform.

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PRELIMINARY INTERIM REPORT

EXECUTIVE SUMMARY

After the DPC considered the Tort Law Reform Working Group's January 12, 1990 Memorandum describing various issues related to medical malpractice insurance and litigation, the DPC requested that the working group develop plans of action that might be taken pursuant to several groups of options. The following outlines the activities and analyses that ensued (with relevant subgroup reports attached at designated tabs), and seeks further direction for the completion of the matter.

The working group has now developed interim recommendations for action in three areas:

- a. Federal pilot projects;
- b. Amendments to the Federal Tort Claims Act (FTCA); and
- c. Broad-based national reforms.

The pilot projects considered include a Federal Employees Health Benefits Plan package offering an alternate disputes resolution (ADR) process to replace costly and time-consuming traditional litigation. We also describe an OB-GYN Community Clinics Pilot Project directed at providing obstetrical and gynecological services in designated rural and urban areas.

Whereas the first of these projects has an obvious connection with litigation and related factors that have increased insurance premium costs, the second is premised upon the assumption that the status quo has so limited the access of the urban and rural poor to physicians in a critical medical specialty that an alternative method of service delivery is the only effective short-term response. The other options pursued work to address tort reform and insurance issues directly.

Our approaches to possible amendments to the Federal Tort Claims Act and broader based state reform are essentially the same, the principal matters of distinction being the extent of effect and methods of adoption (purely federal or state-law adoptive or preemptive). Among the reforms here considered are limitations of non-economic damages, caps on awards and deductions for payments from collateral sources. To the extent that the DPC might seek to have the states alter their laws, we discuss several forms of incentives that might encourage or coerce such tort reform.

We also tie our discussion of process-based reforms to enhanced modes of quality assurance. Here we are motivated both by a pure desire to improve the quality of medical services and by the recognition that the current tort law system is justified

by many (although, as we show, the evidence does not support them) as an incentive (threat) to providers to avoid negligence.

Besides considering the options and activities we discuss, the working group would appreciate direction from the DPC concerning several overarching questions:

1. Whether significant preemption of state law through federal legislation (a problematic approach) should continue as a viable option (see II. C. 1 and 2 for discussion of tort reforms and incentives to states);

2. Whether coercive reforms tied to existing programs administered by the Department of Health and Human Services are suitable options for further consideration (see II. C. 2 to compare the range of incentives); and

3. Whether the incentives to the states must be budget neutral, and if not, to what extent they should involve new budget commitments (see I. B. and II. C. 2 and 3).

DISCUSSION

BACKGROUND

Since the mid-1970's there has been growing public concern over the effects of medical malpractice litigation. The past twenty years have seen a substantial increase in claim frequency, claim severity and medical liability insurance. During the mid-1980's medical liability was the fastest growing component of physicians' practice expenses, rising at an average annual rate of 21.9%. The rising costs of malpractice liability and the fear of suit have resulted in a concomitant increase in the cost of health care. Some physicians have responded to the threat of liability by performing arguably unnecessary procedures and by practicing defensive medicine. Others, especially in the field of obstetrics, have either changed specialties, moved to less costly areas of the country, or simply left the practice of medicine. The problem is particularly acute in the inner city and in rural areas. The result of the increased threat of liability, the increased cost of liability insurance and the defensive use of medicine has been an unprecedented escalation in the cost of health care for the average American.

The present medical liability system causes both direct and indirect costs. Direct costs include malpractice insurance, legal fees, and awards not covered by insurance. Indirect costs arise from professional services and tests that are not medically necessary, i.e., defensive medicine. The largest direct cost is malpractice insurance. Nationwide premiums for physicians totaled \$3 billion in 1984, being 4% of total spending for physician services. The adverse impact of unwarranted or

exaggerated medical liability concern is preventing the nation from having a health care system that produces the best outcomes at the least cost.

In an efficient world, damage awards would equal actual costs, individuals who were liable would pay those costs, and no physician would be induced by liability concerns to deliver more services than are medically necessary. In this ideal world the tort system would act as a deterrent to medical malpractice. Our research suggests, however, that at present the tort system does not deter medical malpractice because of certain inefficiencies. The ways the current world differs from the most efficient include:

- ° Insurance insulates liable individuals from the costs of their actions;
- ° Liable individuals have the ability to pass on those costs to third parties, usually insurers.
(Availability of obstetric services appear affected by medical liability for women to whom costs can not be passed along -- Medicaid recipients.)
- ° Among physicians there is widespread belief that awards are random. This is supported by a study by the Harvard School of Public Health which reviewed a large number of hospital records for evidence of negligence. Of the liability claims arising from the same universe of claims, one-half of those leading to awards were not among those the reviewers identified as instances of negligence.
- ° When adverse medical outcomes are observable, negligence is usually not. Even if we videotaped all patient/physician encounters, no template could be placed on the screen to see if the care was negligent. Any adjudication system must turn to observable like case notes and x-rays in deciding if negligence contributed to the adverse outcome.

To address these defects in the present system, the Working group examined several options, including federal pilot projects as well as model legislation backed by incentives for states to adopt the proposed reforms.

I. FEDERAL PILOT PROJECTS

A. Option I--Federal Employees Health Benefits Pilot Project

Establish a pilot project within the Federal Employees Health Benefits Program (FEHBP) offering an Alternative Disputes Resolution (ADR) process instead of costly and time-consuming litigation.

Tab A provides additional details.

Explanation

The FEHBP would offer a health-benefit package that would mandate the use of ADR as an alternative to litigation. This ADR process would require any enrollee (or any representative of the enrollee) seeking damages for alleged negligent medical treatment or care under an FEHBP contract to submit his or her claim for damages to binding arbitration or other ADR methods. Theoretically, the incentive for the enrollee would be lower premiums and immediate resolution of malpractice complaints. A neutral arbitrator would conduct a hearing and issue a decision binding on both the provider of medical services and the enrollee.

Purposes

This pilot project would test whether an ADR approach would result in beneficial effects such as the potential for a quicker, less costly resolution to claims, as well as a lowering of malpractice premiums for providers. In turn, whatever savings are achieved can be passed on to enrollees in the form of lower health insurance premiums.

PROS AND CONS

- Pros: ° Because arbitration is currently used in the private sector, establishing its use through a pilot project within the FEHBP can be done with relative ease.
- ° The visibility of a pilot project will demonstrate the Administration's concern about the adverse effects of protracted litigation on providers and enrollees.
- ° A pilot project would advance the President's interest in lowering the cost of health care.
- Cons: ° ADR may be viewed by enrollees as taking away some of their legal rights.

- ° The effects on defensive medicine will be difficult to measure.
- ° It is not certain that the benefits of ADR will result in a significant lowering of premiums such that enrollees will be willing to participate.

B. OPTION II--OB-GYN COMMUNITY CLINICS PILOT PROJECT

Background

The January 11, 1990 paper presented to the Domestic Policy Council tasked the Tort Reform Working Group with

[Developing] Special Measures to Mitigate [the] Impact of High Malpractice Premium Costs on Access to Obstetrical Care....

The paper states further, "DHHS would develop policy options and demonstration proposals involving limited non-preemptive Federal intervention where the high cost of liability insurance, coupled with inadequate reimbursement or a small client base (such as in isolated rural areas), is impeding access to obstetrical care."

Causes of the Problem

The task, described above, suggests that liability insurance costs alone are the principal reason that rural and urban low income woman may have difficulty finding adequate obstetrical care. While it is generally true that Ob/Gyns have either quit practicing or shifted to other areas of practice, we found other, more compelling reasons, why obstetrical care is inaccessible in certain areas of the country. For example, the isolation in rural areas makes it difficult for patients to find any medical care. In turn, women who do not have good prenatal care place themselves at greater risk of having an unhealthy baby or difficult birth. Women in rural areas live miles from an obstetrician and must travel distances for medical care and bear the added costs.

The Pilot Project

A pilot project in selected communities could coordinate and consolidate the existing diverse health and social services under one roof as easily accessible clinics. Their location could be near public housing which could increase the number of low income women who receive early and comprehensive care, thereby improving their health status and pregnancy outcomes.

A pilot project at the community level could require private sector funding as well as federal government monies and the use

of private and public sector facilities. A facility could assemble a team of mid-level practitioners such as nurse midwives, physician assistants, and nutritionists. Practitioners would be available twelve hours a day, seven days a week and take part in an on-call rotation for emergencies.

An obstetrician could attend at least once a week and identify those births which could be handled at that site and those which would have to be moved to more technically sophisticated sites. Communities would be made aware of the Georgia state model which has five regional centers for referral of difficult deliveries. There, expectant mothers are helicoptered to the hospital in emergency situations.

