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DOCUMENT NO.	FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
001	Memorandum	Draft Section-by-Section Summary [4 PAGES RELEASED IN WHOLE ON PRA RE-REVIEW 09/11/2025 JLS]	4	N.D.	
002	Memorandum	Malpractice Obstacles [4 PAGES RELEASED IN WHOLE ON PRA RE-REVIEW 09/11/2025 JLS]	4	N.D.	

COLLECTION TITLE:
Counsel's Office, White House

SERIES:
Kavanaugh, Brett - Subject Files

FOLDER TITLE:
Medical Malpractice Reform

FRC ID:
9702

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
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DOCUMENT NO.	FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
001	Memorandum	Draft Section-by-Section Summary	4	N.D.	P5;
002	Memorandum	Malpractice Obstacles	4	N.D.	P5;

COLLECTION TITLE:
Counsel's Office, White House

SERIES:
Kavanaugh, Brett - Subject Files

FOLDER TITLE:
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COUNCIL OF ECONOMIC ADVISERS
April 23, 2002

Update on Malpractice Cost Increases

Background

- **Rising liability costs are a concern not only to health care providers but also to the Federal government.** For example, Medicare incorporates malpractice costs its provider payment calculations. Most state Medicaid plans also account for some part of liability costs – and to the extent they do not, providers may refuse to treat Medicaid patients. Higher liability costs are also incorporated in private insurance premiums, which are tax-subsidized. Thus, eventually, a large share of the costs of higher liability are eventually borne by the Federal government.

- **The cause of rising liability costs is rapidly rising malpractice awards – to the point that some malpractice carriers are refusing to offer insurance altogether.** The second section of this memo describes the serious problems that providers are facing in many states.

- **The national medical malpractice combined ratio (the ratio of paid claims to premiums) is nearing the level experienced at the height of the 1980s medical malpractice crisis.** In 2001, insurers likely paid out $1.40 in claims for every dollar of premiums, compared with $1.60 in claims at the height of the 1980s' crisis.

- **Jury awards for malpractice have skyrocketed in recent years.** The median malpractice award grew 60% between 1997 and 1999 (from $500,000 to $800,000). In 1999 the median punitive damage award for medical malpractice cases was $515,000. The only cases with a higher median award were products liability suits ($2 million), where defendants are often large corporations.

- St. Paul (the largest medical malpractice insurance writer in the U.S. prior to its exit from the market in December 2001) saw twice as many claims for $1 million or more in 2000 than they did in 1999. Only 1.5% of all claims paid in 1990 were for $1 million or more, while 4.5% in 1998 were. Many analysts view this rapid and difficult-to-predict trend as a driving factor in the decision by St. Paul to pull back from the malpractice insurance markets (see below). Its exit will affect 42,000 physicians.

- The number of medical malpractice payment reports increased in 1999 and 2000 after falling at an average rate of 4% per year between 1996 and 1998. In the past 5 years the number of "reportable action reports" increased by almost 10% while the number of medical malpractice payment reports only increased by 1%.

- **A rising number of large awards is thus the main contributing factor to the increase in malpractice costs for doctors.** In 2000, median malpractice payments (by state) ranged from $55,000 (California) to $262,000 (Maine). The mean malpractice payment (by state) ranged from $142,637 (California) to $584,338 (Washington DC). Kansas was the only state

in which the mean malpractice payment was less than the median. 40% of all jury awards are over $1 million, compared with 35% in the period from 1993 to 1995.

- High awards are generally related to poor outcomes that follow complex procedures – and in most cases are not the result of care that medical experts judge to be negligent. The highest average and median malpractice payments are for obstetrics and the most malpractice payments were made for claims that were diagnosis or surgery related.

- **Medical malpractice premiums skyrocketed in recent years.** In an AMA survey 8 States (AR, CT, IL, NV, NC, OH, PA & TX) reported premium increases of over 30% in 2002. The Texas Medical Liability Trust has raised rates by 100% over the last 2.5 years. New Jersey hospital medical malpractice insurance premiums jumped an average of 250% from 1999 to 2002.

- **Considerable research indicates that higher malpractice premiums cause doctors to practice more "defensive medicine,"** such as ordering extra tests or unnecessary procedures to provide legal cover in case a patient has a bad outcome. In a recent survey, roughly three quarters of physicians acknowledged that fear of litigation lead them to order more tests and more frequently refer patients to specialists than they would based only on their professional judgement of what is medically necessary. The excess health care costs resulting from defensive medicine are much greater than the direct costs of the malpractice system – potentially adding 2 to 4 percent each year to the costs of the entire health care system.

- Malpractice liability also leads to worse care and worse health for other reasons. As noted below, high malpractice costs are significantly threatening access to care in many parts of the country. And health care providers are reluctant to undertake initiatives to eliminate medical errors and improve quality, for fear that any information they develop on opportunities to improve care will be used against them in court. Additionally, 61% of physicians have noticed physicians being reluctant to make what they categorize as humane choices at the end of a patient's life due to a fear of litigation.

Long Term Care

- **Rising liability costs in nursing homes are a major cause of rapid growth in the cost of nursing home care, which is mostly financed by Medicaid and Medicare.** Between 1990 and 2001 general liability and professional liability (GL/PL) loss costs increased from $240 per annual occupied skilled nursing bed to $2,360 per bed. Most of this increase took place after 1995. Florida ($11,000) and Texas ($5,500) had the highest per bed costs in 2001.

- **Nursing home malpractice costs are rising because of rapid increases in both the number of lawsuits and the size of awards.** Between 1990 and 2001, the average size of a GL/PL claim tripled and the average number of claims for long term care operators increased from 3.6 claims per 1000 beds to 11 claims per 1000 beds.

- **A very large share of these liability costs go to lawyers.** Altogether, *47%* of the total GL/PL claims costs goes to attorneys (this includes the defendant's legal costs, which are roughly 40% of the total dollars that attorneys get).

- **Even excluding "high cost" states, GL/PL loss costs are increasing at a rate of 20% per year.** This is much faster growth than in other industries, where GL/PL claim costs tend to increase between 5% and 10% per year.

State Malpractice Laws Have Major Implications for Malpractice Costs, Federal Health Care Spending, and Access to Care

California

- California (like Utah, New Mexico, and other states) has a cap on jury awards for pain and suffering. California limits such awards to $250,000.

- The 5 largest California insurers requested malpractice insurance rate increases of only 2% to 8% for 2002, while the rest of the country faced increases of 10% to 30%. Furthermore, the rates in California are already relatively low. The base rate for a California obstetrician is around $35,000 per year. The same doctor would pay between $80,000 and $120,000 in Pennsylvania. (*San Francisco Business Times*, October 15, 2001).

- Medical malpractice insurance is only about 10% of doctors' revenues in California, down from 25%. Nationally, premiums generally average between 10% and 25% of a physician's gross revenues. The premium for an obstetrician in PA would be more than twice as much as it would be for the same obstetrician in CA.

Mississippi and Louisiana

- Stories from Mississippi and Louisiana suggest that Mississippi doctors are moving their practices to Louisiana to take advantage of its more favorable malpractice laws. In Louisiana, a doctor's insurer is only exposed to $100,000 per plaintiff with a state-run compensatory fund paying some additional damages.

- In a survey of doctors in a county on the Mississippi side of the Mississippi-Louisiana border, two-thirds of the doctors indicated they were "ready to leave Mississippi."

- Greenville, Mississippi has lost 6 of its 76 doctors since the beginning of 2002 and is expecting to lose more over the summer.

Pennsylvania

- Ohio, Pennsylvania, West Virginia have relatively high medical malpractice costs, and have faced significant cost increases this year.

- The PA Medical Association found that it costs $96,199 to cover an orthopedic surgeon in PA and less than $40,000 to cover one in Delaware and New Jersey. According to the president of the PA Medical Society, their 2001 survey found that 72% of doctors deferred purchasing new medical equipment or didn't hire needed staff because of "sudden and sharp increases" in malpractice insurance premiums.

- PA has recently taken legislative steps to try to curb the cost increases (including the partial privatization and eventual phase-out of the PA CAT fund, shortening the statute of limitations, and allowing judges to lower awards in some cases).

Nevada

- Malpractice Insurance Availability in Nevada:

  - The Nevada Division of Insurance conducted a survey of 11 insurers offering medical malpractice insurance in Nevada. The respondents indicated that punitive damages were the largest contributor to the cost of claims, followed by legal fees.

