Medical Malpractice Insurance and Health Reform

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Summary

Medical malpractice liability insurance has attracted congressional attention numerous times over the past few decades, particularly in the midst of three "crisis" periods in the mid-1970s, the mid-1980s, and the early 2000s. These crises were marked by sharp increases in physicians' liability insurance premiums, difficulties in finding any insurance in some areas as insurers withdrew from providing coverage, reports of physicians leaving areas or retiring following insurance difficulties, and a variety of public policy measures at both the state and federal levels to address the crises. Which public policy measures have been effective in addressing the successive insurance crises has been a matter of debate, in part because these crises have been at the intersection of the health care, tort, and insurance systems.

Currently, the medical liability insurance market is not exhibiting crisis symptoms. Over the past few years, losses incurred by medical malpractice insurers have dropped dramatically and premiums paid have fallen, albeit more modestly. Problems with the affordability and availability of malpractice insurance persist but are less acute compared with other time periods. Even during a non-crisis period, the current malpractice system experiences issues with equity and access. For example, some observers have criticized the current system's performance with respect to compensating patients who have been harmed by malpractice, deterring substandard medical care, and promoting patient safety. Yet there are differing opinions as to the extent that each of these particular areas has been affected by the current malpractice system.

The latest legislative interest in medical malpractice reform differs from the past in that it is largely driven by overall health reform, rather than an immediate crisis in medical malpractice insurance. In terms of direct costs, medical malpractice insurance adds relatively little to the cost of health care. According to the National Association of Insurance Commissioners (NAIC), medical malpractice premiums written in 2009 totaled approximately $10.8 billion, while health expenditures are estimated by the Congressional Budget Office (CBO) to total $2.6 trillion. Indirect costs, particularly increased utilization of tests and procedures by physicians to protect against future lawsuits ("defensive medicine"), have been estimated to be much higher than direct premiums. These conclusions, however, are controversial, in part because synthesis studies have claimed that national estimates of defensive medicine are unreliable.

The recently enacted Patient Protection and Affordable Care Act (P.L. 111-148) included language that allows states to receive grants to enact and implement alternatives to tort litigation. In the 112th Congress, H.R. 2, which would repeal P.L. 111-148, passed the House on January 19, 2011. In addition, the House Committee on the Judiciary held a hearing on medical liability reform on January 20, 2011, and H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, was introduced shortly thereafter on January 24, 2011. Among other things, the HEALTH Act would implement a cap on non-economic damages for health care lawsuits.

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Introduction

Medical malpractice insurance has attracted congressional attention numerous times over the past few decades, particularly in the midst of three "crisis" periods in the mid-1970s, the mid-1980s, and the early 2000s. These crises were marked by sharp increases in physicians' liability insurance premiums, difficulties in finding any liability insurance in some areas as insurers withdrew from providing coverage, reports of physicians leaving areas or retiring following insurance difficulties, and a variety of public policy measures at both the state and federal levels to address the crises. In each case, the crisis receded after a few years as premium increases moderated and market conditions calmed. Over time, the availability of medical liability insurance and premiums for such insurance has exhibited cyclical characteristics.

Which public policy measures have been effective in addressing the successive insurance crises has been a matter of debate. Sharply drawn conclusions about the causes of the crises have also been strongly debated. During the most recent crisis, in the early 2000s, the debate largely focused on implementing federal limits on the tort system. The Congressional Budget Office (CBO) has estimated that a nationwide limit on torts for medical malpractice would lower malpractice insurance premiums by approximately 10%.[1] Other studies have found both higher effects and negligible effects from state tort reforms.[2]