Summary of Proposal

The pilot project could:

- ° Expand the number of services the mid-level practitioners can safely provide to pregnant women;
- ° Locate facilities in Physician Manpower Shortage areas;
- ° Strengthen outreach and accessibility of services through publicity campaigns, indigenous workers, and volunteers;
- ° Link specialized services such as mental health services and substance abuse prevention to obstetrical care program;
- ° Provide education efforts regarding risk factors associated with births;
- ° Establish incentives, including office space for physicians, grants or loan forgiveness) to attract private sector health care providers to obstetrical care sites.
- ° Utilize volunteers;
- ° Institute transportation or referral services for likely high risk babies;
- ° Seek National Health Service Corps persons.

Tab B provides additional details.

Incentives for Participation

A significant consideration for those who participate in this pilot project would be providing a means for reducing potential liability to tort claims. Participation could be encouraged through a variety of means including--

- a. Designing the program to make use of one or more attractive Alternative Dispute Resolution techniques (see discussion at C (1) (g) below);
- b. Making HHS grant funds available (see Tab B); and
- c. Utilizing existing resources with HHS acting as a catalyst for improved efficiency.

PROS AND CONS

- Pros:
- ° The pilot project could target resources to areas in greatest need and give visibility to communities striving to redress the problem.
 - ° It could provide a catalyst for communities to coordinate services and resources in addressing the complex causes of inaccessible obstetrical care.
 - ° It relies on appropriate principles of federalism.
- Cons:
- ° The pilot project is a limited approach.
 - ° If money is not specifically budgeted it could divert funds from other planned federal efforts.
 - ° The approach does not address liability insurance or tort reform; it assumes that the status quo has created an identifiable need so severe that an alternative medical delivery system is the only reasonable short-term solution as broader tort reforms are encouraged and allowed to evolve.

II. BROAD-BASED NATIONAL REFORMS

A. Findings of Data Research Group

The Data Research Subgroup has completed an examination of state medical liability tort reform statutes and their impact on claim frequency, claim severity and insurance premiums. Based on available data, two reforms appear to be most effective. The first is capping -- placing a limit -- on either total damages or on non-economic damages such as pain and suffering (for example, the California statute has capped damages for non-economic losses

in medical malpractice cases at \$250,000). The second is reducing the amounts awarded by collateral payments attributable to the injury. Studies assessing the impact of state legislated reforms have found that limiting total recoveries is a most effective intervention, leading to drops in costs per claim of between 23% and 39%. Limiting non-economic costs -- "pain and suffering" -- has cut costs by up to 31%. Requiring offsets against amounts paid by other sources -- health insurance, workmen's compensation, etc. -- has been found to reduce costs by 11% to 21% and reduce the frequency of claims by 14%.

A condensed version of the Data Research Subgroup's findings is attached at Tab C.

In addition to capping awards and reducing awards by applying collateral sources, other reforms (such as Arbitration and Pre-trial Screening) also appear to be effective in reducing the amount awarded per claim. Care must be taken, however. Some variations of these reforms may actually increase the total payouts because they increase the ease of filing and obtaining resolution of claims.

Some reforms, while useful at the state level, may be counterproductive in practice if tied to federal statutes. Thus, the Federal Tort Claims Act -- the vehicle for recovering damages for medical malpractice claims arising from acts or omissions of government doctors -- could be adversely impacted if there were a prohibition on pleading the amount sought in complaints. Finally, opinion surveys indicate that an elimination of joint and several liability may have such an impact.

B. Findings of the Court Reform Subgroup

Numerous potential tort reforms have been reviewed by the Court Reform Subgroup. Three questions pertain to selection of the best reforms: (1) Which reforms work most effectively? (2) What mechanisms are most appropriate vehicles for implementation of reforms? and (3) What improvements in medical care can be linked with tort reforms?

The Court Reform Subgroup has approached its analysis by making a basic distinction between reforms which can be adopted as a matter of federal law and state law reforms. Of course, federal law reforms would in many instances not impact medical costs tied to insurance rates since the reforms would be effected only for claims against the United States.

C. Options for Broad-Based Reform

1. STATE LAW REFORMS

The following reforms could be included in a model state statute that could be promoted by incentives outlined in Part 2: "Incentives for state law reforms."

- a. Limit recovery through legislation by placing a cap on total damage awards or by placing separate caps on awards for economic and non-economic damages at a reasonable limit.

Damage awards for medical malpractice usually consist of two components: recovery for pecuniary losses, such as medical expenses and lost income, and compensation for non-economic damages, such as pain and suffering, loss of enjoyment of life and loss of consortium. Some jurisdictions also allow punitive damages in medical malpractice cases. Some states have placed caps on total recovery; others have placed separate caps on economic and non-economic damages.

PROS AND CONS

- Pros: ° Experience indicates that this reform can significantly reduce medical malpractice awards.
- ° This reform should materially affect the willingness of insurers to provide coverage at a reasonable costs.
- ° Twenty-nine states have passed laws limiting total damages or non-economic damages. Only six were declared unconstitutional by the relevant state supreme courts. Of those six states, three have passed revised legislation that has not been contested. Five states limit total damages: Colorado, Indiana, Virginia, Nebraska, South Dakota, and Ohio. The first three have upheld the constitutionality of the limits.
- Cons: ° A similar proposal was rejected by the Administration in recent product liability legislation. (Product Liability Reform Act, S. 1400)
- ° Capping awards strikes some persons as too extreme a course of action since it is viewed as denying a person full recovery of compensatory damages.

b. Prohibit double compensation by eliminating the collateral source rule.

Award damages reduced by the amount of compensation a person is entitled to receive from other sources, e.g., Social Security Disability, Medicare or Workmens Compensation.

The collateral source rule provides that benefits received by an injured party from sources other than the defendant (e.g. Workmen's Compensation) may not be used to offset the damage recovery from the defendant. This permits the plaintiff to obtain double recovery of certain components of damages. The rule has been accepted by almost all jurisdictions and has been applied both as a rule of evidence and as a rule of damages. The rationale for the collateral source rule is that a wrongdoer should not be relieved of paying a tort injury simply because the plaintiff had access to other resources.

PROS AND CONS

Pros: ° Elimination of public payments from medical malpractice tort awards is more reasonable than permitting plaintiffs to obtain a double payment for the same damages.

- ° Reduction of damages by the amount of payments from public sources can have a substantial impact on damage awards.

Cons: ° Enactment of this modification in the collateral source rule may only have a marginal impact on medical malpractice insurance rates.

- ° The proposal might require modification of enactments benefiting the Social Security Trust Funds.

c. Require structured judgments in some cases.

Require or permit courts to award damages in the form of structured payments in some cases either for all damages or for damages attributable to future payments and costs.

Traditionally, medical malpractice judgments and settlements are paid in lump sums. These payments often include compensation for anticipated future medical expenses or lost earnings. The premature death of the claimant often creates a windfall for the heirs if a significant portion of the judgment or settlement is based upon future damages.

PROS AND CONS

- Pros: ° Structuring future payments will prevent windfalls.
- ° The provision for payments over time may assist in risk assessment and insurance underwriting.
- Cons: ° These provisions may be used as an excuse for introduction of evidence of very speculative damages.
- ° Structured payment provisions may inhibit careful post-trial and appellate review of the amounts of damages awarded.
- d. Shorten the statutes of limitations.

Limit the period in which the statute of limitations can be tolled due to minority, enact a reasonable discovery rule and enact a statute of repose.

The primary purpose of a statute of limitations is to prevent the prosecution of stale claims. With the passage of time, evidence may be lost and witnesses may disappear. Many courts felt that the traditional statute of limitation rules were too harsh in medical malpractice actions and they fashioned what is commonly known as the discovery rule. Under the discovery rule, the patient's statute of limitations period does not begin to run until he or she discovers or reasonably should have discovered the medical injury. This open-ended discovery principle, however, created problems for health care providers and insurers. The uncertain and potentially long period within which a medical malpractice action could be brought made it difficult for insurers to develop actuarial estimates upon which to base medical malpractice premiums.

PROS AND CONS

- Pros: ° Limitation provisions have almost been disregarded because of the numerous escape valves in current law; the reforms will provide more of a legal basis for applying reasonable reforms.
- ° Fraudulent claims and claims pursued tardily when the evidence to rebut the claims is lost will be limited.

- ° Many state laws on their face permit too many exceptions.

Cons: ° Reform of limitations will cause uncertainty in areas where the law is currently settled.

- ° The effect of these reforms on medical malpractice costs will be seen only after years have past.

e. Eliminate joint and several liability.

Eliminate joint and several liability for non-economic damages (pain and suffering and emotional distress) only.

Under the rule of joint and several liability, plaintiffs may require any one of two or more defendants to pay the full amount of a judgment. In most jurisdictions, the paying defendant frequently has a right to recover from the co-defendants. However, if the non-paying defendants are insolvent, this right of recovery is meaningless. As a result, in many cases the defendant with the most limited role in causing the injury but with the deepest pocket bears the greatest share of the damage award.

