

Policy Brief

FINDINGS FROM THE CONFERENCE ON MEDICAL MALPRACTICE SPONSORED BY THE COUNCIL ON HEALTH CARE ECONOMICS AND POLICY, MARCH 2003.

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MEDICAL MALPRACTICE IN CRISIS

by David Shactman, Michael Doonan and Brian Rosman

Doctors have gone on strike in West Virginia and New Jersey. Trauma care had to be discontinued at the University of Nevada Medical Center. And malpractice premiums for some obstetricians in Cleveland exceed \$100,000. Physicians claim that rising premiums, driven by an increasing number of lawsuits and huge settlements, are forcing them out of practice and diminishing access to care. Consumer groups and trial lawyers counter that recent premium increases are temporary, largely caused by the insurance cycle and reduced investment returns, and are not justification for limiting the fundamental right to a jury trial. The U.S. House, with the support of the President, has voted to reform the medical malpractice system by placing caps on awards for pain and suffering. But health policy analysts contend that caps will do little to reform a system that simply doesn't work. There is, perhaps, only one thing that all stakeholders agree upon; there is a serious problem with malpractice insurance.

Convening experts from across the country, the Council on Health Care Economics and Policy addressed the major questions surrounding this issue. Council Chair Stuart Altman challenged the participants to provide data and analysis to sort out the conflicting claims and the heated political rhetoric. Why is there a disconnect between politicians and policy analysts? What is driving malpractice premiums? Is it the cyclical nature of the insurance industry or is it the secular trend of increasing law-suits and bigger awards? Is this crisis fundamentally different than the malpractice crises in the 70s and 80s? Are caps on non-economic damages the right answer? Do we need short-term solutions, long-term solutions, or both, and what are the potential policy alternatives?

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SINGING A DIFFERENT SONG: THE DISCONNECT BETWEEN POLITICIANS AND POLICY ANALYSTS

Remarkably, in a conference with experts from across the political spectrum, there was general agreement on two overriding conclusions:

1. The current malpractice system does a poor job at compensating patients and deterring medical errors - its two primary goals.
2. The solutions being debated in Congress will do nothing to correct the failure of the system to accomplish its two primary goals.

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The chief concern of health policy analysts is to fix a broken system. Michelle Mello of the Harvard School of Public Health presented a graphic showing how badly the current system performs (Figure 1 below).

Less than one in seven patients injured by negligence file a claim, and only one in six claims that are filed actually involve a negligent injury. Approximately 60% of payouts go to administrative and legal costs rather than to injured patients, and it can often take 5-10 years to settle a claim.

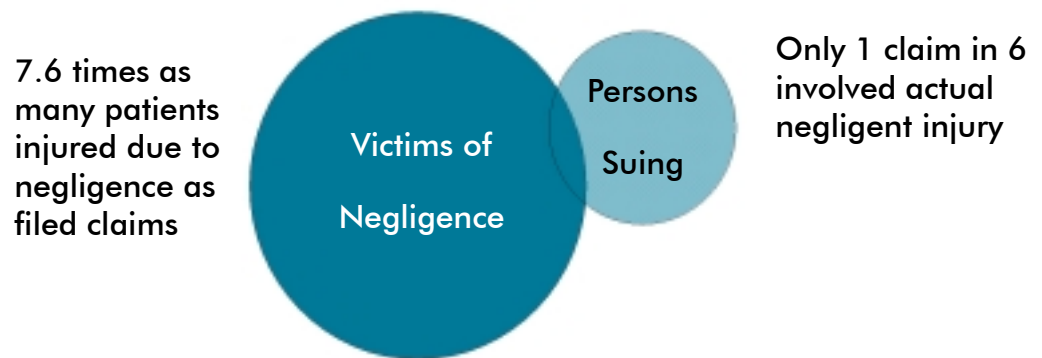
Mello explained that the system does an equally poor job in deterring errors. The economic incentive to avoid error is nearly eliminated because everyone has insurance, and because individual premiums are not tied to past experience. She describes the malpractice system as "punitive in orientation, individualistic in focus, and adversarial in process." This is in direct conflict with "the non-punitive, systems-focused, cooperative approach" of the patient safety movement. Mello contends that a real reform agenda would restructure the

system to offer incentives for providers to acknowledge and eliminate errors while adequately compensating patients for avoidable injuries.

