NGA Center for BEST PRACTICES

Issue Brief

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Containing Medical Malpractice Costs: Recent State Actions

Summary

The cost of medical malpractice premiums has risen significantly in the past several years, spurring many physicians to claim they may have to leave their practices for states with lower insurance rates or stop practicing altogether. Although there is no definitive explanation for rising costs, states have explored a variety of approaches to keep them down. A 2002 National Governors Association issue brief, *Addressing the Medical Malpractice Insurance Crisis,* discussed early work in state-level reforms and initiatives to contain medical malpractice costs. This brief revisits the issue, examining continued state efforts to reduce costs to physicians and improve patient care.

Tort reform is the most frequently used method to hold down rising premiums. However, states also are providing financial assistance to physicians through direct tax credits and adopting regulations that restrict premium increases to covering insurance costs only—excluding the insurer's business losses. In addition, a variety of efforts seek to reduce medical errors and strengthen reporting guidelines. A growing number of states are creating patient safety centers that function as both a reporting center and a source of assistance and practical recommendations for providers to improve the care of their patients.

Background

Last year nationwide malpractice insurance premiums for general practitioners increased by 15 percent, while the higher-risk specialties, such as obstetrics and gynecology and neurosurgery had a 22 percent increase. As insurance costs continue to rise, many physicians claim they must leave their practices for states with lower insurance rates, or stop practicing altogether.

Many health care providers cite the cost of jury awards in malpractice cases as the cause for these price hikes, although the evidence to support this is not definitive. In fact, there have been spikes in insurance costs in past decades. Rapid increases in medical malpractice premiums were seen in the early 1980s, and current increases could be another example of market fluctuation and adjustment. Consequently, policies that focus on tort reform and reducing medical malpractice claims may have only limited influence on insurance premiums.

A 2002 National Governors Association issue brief on medical malpractice, *Addressing the Medical Malpractice Insurance Crisis,* discussed early work in state-level reforms and initiatives to contain medical malpractice costs. At the time, there was considerable debate on how to approach the problem of stemming the growing costs of medical malpractice insurance. Since then, a number of states have continued exploring options to reduce medical malpractice premiums and ensure that health care providers can stay in the state and continue to practice. These options include:

- Medical malpractice tort reform
- Assistance to physicians
- Patient safety centers and reporting guidelines
- Medical error reduction

Medical Malpractice Tort Reform

In the past 17 months, 29 states have adopted some aspect of tort reform to curb the cost of medical malpractice insurance. Torts are civil wrongs that serve as the grounds for a lawsuit. Some torts are punishable by criminal law, but medical malpractice torts are based mainly in civil courts, which award monetary relief for damages.

Caps on damages. While many states are beginning to implement and strengthen other supports to curb the growth of medical malpractice insurance, the area of reform with the greatest industry support continues to focus on capping awards. Caps set a maximum award amount for various types of damages. The most common type of tort reform is a cap on noneconomic damages—those that cannot be directly attributed to medical expenses, loss of wages, or other direct costs. Noneconomic damage awards provide financial recompense for pain and suffering caused by the loss of life, companionship, limb, or bodily function (i.e., hearing, vision, and mobility), or physical deformity. Because these damages are intangible, the amounts of noneconomic damage awards are highly subjective.

Increasingly, states link noneconomic damage caps to the Consumer Price Index, which allows caps to rise with inflation. Although many states have been able to establish damage caps, some state courts have forced their repeal. For example, **Ohio's** state supreme court has twice ruled that noneconomic damage caps are unconstitutional.[1]

Limits on attorneys' fees. Another approach in medical malpractice tort reform is to limit plaintiff's attorneys' fees. Some states are instituting a sliding scale based on the total award, while others are specifying an acceptable percentage of an award that attorneys can charge. In some states, as part of the award process the court determines whether an attorney's fees are within a "reasonable" range.