  - St. Paul, the largest insurer, pulled out of Nevada in 2001 and 4 other insurers left the market in 2002. Those 5 insurers provided 70% of the State's malpractice coverage.

- The Governor's Plan:

  - It was concluded at a state hearing in March, 2002 that medical malpractice insurance was not readily available in Nevada, so the state was designated as the insurer of last resort. Beginning on April 15, 2002, Nevada will sell medical malpractice insurance through the newly established Medical Liability Association of Nevada. This is meant to be a stop-gap measure, and the Governor intends to work with the Legislature to institute market reforms.

  - Premiums will be set to cover projected losses and expenses and are not expected to be below the rates available in the private market. The Association will have the right to refuse to insure physicians deemed to be an "unacceptable risk." Participating medical professionals will each be assessed a one-time fee to cover any Association losses. The Board will also develop a "cost stabilization option" so that each physician could choose to pay a fee in lieu of any end of the year assessments. The plans offered by the State will not cover prior acts. According to local newspapers, physicians expect to pay as much as $100,000 for "tail coverage."

- Anecdotes from Nevada Newspapers:

  - "More than half of the surgeons working at Southern Nevada's only trauma center are poised to quit if Gov. Kenny doesn't soon commit to limiting malpractice liability in Nevada" (*Las Vegas Review-Journal*, March 21, 2002).

- Over 20% of Clark County's OB-GYNs are actively considering leaving Nevada (i.e calling medical boards in other states to transfer certification, looking for other jobs, etc) because malpractice rates are going from $40,000 to as much as $200,000. 78% of Clark County physicians responding to a survey by a researcher at the University of Nevada School of Medicine indicated that they will leave the State if the legislature does not undertake tort reform. These physicians represent 40% of the OB-GYNs in Clark County (*Las Vegas Review-Journal*, March 23, 2002)

Draft Section-by-Section Summary of the
"Patient Safety and Quality Improvement Act" (Jeffords-Frist-Breaux)

Purpose – To amend title IX of the PHS to provide for the improvement of patient safety and to reduce the incidence of events that adversely effect patient safety. Specifically, this act will encourage a culture of safety by providing legal protection of information reported voluntarily for the purposes of quality improvement and patient safety, and ensure accountability by raising standards and expectations for continuous quality improvements.

Section 1. Gives the Act the short title of the "Patient Safety and Quality Improvement Act."

Section 2. Establishes a series of findings which point to the drastic need for legal protections for information voluntarily collected, used, or reported for the purposes of quality improvement and patient safety.

Section 3. Defines relevant terms, including non-identifiable information, patient safety data, patient safety organization and provider.

Section 3 further provides for confidentiality and peer review protections for any patient safety data. This is new information specific to the learning process and does not apply to that information that has been developed or maintained outside of this process, e.g., medical record. This patient safety information is privileged and confidential and, therefore, cannot be subjected to civil, criminal, or administrative subpoena; subject to discovery in connection with a civil, criminal, or administrative proceeding; disclosed pursuant to FOIA; admitted as evidence in any civil, criminal, or administrative subpoena; or utilized to carry out an adverse personnel action.

However, this protection does not imply that a provider should not comply with authorized requests for information that has been developed, maintained, or exists separately from the process of collecting or developing information for a patient safety organization. Additionally, a provider or patient safety organization could disclose patient safety data in a criminal or administrative proceeding if such data is material to the proceeding, within the public interest, and not available from any other source. Finally, a provider or patient safety organization can disclose relevant information to the FDA, and share information as part of the business relationship between a patient safety organization and a provider. Any violation of these provisions is subject to the penalties under the current section 924(d) of the PHSA, which outlines a $10,000 fine for each violation.

Additionally, section 3 clarifies that this privilege is meant to be a Federal floor and provides States the opportunity to provide greater protections. It also clarifies that this legislation is not intended to alter the Health Insurance Portability and Accountability Act. Section 3 also has a survey and Congressional report from the Attorney General regarding state peer review laws.

Section 3 also grants the Secretary the authority to establish a national database or designate other entities to collect relevant non-identifiable data. This non-identifiable data will be voluntarily reported from a patient safety organization. The Secretary may also establish common formats for the reporting of such data. All non-identifiable patient safety data transferred to the database will be privileged and confidential.

Section 3 contains a provision to allow the Secretary, acting through the Director of AHRQ, to provide technical assistance to patient safety organizations, which shall include annual meetings.

Finally, section 3 requires the Secretary to develop or adopt voluntary national standards within 36 months to promote the integration of health care information technology systems.

Section 3 authorizes for appropriations "such sums as necessary".

Section 4 requires the Secretary to **conduct a study to assess the impact of medical technologies and therapies on patient safety, patient benefit, health care quality and cost of care as well as productivity growth.**

Proposals to Limit Medical Malpractice Liability (DOJ)

Several pending bills, such as S. 1135 (Medicare Reform Act of 2001), which address various programs, such as Medicare and Medicaid, which utilizes federal funds to subsidize medical services, could be used as vehicles limiting liability for medical malpractice. However, more analysis needs to be done to fit the above concepts into existing legislative vehicles. Proposals to be considered for inclusion in any comprehensive Medicare/Medicaid Reform Bill include:

- For products or services obtained with federal funds under these programs, in any claim against the provider of these services or products, the following limitations or combinations thereof should be considered:

    1) Caps on punitive damages;
    2) Limitations on non-economic damages;
    3) Limitations on future harms (e.g., reduction to net present value);
    4) Limitations on joint and several liability;
    5) Specific causation requirements (e.g., define proximate causation);
    6) Bar on prejudgment interest;
    7) Raising burdens of proof (e.g., requiring clear and convincing evidence to establish liability or specific elements of the cause of action).

- Where experimental or innovative treatments are to be covered, patients opting for such treatment should be apprised of all associated risks and accept those risks as conditions for experimental treatment. Patients opting for such treatment should be required to waive litigation rights associated with the treatment.

- Where preventive care is to be covered, there should be some correlative protection for missed or failed diagnoses, unless the doctor exhibits willful misconduct or wanton and reckless disregard for the safety of the patient (something more than simple negligence).

- If prescription drug coverage is to be covered, suits against pharmaceutical manufacturers, distributors, and retailers should be limited to those cases 1) where clear and convincing evidence of negligence exists, or 2) where the defendant had knowledge of possible adverse effects and failed to warn about such possibility.

- Doctors and health care providers convicted of Medicare/Medicaid fraud should be stripped of some or all of these protections.

These various alternatives could be altered to fit into a legislative scheme whereby federal funds are used to acquire private insurance. These proposals may also altered to apply to medical services paid partially with federal funds and partially with private supplemental insurance.

Some of the above recommendations may pose federalism concerns, because these cases are generally filed in state courts under state law. The above proposals can be effected through a federal cause of action enforceable in state courts, similar to the Bush-Norwood compromise with respect to Patients' Bill of Rights, H.R. 2563.

Early Offers (HHS)

Early Offers would encourage rapid settlement of cases and, where invoked, provide quick payment of economic compensation in deserving cases and avoid the delay, cost, and emotional distress of litigation. It works this way.

Within a specified period (e.g., 180 days) after an adverse event or the filing of a claim, a potential or named defendant may make an Early Offer to the claimant. The terms of the Offer would be set by the statute. In essence, the Offer would commit the offeror to pay the claimant's economic loss (net of collateral sources) as it accrues over time, plus reasonable attorneys fees to evaluate the Offer (this could be made contingent on the lawyer agreeing not to represent the claimant in any subsequent litigation). Economic loss would be defined in the statute to include health care and rehabilitation costs, wage loss, cost of fixing up the house and car, etc.

The claimant's losses would not have to be estimated in advance; they would be paid over time as they accrue. Disagreements on whether an item is covered (e.g., is a trip to Bermuda necessary for therapy?) would be handled by arbitration; these disputes would be simpler than issues of liability and future damages. Potential co-defendants could join in the Offer (and their respective share would be resolved by arbitration among the offering parties if necessary).

The claimant could accept or reject an Offer. If he accepts the Offer, the litigation is over. If she rejects it, she can go to court. The fact that an Offer was made could not be disclosed in the litigation. The litigation would be conducted under the existing rules, with two exceptions. To encourage defendants to make Offers and plaintiffs to accept them, the standard of liability (wanton or intentional misconduct) and burden of proof (clear and convincing evidence/beyond a reasonable doubt) would be heightened.