According to the latest summary information published by the Medical Liability Monitor in 2010, the market "remains 'soft' or perhaps 'flat' with 67 percent of all rates holding at last year's level."[3] Premiums for 2010 for malpractice insurance "have eased nationwide."[4] Data gathered by the National Association of Insurance Commissioners (NAIC) indicate that total premiums for medical malpractice liability insurance have dropped every year from 2006 to 2009. Although the current medical liability insurance market is not exhibiting crisis symptoms, problems still exist with affordability of malpractice insurance for certain specialties and in particular geographic regions; such problems, however, are not as acute as compared with other crisis periods. Thus, by extension, physicians and physician groups (primarily the American Medical Association) are not responding to current market conditions in the same manner as during crisis periods. For example, during a crisis period, physicians and physicians groups have engaged in more public displays of dissatisfaction such as participating in "strikes." However, even during a non-crisis period, the current malpractice system experiences issues with equity and access. For example, some observers have criticized the current system's performance with respect to compensating patients who have been harmed by malpractice,[5] deterring substandard medical care,[6] and promoting patient safety.[7]

[1] Congressional Budget Office (CBO), "CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ("Tort Reform"), Letter to the Honorable Orrin G. Hatch," October 9, 2009, *available at* http://www.cbo.gov/doc.cfm?index=10641.

[2] *See, e.g.*, Kenneth E. Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms," *Health Affairs*, Web Exclusive, January 21, 2004, and General Accounting Office, "Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms," GAO/HRD-87-21, December 1986.

[3] Chad Karls, *Medical Liability Monitor*, Vol. 35, No. 10, October 2010, p. 1

[4] Amy Lynn Sorrel, "Liability premiums stay stable, but insurers warn this might not last," *American Medical News*, November 23, 2009, *available at* http://www.ama-assn.org/amednews/2009/11/23/prl21123.htm.

[5] E. Thomas, et al., "Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado," *Medical Care*, Vol. 38, No. 3, (March 2000); T. Brennan, et al., "Incidence of Adverse Events and Negligence in Hospitalized (continued...)

Medical Malpractice and Health Reform

The current legislative interest in medical malpractice reform differs from the past in that it has been largely driven by overall health reform, rather than an immediate crisis in malpractice liability insurance. As such, the focus of reforming medical malpractice may be broadened. Instead of narrowly addressing what can be done to stabilize premiums for malpractice insurance, Congress may decide to focus on how changes to the medical malpractice system might affect overall health reform.

In terms of direct costs, medical malpractice insurance adds relatively little to the cost of health care. Medical malpractice premiums written in 2009 totaled approximately $10.8 billion,[8] while health expenditures estimated by CBO total $2.6 trillion.[9] Indirect costs, particularly increased utilization of tests and procedures by physicians to protect against future lawsuits ("defensive medicine"), have been estimated to be much higher than direct premiums. These conclusions, however, are controversial, in part because synthesis studies have claimed that national estimates of defensive medicine are unreliable.[10]

CBO conducted its own analysis, as well as synthesized and analyzed previous studies on the relationship between medical malpractice and health care costs.[11] The most recent CBO analysis estimated that *federal* tort reforms would reduce national health care spending by about 0.5% in 2009 (equivalent to approximately $11 billion).[12] This estimate is the cumulative impact of tort reform on both lowering medical malpractice insurance premiums and reducing use of health care services, and takes into account the fact that because some states have implemented tort reforms, a significant proportion of potential cost savings already has been realized. Other earlier studies have estimated the reduction of health care spending attributable to *state* tort reforms. These studies compared pre- and post-reform spending within each state that implemented such reforms, and found varying impact (e.g., a set of studies found 4%-9% reduction in hospital spending for Medicare patients with heart disease; another study found that state tort reforms reduced personal health care expenditures by 3%-4%).[13]

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Patients," *New England Journal of Medicine*, Vol. 324, No. 6, (February 7, 1991).

[6] Michelle M. Mello and Troyen A. Brennan, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," 80 Tex. L. Rev. 1595 (2002).

[7] L. Sato, et al., "Legal Liability and Protection of Patient Safety Data," Harvard Risk Management Foundation, 2005.

[8] NAIC, "Countrywide Summary of Medical Malpractice Insurance, Calendar Years 1991-2009," provided to CRS on December 16, 2010.