But the entire political discussion on Capitol Hill is about cost control: whether to reduce the rate of growth in malpractice premiums by legislating "caps" or limits in awards for non-economic damages (pain and suffering). But caps on pain and suffering will not address any of the problems cited above. They are likely to have some effect in reducing premium growth and could provide some near-term relief. Nevertheless, there is a total disconnect between politicians trying to control malpractice premiums and health researchers trying to reform the system.

Paul Ginsburg observed that some issues become so politicized and highly charged that they are taken out of the policy analysis realm. Caps on non-economic damages may illustrate this phenomenon. They have strong political backing from the White House and the Republican majority in Congress, and they are part of a larger

Figure 1



Data source: Mello 2003 based on HMPS (1984 data). Graphical conceptual design derived from work by Don Harper Mills and Randall Bovbjerg.

political battle to enact tort reform. As a result, the voices of academicians and policy analysts are not even part of the debate. But as long as medical errors are treated distinctly from tort reform, a golden opportunity to improve the health care system could be lost.

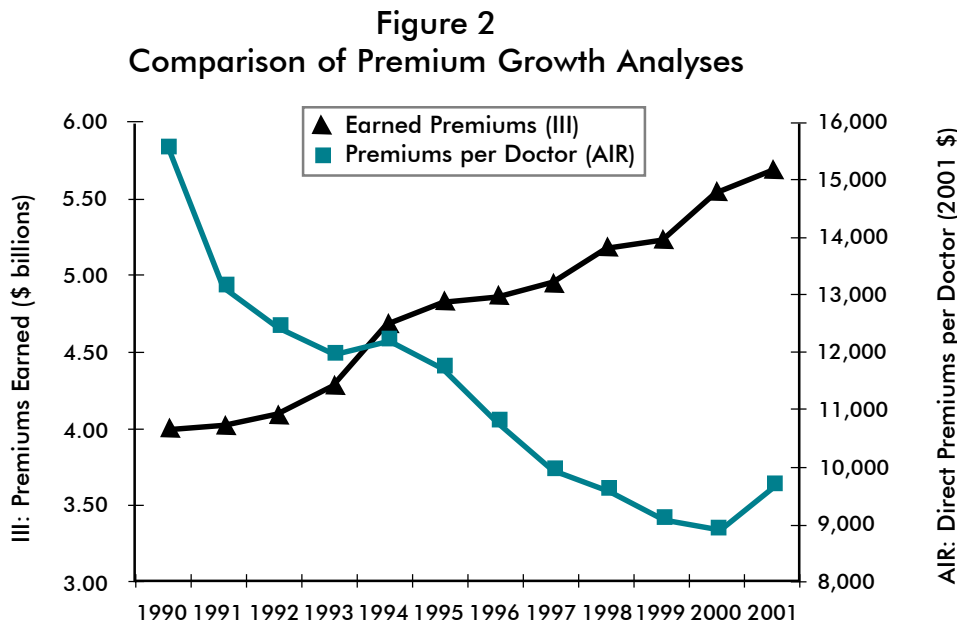
DIFFERENT WORDS TO THE SAME SONG: (THE DUELING BANJOS OF HEALTH CARE DELIVERANCE)

The precise cause of the current crisis is the subject of considerable debate. Industry calculations, depicted by the black line in Figure 2 (using the scale on the left) show that premiums charged by insurance companies have risen steadily from 1990 to the present. This represents an increase of over \$1.5 billion in the past decade. But, the scope of the problem varies substantially depending on state and physician specialty. Annual premiums for doctors

practicing internal medicine range from \$3,000 in Arkansas to \$50,000 in Florida. According to Ken Thorpe, the median increase in malpractice premiums over the past three years was between 15 and 30 percent, but some states, such as Florida, saw increases between 50 and 60 percent.

