



Medical malpractice —Update

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This update draws on research conducted by Michelle Mello and Allen Kachalia for the Medicare Payment Advisory Commission. A comprehensive report and list of studies reviewed is available at http://www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf. The findings, statements, and views expressed are those of the authors and do not necessarily represent those of the Commission.

SUMMARY OF KEY FINDINGS

- > Except for caps on non-economic damages, there is little or no evidence that most traditional malpractice reforms significantly affect medical liability costs or defensive medicine.
- > Although study findings are mixed, the weight of the evidence suggests caps on noneconomic damages substantially reduce average claim payments, modestly constrain the growth of malpractice insurance premiums, and reduce at least some defensive-medicine practices.
- > Several more innovative reforms are promising, though they have not been widely implemented or evaluated.

This update reviews the evidence on the effects of malpractice reforms, including studies published since the 2006 release of the synthesis report, “Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms.”

Although the malpractice crisis—the inability of health care providers to obtain affordable liability insurance—has abated in many states, medical liability costs and pressures remain a concern. Insurance premium costs continue to be a financial burden for many health care providers, and may be passed on to patients and health insurers in the form of higher prices. Moreover, the perceived threat of litigation spurs “defensive medicine”—the practice of ordering services primarily to reduce the physician’s liability exposure rather than because they are medically necessary. Defensive medicine contributes to the growth of health care expenditures. There is wide consensus that liability pressure undermines efforts to curb overuse of health services, although there is disagreement about the magnitude of its effect.

For these reasons, interest in medical malpractice reforms among state and federal policy-makers remains high. In recent months, President Obama authorized the appropriation of \$75 million to fund demonstration projects of innovative liability reforms that advance patient safety. At the same time, courts in several states have struck down the cornerstone of more traditional approaches to liability reform: caps on noneconomic damages. At this point, what are the most promising approaches to liability reform?

This update reviews the evidence concerning the effects of both traditional and innovative medical liability reforms on defensive medicine and medical liability costs. Since the original synthesis report was released in 2006, the quantity and quality of studies in this area have increased substantially, incorporating more recent data than the studies previously reviewed.

Do traditional tort reforms reduce liability costs?

Strong evidence exists on the effects of traditional reforms on the number and cost of malpractice claims, liability insurance premiums and the system’s overhead costs. There is a large base of well-designed studies evaluating the effects of traditional malpractice reforms, which have been widely implemented by states over the past three decades (see sidebar). Although some study findings have been mixed, it is possible to draw fairly strong conclusions based on this research (see Table 1).

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Most traditional tort reforms do not reduce liability costs or defensive medicine.

TRADITIONAL MALPRACTICE REFORMS

Several types of reforms have been widely implemented by states and widely studied by researchers.

Caps on noneconomic damages:

Limit the amount of money that a plaintiff can receive as an award for noneconomic losses, or “pain and suffering,” in a malpractice suit.

Pretrial screening panels:

Review a malpractice case at an early stage and provide an opinion about whether a claim has sufficient merit to proceed to trial. Typically, a negative opinion does not bar a case from going forward, but can be introduced by the defendant as evidence at the trial.

Certificate of merit: Requires a plaintiff to present, at the time of filing the claim or soon thereafter, an affidavit certifying that a qualified medical expert believes there is a reasonable and meritorious cause for the suit.

Attorney fee limit: Limits the amount of a malpractice award that a plaintiff’s attorney may take in a contingent-fee arrangement.

Joint-and-several liability reform: Limits the financial liability of each defendant to the percentage fault that the jury allocates to that defendant.

Statute of limitations/repose: Limits the amount of time a patient has to file a malpractice claim.

Table 1. Summary of evidence concerning the effects of traditional tort reforms

	Claims frequency	Claims costs	Overhead costs	Malpractice premiums	Defensive medicine
Caps on noneconomic damages	0 (Moderate)	↓↓ (Moderate)	↑ (Low)	↓ (Moderate)	↓ (High)
Pretrial screening panels	0 (High)	0 (High)	↑ (Low)	0 (Moderate)	↓ (Low)
Certificate of merit	0 (Low)	0 (Low)	↑ (Low)	0 (Low)	0 (Low)
Attorney fee limits	0 (High)	0 (High)	↑ (Low)	0 (High)	0 (Low)
Joint-and-several liability reform	0 (Low)	0 (High)	0 (Low)	0 (Moderate)	0 (Moderate)
Collateral-source offsets	0 (Moderate)	0 (High)	0 (Low)	0 (Moderate)	0 (High)
Periodic payment	0 (Low)	0 (Moderate)	0 (Low)	0 (Low)	0 (Low)
Shorter statute of limitations/repose	0 (Moderate)	0 (Moderate)	0 (Low)	↓ (Moderate)	0 (Low)

Notes: Effects are classified as large increase (↑↑), modest increase (↑), no change (0), modest decrease (↓), or large decrease (↓↓). Evidence or certainty levels for these effects are classified as low or theoretical only (low), moderate, or high.