[9] Douglas Elmendorf, "Expanding Health Insurance Coverage and Controlling Costs for Health Care," testimony provided to the Senate Budget Committee, February 10, 2009.

[10] *See, e.g.*, Michelle Mello, "Understanding medical malpractice insurance: A primer," Robert Wood Johnson Foundation, Research Synthesis Report No. 8, January 2006, and Office of Technology Assessment, "Defensive Medicine and Medical Malpractice," 1994.

[11] *See* CBO, "Budget Options, Volume 1: Health Care," December 2008.

[12] CBO, "CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ("Tort Reform"), Letter to the Honorable Orrin G. Hatch," October 9, 2009, *available at* http://www.cbo.gov/doc.cfm?index=10641.

[13] *See* P. Danzon, "Liability for Medical Malpractice," *Handbook of Health Economics*, Culyer and Newhouse, eds., 2000; D. Kessler and M. McClellan: "How Liability Law Affects Medical Productivity," Working Paper No. 7533, National Bureau of Economic Research, Feb. 2000), and "Do Doctors Practice Defensive Medicine?," *Quarterly Journal of Economics*, Vol. 111, No. 2, May 1996; and F. Hellinger and W. Encinosa, "The Impact of State Laws (continued...)

CBO also estimated the effect of malpractice tort reform on the federal budget. In its latest analysis, CBO estimated that such reforms would reduce spending under Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program by approximately $41 billion from 2010 to 2019. In addition, Congress's Joint Committee on Taxation (JCT) estimated that such reforms would lead to an increase in federal revenues by $13 billion over the same 10-year period.[14] By combining the impact of tort reform on mandatory health spending and tax revenues, CBO estimated that tort reforms could reduce the federal budget deficit by approximately $54 billion over 10 years.[15]

Health Reform and Medical Malpractice Legislation

The Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) was signed into law on March 23, 2010. The language of PPACA was that of H.R. 3590, which was passed by the Senate on December 24, 2009. It includes two provisions related to medical malpractice liability reform. As will be discussed below, it is the states that regulate or that have implemented tort reform for medical malpractice law suits. PPACA is the first law enacted where Congress not only expresses that it should establish state demonstration programs to evaluate alternatives to tort litigation, but in fact establishes such an initiative, which will be in effect for five years.

Section 6801 expresses the Sense of the Senate that (1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; (2) states are encouraged to develop and test litigation alternatives while preserving an individual's right to seek redress in court; and (3) Congress should consider establishing a state demonstration program to evaluate alternatives to the existing civil litigation system with respect to medical malpractice claims.

Section 10607 creates a new Public Health Services Act section 933V-4, which appropriates $50 million for a five-year period beginning in FY2011 for the Secretary to award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or organizations. These grants will exist for no more than five years. States that receive a grant are required to develop an alternative that (1) allows for the resolution of disputes caused by health care providers or organizations, and (2) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to the resolved disputes.

Prior to receiving a grant, a state will have to demonstrate that its alternative (1) increases the availability of prompt and fair resolutions of disputes, (2) encourages the efficient resolution of disputes, (3) encourages the disclosure of health care errors, (4) enhances patient safety by reducing medical errors and adverse events, (5) improves access to liability, (6) informs the patient about the differences between the alternative and tort litigation, (7) allows the patient to

(...continued)

Limiting Malpractice Damage Awards on Health Care Expenditures," *American Journal of Public Health*, Aug. 2006.

[14] Much of health care consumed in the private sector is provided through employer-sponsored health benefits that are not taxed as income for the employee. The JCT assumed that implementation of tort reforms would lead to lower health care costs, which in turn, would lead to higher wages, which are taxable. Thus, higher taxable income would result in greater revenue.

[15] CBO, "CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ('Tort Reform')," Letter to the Honorable Orrin G. Hatch, October 9, 2009, *available at* http://www.cbo.gov/doc.cfm?index=10641.

opt out of the alternative at any time, (8) does not conflict with state law regarding tort litigation, and (9) does not abridge a patient's ability to file a medical malpractice claim.