PROS AND CONS

Pros: ° This reform is in concert with recent Administration proposals in product liability legislation. (Product Liability Reform Act, S. 1400)

- ° This reform builds upon recent state (e.g. California) reforms.

Cons: ° Only tackles a fraction of the problem caused by malpractice liability.

- ° Does not have a strong theoretical basis, i.e., all forms of "compensatory" damages rationally should be treated in the same manner within the judicial system.
- ° Limitations that only apply to joint and several liability for non-economic damages can be evaded by increasing economic damages without regard to the damages actually proved.

f. Prohibit use of ad damnum clauses.

Prohibit specific monetary requests in pleadings.

An ad damnum clause in a complaint states the amount of recovery sought by plaintiff. In medical malpractice actions, the amounts of damages claimed may be greatly inflated. As a result, the insertion of a large ad damnum in the complaint can condition the public to accept extremely large sums as appropriate measures of damages.

PROS AND CONS

- Pros: ° Prohibiting use of ad damnum clauses will limit somewhat unfair publicity when a suit is filed.
- ° By limiting the publicity value of a large ad damnum, physicians' fears may be reduced.
- Cons: ° The abolition of ad damnum clauses will not have any effect on medical malpractice costs.
- ° There is no benefit to the government in elimination of ad damnum clauses.

g. Alternative dispute resolution.

The following is a list of alternate dispute resolution (ADR) techniques that could be incorporated, in whole or part, as part of the tort reforms to be enacted by the states.

Arbitration

PROS AND CONS

- Pros: ° A neutral opinion can effect a reasonable resolution without the expense incident to trial.
- ° Arbitration permits speedy resolution of claims.
- Cons: ° Litigants will want their "day in court."
- ° Arbitration procedures will not permit full development of the relevant facts bearing on liability and damages.

Mediation

- Pros: ° Mediation may enable parties to arrange a settlement more readily than would otherwise be the case.
- ° Mediation is not coercive in the sense that it contemplates that the parties will need to mutually agree to any resolution and will themselves design the parameters of any settlement (with the mediator's assistance).
- Cons: ° Mediation may not be effective since there is no sanction attached to failure to proceed reasonably.
- ° Mediation does not work as well until after a substantial effort has been expended in litigation through the discovery process.

Mini-trials

PROS AND CONS

- Pros: ° A mini-trial permits the fact finding process to be brought to bear on a claim while avoiding expenditures necessitated by a full trial.
- ° Some cases can be settled after a mini-trial.
- Cons: ° Mini-trials require a substantial expenditure of resources.
- ° By adding still another procedural vehicle to the litigation process, mini-trials may delay and make more expensive the already drawn out litigation process.

Pretrial screening panels

PROS AND CONS

- Pros: ° The Maryland experience and some others indicate that this reform can be effective in reducing liability costs.
- ° Pretrial screening is readily tied to quality of care reform.
- Cons: ° Pretrial screening is frequently viewed as physician controlled.
- ° Pretrial screening is sometimes viewed as just another

procedural addition adding to the complexity and cost of litigation.

Mandatory notice to clients of ADR options instead of trial

PROS AND CONS

- Pros: ° Notice assures that the client has the final say before drawn out litigation proceeds.
- ° Notice is not coercive--it is informative.
- Cons: ° This reform may not produce any material effect on the litigation process.
- ° The notice requirement is dependent upon the development of attractive options.

Mandatory settlement conferences

PROS AND CONS

- Pros: ° The pros for mediation apply here.
- Cons: ° The cons for mediation apply here.

No Fault System (O'Connell)

PROS AND CONS

- Pros: ° Provides a way out of the tort system that could benefit all concerned. Claimants could receive compensation more rapidly. Putative defendants could on the average pay less.
- ° The decision to offer a payment rests with the person who can otherwise anticipate suit.
- ° The adverse political baggage of other, exclusive remedy type reforms may not be present.
- Cons: ° It may be over-optimistic. Prospective defendants may utilize this approach only when they are clearly liable and damages can be ascertained at an early date.
- ° It may prove to be difficult to purchase insurance covering all future economic losses when the losses are debatable or uncertain.
- ° Efforts to perfect this reform may detract from other needed reforms.

Certificates of Merit¹

PROS AND CONS

- Pros: ° Maryland's experience indicates that this requirement reduces the number of claims.
- ° Screens claims that are devoid of merit out of the litigation process.
- Cons: ° This requirement may prove too onerous if the sanction closes the courthouse door to an injured person.
- ° The requirement might be so broadly drawn as to invite a "conspiracy of silence" argument from opponents.

Offers of Judgment

PROS AND CONS

- Pros: ° Offers of judgment force parties to assess the strengths and weaknesses of their cases soberly.
- ° If settlement is unreasonably refused, costs are shifted to the unreasonable party.
- Cons: ° Offers of judgment are available to defendants in many instances already.
- ° The threat of shifting costs may be ephemeral to a plaintiff who has no assets.

2. INCENTIVES FOR STATE REFORMS

Selection of the best tort reforms depends, not only upon the intrinsic merit of each reform, but also upon the mechanism utilized to adopt the reform. While amendment of the Federal Tort Claims Act is feasible, that approach will not affect medical costs, insurance availability or availability of medical care. State reforms will be necessary to accomplish these ends.

Mechanisms vary for adoption of state reforms; these mechanisms carry baggage that may not be desirable for policy reasons separate from the effects of the reforms on the medical

¹ This is not technically an ADR method. However, it has been used successfully in Maryland and other states with various ADR approaches.

care/tort systems. Pros and cons of a coercive, preemptive type of mechanism include--

PROS AND CONS

- Pros: ° A preemptive approach will not be subject to invalidation on state constitutional grounds.
- ° Preemptive legislation need only be enacted by one legislature--the Congress--rather than by 50 different legislatures in each state.
 - ° The Administration can control reforms most directly through selection of preemptive mechanisms.
 - ° A preemptive approach will be effective in reducing medical malpractice costs.
- Cons: ° Use of preemptive mechanisms to impose tort law upon states may be difficult to reconcile with federalism principles.
- ° Even limited preemptive mechanisms will require legislation; it will be very difficult if not impossible to obtain effective legislative action at least in the immediate future.
 - ° Utilization of preemptive mechanisms tied to availability of other federal programs/funds may be perceived to be harmful to the programs' beneficiaries.
 - ° The limited scope of some preemptive measures would result in reforms being only partially effective.

Incentive Options

The following incentives could be used to encourage states to adopt malpractice reforms. They are listed in descending order from the most preemptive to the least.

- (1) If states fail to enact minimal malpractice and quality of care reforms within a specified period of time, state medical malpractice tort laws could be preempted by federal law.

PROS AND CONS

- Pros: ° This option is the most straightforward, and the option most likely to lead to rapid compliance.
- ° Preemption could be coupled with a specific exclusion for states meeting federal standards in their own law

and practice--this approach has been used successfully in other cases (occupational safety and air pollution control).

- ° Does not involve the political risk inherent in incentives that involve cutting off federal benefits.

- Cons:
- ° Difficult to reconcile with Federalism principles.
 - ° May conflict with view that preemption should be reserved as a measure of last resort for special cases.
 - ° Would require a detailed specification of how federal laws would preempt state laws in the event of a state's failure to act.
 - ° Would be politically impractical. The proposal would be referred to judiciary committees, which are likely to be less receptive than health committees.

(2) If states fail to enact malpractice and quality of care reforms that meet minimum standards within a specified period of time, HHS could discontinue certain discretionary funding for those states.

PROS AND CONS

- Pros:
- ° Could be effective since few states are likely to risk the penalty involved.
 - ° Could be characterized as necessary to help reduce adverse impact of "defensive medicine" costs on health care programs.
- Cons:
- ° Could give the appearance of depriving innocent beneficiaries of medical care or of using trust funds for unrelated "political" purposes.
 - ° States may not be willing to try to pursue goals and objectives required by the Federal government.
 - ° Places the Secretary of HHS in the position of withholding funds from a large segment of the population.

(3) If states fail to enact malpractice and quality of care reforms that meet minimum standards within a specified period of time, a surcharge may be imposed on Medicare premiums in those states.

PROS AND CONS

- Pros:
- ° By enlisting political support of elderly groups at state level, may help to ensure that states enact desired reforms.
 - ° A modest 5-10% surcharge could be justified by assumption of higher costs to Medicare due to defensive medicine in states that have not enacted the minimum reforms.
 - ° Avoids the negative impact of threatening to terminate Medicaid or Medicare benefits.
- Cons:
- ° Enactment of a surcharge at the federal level is likely to be strongly opposed by elderly groups.
 - ° May be somewhat less effective in ensuring state compliance than other stronger incentives.
 - ° Would penalize elderly groups and is not directly related to Medicare program.