The blue line in Figure 2 (using the scale on the right) depicts data from a consumer organization, Americans for Insurance Reform (AIR). This shows what appears to be the opposite trend. Premiums per physician, adjusted for medical inflation, declined throughout the 90s and did not begin to increase until 2000. Furthermore, the Consumer Federation of America found that as a total share of health care costs, malpractice insurance reached a low of .55 percent in 2001. In order to sort out this conundrum of conflicting claims, we look at the separate cost factors that have emerged, and ask if they represent a fundamentally different problem from what went on in the past.

THERE IS A TOTAL DISCONNECT BETWEEN POLITICIANS TRYING TO CONTROL MALPRACTICE PREMIUMS AND HEALTH RESEARCHERS TRYING TO REFORM THE SYSTEM.



Sources:
 III: Insurance Institute of America 2003
 AIR: Americans for Insurance Reform 2003.

“I BELIEVE THE PRESIDENT GOT IT EXACTLY BACKWARD. LITIGATION COSTS ARE HIGH BECAUSE HEALTH CARE SPENDING HAS INCREASED.”
-WILLIAM SAGE, COLUMBIA UNIVERSITY SCHOOL OF LAW

COST DRIVERS - (SAME OLD SONG OR A DIFFERENT MEANING SINCE THINGS WENT WRONG)?

Increases in the Cost and Technological Capabilities of Medicine

Are the factors driving today's costs different from those in the malpractice crises in years past? Bill Sage of the Columbia University Law School made the case that we are identifying old solutions for new problems. "We are like Rip Van Winkle," he said, "waking up twenty years later and fighting the same battle but not realizing that the world has changed." Medical progress, he pointed out, routinely diagnoses and treats people with diseases who previously had no expectation of cure and often would have died. Today the misdiagnosis of previously incurable cancer, or the side effects of complex treatments, opens the doorway to liability where none existed before. Furthermore, if the patient is disabled, extensive costs of treatment and much longer survival profiles yield economic damages that are monumental relative to previous times. Sage criticized President Bush's argument that "frivolous and junk lawsuits" are driving up the cost of medical care. "I believe the President got it exactly backward," he said. "Litigation costs are high because health care spending has increased." Sage concluded that the increased exposure of a much more expensive and technologically advanced system is beyond the ability of individual physicians to insure against.

Growth in Amounts and Frequency of Malpractice Awards

Ken Thorpe of Emory University presented figures that malpractice awards per paid claim (jury awards and settlements) doubled in real terms between 1990 and

2001. He identified several factors such as the rising cost of economic damages, higher severity of injury per claim, rising defense and administrative costs, and a rising proportion of million-dollar awards. Eight percent of awards now exceed \$1 million, double the proportion of just five years ago. Although the frequency of awards was relatively steady through most of the 90s, awards rose sharply toward the end of the decade, resuming a long-term upward trend. However, the frequency of malpractice claims per physician has been generally flat in most states, with a few states experiencing some increases.

The Insurance Cycle and Investment Returns

Malpractice, similar to other insurance markets, experiences an underwriting cycle. During the "soft" phase of the cycle companies tend to have ample reserves and they compete to gain market share by offering lower premiums. This can often coincide with periods of high investment returns from financial markets, particularly bonds that comprise about 90% of insurance company investments. The amount of claims insurance companies pay out often exceeds the amount of premiums they earn, but they still make a profit because of investment returns. As reserves diminish, the cycle begins to enter its "hard" phase. Premiums are raised to maintain future reserves, and often raised further to make up for lower investment returns. These returns are significant because reserves are often held for long periods before being paid out. Thorpe reported that a 1% reduction in investment yield translates into a 2-4% increase in premium rates. The current cycle is not materially different from those in the past. However, it may be particularly severe because interest rates are at their lowest level in several decades.