Periodic payment plans. An additional reform option changes how the awards are paid. Traditionally, jury awards were made in one lump payment, but many states are requiring periodic payment of any awards for noneconomic damages (i.e., other than lost wages and medical expenses). Periodic payments do no necessarily reduce the insurer's overall costs, but they tend to dampen major cost spikes. In **Ohio**, upon petition of the court, damage awards in excess of $50,000 may be paid in periodic payments rather than one lump sum.[2] **New York** requires payment of any noneconomic damage awards over a period of eight years.[3]

Consideration of full payout in setting award amounts. Some states are having juries consider the full payout to the plaintiff when they set award amounts. Historically, juries have considered award amounts for each type of damage separately, without regard to the other awards. Many believe that if juries consider the total of all awards to the plaintiff, the total award amount will be reduced.

Pretrial screening and arbitration. In an effort to prevent frivolous lawsuits, a number of states require that claims undergo pretrial screenings to certify their validity. Many states also are encouraging or requiring parties to enter into arbitration or other settlement conferences before proceeding to trial.

Appendix A lists the various types of medical malpractice tort reform instituted by states.

Assistance to Physicians

In addition to using tort reform to reduce the cost of malpractice awards, some states provide financial relief to help physicians with medical malpractice costs and keep them practicing in the state. This can be particularly effective for certain practice areas that incur the highest medical liability insurance costs, including obstetrics and gynecology, neurology, and anesthesiology. For example, the typical premium for an obstetrician-gynecologist practicing in Detroit climbed from $87,444 in 2000 to $123,890 in 2002 and $138,970 in 2004.

Tax credits. One mechanism of support is a straightforward tax credit. Physicians in **West Virginia,** for example**,** are eligible for an annual tax credit equal to 21 percent of their medical liability premiums.[4]

Insurance premium controls. States also are implementing various controls to combat the rise in medical malpractice premiums. **Nevada** prohibits insurers from increasing their malpractice insurance rates to cover their company's investment losses.[5] For medical liability insurance purchased through the state purchasing pool, **Pennsylvania** offers a 15 percent discount to "loss-free" health care providers—those whose insurers have not had to pay any claims in the past year.[6]

Limited liability exposure. States are looking at reducing malpractice costs by limiting a physician's liability exposure. One approach is to enact a statute of limitations. For example, one aspect of **New Jersey's** tort reform law limits a physician's liability for birth-related injuries and damage to the patient's thirteenth birthday.[7] Other states require physicians who deliver babies to maintain medical liability insurance only until their last patient is 21 years old.

Patient Safety Centers and Reporting Guidelines

In a strategic approach to reducing the cost of malpractice insurance and jury awards, states are working to improve the quality of care and reduce medical errors. States can guide patient safety measures through patient safety centers and authorities, which provide standards and guidelines for reporting medical errors and adverse events and serve as repositories for reported information. Regulations require health care providers to report to these centers or authorities. Through these information systems, providers can improve their protocols.

Currently, at least 20 states require reporting of some medical errors and adverse events through a variety of mechanisms. Some states, such as **New Jersey**, allow anonymous reporting by health care providers.[8]

The **Pennsylvania** Patient Safety Authority is an independent state agency established under the 2002 Medical Care Availability and Reduction of Error Act. It aims to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety in hospitals, ambulatory surgical facilities, and birthing centers. Pennsylvania is the first state in the nation to require the reporting of both actual events and "near misses."[9] The authority has implemented a mandatory statewide reporting system, through which more than 400 health care facilities subject to Act 13 reporting requirements submit reports.

Minnesota requires hospitals to report any occurrence of 27 “never events”—identified by the National Quality Forum, a nonprofit national coalition of physicians, hospitals, businesses, and policymakers - as preventable events that should never happen in a hospital. These events include performing the wrong surgical procedure, using contaminated drugs or devices, and allowing the criminal abduction of a patient.[10].

The **Iowa** Department of Health works jointly on a quality improvement effort with the University of Iowa College of Public Health. The program focuses on improving patient safety system wide by developing collaborative, evidence-based best practices. Its key goals are to create a nonpunitive learning environment that nurtures information sharing; rely on evidence to generate innovations and engage stakeholders to ensure a long-term commitment statewide; and involve consumers in education, decision making, planning, implementation, and evaluation to improve patient safety. The health department also is developing a strategy to enforce the rights and responsibilities of health care providers and patients while assuring the confidentiality of data for all stakeholders.[11]

Medical Error Reduction Strategies

Most medical errors are caused by three things: misunderstanding a physician’s written prescription or order, inability to access patient information, and incorrect identification of a patient. Early analysis of patient safety center data can point to potential ways to prevent medical errors. Several state initiatives to reduce errors center on technology.