Caps on noneconomic damages substantially reduce average claim payouts and modestly affect liability insurance premiums. Average awards are reduced by 20 percent to 30 percent, and premiums in states with caps rise 6 percent to 13 percent more slowly than premiums in states without caps. The Congressional Budget Office (CBO) recently determined that implementing a package of five traditional reforms, including a \$250,000 noneconomic damages cap, in all states would reduce the total amount paid for malpractice insurance nationwide by 10 percent (Reference 1).^a Studies examining the effects of caps on the frequency of malpractice claims have returned conflicting findings. The evidence is too equivocal to support a firm conclusion about this effect.

Other traditional reforms have not significantly affected the frequency of claims, average payouts, or liability insurance premiums. A possible exception is that shorter statutes of limitations may help constrain the growth of premiums. The size of the evidence base varies depending on the type of reform, but where multiple studies exist on a particular reform’s effects, their findings tend to be fairly consistent.

Traditional reforms do not reduce the overhead costs of the medical liability system. Indeed, there is some evidence to suggest that certificate of merit requirements, damages caps, and attorney fee limits may increase litigation costs. Obtaining a certificate of merit can cost \$1,000–\$5,000. Because damages caps decrease the risk of large jury awards, insurers may be less willing to settle cases and more willing to go to trial, incurring higher litigation expenses (Reference 2). Attorney fee limits may increase average defense costs because attorneys are less inclined to bring small claims (Reference 2).

^a The other reforms included were a punitive damages cap of \$500,000 or twice the economic damages award, collateral-source rule reform, a 1-year statute of limitations for adults and 3-year limit for children, and joint-and-several liability reform.

Tort reforms reduce health spending, but the size of the reduction is subject to debate.

Do traditional tort reforms reduce defensive medicine?

There is good, but not uniform, evidence that noneconomic damages caps reduce defensive medicine (Table 1). Study findings have varied somewhat depending on the specific health services examined. However, the CBO recently concluded that the weight of the evidence demonstrates a link between tort reforms and health care spending (Reference 1).

Most studies have found that other traditional reforms do not reduce defensive medicine. However, one study found that pretrial screening panels were associated with lower defensive medicine in obstetrical care.

What is the effect of tort reforms on health expenditures?

The size of the effect of tort reforms on health spending is controversial. CBO estimates that implementing the package of tort reforms described above would result in a 0.5 percent decrease in health expenditures (Reference 1), while other methodologically strong studies put the effect of “direct” reforms (noneconomic damages caps, collateral-source rule reform, not allowing punitive damages, and not requiring defendants to pay prejudgment interest on damages awards) in the 5 percent range (Reference 4, 5).

What is the potential for more innovative reforms to improve the medical liability system?

In part because of the lack of success of many traditional reforms in affecting liability costs and patient safety, a number of alternative reforms have been discussed at the state and national levels (see sidebar).

The quality of the evidence base for judging the effects of innovative reforms is generally low (see Table 2). Noneconomic damages schedules and health courts have not been implemented in the U.S. medical malpractice system, so evidence is based on simulation studies, reports from other countries, or reports from other compensation systems in the United States. There has been limited experimentation with safe harbors for adherence to practice guidelines in a few states, but the effects on malpractice litigation and costs were not rigorously evaluated. Disclosure-and-offer programs have been implemented by several liability insurers and hospital systems, but have not been evaluated by external researchers.

There are good theoretical reasons to believe that a noneconomic damages schedule would reduce overhead costs and defensive medicine. Improving the predictability of jury awards should promote settlement, reducing litigation costs. Because physicians tend to overestimate their potential liability exposure, improved predictability may also reduce defensive practice. Effects on claims frequency and payouts are unclear.

TRADITIONAL MALPRACTICE REFORMS (CONTINUED)

Collateral-source offset:

Requires that if a plaintiff has received reimbursement for injury-related expenses from other sources, such as health insurance, that amount be deducted from the award that a defendant who is found liable for the injury must pay.

Periodic payment: Allows or requires insurers to pay out malpractice awards over a long period of time, rather than in a lump sum.

INNOVATIVE TORT REFORMS

Many of the reform ideas receiving attention today have not been widely implemented or evaluated. These include:

Schedule of noneconomic

damages: Involves a tiering system for purposes of categorizing injuries and ranking them by severity. A dollar value range for “pain and suffering” awards is assigned to each severity tier. The schedule is used by juries and judges either as an advisory document or as a binding guideline.