Reduction in the Number of Companies Providing Malpractice Insurance

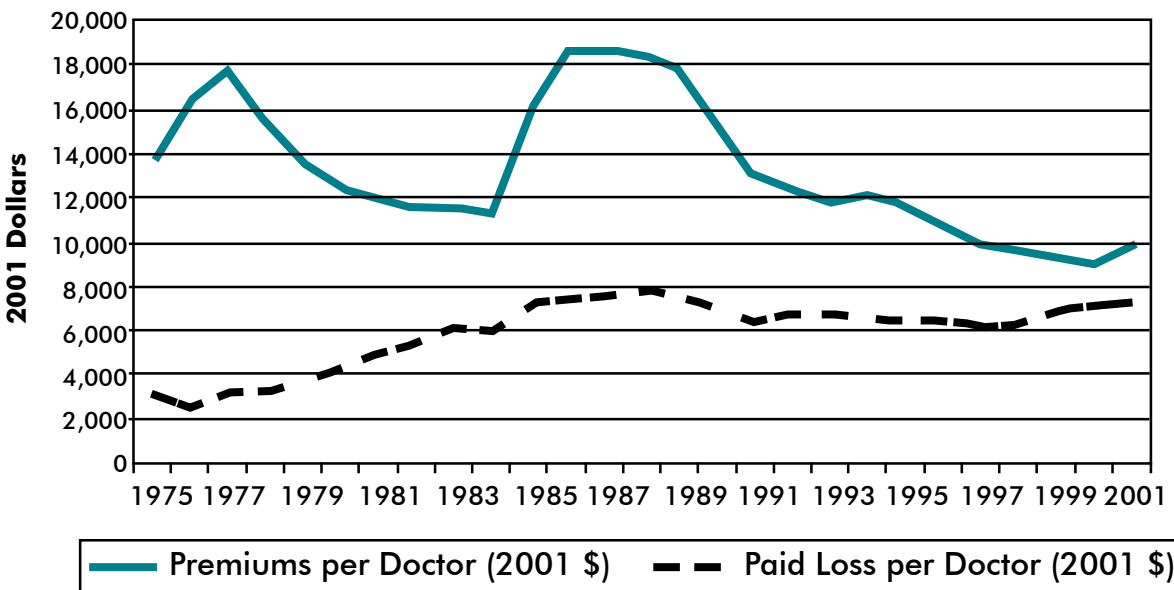
In the current crisis, the transition into the hard part of the insurance cycle was accompanied by a reduced number of companies supplying insurance. St. Paul's, which underwrote approximately 10% of the malpractice market nationally, withdrew from the market in 2001. Several states in which St. Paul's was the largest carrier later reported steep increases in premium prices. In addition, many physician-owned companies that entered multi-state markets in the 90s exited those markets by 2001. Thorpe reported that in West Virginia, 43% of premiums in 2001 were written by St. Paul or by carriers that became insolvent in the preceding five years. One of the factors that makes this cycle particularly harsh is the reduced supply of carriers that has exacerbated the rise in premiums.

**WHO'S CALLING THE TUNE?
ARE THE REASONS FOR THE
CURRENT CRISIS
CYCLICAL OR SECULAR?**

Are the doctors and insurance companies right? Is the crisis caused by a relentless, secular increase in rates driven by frivolous lawsuits and exaggerated awards? Or are consumer groups and lawyers correct? Is this just a harsh repeat of the insurance cycles of the 70s and 80s that should be allowed to play out without stripping injured patients of their legal rights? One of the most intriguing charts at the conference was developed by Robert Hunter and appears below (Figure 3). The top line shows the average amount of premiums per doctor that insurance companies collected each year from 1975 - 2001. The line is quite volatile, reflecting

THE CURRENT CYCLE IS NOT MATERIALLY DIFFERENT FROM THOSE IN THE PAST. HOWEVER, IT MAY BE PARTICULARLY SEVERE BECAUSE INTEREST RATES ARE AT THEIR LOWEST LEVEL IN SEVERAL DECADES.