Benefits

- Provides incentives to settle cases early in the process, before most costs have been incurred and attitudes hardened.
- Defendants are not required to make an Offer in any particular case, but can decide on ad hoc basis. This is not no-fault.
- When an Offer is made and accepted, the claimant receives compensation for on-going expenses immediately. The defendant does not have to pay pain and suffering and punitive damages (and incurs far less in attorney fees). Plaintiffs and defendants benefit by sharing the savings that result from not litigating.
- Improves quality. Early Offers gives an incentive to discover (and within an institution to report) bad events quickly. More and speedier reporting will improve quality.
- Can be used to change the atmosphere: The statute could require that an Offer be accompanied by an offer to meet with the claimant and discuss the circumstances of the adverse event.

Drawback

The main issue presented by Early Offers is how to handle cases where there is serious injury but no (or little) economic damage—i.e., a lawyer who loses a finger or a young person (not a model) who is scarred. On the one hand, it can be argued that the tort system should concentrate on economic loss and not try to rectify non-economic losses with money. On the other hand, the horse is long gone

from this barn. One way to handle this issue is to require that an Early Offer include scheduled compensation for certain types of injuries (like Workers Compensation).

PROs and CONs of including this proposal

PROs

- Early Offers is a different kind of tort reform. The traditional measures impose caps on recovery after the plaintiff has gone through litigation and won. They are a "takeaway" with no benefit for the plaintiff. While some states have adopted caps, Congress has refused to do so. Early Offers, on the other hand, offers a benefit to the plaintiff in exchange for the "limitation" on damages: he gets a commitment for quick payment without litigation. This is the quid pro quo that underlies Workers Compensation: exchanging the right to sue for payment of economic damages (as defined).

- The Early Offers approach was first introduced in 1984 by Congressmen Henson Moore and Richard Gephardt (H.R. 5400). That version applied to health care under Medicare and Medicaid and other Federal programs in states that did not introduce their own reform. H.R. 5400 was more stringent than the approach described above; under the original version the plaintiff had no choice if an Offer was made.

CONs

Trial lawyers and their allies in the "consumer protection" community will claim that Early Offers takes away rights—i.e., to sue for non-economic damages and participate in the litigation lottery. Advocates also will claim that Early Offers discriminates against low-wage earners and the retired since the amount of compensation will vary by pre-injury wages. Unlike the current tort system? In fact, the poor would benefit most, since they get the chance to receive compensation of their economic loss right after the injury, when they most need it.

Malpractice Obstacles to Volunteer Health Care Providers at Free Clinics (HHS)

ISSUE

Section 194 of the Health Insurance Portability and Accountability Act, originally proposed by Senator Coats, provides for coverage of malpractice claims for certain volunteer health practitioners in free clinics. The claims are paid under the Federal Tort Claims Act (FTCA) through a HRSA fund with an annual authorization of $10 million. To date the Department has never sought funds for this purpose and funds have never been appropriated; thus the provision has never been implemented.

Several Senators have asked the Department to implement Section 194 in order to improve access to care for the uninsured and other vulnerable populations. Volunteer efforts by private sector physicians are a critically important component in the nation's health care safety net, particularly for specialty services. The need to encourage volunteer provision of medical services is underscored by recent findings from the Community Tracking Study Physician Survey, conducted by the Center for Studying Health System Change, which reports that the proportion of physicians providing charity care dropped from 76 percent to 72 percent between 1997 and 1999.

BACKGROUND

Free clinics play a significant role in some communities in meeting the health needs of the uninsured, particularly at a time when there are indications that physicians may be less likely to provide free care in their offices. They provide a venue for some providers to volunteer their services, although their hours of operation may be limited. Many of these clinics are faith-based. There are indications that free clinics are becoming more organized. There are membership associations of free clinics in several States, a national presence on the internet, and technical assistance resources directed to them.

One limitation to expansion of this resource is the issue of malpractice liability for volunteer services. This is a particular issue for retired professionals who maintain a license but not a practice. Some States have addressed this issue by providing volunteer health practitioners indemnity or immunity or by setting up legal defense funds, but there is no standardized approach to this problem.

The FTCA originally provided a process for, among other things, claims against the United States from acts of Federal employees, acting in the scope of their employment, which result in malpractice claims. An injured party goes through an administrative claims process and if the claim is denied or the party is unhappy with the outcome, he can bring suit. Suits are heard in the United States District Court, and the U.S. Attorney's Office provides representation. The tort law of the particular State applies.

FTCA coverage was extended to Public Health Service Act section 330 health centers (community health centers, migrant health centers, health centers for the homeless, health centers in or near public housing) in 1993, allowing them to receive malpractice liability coverage for the center, its officers, board members, employees and contractors provided through the FTCA. Payments for judgments found against Section 303 health centers are made from a fund that receives an annual appropriation from within HRSA's health center appropriation.

That amount has stood at $5 million/year since 1993, but in the FY 2003 budget request, because of the rising volume of care at Section 303 health centers and resulting increases in claims, settlements, and judgments, $30 million has been proposed. Currently 587 organizations, their 4,000 physicians and 16,600 other health care personnel are covered in this way and account for approximately 30 million

medical encounters annually. (NOTE: These figures exceed original estimates of 150 participating centers and 7 million annual encounters upon which the 1993 estimates were based.) As the number of claims against the Department has grown, there are also reports that the Department of Justice has sometimes been overly quick to settle cases.

PROPOSAL

Section 194 of HIPAA would provide similar liability coverage to volunteer health care practitioners who provide services in "free clinics," who would be deemed employees of the Public Health Service, provided certain conditions were met. While the practitioners could receive payment for expenses and the free clinic could receive voluntary donations, the entity using these volunteer practitioners, by statute, could not receive any form of third party reimbursement. The entity would need to be licensed in accordance with applicable state law. Practitioners would be sponsored by the free clinic and individually approved by the Department.

Although definitive information on the number of clinics and physicians who may wish to participate in Section 194 malpractice coverage can not be ascertained, available evidence suggests that there are currently 353 free clinics in the country with 10,323 volunteer physicians providing services in these clinics.

DISCUSSION

Budgetary concerns have been raised related to extending FTCA coverage to volunteer physicians and other practitioners. These concerns generally focus on the level of uncertainty surrounding the Department's potential exposure to liability, particularly in light of the difficulty in predicting the number of potential participants and their predicted expenses. With rising claims, settlements, and judgements against health center providers, the level of OGC staffing required to operate the program raises additional concerns. While DHHS establishes the HRSA fund for covering settlements and judgements against Section 303 health center physicians (and should this proposal be implemented, volunteer physicians, as well), DOJ staff is responsible for handling the litigation of defendants covered under FTCA. While DHHS maintains the monetary liability for these suits, DOJ bears the administrative costs of this litigation. DOJ has historically maintained that FTCA coverage should be limited to Federal employees.

Although the HIPAA statute precludes the Department from establishing liability limits (e.g., fixed dollar amounts, or fixed number of participants), it does allow for mechanisms that will significantly constrain the Department's liability risk. The statutory provisions of section 194 of HIPAA (now codified at section 224(o)(1) et seq. of the Public Health Service Act) themselves restrict eligibility for coverage, limiting the number of covered entities and providers who would be eligible for coverage to:

Clinics whose volunteers are eligible must be truly "free" and not accept any form of third party payment. Not all free clinics meet this criterion.

Volunteer staff of free clinics. Many of the eligible "free" clinics, especially larger ones, are staffed by a mix of volunteers and paid staff. Paid staff would not be eligible for this coverage. Furthermore, volunteers do not usually provide services full time. A volunteer working one evening a week would see perhaps one tenth the number of patients a provider working full-time might see. Many volunteers work fewer hours. Exposure would not be equivalent to that of a full-time employee.

The statute provides further opportunities for setting reasonable constraints on participation in this program by stating at section 224 (g)(1)(D) that an individual volunteer cannot be deemed as an " employee of the Public Health Service" for purposes of this section unless the clinic has submitted an application " in such form and such manner as the Secretary shall prescribe." Current rules at 42 CFR 6.5 describe the deeming process to be used for extending Federal Tort Claims Act coverage for federally-funded health centers but are general in nature (i.e. " ...The Secretary will receive such assurances and conduct such investigations as he or she deems necessary."). Developing a prescribed stringent process for determining the eligibility of clinics and their providers would help assure that providers covered under this provision are capable of providing adequate care. Through rule making, the Department would establish criteria for participation in the program.