Each state will have to identify the sources from and methods by which compensation will be paid, which can include public and private funding sources. In addition, each state will have to establish a scope of jurisdiction to whom the alternative will apply so that it is sufficient to evaluate the effects of the alternative. The Secretary will provide to the states that are applying for the grants technical assistance, including guidance on common definitions, non-economic damages, avoidable injuries, and disclosure to patients of health care errors and adverse events.

When reviewing states' grant applications, the Secretary will consult with a newly established review panel that will be composed of relevant experts appointed by the Comptroller General. There are various reporting requirements that must be completed. First, states that receive a grant must submit a report to the Secretary covering the impact of the activities funded on patient safety and on the availability and price of medical liability insurance. Second, the Secretary must submit an annual compendium to Congress that examines any differences that may result in the areas of quality of care, number and nature of medical errors, medical resources used, length of time for dispute resolution, and the availability and price of liability insurance. Third, the Secretary, in consultation with the review panel, must contract with a research organization to conduct an overall evaluation of the effectiveness of grants awarded. This evaluation must be submitted to Congress no later than 18 months following the date of implementation of the first funded program. Fourth, the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) must each conduct an independent review of the impact of state-implemented alternatives on their programs and beneficiaries. These reports must be submitted no later than December 31, 2016. These reports may provide new and informative data about the impact and effect of tort reform.

The section does not limit any prior, current, or future efforts of any state to establish any alternative to tort litigation.

Congressional Action in the 112th Congress

The 112th Congress has acted quickly to address health reform generally and medical malpractice issues specifically. H.R. 2, which would repeal P.L. 111-148 in its entirety, was introduced by Representative Eric Cantor on January 5, 2011. This bill was passed by the House on January 19, 2011.

Medical liability reform was the topic of the first committee hearing in the House Committee on the Judiciary, held on January 20, 2011. Shortly thereafter, H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, was introduced by Representative Phil Gingrey on January 24, 2011.[16] H.R. 5 would impose national medical malpractice laws, and thus would effectively preempt existing state medical malpractice laws, with certain exceptions. A "health care lawsuit" would encompass not only suits between a physician and patient, but also any claim against a health care organization, manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product and any claims concerning health care goods and services

[16] Notably, prior versions of this bill have been introduced in past congresses. *See* H.R. 4600, 107th Cong. (2d Sess. 2002); H.R. 5, 108th Cong. (1st Sess. 2003); H.R. 4280, 108th Cong. (2d Sess. 2004); H.R. 5/H.R. 534 (1st Sess. 2005); H.R. 2580, 110th Cong. (1st Sess. 2007); H.R. 1086, 111th Cong. (1st Sess. 2009).

or medical products affecting interstate commerce. Among other things, H.R. 5 would mandate a uniform statute of limitations for health care lawsuits, set parameters and caps for non-economic damages, punitive damages, and attorneys fees. However, it would also grant states flexibility in that it would not preempt any state law that imposes greater procedural or substantive protections for health care providers and organization from liability, loss, or damages, and it would not preempt any state law that specifies a particular monetary amount of compensatory or punitive damages, regardless of whether the state's monetary amount is greater or lesser than is provided for in the act.

Challenges in Medical Malpractice Policymaking

Addressing problems in the medical malpractice insurance markets can be challenging, as these markets react to three different systems, each of which is complex in its own right: health care, tort, and insurance.

Health Care System

Medical errors can lead to injury, and injury is the medical basis on which a malpractice claim is made. Reducing errors through improved medical practices and effectuating penalties against poorly performing physicians may benefit the overall performance of the medical malpractice insurance system.