The **Rhode Island** Quality Institute, a collaborative effort among health care stakeholders, the business community, academia, and government, was formed to improve the quality, safety, and efficiency of health care in Rhode Island. Its first collaborative project is linking all prescribers with all pharmacies in the state to improve the efficiency and safety of medication prescribing. This computerized system allows a prescriber to electronically transmit a prescription directly to a pharmacy of the patient’s choice, reducing the amount of time prescribers spend on the telephone to clarify prescriptions and pharmacists spend processing paper prescriptions.[12]

Applied Strategies for Improving Patient Safety (ASIPS), a collaborative effort among the State of **Colorado**, University of Colorado Department of Family Medicine, and numerous organizations, analyzed the causes and effects of errors in primary care based on reports of errors or incidents collected through the voluntary Patient Safety Reporting System. The system accepts confidential or anonymous reports of errors via its Web site, telephone hotline, or on paper. ASIPS also combines two practice-based research networks: the Colorado Research Network (CaReNet), which focuses on rural and urban minority and underserved primary care populations, and the High Plains Research Network, which focuses on rural, “frontier” primary care practices and hospitals. ASIPS has become a resource in the Rocky Mountain area and beyond for implementing a proven error reduction strategy that is appropriate for a variety of settings.[13]

Through a pubic-private partnership, **Delaware** is creating a statewide electronic access system for clinical information that can be accessed by the health care provider. The system not only will provide accurate

and timely data on the patient, but it also will be available to any of the patient's providers throughout the state. This system is being used to reduce errors and improve the safety and quality of care.[14]

Conclusion

States continue working to curb the growth of medical malpractice insurance premiums and payouts and reduce the errors that cause these insurance costs to grow. At the same time, states are helping physicians and health care providers to manage their malpractice costs to ensure that they stay in the state and continue to practice. Through a wide array of innovative policies, regulations, and programs, states are creating a menu of options to both contain crippling malpractice costs and improve the quality of care.

Additional Information

NGA's *Addressing the Medical Malpractice Insurance Crisis*:
http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_4703,00.html .

Appendix A

Types of Tort Reform Instituted by States (*as of June 1, 2005*)[15]