At a minimum, the Department would seek to include the following processes to ensure the competency and eligibility of participating physicians and other practitioners:

1) Submission of applications through the State, as state officials are best positioned to monitor the credentials and practice history of licensed physicians and other practitioners.

2) State assurance that the provider is licensed and in good standing with the State licensing board.

3) Required checks against the National Practitioner Data Bank and HIPDB prior to submission of the application (through self-query by the practitioner or in some other manner, although the latter would most probably require legislative change.) We could exclude providers, for example, who are excluded from Medicare or Medicaid or providers with extensive malpractice histories.

4) Evidence that the practitioner has practiced within the last three years.

5) An affidavit of support from local or state professional society.

6) Aggressive use of the existing authority to exclude from coverage providers who develop a bad history with this type of coverage.

7) Required recording of complaints against its providers with aggressive follow-up required.

8) Required reporting to the State and/or federal government of complaints and follow-up.

9) Required completion of continuing education requirements, as established by the State.

10) Required participation of <u>all</u> practitioners in the clinic to ensure a consistent level of quality.

11) Required (or strongly recommended) use of user satisfaction surveys and other internal mechanisms to pinpoint potential problems.

These provisions, either " as is" or as augmented through consultations with others, could be fleshed out through rulemaking. Given the significant involvement of the States in implementing this program, it will be important to work closely with States to develop the rules that will govern the program' s application and monitoring processes.

Based on available information, ASPE staff estimate that approximately 353 clinics and 10,323 physicians would be eligible to participate under Section 194 coverage. This translates into $969 of appropriated funds for every physician likely to be covered. This funding level compares to $1,250/physician under the current health clinic fund and $7,500/physician under the funding levels proposed by the Secretary in the FY 2003 budget. Estimates on potentially eligible clinics and practitioners are not precise. However, we assume these are conservative comparisons, given that volunteer physicians rarely practice full time, whereas health center physicians typically practice on a full-time basis.

EMERGING PROBLEMS IN MEDICAL MALPRACTICE INSURANCE SYSTEM

Medical Malpractice Insurance Premiums

- Premium increases for St. Paul Companies averaged 24% in 27 States in 2000[1]
- In Texas, premiums increased 30% - 200% in 2002; Texas Medical Liability Trust has raised rates by 100% over last 2 ½ years[2];
- Doctors Insurance Reciprocal, Va-based, raised premiums by 75% across the board in 2002, regardless of physician risk or history[3];
- Florida malpractice rates will increase an average of 30 percent in 2002 for surgeons, radiologists, obstetricians and gynecologists[4];
- OHIC Insurance Co., Columbus-based, raised rates in 2002 by 25%-30% across the board[5];
- Five insurance carriers in Ohio (representing 70% of the state's market) increased premiums an average of 30% in 2001[6];
- Pennsylvania insurance carriers increased rates from 21% to 60.4% in 2001;
- Sierra Health Services, Inc. (Nevada-based) has seen rate increases for its physicians of 70% in 2002[7];
- AMA survey showed that eight states reported premium increases over 30% in 2002 (Arkansas, Connecticut, Illinois, Nevada, North Carolina, Ohio, Pennsylvania, Texas)[8]
- New Jersey hospital medical malpractice insurance premiums jumped an average of 250% from 1999-2002[9]

Cost of Medical Malpractice Insurance

- medical malpractice insurance premiums contribute about 1% to the overall cost of health care (before considering the cost of defensive medicine)[10];
- aggregate medical malpractice claims paid in 2000 totaled $4.187 Billion[11]
- premiums average between 10% and 25% of a physician's gross revenue
- Sample of Highest Annual Premiums[12]:
  Internists: Florida $27K-$51K, Michigan $18K-$40K
  General Surgeons: Florida $63K-$159K, West Virginia $36K-$56K
  OB/GYNs: Florida $143K-$203K, Texas $70K-$160K, New York $89K-$115K

Cause for Premium Increases

- average of medical malpractice jury awards rose 76% from 1996-1999[13]:
  - ✓ median medical malpractice award in 1999 was $800K; 6.7% increase over the 1998 figure of $750K
  - ✓ median medical malpractice award for obstretricians and gynecologists jumped 43 percent in one year, from $700K in 1999 to $1 million in 2000[14]
  - ✓ 40% of all jury awards are over $1 million, compared with 35% during 1993-1995
- profitability of medical malpractice insurance decreasing[15]
  - ✓ The national medical malpractice combined ratio (across all medical

malpractice insurers) is likely to hit 140% in 2001 (for every one dollar in premiums, insurers pay out $1.40 in claims); this approaches the 160% experienced at the height of the 1980's medical malpractice crisis;

- ✓ MIIX Group reported losses for 2001 of $157 million, resulting in a downgrading of its insurance rating; MIIX is pulling out of 21 states[16];
- ✓ Insurance carriers in Texas paid out $381 million in claims in 2000, an 87% increase since 1995 (Texas Dept. of Insurance)[17]

Shrinking Availability of Malpractice Insurance: Examples of Hard Hit Areas

- Florida and Texas insurers are withdrawing nursing home coverage, while continuing coverage for other medical specialties[18];
- In Texas the number of malpractice insurers has shrunk from 17 to 4 over the past few years[19];
- Florida's 4th largest insurer (Clarendon National), and 6th largest (Phico), and 8th largest (St. Paul), are leaving the state[20];
- SCPIE Holdings Inc (LA-based insurer) stopped writing medical malpractice contracts in TX after it experienced 200% paid loss ratio in 2000[21];
- In Nevada, 60% of physicians were covered by the St. Paul before it pulled out in 2001, and four other malpractice insurers have exited the Nevada market in 2002 (in total, they provided 70% of the state's malpractice coverage)–estimates are that Nevada could lose 100 to 300 physicians in 2002[22];
- Doctor's Insurance Reciprocal stopped writing group specialty coverage in January, 2002 because it posed too much risk[23];
- In Mississippi, three companies (St. Paul, Phico, and Frontier Insurance Group) covering 14% of the physicians in the states are no longer in business[24];
- St. Paul was the largest writer of medical malpractice in U.S. (6 percent). It left the market in December of 2001. Loss in 2001 was $940 million, almost twice the amount of premiums collected ($540 million); this move will affect 42K physicians in all 50 States[2526];
- PIC Insurance Group and PIE Mutual Insurance were taken over by regulators in 2001[27];
- "Claims costs are a problem, and the severity of losses has really spiked in the last two years", Alabama-based ProAssurance, #4 Malpractice Insurer in U.S.
- PHICO Insurance Group , Pennsylvania-based, filed for bankruptcy in August of 2001, surplus dropped from $127 million to $6 million in just six months–2,400 doctors, 572 in New Jersey need new coverage[28];
- Frontier Insurance Group, which wrote $69.3 million in direct medical malpractice premiums, stopped offering insurance in 2002[29];
- West Virginia, about 1,300 doctors (1/3 of the state's doctors) looking for coverage because of St. Paul & PHICO's departure[30].

Impact of Fear of Litigation on Practice of Medicine (Harris Survey, 2002 conducted for

Common Good)[31]

- 83 % of physicians and 72% of hospital administrators do not feel that physicians can trust the current system of justice to achieve a reasonable result if sued;
- 76% of physicians are concerned that malpractice litigation has hurt their ability to provide quality care
- 29% of physicians has stated that they have been interested in a certain specialty but shied away from it due to fear of higher legal exposure
- Because of the resulting legal fear:
  - ✓ 79 % of physicians acknowledge ordering more tests than they would based only on professional judgment of what is medically needed, 91% of physicians have noticed other physicians ordering more tests;
  - ✓ 74 % refer patients to specialists more often than they would based only on professional judgment of what is medically needed;
  - ✓ 61 % of physicians have noticed physicians being reluctant to make what they believe to be humane choices at patients' end of life because of concerns that a family member might bring suit;
  - ✓ 51 % of physicians suggest invasive procedures such as biopsies to confirm diagnoses more often than they would based only on their professional judgment of what is medically needed;
  - ✓ 41 % of physicians acknowledge prescribing more medications such as antibiotics than they would based only on their professional judgment of what is medically needed, and 73 percent have noticed other doctors prescribing similarly excessive medications
- fear of liability is cited by physicians as the leading factor that discourages medical professionals from openly discussing and thinking of ways to reduce medical errors, and nearly all physicians (94%) believe that written descriptions of cases are very often or sometimes influenced by the fear of litigation.