States have the primary authority to define the process for granting and renewing a medical license, and regulating the medical practice. Currently, there is a lack of uniformity across states regarding both medical licensure and the medical practice. Moreover, states face financial challenges and many lack clinical expertise to fully implement patient safety strategies. For example, current state initiatives vary regarding the existence, scope, and robustness of data-collection efforts to track and analyze medical errors and possible instances of malpractice. Federal input may be implemented through a variety of approaches, both voluntary (e.g., support for research on evidence-based medicine, and toolkits to evaluate the adoption of patient safety efforts) and mandatory (e.g., "conditions of participation" standards for institutional providers under the Medicare program).

While reducing medical errors may be a worthy goal in its own right, it is unclear to what degree medical malpractice insurance will be affected if only patient safety concerns are addressed. Multiple studies have found that the majority of malpractice claims filed involve medical injuries not caused by negligence.[17] Moreover, only a small proportion of patients whose injuries are caused by negligent medical care actually end up filing a malpractice claim.[18] These findings speak to the complexity of the existing medical liability system, and difficulty in designing effective policies without consideration of the interrelated systems.

[17] *See, e.g.*, David Studdert, et al., "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care*, (March 2000); Paul Weiler, et al., A Measure of Malpractice (1993); T. Brennan, et al., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I," *New England Journal of Medicine*, Vol. 324, No. 6, (February 7, 1991).

[18] David Studdert, et al., "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care*, (March 2000).

Some observers suggest that the current malpractice system encourages the practice of "defensive medicine," that is, the fear of liability and the potential negative outcomes associated with malpractice claims lead physicians to administer additional health care treatments or avoid high-risk services primarily to reduce their liability risk. The implication is that defensive medicine results in either an increase in overall consumption of and spending on health care services that may not be medically necessary, or a decrease in access to certain services or for certain patients. Multiple studies have found some evidence of defensive medicine, but even physician and other provider groups acknowledge that it is a difficult concept to measure.[19] Moreover, some evidence suggests that factors other than defensive medicine, such as physician payment systems (e.g., fee-for-service vs. capitation) and financial incentives, may explain the alleged over-provision of health services.[20]

Tort System

The tort system acts as a mechanism through which a person suffering injury due to medical errors is monetarily compensated when he or she establishes that a physician provided substandard health care. Some argue that the tort system is an efficient way to both compensate those who suffer from an injury and to deter the errors that created the injury, and that the tort system is the primary way that the present system deals with such issues. However, there are those who argue that, in the case of medical malpractice, the current system does neither particularly well.[21] Some observers have suggested that the medical malpractice tort system is arbitrary in its outcome.[22] As noted above, many valid claims are never filed and many filed claims are not the result of negligence. Jury verdicts can vary significantly from case to case, with substantial variation also occurring among states and among counties within states.

Some medical malpractice reforms also contribute to this variation. For example, in a case where there is a permanently disabled mid-career high wage earner compared to a non-wage earner with the same injury, a jury awarding non-economic damages [23] where there is no cap may tend to give the working person higher non-economic damages. However, where there is a cap on non-economic damages, this may mean that the high wage earner is prevented from being compensated as highly for his non-economic damages. Data on tort outcomes for medical malpractice are difficult to gather as there is no central or authoritative tracking source from the counties where many trials occur, nor is there such a source from the states or the federal government.[24]

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[19] General Accounting Office, "Medical Malpractice: Implications of Rising Premiums on Access to Health Care," GAO-03-836, August 2003.

[20] Ibid.

[21] *See* analysis presented by M. Mello and D. Studdert, "The Medical Malpractice System: Structure and Performance," Medical Malpractice and the U.S. Health Care System, W. Sage and R. Kersh, eds., Cambridge University Press, 2006.

[22] "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, March 3, 2003.

[23] Non-economic damages typically compensate for intangibles such as pain and suffering and capacity to enjoy life, as opposed to economic damages which compensate for more tangible elements such as medical expenses and loss of earnings.

[24] However, a private company, Jury Verdict Research, is a commonly cited source for information on awards from medical malpractice cases as they collect and analyze data.