(4) If states fail to enact malpractice reforms that meet minimum standards within a specified period of time, Medicare payments to hospitals and physicians could be reduced by 5 percent to offset higher costs of defensive medicine.

PROS AND CONS

- Pros:
- ° Provides added political pressure at state level to enact reforms.
 - ° Does not involve the political risk inherent in incentives that involve cutting off federal benefits.
- Cons:
- ° May be perceived by health care providers as an unfair approach.
 - ° May put Medicare beneficiaries at risk.

(5) Positive incentives, such as technical assistance, planning grants, and start-up grants to states willing to enact reforms, should be created.

PROS AND CONS

- Pros: ° Demonstrated benefits of reform in an increasing number of states would, over time, create the political climate for reform in other states and even for enforceable penalties for a small number of recalcitrant states.
- ° Would not penalize indigent or elderly persons.
 - ° Would be directly related to reforms.
 - ° Would not run counter to federalism principles.
- Cons: ° To be effective, incentives would have to be of sufficient magnitude to cause states to enact reforms. This would have negative budgetary implications.

The "carrots/sticks," described above, will be implemented if the states succeed/fail in adopting the proceeding court reforms and the following quality of care reforms. These proposals have not been fully developed, but represent a prototype of a possible malpractice/quality of care reform proposal.

3. QUALITY ASSURANCE PROGRAMS

Any state reforms would need to be accompanied by appropriate quality assurance programs. The working group needs to study this area further. In particular, the Data Research Subgroup is gathering data to ascertain the effectiveness of quality assurance and state licensure mechanisms in bringing down the incidents of medical malpractice. The working group is exploring the following options.

Quality Assurance Options

In order to improve the quality of care and reduce the incidence of malpractice, states could be required to adopt the following quality of care reforms:

1. Require professional society review of malpractice complaints (either liability actions or complaints made to state boards) against member physicians to ascertain whether the allegations of malpractice have merit. If so, expulsion from the professional society should be the potential penalty.

PROS AND CONS

- Pros: ° Professional societies are best able to determine whether malpractice has occurred.
- ° Membership in professional societies is extremely important to most physician--far more physicians belong to professional societies than medical associations. The threat of a negative report or termination from the professional society will have an impact on physicians.
 - ° It is in the professional societies' best interest to ensure that their members are providing quality care to their patients and to remove those physicians that are providing substandard care.
- Cons: ° Professional societies may be reluctant to expel their own members.
- ° Expulsion from professional societies does not necessarily result in the loss of a medical license.

2. Expand membership of the governing councils of state medical licensing boards to include a majority of non-physicians.

PRO AND CONS

- Pros: ° This proposal is advocated by the American Medical Association's fault-based administrative system proposal.
- ° Could make medical licensing boards more responsive to public concerns.
- Cons: ° Could increase fiscal burden on some states.
- ° Mandated funding or staffing might be used ineffectively.
 - ° May be difficult to be sure that funding reaches actual entity that is responsible for investigating and taking disciplinary action.

3. Require periodic re-examination of physicians.

PROS AND CONS

- Pros: ° Could strengthen public confidence in the profession.
- ° Could assess knowledge base needed for competency
 - ° Could provide strong incentives for physicians to be serious about continuing education.
- Cons: ° Written examinations cannot test manual skills and character traits needed for competency. May favor physicians newly admitted to practice who are familiar with test-taking and discriminate against physicians who have not taken written examinations for a number of years.
- ° Could be difficult to develop fair traits.
 - ° Could be perceived as a new form of bureaucracy.

4. Require collection of patient outcome statistics by state boards to facilitate monitoring of quality and targeting of corrective action.

PROS AND CONS

- Pros: ° Could assist disciplinary entities by providing access to quality of care statistics.
- ° Would permit state boards to monitor quality of care, and target investigations and corrective actions more effectively.
 - ° Builds on systems being developed to monitor quality of care for Medicare.
 - ° Data gathering is also needed to conduct effectiveness and outcomes research.
- Cons: ° A substantial cost could be imposed on state boards or on hospitals; question whether clerical personnel would be able to review and abstract clinical and outcomes data from hospital medical records.
- ° Question whether extending data system from Medicare to all patients would yield sufficient additional information to justify the added cost.

- ° Could create presumption of liability if quality of care standard is not met, but negligence has not occurred.
- ° Could be perceived as a new bureaucratic organization.
- ° Unfunded mandate imposed upon the states.

5. Require state boards to conduct ongoing reviews of hospital and physician office records to detect quality of care problems (similar to the Medicare PRO program).

PROS AND CONS

- Pros:
- ° Boards would become more proactive and would search out quality of care problems.
 - ° Hospitals have the greatest leverage over physicians. Fear of losing hospital privileges should have a significant impact on physician behavior.
 - ° Would be similar to Medicare PRO reviews.
- Cons:
- ° Could be very expensive.
 - ° Dilemma of whether to disclose findings of review to patient in cases where substandard care is detected.
 - ° Might increase transaction costs for physician.
 - ° Would be extremely difficult to review all physician office records. Could discourage record-keeping.
 - ° Imposes an unfunded mandate on the states.

6. Apply organizational liability to hospitals and managed care providers. (Hold organization primarily liable for actions of physicians.)

PROS AND CONS

- Pros:
- ° Could create strong incentives for more effective institutional oversight of physician practice and effectively ensure quality control.
 - ° Could reduce the burden of high insurance premiums on individual practitioners.
 - ° Would reduce "finger-pointing" between physicians and hospital personnel during malpractice litigation and help reduce transaction costs.
- Cons:
- ° Could lead some hospitals to inappropriately narrow their range of services, with a tendency to reduce high risk procedures.
 - ° Could intensify anti-competitive tendencies that could come into play in the process of extending medical staff privileges.
 - ° Likely to be opposed by physicians because of a fear of loss of control and autonomy.
 - ° Likely to be opposed by hospitals and managed care providers because of the cost of extending liability coverage.
 - ° Third-party payers would need to readjust payment rates for hospital and physician services. This might be a fairly complex undertaking.

4. FEDERAL REFORMS THROUGH AMENDMENTS TO THE FEDERAL TORT CLAIMS ACT

The same reforms listed in the "State Law Reforms" section above could be enacted through the Federal Tort Claims Act (FTCA). This would mean that the reforms would apply in cases where the government is sued in tort. Such an approach could provide a laboratory within which to ascertain the effectiveness of each reform. It would provide a model for the states in a less preemptive fashion than described above.

PROS AND CONS

- Pros: ° A federal enactment would encourage state legislatures to follow the same course.
- ° A federal enactment would apply only to tort suits against the government and would be less preemptive.
- Cons: ° Amendment of the FTCA will not affect malpractice insurance rates.
- ° Amendment of the FTCA will not affect the physicians' liability since payments under the FTCA do not come from physicians or from agency appropriations.

Since the impact of amendments to the FTCA is limited to the effect of the amendments on the federal treasury (judgments and settlements are not paid from agency funds but instead are paid from the general government-wide Judgment Fund), any reforms to the FTCA will not affect medical malpractice insurance costs or defensive medicine practices either in the federal government or privately. There will be no constituency for any such amendments. However, such amendments might serve as a model for state reforms.

Alternative Disputes Resolution

Option 1 - Federal Pilot Project

Establish a pilot project within the Federal Employees Health Benefits Program (FEHBP) using an Alternative Disputes Resolution (ADR) process as an alternative to litigation.

Explanation

The FEHBP would offer a health-benefit package which would mandate the use of ADR as an alternative to litigation. This ADR process would require any enrollee (or any representative of the enrollee) who is seeking damages for alleged negligent medical treatment or care under an FEHBP contract to submit that claim for damages to binding arbitration. Theoretically, the incentive for the enrollee would be lower premiums and immediate resolution of malpractice complaints. A neutral arbitrator would conduct a hearing and issue a decision binding on both the provider of medical services and the enrollee. The pilot project would be limited at first to staff model health maintenance organizations (HMO) and their enrollees because of the direct providing of medical services inherent in the nature of an HMO. Later, we would consider expanding the scope to other plans, including fee for service, although the fee for service plans present unique and difficult legal questions.

Purposes

This pilot project would test whether an ADR approach would have some beneficial effects on resolving serious disputes regarding the providing of medical services. The more immediate effect is the potential for a quicker, less costly (both in terms of administrative to the provider and personal to the enrollee), and less traumatic resolution to these types of disputes. The less immediate and more difficult to measure effect is the potential for this process to result in lower malpractice premiums for providers which, in turn, can be passed on to enrollees in the form of lower health insurance premiums. An even more indirect effect is the potential for a decrease in the practice of defensive medicine e.g. unnecessary testing and hospital stays, of providers which could also translate into premiums savings.

Pros and Cons

Pros:

- Because arbitration is currently used in the private sector, the establishment of a pilot project within the FEHBP can be done with relative ease.