1. Medical Malpractice, III Insurance Issues Update, March 2002.

2. The Dallas Morning News, January 20, 2002.

3. Modern Physician, February, 1, 2002.

4. Tampa Tribune, December 19, 2001.

5.Akron Beacon Journal, January 11, 2002.

6.Business First, January 4, 2002.

7. Managed Care Week, April 15, 2002.

8. The Dallas Morning News, January 20, 2002.

9. Business Wire, "Survey: Triple-Digit Malpractice Hikes Could Have Lingering Impact on Healthcare System", March 14, 2002.

10. Harvard Study commissioned by New York States, 1986, released in 1990.

11.Lankarge, Vicki, "State-by-State chart of medical malpractice payments", Insure.Com Website, 2002.

12. Medical Liability Monitor, "Trends in 2001 Rates for Physicians' Medical Professional Liability Insurance, Vol.26, No.10, October, 2001.

13. Medical Malpractice, III Insurance Issues Update, March 2002.

14. "Lawsuits Fueling Health Care Crisis", Fox News Channel, May 14, 2002, source from American College of Obstretricians and Gynecologists (ACOG).

15. Medical Malpractice, III Insurance Issues Update, March 2002.

16. The New York Times, "Doctors Face a Big Jump in Insurance," March 22, 2002.

17. The Dallas Morning News, January, 20, 2002.

18. Medical Malpractice, III Insurance Issues Update, March 2002.

19. Medical Malpractice, III Insurance Issues Update, March 2002.

20.Tampa Tribune, December 19,2001.

21. The Dallas Morning News, January 20, 2002.

22. Los Angeles Times, "Physicians Fold Under Malpractice Fee Burden," March 4, 2002.

23. The Clarion-Ledger, "Lloyd's of London agrees to insure Mississippi doctors but 25-member group will pay rates 400% higher", December 22, 2001.

24. Best's Insurance News, " Mississippi Looks for Answers to Lack of Med-Mal Coverage," December 28, 2001.

25. Medical Malpractice, III Insurance Issues Update, March 2002.

26. Modern Healthcare, January 7, 2002.

27. The Record (New Jersey), December 23, 2001.

28. The Record (New Jersey), December 23, 2001.

29. The New York Times , "Doctors Face a Big Jump in Insurance," March 22, 2002.

30. Stateline.org, "States Grapple with Malpractice Crisis," April 3, 2002.

31. All the results that follow are from "Common Good: Fear of Litigation Study, The Impact on Medicine," Final Report, April, 11, 2002.

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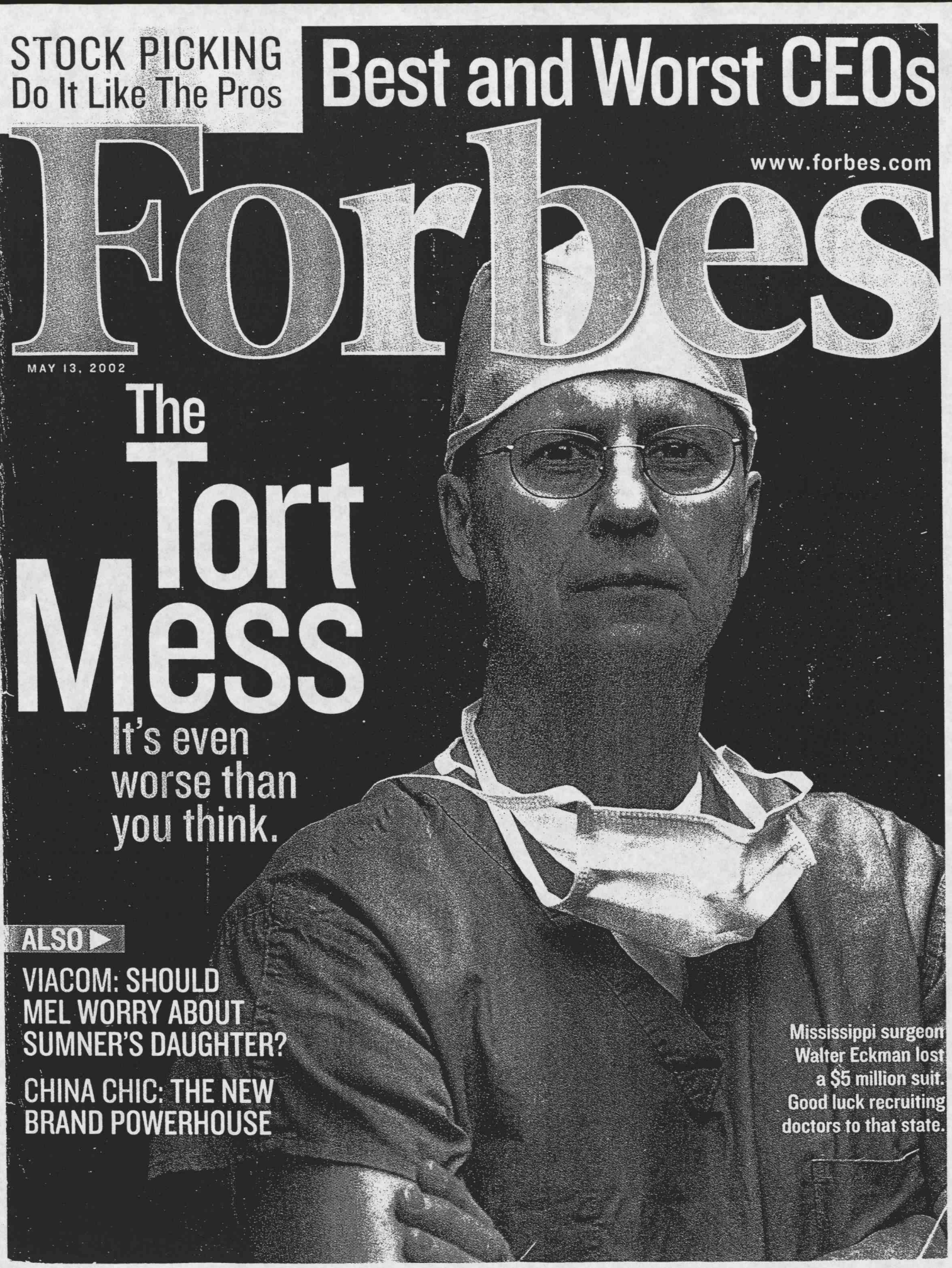
The Tort Mess

It's even worse than you think.



Mississippi surgeon Walter Eckman lost a $5 million suit. Good luck recruiting doctors to that state.

ALSO ▶

VIACOM: SHOULD MEL WORRY ABOUT SUMNER'S DAUGHTER?

CHINA CHIC: THE NEW BRAND POWERHOUSE

Tort Mess

BY MICHAEL FREEDMAN

FOR TWO AND A HALF WEEKS THIS WINTER, Dr. Walter Eckman, 58, sat in a courtroom in the center of Tupelo, Miss. as a defendant in a lawsuit. In 1999 a 27-year-old man had taken a fall at a movie theater and was admitted to the emergency room at the North Mississippi Medical Center, where Eckman was on call as a neurosurgeon. The patient was alert and awake but he had a headache and a cut on the back of his head. Two days later he went into respiratory arrest, resulting in severe brain damage. He died 15 months later.

Did Eckman screw up by not ordering enough tests? Yes, testified the widow's medical experts; no, responded Eckman's equally qualified experts. It appeared to be the kind of judgment call doctors make daily, this one with a tragic ending. But doctors and insurance companies are easy targets in the hands of tort lawyers. The jury awarded the widow $5 million, double what a similar case might have yielded just a few years ago.

The country has grown immune to verdicts like these: $5 million for a medical tragedy; $50 million in punitive damages for business interference in a case involving $1.5 million; $150 million to six Mississippi plaintiffs in October who are not sick but fear they may suffer someday from asbestos-related illnesses; $1 billion for punitive damages over the alleged contamination of 33 acres of land. It sounds at first like yesterday's news—weren't we hearing a decade ago about a $3 million verdict for a hot cup of coffee or $4 million for a repainted BMW? The tort crisis, though, is really tomorrow's news. If the momentum of litigation costs cannot be slowed, it could easily, in the space of a few years, crush important parts of the economy.