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
Alabama	None. Limits declared unconstitutional.	Voluntary arbitration, agreed to in writing.	No limitations.	None provided.
Alaska	Noneconomic damages limited to $400,000 or plaintiff's life expectancy calculation. For severe injury, limited to $1 million or life expectancy calculation. Punitive damages limited to $500,000 or 3 times compensatory damages.	Voluntary arbitration, cannot be a prerequisite to receiving care or treatment. Expert advisory panel used after lawsuit is filed. Must issue report within 30 days of selection on the facts of the case. Report is admissible evidence in trial.	No limitations.	None provided.
Arizona	None. Limits declared	Good cause hearing determines if a basis exists	Not limited, but court reviews reasonableness of fees upon request of	None provided.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
	unconstitutional.	to go to trial.	either party.	
Arkansas	Punitive damages limited to $250,000 per plaintiff or 3 times amount of economic damages, not to exceed $1 million. Limits adjusted for inflation at 3-year intervals beginning in 2006. Contingent on proof of recklessness or intentional malice.	Voluntary arbitration and dispute resolution. Courts permitted to set mediation and/or arbitration to encourage their use to promote settlement of cases.	No limitations.	None provided.
California	$250,000 limit for non-economic damages.	Voluntary arbitration contract. Entering contract removes option for trial and is binding.	Sliding scale, not to exceed 40% of first $50,000, 33 1/3% of next $50,000, 25% of next $500,000, and 15% of damages exceeding $600,000.	None provided.
Colorado	$1 million total limit on all damages; $300,000 limit for noneconomic damages.	Court may refer case to mediation. Voluntary arbitration.	No limitations.	Stabilization reserve fund fully outlined and enacted; however, provisions never funded and implemented.
Connecticut	None.	Medical screening panel selected when all parties agree. Proceedings confidential.	Sliding scale, not to exceed 1/3 of first $300,000; 25% of next $300,000; 20% of next $300,000; 15% of next $300,000; and 10% of damages exceeding $1.2 million.	None provided.
Delaware	Punitive damages may be awarded only on finding of malicious intent to injure or willful or	Medical negligence review panel part of court review; panel's findings admissible as evidence at trial.	Sliding scale, not to exceed 35% of first $100,000; 25% of next $100,000; and 10% of all damages exceeding	Stabilization reserve fund created.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
	wanton misconduct. No mandated limit.		$200,000.	
Florida	Noneconomic damages limited to $500,000 per claimant. For death or permanent vegetative state, noneconomic damages not to exceed $1 million. Punitive damages limited to the greater of 3 times amount of economic damages or $500,000. If deliberate intent to harm, no limit on punitive damages.	Pre-suit investigation and informal discovery conducted by defendant's insurer prior to submission to courts. Court may require submission of claim to arbitration, nonbinding, limits on what is admissible at trial. Mandatory mediation and mandatory settlement conference held prior to trial if no binding arbitration agreed to.	Limits attorney fees in malpractice lawsuits to 30% of first $250,000; 10% of any award over $250,000.	Patient's compensation fund and birth-related neurological compensation fund fully outlined and enacted. Provisions never implemented.
Georgia	$250,000 limit on punitive damages, unless demonstrated intent to harm.	Voluntary arbitration subject to court review; binding if prior agreement to make it so.	No limitations.	Health care corporation regulations require insurers to establish and maintain reserve funds for unpaid claims and other known liabilities.
Hawaii	$375,000 limit for pain and suffering damages.	Mandatory nonbinding arbitration for all cases involving $150,000 or less. Mandatory submission to medical claim conciliation panel; results not admissible at trial.	Attorney fees must be approved by court.	None provided.
Idaho	$250,000 limit on noneconomic damages, adjusted annually according to the state's adjustment of the average annual	Mandatory submission of claim to hearing panel; results nonbinding and not admissible at trial.	No limitations.	None provided.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
	wage. Punitive damages limited to $250,000 or amount 3 times of compensatory damages.			
Illinois	Noneconomic damages can be awarded against individual doctors are capped at $500,000 and capped at $1 million for hospitals.	Arbitration may be court ordered for cases totaling less than $50,000.		None provided.
Indiana	$1,250,000 total limit. Liability limited to $250,000 per health care provider. Any award beyond limits covered by patient compensation fund.	Optional medical review panel at request of either party; 2 panelists must be of same specialty as defendant. Panel findings are admissible at trial.	Plaintiff's attorney fees may not exceed 15% of any award made from patient compensation fund.	Patient compensation fund pays awards over $250,000 up to $1,250,000.
Iowa	None.	Written arbitration agreement not mandatory, but binding once entered into.	Court to review plaintiff attorney fees in any personal injury or wrongful death action against specified health care providers or hospitals.	None provided.
Kansas	$250,000 limit on noneconomic damages recoverable by each party from all defendants. Punitive damages limited to lesser of defendant's highest gross income for	Voluntary submission to medical screening panel upon request of party; panelists must include medical professional of same specialty as defendant.	Attorney fees must be approved by court.	Health care stabilization fund pays claims over $200,000, maximum payout of $300,000 per year on claim. Mandatory participation by medical professionals.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
	prior five years or $5 million. If profitability of misconduct exceeds limit, court may award 1.5 times profit instead; judge determines punitive damage.			
Kentucky	None.	Written arbitration agreements voluntary; once entered are considered enforceable and irrevocable. Courts encouraged to make referrals to mediation prior to trials.	No limitations.	None provided.
Louisiana	$500,000 limit for total recovery. Health care provider liability limited to $100,000. Any award in excess of all liable providers paid from patient compensation fund.	Voluntary arbitration, considered binding and enforceable once entered.	No limitations.	Patient compensation fund pays claims over $100,000 up to $500,000. Physicians levied surcharge directly into fund for purpose of paying malpractice claims.
Maine	Damage limits granted only in wrongful death cases. Noneconomic damages limited to $400,000, punitive damages limited to $75,000.	Mandatory pre-litigation screening and mediation panel, findings confidential except under certain provisions.	Sliding scale, not to exceed 1/3 of first $100,000; 25% of next $100,000; and 20% of damages exceeding $200,000.	Stabilization reserve fund repealed in 1995. Was part of Title 24, Chapter 20, Insurance Underwriting.
Maryland	Noneconomic damages limited to $650,000 from 2005 to 2008, thereafter increasing by $15,000 per year	Mandatory ADR or mediation within 30 days of filing defendant's answer or defendant's certificate of qualified expert, whichever is later. No mandatory	No limitations.	People's insurance counsel reviews rate increases of 10% or more. Premium tax of 2% assessed on HMOs and MCOs and used to offset malpractice premium rates. (Other