- The visibility of the pilot project will demonstrate the administration's concern about the adverse effects of protracted litigation on providers and enrollees.
- The pilot project would advance the President's interest in lowering the cost of health care.

Cons:

- ADR may be viewed by enrollees as taking away some of their legal rights.
- The effects on defensive medicine will be difficult to measure.
- It is not certain that the benefits of ADR will result in a significant lowering of premiums such that enrollees will be willing to participate.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

April 2, 1990

TO: Stuart M. Gerson
Assistant Attorney General
Department of Justice
Chairman, Tort Reform Working Group

FROM: Grover G. Hankins *LYN 4/2/90*
Principal Deputy General Counsel

RE: Draft Status Memorandum

Earlier today I forwarded a copy of the Report of Subgroup 2 (hereafter "the Report") on Access to Obstetrical Care to Steve Brandsorfer for review and comment. The Report has not received the Department's official blessing and must be reviewed by the Department's Policy Council before it can be viewed as the Department's position on the matter.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

TO: Stuart M. Gerson
Assistant Attorney General, DOJ
Chairman, Tort Reform Working Group

FROM: Grover G. Hankins *Grover Hankins*
Principal Deputy General Counsel
Chair, Option 2 Subgroup

SUBJECT: Report of Subgroup 2 on Access to Obstetrical Care

This report describes the purpose of our subgroup work, discusses reasons for inadequate obstetrical care, and presents our proposed pilot project, including a discussion of its merits and faults. In an attachment we provide a brief overview of current and planned DHHS activities on issues related to access to obstetrical care and describe a few state programs.

The proposal has not yet been reviewed by the Policy Council at the Department of Health and Human Services, largely because of time constraints. We are preparing for that meeting but do not expect it before the Domestic Policy Council meets.

PURPOSE

The purpose of our effort was defined by the Tort Reform Working Group as Option 2 in the January 11, 1990 paper to the Domestic Policy Council.

[Develop] Special Measures to Mitigate [the] Impact of High Malpractice Premium Costs on Access to Obstetrical Care....

The paper states further, "DHHS would develop policy options and demonstration proposals involving limited non-preemptive Federal intervention where the high cost of liability insurance, coupled with inadequate reimbursement or a small client base (such as in isolated rural areas), is impeding access to obstetrical care."

REASONS FOR THE PROBLEM

The above description of the task suggests that liability insurance costs alone are the principal reason the rural and urban low income woman may have difficulty finding adequate obstetrical care. We found other, more compelling reasons that obstetrical care is inaccessible. For example, the isolation in rural areas makes it difficult for patients to find any medical

care. In turn, women who do not have good prenatal care place themselves at greater risk of having an unhealthy baby or difficult birth.

Women in rural areas live miles from an obstetrician and must travel distances for medical care and bear the added costs.

The problem of inaccessible medical care generally due to isolation is exacerbated by several factors: (1) low Medicaid reimbursement rates and (2) trends in birth rates. The decrease in births of middle-income infants and increase in those of lower income may be discouraging medical students from entering the obstetrical specialty. In addition, reference is often made to the high cost of malpractice insurance.

Because of the number of persistent and long-standing conditions that could cause shortages of obstetrical care, we defined the task as one of improving access to prenatal and obstetrical care, and not on ways to pay for liability insurance. The reasoning is that if we improve the likelihood of a healthy baby we reduce the opportunities for suit and need for liability insurance. Furthermore, because of the minor role insurance plays, the Department considers it unsound public policy to pay liability insurance premiums of one or a particular group of physicians. Subsidizing a group of non federal physicians would set the wrong precedent.

As indicated in the attachment, the Federal, State and community governments have been innovative in recruiting more obstetricians and related providers, in financing medical care and in educating low income women so as to get the necessary perinatal care to make deliveries less troublesome. These efforts should begin to alleviate the problems despite the complexity of causes.

PILOT PROJECT **Increasing Service Delivery in Shortage Areas.**

General Description.

Low income women and their babies are at high risk for adverse outcome, due in part to their failure to receive proper medical treatment, poor nutrition, opportunities for drug and alcohol use, erratic employment patterns and a host of other social factors. They need, and are eligible for a variety of health and social services. These services may be available from multiple public and private agencies but they have different and confusing requirements. In addition, the splintered services make travel to numerous sites a necessity. The time and effort necessary to find the services create additional barriers to the use of the services.

The concept and components of this proposed demonstration project would coordinate health and social services as feasible. We

think that coordination of health services, for example, near public housing will increase the number of low income women who receive early and comprehensive care, thereby improving their health status and pregnancy outcomes.

The pilot project at the community level would require private sector funding as well as federal government monies and the use of private and public sector facilities. The facility would assemble a team of mid-level practitioners such as nurse midwives, physician assistants, and nutritionists. Practitioners would be available twelve hours a day, seven days a week and take part in an on-call rotation for emergencies.

An obstetrician would attend at least once a week and identify those births which could be handled at that site and those which would have to move to more technically sophisticated sites. Communities would be made aware of the Georgia state model which has five regional centers for referral of difficult deliveries. There, expectant mothers are helicoptered to the hospital in emergency situations.

Outreach

A number of demonstrations have confirmed that community based comprehensive programs are highly beneficial for the underserved. Outreach, case management, and tracking systems for the high-risk woman are key components of a successful effort. Successful outreach requires a variety of activities, including information campaigns. The use of indigenous workers and/or volunteers could also help.

Location

An excellent location would be near public housing so as to minimize the transportation difficulties. Sites which have existing outreach services and emphasize primary care would also be good. Other good candidates include sites where state or community and private funds are already involved or where particular efforts service minority populations.

The site must be within one of the nearly 2000 areas identified in the (primary physician) Manpower Shortage Areas list.

Funding

The federal government will make available grant funds to communities that can assemble the practitioners identified above and can demonstrate that the community leaders are committed to its success. Under Section 339 and 340 of the Public Health Service, funds have already been designated for community health centers.

States and communities are encouraged to integrate the use of funding authorities already in existence such as block grants, categorical grants, entitlement programs and research and demonstration authorities.

The Use of Volunteers

There are numbers of federal volunteer programs which might be tapped for use at the sites. These include ACTION, VISTA, Foster Grandparents, and Retired Senior Volunteer Program.

Volunteers from community based groups might also be available and should be considered.

Adjudicating Malpractice Liability Claims

The willingness of the community to set up arbitration or pre-trial screening panels is required. Arbitration is an alternative to and in lieu of trial by jury: it is not merely a condition precedent to trial. In addition, any subsequent judicial review of the claim is limited. In these elements it is distinguished from pretrial screening panels.

Arbitration could be elected by the injured party or heirs by means of a contract, executed either before or after filing a claim, or it could be statutorily mandated. Medical liability claims currently can be arbitrated in most states under the general arbitration statutes of those states.

Some advantages of arbitration are:

- o For the patient, the claim should be resolved more quickly.
- o More patients could file a claim and receive compensation. Currently lawyers are reluctant or unwilling to handle small claims because there is little or no revenue for them.
- o For providers, arbitration is a less visible process and less damaging to their reputations.
- o For providers the decision is less emotional and more likely to be determined on the basis of technically correct information.

Pre-trial Screening Panels. These are non judicial mechanisms which hear the merits of medical injury cases and conclude with an opinion. They are different from arbitration because they precede a trial and are not in lieu of it. Unlike arbitration, the panel's decisions are not binding. Although the results may be used in court, the panel's findings are not binding upon the

court.

No Fault Liability Model Under this model, a provider would have 180 days to offer a settlement to a patient. Such a settlement would be limited to economic losses and would not include payment for pain and suffering or punitive damages. In response to a timely offer, a patient could request an administrative hearing to determine the sufficiency of the settlement, but would be foreclosed from going to court.

Federalization of Health Care Professionals High risk health care zones would be established for purposes of meeting obstetrical care needs. Criteria to establish these zones would include but are not exclusive to high incidence of low birth weight babies and babies that evidence complications pre, during, and post delivery. Once a community is designated as a high risk zone, health care professionals in or near the area in question may be "deputized" to work in the zones under the umbrella of the Federal Torts Claim Act.

General Criteria for Selection

Because of the diversity of geographic areas and available resources, the following features would be given priority. These are adapted from the Community Based Infant Health Initiative, previously sent to the Domestic Policy Council.

- o Expand the number of services the midlevel practitioners can safely provide to pregnant women.
- o Locate the facility in one of the Physician manpower Shortage areas.
- o Strengthen outreach and accessibility of services through publicity campaigns, indigenous workers, and volunteers.
- o Link specialized services such as mental health services and substance abuse prevention to obstetrical care program.
- o Provide education efforts regarding risk factors associated with births.
- o Establish incentives to attract private sector health care providers through creation of obstetrical care sites. Incentives could include: provision of office space to physicians, grants or loan forgiveness.
- o Utilize volunteers.
- o Institute transportation or referral services for

likely high risk babies.