Insurance System

Liability insurance insulates physicians from the direct cost of medical malpractice. It acts as a buffer between the actual award for malpractice determined under the tort system and the physician who may have committed malpractice. The vast majority of physicians have liability insurance, although there is anecdotal evidence about some physicians practicing medicine without malpractice insurance. By its nature, insurance spreads the costs across a wide base of physicians in a particular specialty or geographic area, so that the actions of a relatively small number of physicians can have a wider impact.

Specific aspects of the insurance system can arguably catalyze or magnify crises. Medical malpractice claims tend to play out over an extended period of time, due both to the lag in recognizing that a claim might exist and to deliberations in the court system. Insurance is based on estimating future claims and estimating the investment returns on premium payments from the time premiums are paid until the time claims are paid. The longer time period associated with liability insurance losses increases uncertainty in these estimations, with such uncertainty possibly leading to increased volatility in premiums.

Medical malpractice liability insurance is regulated by the individual states under the federal McCarran-Ferguson Act of 1945,[25] which also provides a limited exemption from federal antitrust laws. This has resulted in variations in the structure of the markets as well as in the data generated. NAIC aggregates some insurance data; however, much potentially useful data is either not collected or not available. For example, data encompassing all the medical malpractice claims closed by insurers can give a broad picture of the situation in medical malpractice insurance; however, only a handful of states either collect such data or make it available to researchers.

Recent Experience in Medical Malpractice Insurance

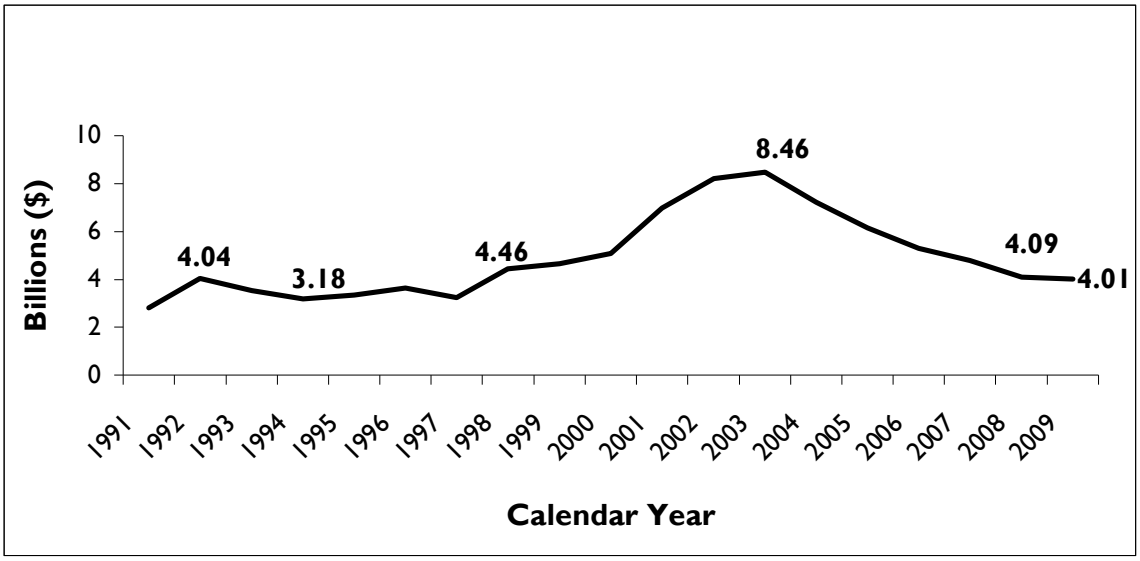
The cyclical experience of medical malpractice insurers is reflected in aggregate data about the industry compiled and analyzed by the NAIC (see **Figure 1**). From 1992 to 1998, direct incurred losses[26] were relatively stable, varying from a low of $3.18 billion in 1994 to a high of $4.46 billion in 1998. However, from 1998 to 2003, losses grew steadily year after year, to a high of $8.46 billion in that last year, coinciding with the last crisis period. Since 2003, losses have fallen every year. In 2009, losses totaled $4.01 billion, the lowest amount in more than a decade. (The loss data is in nominal dollar amounts.)[27]

[25] 15 U.S.C. Sec. 1011 *et seq*.