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
	beginning on January 1 of the applicable year.	mediation if court finds it unproductive and if all parties file agreement not to participate.		providers already pay this, HMOs and MCOs are now no longer exempt.)
Massachusetts	$500,000 limit for noneconomic damages, some exceptions released from limitations.	Mandatory submission of claims to medical malpractice court tribunal, decision admissible at trial.	Sliding scale, not to exceed 40% of first $150,000; 33.33% of next $150,000; 30% of next $200,000 and 25% of award over $500,000.	None provided.
Michigan	$280,000 limit on noneconomic damages; $500,000 limit on non-economic damages applies to certain other circumstance. Limit adjusted annually by state treasurer according to consumer price index.	Mandatory review by mediation panel, findings not admissible at trial. Voluntary arbitration binding if total damages claimed less than $75,000.	Maximum contingency fee for personal injury action is 1/3 of amount recovered.	None provided.
Minnesota	No limitation for punitive damages but are only allowed if defendant proven to have deliberate disregard to safety. Award subject to judicial review.	Alternative dispute resolution program. Plaintiff must consult with expert prior to trial to determine validity of claims asserted.	No limitations.	None provided.
Mississippi	$500,000 limit on non-economic damages. Punitive damages only awarded if willful malice or gross negligence proved. Court then	Voluntary arbitration must be agreed to in writing. Malpractice complaint filed must be accompanied by certificate stating that plaintiff's attorney consulted with at least one medical expert qualified to render	No limitations.	None provided.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
	determines if award granted and amount. Damages limited based on defendant's net worth.	testimony on standard of care.		
Missouri	Limit on noneconomic damages adjusted annually for inflation; set at $565,000 in 2004.	No provisions.	No limitations.	Tort victim's compensation fund; not for improper health care.
Montana	$250,000 limit on noneconomic damages. Liability for punitive damages determined by court; defendant must have been proven guilty of deliberate malice.	All malpractice claims submitted to medical legal panel for review unless voluntary arbitration agreed to. Findings not admissible into court evidence.	No limitations.	None provided.
Nebraska	Total damages limited to $1,750,000. Health care provider liability limited to $500,000. Any excess of total liability of all health care providers paid from excess liability fund.	Mandatory review of malpractice claims by medical review panel.	No limitations, but court can review for reasonableness.	Excess liability fund established, participation required and surcharge assessed to physicians. Pays claims over $500,000 per defendant up to $1,750,000.
Nevada	$350,000 limit on noneconomic damages, no exceptions. $300,000 or 3 times compensatory	All parties, insurers, and attorneys required to participate in settlement conference before district judge other than trial judge.	Amends NRS Ch. 7. Creates sliding scale for attorney fees, not to exceed 40% of first $50,000; 33 1/3% of next $50,000; 25% of next $500,000; 15% of	State insurance commissioner may create insurance coverage through regulation if access to essential insurance in voluntary market is limited.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
	damages limit on punitive damages, only awarded by court for fraud, oppression, or malice.		any amount over $600,000.	
New Hampshire	None. Limits declared unconstitutional.	Claimant may informally and voluntarily submit to hearing panel prior to beginning litigation. Panel to have layman, doctor selected by court, judicial representation.	Sliding scale, not to exceed 50% of first $1000; 40% of next $2000; 1/3 of next $97,000; 20% of excess of $100,000. When settled out of court, fee limited to 25% of up to $50,000.	None provided.
New Jersey	$350,000 limit on punitive damages, or 5 times compensatory damages, whichever is greater.	Mandatory arbitration of medical claims under $20,000; voluntary if over $20,000. Presiding judge may refer malpractice action to complementary dispute resolution mechanism within 30 days after trial discovery end date.	Sliding scale, not to exceed 1/3 of first $500,000; 30% of next $500,000; 25% of third $500,000; and 20% of fourth $500,000. 25% limit for minor or incompetent plaintiff.	None provided.