- o Seek National Health Service Corps persons.

Pros

- o Targets resources to areas in greatest need and gives visibility to communities striving to redress the problem.
- o Provides a catalyst for communities to coordinate services and resources in addressing the complex causes of inaccessible obstetrical care.
- o Relies on appropriate principles of federalism.

- o Should reduce malpractice suits and the threat of suit, thus allowing liability premiums to stabilize. Reducing the threat of suit should improve the patient doctor relationship.

Cons

- o Is a limited approach.
- o Unless \$6 - \$10 million is specifically budgeted for this effort, it could divert funds from other planned Federal efforts.

Attachment A

FEDERAL GOVERNMENT ACTIVITIESOn-going Efforts Related to Obstetrical Care

In fiscal year 1990, The Department of Health and Human Services will spend more than a quarter billion dollars in a number of programs and block grants to help the underserved pregnant woman.

- o For example, the Maternal and Child Health Block Grant will spend \$554 million this year. States have discretion to apportion those funds according to the particular health needs in their jurisdictions.
- o An additional \$516 million is earmarked for the Community Health Center and Migrant health Center (C/MHC) Programs some of which will serve pregnant women. These programs provide primary care to about 5.5 million people, many of whom are low-income women.
- o In fiscal year 1989, an estimated \$2.8 billion and \$2.2 billion was spent by Federal and state governments, respectively, on Medicaid-reimbursed services to infants and pregnant women. Of the total, \$3 billion was spent for pregnant women.

Planned Activities

The Departmental has proposed three initiatives related to obstetrical care: two, Access to Care and Minority Health, would highlight ways to remedy access to care generally; the third, Infant Mortality, deals directly with the problems of the pregnant woman.

- o Task Force on Infant Mortality: Domestic Policy Council Working Group on Health Policy

Because infant mortality is an issue which cuts across many areas of Federal responsibility in addition to the Department of Health and Human Services, a task force on infant mortality was created in July 1989 at the request of the Domestic Policy Council Working Group on Health Policy. It was charged with assessing the nature and causes of infant mortality and proposing actions that would have the potential for reducing infant mortality and improving maternal and child health.

The Task Force included representatives from nine

departments and one agency of the Federal government and six offices within the Office of the President and was chaired by Dr. James O. Mason, Assistant Secretary for Health. A draft report containing policy options was presented by the Secretary to the Domestic Policy Council on November 30, 1989.

The general approach taken by the Task Force was to expand access to prenatal care. The recommendations can be divided into three categories: service delivery, financing, and information and education. Since the service delivery options are relevant to Option 2, some are listed below.

1. To increase support for C/MHCs and the Maternal and Child Health Block Grant.
2. To develop research and demonstrations on medical malpractice related matters including the examination of barriers facing midlevel providers of obstetric care.
3. To organize and deliver services that would provide comprehensive prenatal care services to women at risk. The projects would utilize resources from the Federal, State and community governments and the private sector. Specific options include:

The Domestic Policy Council was concerned with the likely costs of the proposals and asked the Task Force to develop additional information about the costs and benefits and resubmit the proposals later in 1990. Work is underway.

o Secretary's Access Initiative

The Secretary's access initiative is one of five DHHS initiatives and is directed specifically at low-income and minority pregnant women and infants. It is seen as the first step in a broader effort to expand access to health care. That broader effort is the subject of the Under Secretary's Health Policy Task Force. The major theme of the initiative is "Making HHS User Friendly" to users and potential users of our services.

The six components or objectives of the initiative are:

- Outreach and Support Services
- One-Stop Shopping
- Availability of Health Care Providers
- Substance Abuse Prevention and Treatment
- Medicaid Eligibility and Reimbursement
- Annual Secretarial Conference on Access to Care/Directory of Federal Assistance

The President's FY 1991 budget requests an increase of \$363

million to reduce infant mortality. This includes \$300 million to the Health Care Financing Administration to expand Medicaid eligibility, as specified in OBRA 1989, and \$63 million for Public Health Service activities. Included in the request for \$63 million is:

- o a \$10 million addition to C/MHCs to recruit and retain additional obstetrical personnel;
- o \$4 million for their expanded use of case managed services for pregnant women
- o and \$2 million to support the operation of "Mom Vans" to provide outreach services to bring women into care.

o Minority Health Initiative

The FY 1991 budget requests \$117 million in new funds to be devoted to improving minority health. Several of the component parts of this initiative are related to Option 2's mission:

1. Expand the National Health Service Corps. A \$55 million expansion of the NHSC would include funds for NHSC loan repayment and scholarships. The purpose is to recruit more doctors by increasing the numbers of areas where they may serve.
2. Provide scholarships through "community service" private organizations. Five million dollars is proposed for this program in the FY 1991 budget. This is a new program which would help community organizations support health professions students of their choice who would owe the community organization a service obligation upon completion of their education.
3. Provide health and other services at locations convenient to public housing. \$35 million is requested. This might be a possible source for funding innovative service delivery demonstrations

STATE ACTIVITIES

A sample of efforts by states to assure the availability of primary care physicians and other providers of obstetrical care for the underserved populations reveals a number of innovations. The following are illustrative.

New Jersey. In May, 1990 New Jersey will launch a program of universal access to prenatal care. The Maternity Outreach and Managed Services program, known as MOMs is

targeted at the estimated 10,500 women in the state above the poverty level. The new program will expand and link two existing ones. The state's 18-month old Health Start for Medicaid eligible women provides free prenatal care and preventive care for children under age 2. The special trust fund which reimburses hospitals for medical care provided to those who cannot pay their bills will provide funding for the new program. The program could save \$4 million if the number of low birth-weight babies could be reduced by one-third.

Small towns in Maine. Six towns in Maine where the combined population is 3500 assured themselves of a physician by paying tuition costs for Roger Pelli to the New England College of Osteopathic Medicine. Dr. Pelli promised to give back to the communities two years of service for each year of schooling they paid for. The townspeople paid the tuition from property taxes, averaging \$5 per year for each man, woman and child. Dr. Pelli has completed college, internship and residency, and is pleased to be serving the townspeople of the six communities.

In Kentucky and California there are programs to supplement physician manpower with physician extenders. There are three types of extenders -- physicians' assistants, nurse practitioners, and Medex. Physician's assistants generally have health care experience as military corpsmen, nurses or allied health workers, about two years of classroom and clinical training and some on-the-job training. Medex have extensive medical experience, usually as military corpsmen, and a year of training, generally under the preceptorship of a physician. The most common PEs are nurse practitioners - registered nurses who usually receive an additional year of classroom and clinical training relating to primary care.

STATE MEDICAL LIABILITY TORT REFORM STATUTES
AND THEIR IMPACT ON CLAIM FREQUENCY,
CLAIM SEVERITY AND INSURANCE PREMIUMS

Prepared for:
Domestic Policy Council
Tort Reform Working Group

State Medical Liability Tort Reform Statutes
and Their Impact on Claim Frequency,
Claim Severity and Insurance Premiums

Overview

Since the mid-1970's there has been growing public concern over the effects of medical malpractice litigation. The past twenty years have seen a substantial increase in claim frequency, claim severity and medical liability insurance. During the mid-1980's medical liability was the fastest growing component of physicians' practice expenses, rising at an average annual rate of 21.9%.¹ The rising costs of malpractice liability and the fear of suit have resulted in a concomitant increase in the cost of health care. Some physicians have responded to the threat of liability by performing arguably unnecessary procedures and by practicing defensive medicine.² Others, especially in the field of obstetrics, have either changed specialties, moved to less costly areas of the country, or simply left the practice of

¹ Gonzalez, M., "Trends in Physicians' Professional Liability Claims and Insurance Premiums." In: Gonzalez, M., et al., Socioeconomic Aspects of Medical Practice, American Medical Association, 1987.

² "Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York," Report by Harvard Medical Practice Study (1990), at 9-11; Reynolds, et al., "The Cost of Medical Professional Liability," 257 Journal of the American Medical Association 2776 (May 1987); Editorial, "Defensive Medicine: It Costs, But Does It Work?," 257 Journal of the American Medical Association 2801 (1987); Schwartz, et al., "Doctor, Damages and Deterrence," 298 N. Engl. J. Med. 1282 (1978).

medicine.³ The problem is particularly acute in the inner city and in rural areas. The result of the increased threat of liability, the increased cost of liability insurance and the defensive use of medicine has been an unprecedented escalation in the cost of health care for the average American.

By the close of 1986, all fifty states and the District of Columbia had either adopted or were considering new tort reforms designed to curb the rise in claims frequency and claims severity in medical malpractice litigation. It was generally believed that such reductions would ultimately reduce the cost of medical malpractice insurance premiums. It was also believed that such reforms would reduce the time and cost associated with resolving claims. The ultimate goal, of course, was to decrease the overall cost of health care.