Look at the devastating consequences in Mississippi. The North Mississippi Medical Center, a hospital that serves 22 counties and 600,000 people, is now finding it all but impossible to recruit new doctors. They're scared away by the state's tort-friendly medical malpractice environment, soaring insurance premiums and word of the $5 million award. The hospital's insurance premiums have doubled in the last year to $2 million. It may have to cut back on emergency services. There is now no neurosurgeon on call one out of every four days. If there's a wreck on the highway that bisects town, or on any of the winding roads in northern Mississippi or Alabama, it will take at least one hour for the victim to be transported to the nearest neurosurgeon in Memphis or Jackson. That hour is crucial; it could cost a life.

In the next few years, predicts insurance consultancy Tillinghast-Towers Perrin, tort costs could increase twice as fast as the economy, going from $200 billion last year to $298 billion, or 2.4% of GDP, by 2005. Since 1994 the average jury award in tort cases as a whole has tripled to $1.2 million, in medical malpractice it has tripled to $3.5 million and in product liability cases it has quadrupled to $6.8 million, according to just released data from Jury Verdict Research.

At the rate tort costs are rising, wide swaths of the country, particularly rural areas, will soon be without medical specialists. Drug companies will elect to stop producing vital but less profitable drugs. Construction companies will give up building the condos and high-density projects necessary to affordable living. And smart corporate directors will recognize that the income and prestige that come with serving on boards are not worth the risk to their personal assets.

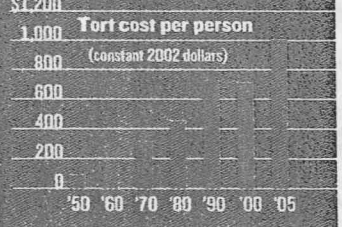
Chicken Little? Who would have predicted asbestos litigation would cripple so many companies? But 52 companies have already filed for bankruptcy and hundreds more, with only the tiniest connection to the material, are being targeted by lawyers. Listen to Houston lawyer W. Mark Lanier, who claims to be looking into a St. Louis company called Metal Goods Corp., which he says once sold fake snow for indoor Christmas trees that was made of pure asbestos. "I'm going to find where the St. Louis metals company is today, and I will bring them to their knees," he says.

It's not Chicken Little to Charlie F. Connor, who is paying $580,000 for an insurance policy for his Bellevue, Wash. construction company—up from $92,000 last year. He's thinking about getting out of building condominiums because they are

ROBERT MAXWELL / ART DEPARTMENT FOR FORBES

Spare a Grand?

Tort costs per person just keep rising, 4.3% each year.

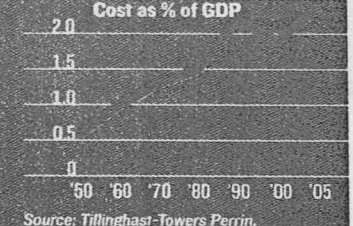


Source: Tillinghast-Towers Perrin.

Average medical malpractice verdicts have increased from $1 million in 1994 to **$3.5 million.** The top 3 awards last year totaled **$299 million.**

The Price Of Litigation

The booming Nineties saw a decline in tort costs as a percentage of gross domestic product. Now, costs are roaring back.



Source: Tillinghast-Towers Perrin.

In the second quarter of 2000 there were **1,700** mold damage claims in Texas alone. A year later there were **5,700.**

especially prone to suits over construction defects. Or to Wal-Mart, which got hit with that $51.5 million verdict in June after requiring a vendor whose contract had ended to remove its vending equipment from stores (now on appeal). Or to Halliburton and 3M, companies that got hit with the $150 million asbestos award. Or to Exxon Mobil, which was hit last May with that $1 billion award (now on appeal).

Tort lawsuits are a necessary evil in a market economy. There has to be a mechanism for making polluters and incompetent doctors and penny-stock scamsters pay. But when the payments lose any tether to the harm caused or the culpability of the defendant, they create economic havoc. "Many will sense that this is a replay of the liability crisis of the 1980s," says Robert Hartwig, chief economist of the Insurance Information Institute. "But it is more broad-based this time and more severe." Here's a look at the impact in five areas of the economy.

*The Doctor
Won't See You Now

In December the nation's second-largest medical malpractice insurer, St. Paul Cos., announced it would abandon this line of business after losing $985 million on it in 2001. It was running up $1.99 in costs and expected ultimate payouts on malpractice for every $1 of premium it was taking in. A liability insurer can make up a small underwriting loss with investment income from its reserve funds. It cannot make up 99 cents on the dollar.

St. Paul's absence will be a huge loss for the industry. It handled 42,000 doctors and 750 hospitals, covering at least 25% of the market in 12 states. When those policies expire over the next 20 months, doctors will pay as much as 300% more for new coverage, or up to $400,000 a year for some legally hazardous specialities (like neurosurgery and obstetrics). Other insurers have also stopped writing new policies, and those still willing to cover doctors have raised rates or scaled back coverage themselves. Legislatures in Nevada, West Virginia, Pennsylvania and Mississippi have considered legislation to stem the tide of lawsuits. But the reform can't come fast enough to save some medical practices. A study by a University of Nevada medical school professor says 42% of obstetricians are making plans to move their practices out of southern Nevada. If that happens, only 78 obstetricians would be left in an area that includes Las Vegas, a city of 1.5 million with 23,000 births last year. The same study notes that 76% of the city's obstetricians have been sued, and 40% have been sued three or more times.

In some parts of the country, doctors say, it is almost better to let a patient die than to attempt heroic surgery, fail and risk a lawsuit. In the border town of Bisbee, Ariz., hospital administrators recently closed the maternity ward because its family practitioners were seeing insurance rate increases of up to 500%, to $88,000 a year. The hospital services 4,000 square miles. Now, hundreds of women must travel at least 60 miles to the closest hospitals, in Sierra Vista or Tucson. Since the ward's closure, four women have delivered babies en route.

Dr. John Angstadt, 44, started looking to move out of suburban Philadelphia when his insurance increased from $14,000 in 1994 to $66,000 last November. In December he joined a large practice in Savannah, Ga., where he pays just $16,000 for insurance. Now, instead of worrying about rising costs and lawsuits, he can practice medicine.

"That was missing in Philadelphia," he says. "I got up in the morning and the idea of facing another day was onerous." That's a lot like how Tupelo neurosurgeon Jimmy D. Miller, 47, felt. He was beginning to see patients as adversaries. So after practicing for seven years he quit medicine in 2000—and enrolled in law school.

*Prescription
For Disaster

The pharmaceutical industry has always been a ripe target for suits. The difference nowadays is simply that the dollar amounts have gotten bigger. Between 1989 and 2000 the 300,000 claimants alleging damage from the Dalkon Shield contraceptive device got $2.6 billion in settlements. By contrast, the 320,000 claimants in the Wyeth (formerly American Home Products) diet drug litigation will share $13 billion. The litigation sliced Wyeth's net worth from $7 billion in 1996 to $2.8 billion in 2000.

If a drug saves 100 lives for every one it loses, someone who faces certain death should not hesitate to use it. But what happens if the tort system says every death must be paid for? The average payout on a wrongful death claim increased from $1 million in 1994 to $5.7 million in 2000 (the most recent data point available), according to Jury Verdict Research. To

merely break even, the drug's maker would have to charge $57,000 for every dose. It can't get away with that. So a potential wonder drug may never see the light of day.

A study in the *Journal of the American Medical Association* estimates that 100,000 people die each year in the U.S. from drug-related deaths. If the families of each sued and won that average of $5.7 million, total liability would hit $570 billion. That's twice the combined revenues of the top 12 drug companies.