[26] Incurred losses are payments for claims during a certain time period, in this case during a calendar year. Incurred losses for any given year include payments for claims submitted prior to that year, and account for outstanding claims at the end of the time period. The NAIC loss data is in nominal dollar amounts.

[27] The distinction between nominal vs. real dollars is significant when considered over the longer time period. For example, while the 2008 loss of $4.09 billion does not seem much more than the 1992 loss of $4.04 billion, because these amounts do not reflect the effects of inflation, the 2008 losses are actually much lower than those in 1992.

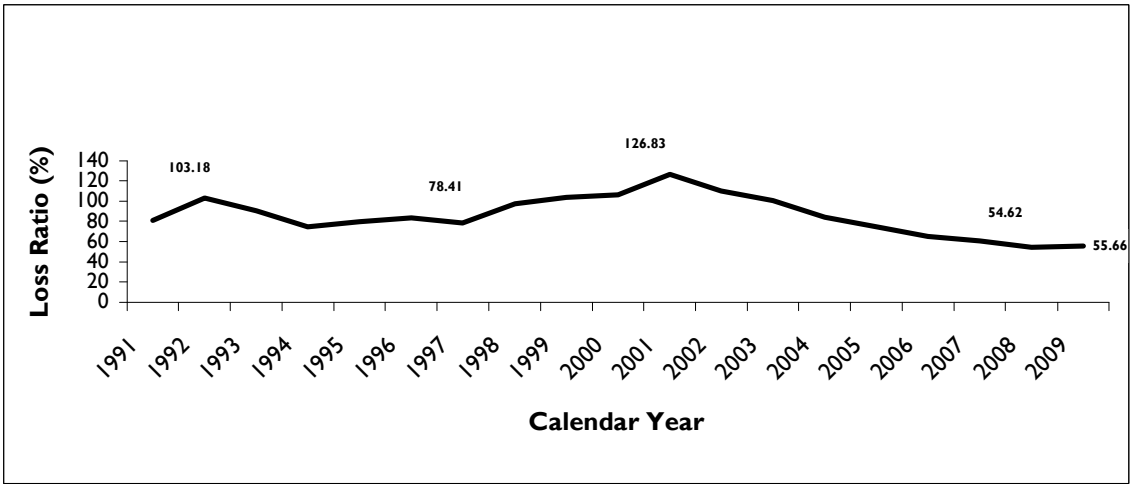
Figure 1. Nationwide Direct Losses Incurred



Source: National Association of Insurance Commissioners.

The trend in malpractice insurance premiums has roughly followed losses as those amounts have increased. However, such premiums have not fallen nearly as much as losses in recent years. The loss ratio, which compares losses to premiums, reflects this uneven trend (see **Figure 2**). A high ratio generally implies lower profits for insurers on the insurance portion of their operations. The loss ratio for the industry rose steadily from 78.41% in 1997 to 126.83% in 2001, tracking closely with the losses trend. Since 2001, the loss ratio has rapidly decreased. In 2008, the loss ratio of 54.62% was the lowest one in nearly two decades and 2009's ratio was the second lowest at 55.66%, meaning that over the past two years, the industry experienced its highest profit margin on direct premiums earned in the calendar years analyzed.

Figure 2. Nationwide Loss Ratio



Source: National Association of Insurance Commissioners.

Notes: Loss Ratio = (Direct Losses + Direct Defense and Cost Containment Expenses Incurred)/Direct Premiums Earned.

Insurers, who are strictly regulated by state insurance regulators, may also profit, or lose, from their investments. In general, with such low loss ratios, theory would suggest that there is an increase in competition because insurers are entering the market in search of profits. This, however, may not be happening as quickly as expected in medical malpractice if prospective insurers are wary due to past variations in medical malpractice losses, or if prospective insurers' capital has been depleted due to losses incurred during the recent financial crisis.

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