Most, if not all, of these statutes were proposed and passed in the 1970s without any empirical evidence that the reforms would have any impact on claim frequency, claim severity or insurance premiums. Subsequent to the passage of much of this legislation, a few empirical and opinion survey studies have been conducted to assess the impact of these reforms. This paper summarizes the findings of these studies.

³ Rosenblatt, et al., "Rising Malpractice Premiums and Obstetric Practice Patterns," 146 Western Journal of Medicine 246 (February 1987); Rosenblatt, et al., "Changing Patterns of Obstetric Practice in Washington State: The Impact of Tort Reform," 20 Family Medicine 101 (1988).

Impact of Specific Tort Reform Provisions on Claim
Frequency, Claim Severity and Insurance Premiums

The various empirical and opinion studies surveyed strongly suggest that limitations on damages, especially on total damages, have a significant impact on claim frequency, claim severity as well as on insurance premiums. Caps on total recovery were the most effective, with caps on noneconomic damages "pain and suffering" rating second. Estimates of the percentage decrease in claims severity, as a result of caps on total recovery, vary ranging from 23% to a high of 39%. The figures for noneconomic damages range from 12% to 31%.

Other reforms that achieved visible results in reducing claims severity and frequency were mandatory collateral source offsets, elimination of ad damnum clauses, and periodic payments. The studies also suggest that these same reforms have had or will have a significant impact on insurance premiums. Although no empirical data exists, some opinion studies suggest that the elimination of joint and several liability as well as shortening statutes of limitation will have an impact on claims severity and frequency in the future.

On the other hand, other reforms have had either a limited impact or no impact on claim frequency, claim severity and insurance premiums.⁴

⁴ A chart summarizing the conclusions of the empirical studies that analyzed the impact of specific types of tort reform statutes on claim frequency, claim severity and insurance premiums is attached hereto as Attachment A.

State Legislative Tort Reforms

I. Review of the Most Effective Reforms: Elimination of Ad Damnum Clauses, Elimination of Collateral Source Rule, Limitation on Damages and Periodic Payments

A. Ad Damnum Clauses

An ad damnum clause in a complaint states the amount of recovery sought by plaintiff. In medical malpractice actions, the amounts of damages claimed may be greatly inflated. As a result, the insertion of a large ad damnum in the complaint can condition the public to accept extremely large sums as appropriate measures of damages.

Effectiveness of the Reform

Statutes eliminating ad damnum clauses may have an impact on claim frequency and severity as well as on reducing the time from filing to closing. The problem in estimating the actual or predicted impact is the conflicting conclusions reached by the two leading empirical studies, Danzon's 1982 study and Sloan's 1989 study.

In her earlier study, Danzon (1982) found that eliminating the ad damnum clause could result in a decrease in total claim costs. Id. at 342. Similarly, Danzon and Lillard (1982) surmised that elimination of the ad damnum clause by some states contributed to reducing claims severity and frequency. Id. at 26.

Sloan (1989), however, found that the effect of the ad damnum clause was only significant with respect to the time from filing to closing. Id. at 677.

B. Collateral Source Rule

The collateral source rule provides that benefits received by an injured party from sources other than the defendant (e.g. workmen's compensation) may not be used to offset the damage recovery from the defendant. This permits the plaintiff to obtain double recovery of certain components of damages. The rule has been accepted by almost all jurisdictions and has been applied both as a rule of evidence and as a rule of damages. The rationale for the collateral source rule is that a wrongdoer should not be relieved of paying a tort injury simply because the plaintiff had access to other resources.

Effectiveness of the Reform

Second to limitations on damages, requiring the mandatory offset of collateral sources has had the most impact on claim severity; it has also had a significant impact on claim frequency. In 1982, Danzon found that mandatory offset of collateral source benefits reduced claim severity by 50%, whereas discretionary offset statutes had no impact. *Id.* at 30. In 1986, Danzon found that permitting or mandating the offset of collateral source benefits reduced malpractice claim severity by 11 to 18% and claims frequency by 14%, relative to comparable states without collateral source offset. The difference between Danzon's 1982 and 1986 findings is that she pooled the figures for mandatory and discretionary offsets in the 1986 study.

Sloan (1989) found that statutes requiring offset for collateral sources reduced payments by 21% on average and

decreased the proportion of claims in which compensation was awarded. Mandatory offsets, however, somewhat increased delay to closure of the claim. Id. at 678. Milliman and Robertson (1985) predicted that collateral source offsets should reduce medical malpractice costs by 8%. Id. at 3. The data on the impact on insurance premiums are not as concrete as they are on claim severity and claim frequency.

Modification of the collateral source rule has been endorsed by the Tort Policy Working Group, the DHHS Task Force, the American Medical Association, and the American Hospital Association. In addition, a public opinion poll conducted by Louis Harris and Associates, Inc. regarding adult Americans' attitudes toward the civil justice system and tort reform found that 67% of Americans favor requiring the trial judge to reduce the damages awarded by a jury by subtracting other compensation already received by the victim from other sources.

C. Limitations on Recovery

Damage awards for medical malpractice usually consist of two components: recovery for pecuniary losses, such as medical expenses and lost income, and compensation for non-economic damages, such as pain and suffering, loss of enjoyment of life and loss of consortium. Some jurisdictions also allow punitive damages in medical malpractice cases. Some state have placed caps on total recovery; others have placed separate caps on economic and noneconomic damages.

Effectiveness of the Reform

A large consensus exists among special interest groups, and the empirical evidence supports these groups, that limitations on damages have had a major impact on claim severity and, therefore, on insurance premiums. The studies convincingly demonstrate that caps on damages are the most effective tort reform to reduce claim severity and insurance premiums. The effectiveness of caps varies depending on the type of cap and the number of exceptions allowed for in the statute.

Danzon (1986) found that limits of awards reduced claim severity by 23%. She observed that the majority of cases would be unaffected by most caps, so the affect on a few large awards would be substantially greater than the average over all cases. Because large awards account for a disproportionate fraction of total dollars, caps that severely reduce the few very large dollar awards can greatly influence the average and total payout. Id. at 26.

Milliman and Robertson (1985) predicted that a \$250,000 cap on non-economic damages would save 12% in medical liability costs. Id. at 3. The Urban Institute (1989) found that limitations on damages could ultimately reduce premiums by 34%. Id. at 25. GAO (1986) found that a majority of health care providers believed that caps on awards have had a major impact on decreasing the size of awards and settlements. Id. at 18. GAO (1987) found that groups surveyed in Indiana and California believed that their states' tort reforms on damage awards had a

major stabilizing effect on premiums. Id. at 2. The Insurance Services Office Study (1987) predicted that caps of \$250,000 on non-economic damages could have an impact on claim payments. Id. at 3.

Sloan (1989) found that limitations on payments, particularly caps on total payment, generated substantial savings. He estimated an average savings of 38 to 39% for caps on total awards. Limitations on non-economic damages above reduced payments by 31%. Limits on punitive damages had no impact on awards. Id. at 678.

The idea of caps on recovery is supported by the DHHS Task Force, the Tort Policy Working Group, the American Medical Association, and the American Hospital Association. According to the Harris poll cited earlier, 66% of Americans favor a \$250,000 cap on "pain and suffering" and other non-economic damages in all civil cases.

D. Periodic Payments

Traditionally, medical malpractice judgments and settlements are paid in lump sums. These payments often include compensation for anticipated future medical expenses or lost earnings. The premature death of the claimant often creates a windfall for the heirs if a significant portion of the judgment or settlement is based upon future damages.

Effectiveness of the Reform

Although the empirical data is inconclusive, there is strong politic support for this reform. Many states enacted periodic payment reforms and several special interest groups have proposed the use of periodic payments. GAO (1986) found that a majority of health care providers believed that periodic payments have had a major impact on decreasing total malpractice costs. Id. at 18. Milliman and Robertson (1985) predicted that use of periodic payments would save 6% in medical liability costs. Id. at 3.

Danzon testified before the Senate Subcommittee on the Judiciary that periodic payments could cut the average settlement by 25%, raise the proportion of cases dropped from 43% to 48% and reduce the share of cases going to verdict by 5.1% to 4.6%. (Testimony before Senate Subcommittee on the Judiciary, March 26, 1986.)

In contrast, Sloan (1989) found that requiring periodic payments reduced the time to closure by half a year but "contrary to conventional wisdom, it had no statistically significant effects on payment size. Discretionary periodic payments increased the proportion of claims in which compensation was awarded although they decreased the time to closure slightly." Id. at 678.

Finally, Danzon and Lillard (1982) found that laws either allowing or requiring periodic payments, together with caps on awards and the elimination of ad damnum clauses, helped reduce

settlement size by 25%, verdict size by 30%, and the volume of cases dropped or taken to verdict. Id. at 26.