New Mexico	$600,000 total limit on all damages. Health care providers not liable for any amount over $200,000; any judgment in excess paid from patient's compensation fund.	Mandatory submission of malpractice claims to hearing panel; panel report not admissible as court evidence.	No limitations.	Patient's compensation fund only expended for purposes of and to extent provided in Medical Malpractice Act. Superintendent has authority to use fund money to purchase insurance for fund and its obligations.
New York	None.	When liability is conceded, either party may call for arbitration of damages amounts.	Sliding scale, not to exceed 30% of first $250,000; 25% of second $250,000; 20% of next $500,000; 15%	Any noneconomic damage awards must be paid out over a period of eight years.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
			of next $250,000; 10% over $1.25 million.	
North Carolina	$250,000 limit on punitive damages, or 3 times economic damages, whichever is greater.	Mandatory pretrial, mediated settlement conference for all civil actions filed in Superior Court.	No limitations.	None provided.
North Dakota	$500,000 limit on noneconomic damages. Economic damage awards in excess of $250,000 subject to court review.	Attorneys must disclose alternative dispute resolutions; good faith effort to resolve dispute required.	No limitations.	Reserve fund enacted but not implemented unless majority of doctors in state have difficulty securing malpractice insurance.
Ohio	No limits on economic damages. $250,000 limit on noneconomic damages or amount equal to 3 times plaintiff's economic loss, determined by court. Maximum noneconomic damages $350,000 per plaintiff or $500,000 per occurrence.	Voluntary arbitration; decision is not admissible as court evidence.	Limit on attorney's fees that exceed the applicable limit on compensatory damages for noneconomic loss, subject to approval of the probate court.	Any damage awards in excess of $50,000 to be paid in periodic payments, rather than a lump sum.
Oklahoma	$300,000 limit on noneconomic damages in all malpractice cases; limit also specific to obstetric and emergency room care. No limits for negligence or wrongful death.	Affidavit to be submitted by plaintiff stating consultation with qualified expert; includes written opinion from expert that act or omission constituted professional negligence and claim is meritorious.	Fee may not exceed 50% of net judgment.	State insurance fund authorized to offer malpractice insurance and/or reinsurance based on claims and loss ratio. State board for property and casualty rates must approve prior to release, based on finding that available reserves are sufficient.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
	Punitive damages awarded based on condition of misconduct.			
Oregon	None. 2004 ballot measure to institute noneconomic damage limits rejected by voters. Punitive damages not awarded if physician is found acting in scope of duties without malice.	All parties and attorneys to participate in some form of dispute resolution within 270 days of action filed unless case is settled or parties voluntarily waive in writing.	No more than 20% of punitive damages to attorney; no limitation of percentage of economic damages.	Professional liability fund established to pay sums as provided that members are legally obligated to as result of malpractice. Maintained by cirector of department of consumer and business services.
Pennsylvania	None. Limits declared unconstitutional. Punitive damages granted only if defendant found guilty of willful misconduct or reckless disregard.	Mandatory conciliation hearing, which may be a settlement conference or mediation as the parties prefer.	No limitations.	Medical professional liability catastrophe loss fund to provide up to $700,000 per occurrence. Participating physicians pay annual surcharge.
Rhode Island	None. Collateral source rule requiring jury to reduce award for damages by sum equal to difference between total benefits received and total amount paid to secure benefits by plaintiff.	Arbitration Act requires request for arbitration be in writing. Voluntary.	No limitations.	None provided.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
South Carolina	None.	No provisions.	No limitations.	Patients' compensation fund to pay portion of malpractice claim, settlement, or judgment over $200,000 for each incident or over $600,000 in aggregate for one year.