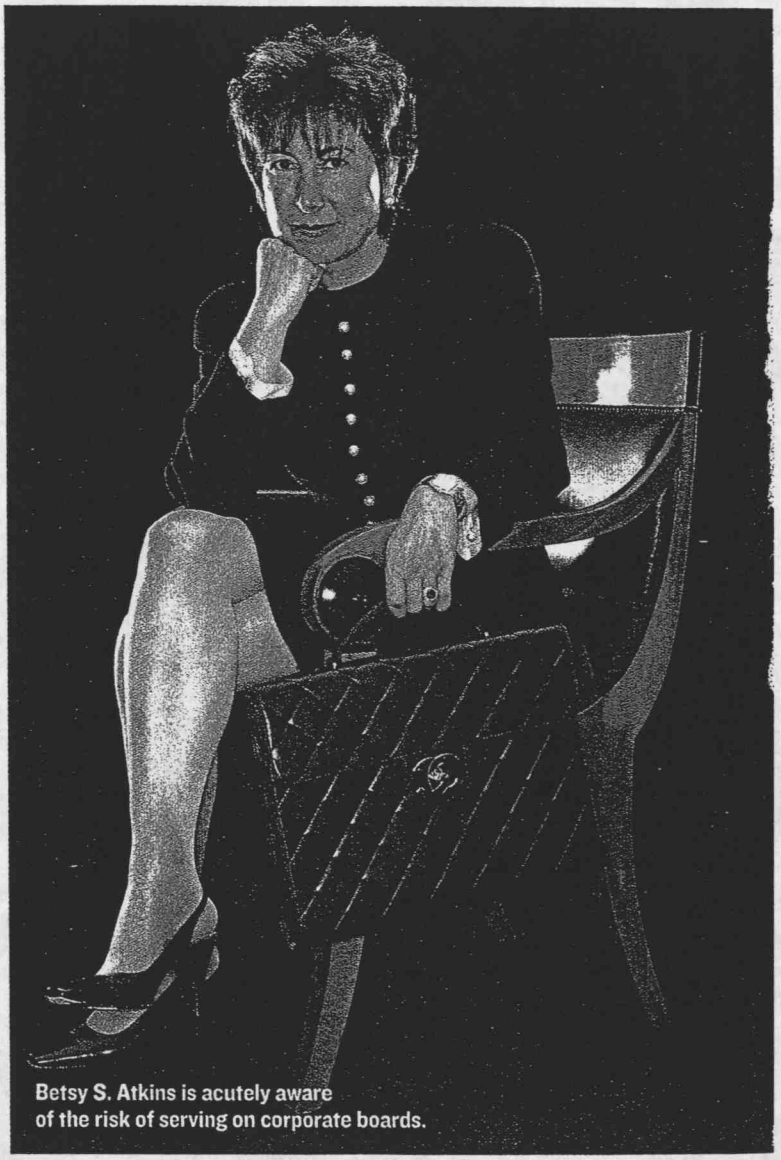
That day is not yet here. But we are inching closer to it. Look at this: A series of pending suits seeks to force vaccine manufacturers to test for autism in every child born in the 1990s—all 30 million of them. Plaintiffs say a preservative once used in vaccines that contains mercury causes the disorder. There are serious legal obstacles to winning such a suit, including liability protection for vaccine manufacturers *(see box, p. 98)*. There is also no scientific evidence of the link. There is, meanwhile, plenty of evidence that vaccines have saved millions of lives. But what if plaintiffs can show a correlation between blood-mercury levels and autism? They are suing for $30 billion, an amount roughly equal to the combined assets of defendants Baxter International and Eli Lilly.

Steven Garber, a researcher at the Rand Research Institute for Civil Justice, says drug companies are willing to take on the risk of lawsuits in marketing blockbusters like Viagra and Vioxx. But in other cases the chance of liability is too great. Garber says companies once stopped making new products for use during pregnancy because of the high risk of birth defects. Companies also limit research on orphan drugs—those that cure rare, often fatal illnesses—because the potential tort liability outweighs the profit potential.

James Beck, a defense lawyer who has represented drug and medical-device manufacturers, studied a series of medical journals and other publications and found liability fears have also stymied AIDS research and the development of new contraceptive devices.

The pharmaceutical firms shy away from discussing their research plans with such a stark calculus. Who could blame them? In a trial, evidence of merely conducting a risk-benefit analysis of a new product can damage a company's defense. Imagine what the plaintiff's lawyer can do with a memo in which people's lives are weighed in the balance against dollars of profit.

Drug company executives worry about another impact, as lawyers try their cases in the popular media. When lawyers filed suits against Novartis Pharmaceuticals in 2000, alleging the company conspired with the medical establishment to push its attention deficit disorder drug, Ritalin, the suits were accompanied by congressional hearings and



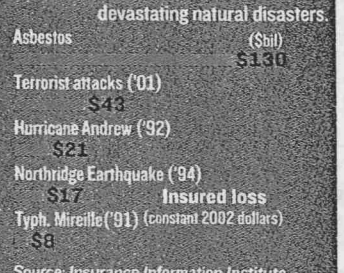
Betsy S. Atkins is acutely aware of the risk of serving on corporate boards.

BRIAN SMITH FOR FORBES

Asbestos insurance payouts are expected to hit **$130 billion,** three times the estimated payout for the Sept. 11 terrorist attacks.

Unnatural Disaster

Asbestos litigation will cost insurers more than terrorism or the most devastating natural disasters.

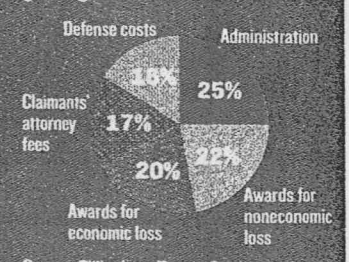


Source: Insurance Information Institute.

Nationwide, **12%** of all jury awards are for $1 million or more. In Mississippi, New York and Pennsylvania, at least **20%** of awards are for that much.

Where's the Money?

Most of the winnings in a lawsuit go to legal fees and administrative costs.

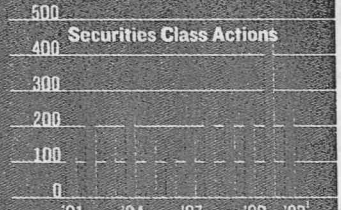


Source: Tillinghast-Towers Perrin.

When a jury awarded a woman **$1.2 million** in a 1966 case involving cholesterol drug MER/29, it was the highest award in U.S. history.

Cashing In

Securities litigation reform in 1995 was meant to curb the tide of lawsuits. It didn't work.

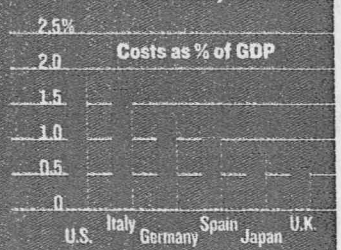


*Annualized. Source: Stanford Securities Class Action Clearinghouse.

Until 1999 it would have been tough to name a single securities settlement worth more than $100 million. The top ten since total **$5.7 billion.**

The American Way

Tort costs as a percentage of gross domestic product are higher in the U.S. than in any other nation.



Source: Tillinghast-Towers Perrin.

news stories. This March the last of those suits was dismissed. But from a medical perspective, the damage was already done. "One of the things we think may be happening," says Steven Sokolow, Novartis Pharmaceuticals' head of litigation, "is that patients who could benefit from these drugs are scared away from taking them."

*Board Games

Want to risk being bankrupted? Join a corporate board of directors and take a chance that you will get enmeshed in the next Enron.

Companies buy insurance to cover the liability of directors and officers. Until recently a board member could safely assume that the insurance would cover any settlement. Not anymore. A typical policy covers only a few hundred million dollars of claims. What if an inattentive board allows a few billion dollars to slip down a rathole? Enron's policy limit was $350 million, scarcely enough to cover the huge losses to shareholders and creditors in that fiasco. And the insurers are reportedly trying to back out of that policy, saying Enron defrauded them.