The DHHS Task Force urged states to provide that, at either the plaintiff's or the defendant's request, future economic damages awarded in malpractice cases that exceed a predetermined figure such as \$100,000 may be paid periodically. The Tort Policy Working Group similarly recommended that defendants be allowed to pay future economic damages over time. The American Medical Association and the American Hospital Association have also advocated periodic payments.

II. Review of Other Reforms

A. Joint and Several Liability

Under the rule of joint and several liability, plaintiffs may require any one of two or more defendants to pay the full amount of a judgment. In most jurisdictions, the paying defendant frequently has a right to recover from the co-defendants. However, if the non-paying defendants are insolvent, this right of recovery is meaningless. As a result, in many cases the defendant with the most limited role in causing the injury but with the deepest pocket bears the greatest share of the damage award.

Effectiveness of the Reform

At this time, the only study addressing the impact of abolishing joint and several liability is the Insurance Services Office Study (1987). This opinion study predicted that abolishing joint and several liability could have an impact on

claim severity. Id. at 7. Elimination of joint and several liability, however, should lend additional predictability to the system.

B. Statutes of Limitations

The primary purpose of a statute of limitations is to prevent the prosecution of stale claims. With the passage of time, evidence may be lost and witnesses may disappear. Many courts felt that the traditional statute of limitation rules were too harsh in medical malpractice actions and they fashioned what is commonly known as the discovery rule. Under the discovery rule, the patient's statute of limitations period does not begin to run until he or she discovers or reasonably should have discovered the medical injury. This open-ended discovery principle, however, created problems for health care providers and insurers. The uncertain and potentially long period within which a medical malpractice action could be brought made it difficult for insurers to develop actuarial estimates upon which to base medical malpractice premiums.

Effectiveness of the Reform

The opinion evidence strongly suggests that reducing statutes of limitations will reduce claim frequency but will have a limited impact on claim severity. Similarly, the empirical evidence found that states enacting shorter statutes of limitations experienced some reduction in claims frequency. Specifically, reducing statutes of limitations for adults by one

year decreased the total claims frequency by 8% and the frequency of paid claims by 6-7%.

III. Alternatives To The Traditional Tort System

Some believe that piecemeal tort reforms are not a solution but rather part of the problem. For example, Professors Moore and O'Connell state that the medical malpractice tort system, "based on adversarial contests between healers and patients to determine and allocate fault, fails to serve the best interests of patients, those who are for them, and the public at large." Moore and O'Connell, "Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss," 44 Louisiana Law Review 1267 (1984).

The report of the Harvard Medical Practice Study of New York reached similar conclusions. Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990). The Harvard study found numerous problems with the current tort system. First, the study found that in a substantial portion of claims filed there was no evidence of medical negligence. Thus, the tort system imposes a cost on providers to defend meritless claims. On the other hand, many meritorious claims are not paid. The study estimates that "about 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system." *Id.* "Executive Summary," page 6. Second, the study was unable to confirm that the tort system has any effect on deterring medical malpractice. Indeed, the study concluded that the more relevant

question was to ascertain the amount of deterrence under other systems, e.g., a no fault system with provisions for quality assurance. Third, the study questioned the goal of the present tort system. If that goal is to compensate injured parties, then that goal is not served. The study demonstrated that a large majority of patients who are injured due to no one's fault are receiving no compensation. In conclusion, the Harvard Group recommends that the current tort system is not working and should be replaced by no-fault system that would compensate certain economic losses (excluding non-economic damages) flowing out of an adverse event resulting from medical intervention. The study projects that the cost of the no-fault system would be equal to or less than total malpractice costs.

CONCLUSION

The weight of the empirical evidence strongly suggests that a few tort reforms -- limitations on damages, mandatory collateral offset, eliminating ad damnum clauses and periodic payments -- have or could have a significant impact on claim frequency and claim severity. Insurance groups in Georgia and California believe that tort reform measures have stabilized premium rates in their states. On the other hand, segments of the insurance industry have conspicuously avoided claiming that tort reform would reduce rates.

SUMMARY OF STUDIES ASSESSING IMPACT
OF SPECIFIC TORT REFORM STATUTES ON
CLAIM FREQUENCY, CLAIM SEVERITY AND
INSURANCE RATES*

STUDIES	DANZON (1982) ¹	DANZON and LILLARD (1982) ²	MILLIMAN and ROBERTSON (1985) ³	SLOAN (1985) ⁴
REFORMS				
AD DAMNUM	Possible negative effect on claim costs, but not on claim frequency or severity	Reduced settlement and verdict size. Decreased number of cases brought to trial		No impact on premiums
ARBITRATION	No impact on claim frequency or severity	50% of out-of-court awards averaged \$26,000		No impact on premiums; claim severity reduced
COLLATERAL SOURCE	Mandatory offset reduced claim severity by 50%, discretionary offset had no impact	Modified rules reduced awards by 18%	Offsets reduced costs by 8%	No impact on premiums
CONTINGENCY FEE	Had small impact on lowering claims severity and total awards	Out-of-court settlement sizes reduced by 9%, cases litigated until verdict reduced by 1.5%	Predicts reduced liability costs of 9%	No impact on premiums
EXPERT WITNESS	No serious impact on claim frequency and severity			No impact on premiums
FRIVOLOUS SUIT				
JOINT & SEVERAL LIABILITY				
LIMITATION ON RECOVERY	Lowered awards by 18% (low estimate because many claims predate reforms)	Limitations (with ad damnum and periodic payment cap reforms) reduced verdicts and settlement size by 30% and 25%	12% in liability costs saved by a \$250,000 cap on non-economic damages	No impact on premiums
PATIENT COMP FUND				No impact on premiums
PERIODIC PAYMENT	No impact on claim frequency or severity	Periodic payments (with ad damnum and cap reforms) reduced verdicts and settlements by 30% and 25%	Predicts 6% in liability costs	
PRETRIAL SCREENING	No impact on claim frequency or severity			Had impact on lowering premiums
STATUTE OF LIMITATIONS	No impact of post-1975 reductions			No impact on premiums

* This chart summarizes those studies that attempt to predict or analyze specific types of tort reform statutes based upon empirical data. Conclusions regarding impact of tort reform measures are noted only where they related to specific types of tort reforms. Accordingly, this chart does not include the two GAO opinion surveys (1986, 1989) of special interest groups, nor does it include conclusions about the impact of the tort reforms in general.

- 1 Examined impact of reforms on claim frequency and claim severity.
- 2 Examined 1974-1976 closed claims to assess impact of certain tort reforms.
- 3 Predicted potential impact of AMA tort reform proposal on premiums.
- 4 Examined impact of certain reforms on premiums.

	Danzon (1986) ⁵	ISO (1987) ⁶	Sloan (1989) ⁷	Urban Institute (1989) ⁸
AD DAMNUM	Average severity reduced by 23%		Impact on filing to closing time only	
ARBITRATION	Reduced claims severity, increase in costs and frequency of claims		No impact on premiums, reduced claim frequency, faster dispute resolutions	
COLLATERAL SOURCE	Offset reduced claim severity by 11 to 18% and claim frequency by 14%	Offset should have impact on claim severity	Offsets reduced payments by 21%, reduced proportion of compensation awarded of claims	Mandatory offsets reduced claims frequency and severity
CONTINGENCY FEE	No effect on claim frequency and award size		Small impact on increasing time to filing and decreasing filing to closing time	Reduces filing of claims
EXPERT WITNESS			No impact on payment, delayed filing time to 4 month average	
FRIVOLOUS SUIT			To avoid risk of losing at trial and liability for costs, claimants file quicker	
JOINT & SEVERAL LIABILITY		Predicts impact on claim severity		
LIMITATION ON RECOVERY	Reduced average claims severity by 23% (had impact mostly on few large awards, not on majority of cases)	\$250,000 cap on non-economic damages could have impact on payments	Caps reduced claim severity by 38 to 39% on average; non-economic damage limitations alone reduced payment by 31%	General surgery premiums reduced by 13% after caps are established ultimate reduction by 34%
PATIENT COMP FUND				
PERIODIC PAYMENT			No effect on payment size, reduced time to closure by half a year	
PRETRIAL SCREENING	No impact on reducing claim severity or frequency		No effect on payment probability or size, reduced filing to closing time by half a year	Reduced OB/GYN premiums by 7% to 20%
STATUTE OF LIMITATIONS	One year reduction reduced claims frequency by 8% and paid claims frequency by 6-7%		One year reduction lowered mean delay to filing by one month	One year reduction cuts general surgery premiums by 3.7%

5 Examined impact of post-1975 tort reforms on claim frequency and severity using 1975-1984 data.

6 Expert opinion study estimating impact of 1986 reforms on indemnity payments in 24 states.

7 Examined closed claims data to assess impact of tort reforms on claim frequency, claim severity and transaction costs.

8 Opinion survey of 14 medical malpractice insurers to estimate impact of tort reforms on premiums.