South Dakota	$500,000 limit on noneconomic damages. No limit on special damages.	Voluntary arbitration.	No limitations.	None provided.
Tennessee	None.	Voluntary arbitration.	Fees limited to 1/3 of award to plaintiff.	None provided.
Texas	$250,000 limit per claimant for noneconomic damages. $500,000 limit per claimant for noneconomic damages in judgments against health care institutions.	Expert reports to be submitted to defendant and defendant's attorney within 120 days of filing claim. Voluntary arbitration.	No limitations.	None provided.
Utah	$400,000 limit on noneconomic damages for actions arising after July 1, 2002. Adjusted annually by Administrative Office of Courts.	Voluntary pre-litigation panel may be requested. Upon written agreement by all parties, proceedings may be considered a binding arbitration hearing.	Contingency fee not to exceed 1/3 of award.	None provided.
Vermont	None.	Voluntary arbitration, panel consists of judicial referee selected by court administrator, layman, and member of same profession as defendant.	No limitations.	None provided.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
Virginia	$1.5 million limit on recovery damages. Increased by $50,000 each year from 2001 to 2006. Increased by $75,000 each year in 2007 and 2008.	Review by pretrial panel by request of either party. Findings admissible in court but not considered conclusive. Voluntary arbitration, decision binding.	No limitations.	Birth-related neurological injury compensation fund to provide compensation for infant sustaining brain damage during birth delivery. Physicians pay annual assessment to fund.
Washington	No specific limits on damage awards. Judgment for noneconomic damages cannot exceed formulation of average annual wage and life expectancy of injured.	Mandatory pretrial mediation. Panel members shall have expertise related to the specialty or action in question, and be a member of the state bar association for minimum of five years or is a retired judge.	Court to determine reasonableness of each party's attorney fees.	None provided.
West Virginia	$250,000 limit for noneconomic damages. $500,000 limit for compensatory damages; limit goes up beginning in 2004 according to inflation index. Physicians must carry at least $1 million malpractice insurance to qualify for limits.	Plaintiff must file notice with certificate of merit stating expert's familiarity with standards, qualifications, opinion of breach of standard of care. Certificates must be filed at least 30 days before filing action, and one certificate for each defendant named.	No limitations.	Medical liability fund to assist in making malpractice insurance more readily available to specific health care providers.
Wisconsin	After 1995, $350,000 damage limit adjusted annually for inflation. $500,000 damage limit for death of a minor, and $350,000	Voluntary. Mediation request must be made prior to court action and tolls statute of limitations until 30 days after the last day of mediation period.	Sliding scale, not to exceed 1/3 of first $1 million, or 25% of first $1 million recovered if liability is stipulated within time limits, 20% of any amount exceeding $1 million.	Injured patients and families compensation fund pays amounts in excess of statutorily prescribed future damages awards. Health care providers required to pay into fund annually.

State	Caps on Damage Awards	Pretrial Screening and Arbitration	Attorney Fees	Patient Compensation or Stabilization Fund
	damage limit for death of an adult.			
Wyoming	Limits prohibited.	Medical review panel to review all malpractice claims and render decision prior to claim being submitted to court. Allows legislature to create statutes requiring alternative dispute resolution or panel review prior to filing malpractice lawsuits.	Recovery $1 million or less: 1/3 if claim settled prior to 60 days after filing; 40% if settled after 60 days or judgment; 30% over $1 million.	Medical liability compensation fund to provide malpractice insurance coverage in event of cause of action. Participating physicians pay surcharge.

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[2] Ibid.
[3] Kenneth E. Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reform," [on line, cited 21 February 2005]. Available at: <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.20v1/DC1>.
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