Administrative compensation systems or “health courts”:

Routes claims into an alternative process involving specialized judges, decision and damages guidelines, neutral experts, and a compensation standard that is broader than the negligence standard.

Innovative tort reforms have potential to reduce malpractice costs and improve patient safety.

INNOVATIVE TORT REFORMS (CONTINUED)

Disclosure-and-offer programs:

Liability insurers and self-insured hospitals provide support to physicians disclosing unanticipated outcomes to patients and make rapid compensation offers, when appropriate. In “reimbursement model” programs, an institution offers to reimburse the patient for out-of-pocket expenses related to the injury and for “loss of time,” up to a preset limit (typically \$30,000). Some types of injuries are not eligible for the program, and patients who accept the money can still sue. In “early settlement model” programs, there are no exclusion criteria or preset limits on compensation; compensation is generally offered only where care was inappropriate, and patients who accept the money waive their right to sue.

Safe harbor for adhering to evidence-based guidelines:

Strengthens a physician’s ability to use his/her adherence to accepted, evidence-based clinical practice guidelines as a defense to a malpractice claim.

Table 2. Summary of probable effects of innovative tort reforms

	Claims frequency	Claims costs	Overhead costs	Malpractice premiums	Defensive medicine
Schedule of noneconomic damages	0 (Low)	0 (Low) ¹	↓ (Low)	↓ (Low)	↓ (Low)
“Health courts”	↑↑ (Moderate)	0 (Low)	↓↓ (High)	0 (Low)	↓ (Low)
Disclosure-and-offer programs	↓ (Low)	↓ (Low)	↓↓ (Moderate)	↓ (Low)	0 (Low)
Safe harbors	0 (Low)	0 (Low)	↓ (Low)	0 (Low)	↓↓ (Low)

¹ Highly dependent on awards levels specified in schedule.

Notes: Effects are classified as large increase (↑↑), modest increase (↑), no change (0), modest decrease (↓), or large decrease (↓↓). Evidence or certainty levels for these effects are classified as low or theoretical only (low), moderate, or high.

Foreign systems’ experience suggests administrative compensation systems have much lower overhead costs and quell physician defensiveness, but would increase claims frequency.

Overhead costs are 10 percent to 20 percent in the Swedish, Danish, and New Zealand medical injury compensation systems, compared with 40 percent in the U.S. tort system (Reference 6, 7). Claiming rates are higher because it is easier to file a claim. Physician defensiveness is reportedly lower in systems that do not require the patient to prove negligence. Whether an administrative compensation system would reduce claims payouts depends on the particular compensation rules adopted.

Anecdotal evidence suggests that disclosure-and-offer programs substantially reduce the frequency of claims and lawsuits, claims costs, overhead costs, and malpractice insurance premiums.

This evidence comes from reports by program administrators at the University of Michigan Health System, COPIC Insurance, and a Veterans Affairs hospital (Reference 8, 9, 10). It is not clear whether other organizations could replicate these results, or whether the “early settlement model” or the “reimbursement model” achieves better outcomes. No evidence is available about the effect of disclosure-and-offer programs on defensive medicine.

Safe harbor laws have strong theoretical appeal, but there is no evidence concerning their effectiveness.

Maine, Florida, Kentucky, Vermont, and Minnesota experimented with demonstration projects of safe harbors in the 1990s. However, little was learned from them because the demonstrations were very narrow in scope, operated for only a few years, and were not evaluated for their effect on malpractice litigation. Maine’s program did improve physicians’ adherence to practice guidelines (Reference 11).

Policy Implications

- > **Among traditional reforms, caps on damages have the greatest impact on important outcomes, but also pose problems.** Caps modestly constrain the growth of insurance premiums, substantially lower average awards, and reduce defensive medicine. But they also disproportionately affect compensation for the most severely injured patients, which raises equity concerns. Additionally, in several states, courts have struck down caps on the basis that they violate the state's constitution.
- > **Based on theory and limited evidence, including international experience and evidence from other U.S. compensation systems, each of the innovative reforms discussed here has the potential to decrease liability costs and defensive medicine.** However, noneconomic damages schedules and administrative compensation proposals may encounter constitutional barriers in some states.
- > **Most of the innovative reforms also hold promise for better aligning the liability system with patient safety improvement goals.** Except for the noneconomic damages schedule, these reforms create incentives for physicians to adhere to evidence-based care and disclose when an adverse event occurs. Administrative compensation systems and disclosure-and-offer programs also build robust databases of adverse event information that can support learning about why medical errors occur.

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