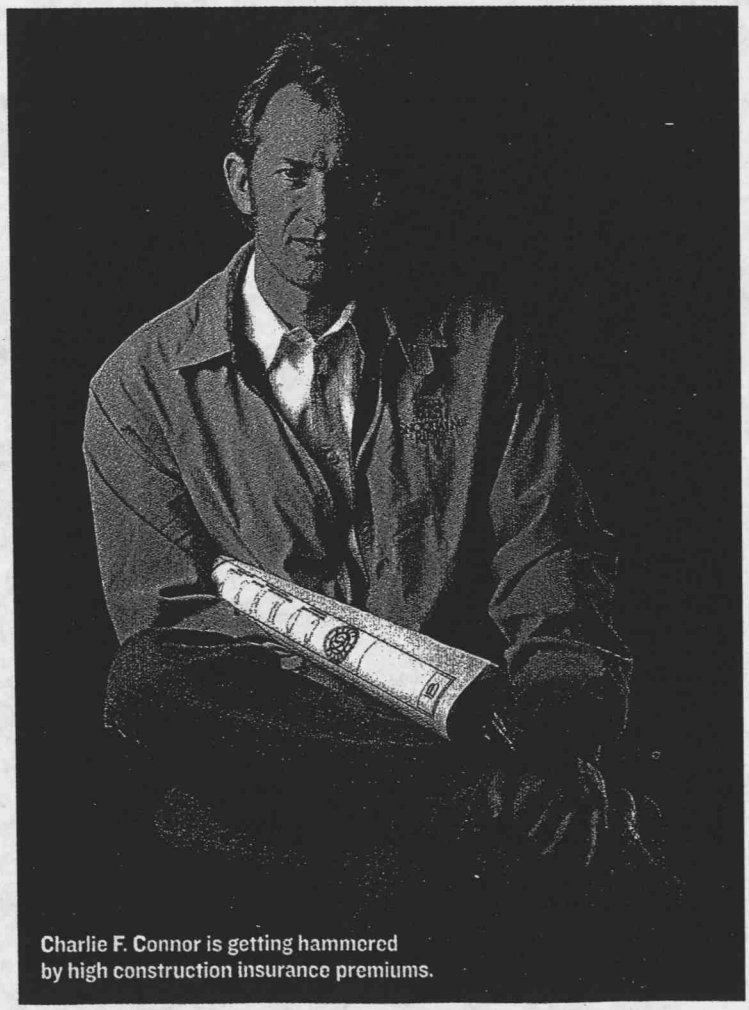
The plaintiff lawyers just might start going after directors' personal assets, as Melvyn Weiss, a leading lawyer of shareholder class actions, makes clear. "I think I would be enormously worried," he says of directors. It's a view held by Joseph Grundfest, a former commissioner of the Securities & Exchange Commission and now a Stanford Law School professor.

Anthony Galban, Chubb Group's manager of D&O underwriting, wonders why candidates for board seats don't worry more than they do. "You've worked hard," he says. "You've got a wife and kids and maybe a house in Aspen. Why would you risk all that?" Charles Elson, head of the University of Delaware's Center for Corporate Governance, expects 10% of all directors to leave by year's end because of liability fears. One director who is having second thoughts, although she has not resigned from seats on the Lucent and Polycom boards, is Betsy S. Atkins. Says she: "I am much more cognizant of risk at a much more gut level than ever before."

All those shareholder suits are costing a ton of money—and the shareholders, in a sad irony, are footing the bill for the litigation that supposedly benefits them. In the last year the premium on a $250 million D&O policy, for instance, doubled to $20 million.

*If You Build It, They Will Sue

Like a lot of trends, suits claiming construction defects began in California. The trend has spread into Texas and Florida and now into Nevada, New York, Colorado and Arizona. Heavyweight class-action plaintiff firms like Cohen, Milstein, Hausfeld & Toll have jumped in, filing claims alleging that the exterior siding known as synthetic stucco was improperly installed and caused water dam-



BRIAN SMALE FOR FORBES

Charlie F. Connor is getting hammered by high construction insurance premiums.

Is There A Way Out?

One solution to out-of-control tort litigation is staring lawyers right in the face: the Sept. 11 Fund, which enables victims to quickly win compensation without having to hire a lawyer to prove fault. If this fund works, it could serve as a model for disposing of mass claims.

A few attempts at tort reform have proven successful. A dangerous vaccine shortage in the 1980s prompted Congress to create a no-fault compensation system for people injured by childhood vaccines, and production quickly rebounded. A 1994 federal law decrees that manufacturers of small airplanes cannot be held liable for crashes of planes more than 18 years old. Result: Cessna resumed production and hired 1,000 workers.

States like California and Louisiana capped pain and suffering damages in medical malpractice cases, resulting in lower average insurance rates and allowing medical centers to more easily recruit good doctors—while the truly injured receive compensation for damages.

Still, wily lawyers have managed to get around limits on liability suits. A Republican Congress passed a law in 1995 that was intended to crack down on suits filed against the management of firms whose stocks go up and down. Before the reform, there were 190 securities class actions filed every year. Now the count is 236 a year.

If there are millions of consumers and employees who would benefit from limits on litigation, there are several thousand lawyers who are adamantly opposed. The 56,000-member Association of Trial Lawyers of America, according to the Center for Responsive Politics, has already given out $1.4 million in the 2001-02 election cycle, mostly to Democratic candidates for federal office. That makes it the largest PAC in the nation. —*M.F.*

age. The year ending June 30, 2001 saw the filing of 13,000 cases alleging mold damage in Texas alone.

It's not just the builders getting sued—insurers are at risk, too. One Texas plaintiff, denied payment of a claim for water damage on a homeowner policy issued by a subsidiary of Farmers Insurance Group, won a $32.1 million judgment. An appeal is pending.

In response to this lawsuit crisis, construction company insurers like CNA are discontinuing coverage for construction defects. Others include exclusions in policies stating that they will not insure for mold or synthetic stucco damage, according to Jeffrey Masters, a Los Angeles defense lawyer.

Even big companies are hurt. A year ago a $500 million (sales) Colorado construction company would have been able to pay $400,000 for a $1 million policy with a $25,000 deductible. Now, if it can get a policy at all, it must self-insure for the first $1 million and then pay $1.5 million for the next $5 million of coverage.

Insurers brought some of this on themselves by undercharging builders for years. Post-Sept. 11 expenses and the weak stock market have contributed to losses as well. But the growing and unpredictable wave of lawsuits has forced builders to either swallow the extra cost, charge more to customers or consider stopping building altogether.

A subsidiary of Lozier Homes in Bellevue, Wash. just finished building a 60-unit condominium and paid $250 per unit for $2 million insurance. That company has not been named in any lawsuits, but insurance for new projects will cost between $5,000 and $10,000 per unit. Lozier President Michael Levy says it's going to be impossible to pass along that kind of a price increase. Solution: Lozier Homes has stopped building condos.

*The Tort That Won't Go Away

Asbestos is an object lesson in how massive litigation starts slowly and spins wildly out of control. Insurers now estimate asbestos liability will hit $200 billion, with literally thousands of firms paying out claims. Much of the money will be extracted from companies with only the most peripheral and limited connection to dangerous asbestos-containing products, and much of it will go either to lawyers or to plaintiffs who are not even sick, just worried about getting sick.

The result: 52 companies have entered bankruptcy to escape asbestos litigation. That group includes Federal-Mogul, a $9 billion (assets) company, 16% owned by employees, that in October 2001 became the 15th-largest bankruptcy in history.

Dozens more could be on the way; 1,000 companies have been named in suits. Ford Motor and General Motors, which had asbestos fibers in brakes, have been named. Pfizer, which once owned companies that sold construction and talc products that contained small amounts of asbestos, has 232,000 claims against it. It gets sillier. Lawyers are looking at consumer product companies like Kimberly-Clark, International Paper and other manufacturers and distributors of facial tissue and writing paper that may have contained traces of asbestos. Is there any scientific evidence that people contracted mesothelioma from Kleenex? No, but Kimberly-Clark has deep pockets to be picked.

Plaintiff lawyers plumb the depths of creativity to find defendants. Houston lawyer Lanier is looking into filing a suit against Hasbro division Milton Bradley because of a clay used in elementary school classrooms. Experts say it's only a matter of time before retailers like Wal-Mart get enmeshed in the asbestos litigation machine.

The mere hint of exposure can kill a company's stock. In January, Georgia-Pacific Chief A.D. (Pete) Correll tried to quash rumors that asbestos litigation was bringing the paper and lumber giant toward the brink of insolvency. In a matter of days the rumor had knocked 20%, or $1.5 billion, off its market value. "Where the hell does everybody believe these future liabilities are going to come from," he fumed.

It was a good speech. But the truth is, like the rest of the tort system, asbestos has proven impossible for defendants to get ahead of. When Johns Manville, a building-materials company, filed for bankruptcy in 1982 in order to settle asbestos litigation, it established a trust fund to pay out 100,000 expected claims. By 1991 the trust had already received 171,000 claims—and they just keep coming. Now Johns Manville expects 2 million claims. Even the insurance industry thought it had finally turned the corner on asbestos in 1997 as unfunded future liabilities appeared to be on the decline. Wrong again. Georgia-Pacific General Counsel James Kelley says the company has learned enough from the experience of others to avoid making their mistakes. But does he know for sure? "Frankly," he says, "we don't know."

Unfortunately for the U.S. economy, when it comes to tort costs there is indeed no end in sight. F