**Figure 3
Consumer Groups' Data on Insurance Cycle**



Source: Hunter 2003.

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insurance cycles in which premiums peaked in the mid-70s and mid-80s, and the beginning of a steep upswing starting in 2000. The uncertainty of settlements that can take up to 10 years, often causes late responses and overreactions by actuaries who attempt to keep reserves at the right level.

The lower line shows the average amount of claims per doctor paid out each year. This line is much more stable because each year is, in a sense, a moving average of claims that originated as far as 10 years back. This line reflects a long-term growth in payouts that is not substantially different from the long-term growth rate in health care spending since the mid-1980s. The interpretation of this graph provoked a cacophony of discussion. Some argued that such a growth rate is sustainable. But Ginsburg pointed out that many of the costs of malpractice are administrative, so the growth rate should be well below that of medical spending. Altman observed that the graph showed that the cyclical was a more important factor than the secular. But others observed that the nature of the bottom line (essentially a 10-year moving average) made such a comparison unclear.

Thorpe added to the complexity, pointing out that the only way to accurately assess the rate of growth of payouts was to calculate for each year the eventual total settlements of all the claims that were originated in that year, even though they would not be settled until as much as 10 years later. Of course, such a measure would always be about 10 years old, so nobody has done it. Questioning what was being measured, Judy Lave suggested that since premium increases were so concentrated in high-risk specialties, maybe only physicians in those specialties should be part of the calculation. If there was any consensus at all, it might be the following:

1. Both the cyclical variation and the secular rise in premiums have contributed to the current crisis. The secular rise has not been particularly steep, but it is significant over time and its impact is greatly exacerbated by the cyclical swings.
2. Regardless of whether the cyclical actually trumps the secular, the fundamental issue in the long-term is not cost control, but a system re-design that includes cost as an important consideration along with equity and quality improvement.

SHORT-TERM POLICY OPTIONS

Not surprisingly, there was disagreement on the need for a short-term solution. If doctors in some specialties find premiums unaffordable, or if access to care is diminished, short-term action may be necessary to stabilize the market.

Caps on Awards

The centerpiece of current reform proposals is a cap on jury awards for non-economic damages. Ken Thorpe reported that malpractice premiums were eight percent lower per physician in an illustrative sample of states with economic caps compared to those without. Current legislation passed by the House includes additional measures to limit awards. These include capping attorney fees, collateral source offsets (i.e. reducing any award by the amount of insurance or other such payments collected), and the elimination of joint and several liabilities. All of these measures engender controversy from opponents who argue that they reduce patients' rights and remedies and are being proposed because they are part of a larger agenda to enact

tort reform. In all, there is mixed evidence on whether caps have saved money in states where they have been enacted, but it is likely that some savings can be anticipated.

Other Short-Term Solutions

- Provide government issued reinsurance that would protect companies against very large settlements.
- Broaden the risk pool by spreading the high cost of premiums across specialties rather than having them concentrated in a few high-risk areas.
- Tax health insurance premiums and use the funds for reinsurance.
- Take no action and ride out the hard phase of the cycle, assuming premiums will stabilize on the other end.

LONG-TERM POLICY OPTIONS

Enterprise Liability

Enterprise liability would make the larger medical institutions, such as hospitals or possibly health care systems, liable for the malpractice claims of affiliated providers. Under an approach outlined by John Harty of the Pittsburgh law firm Harty, Springer & Mattern, the same insurer would cover the hospital and affiliated physicians and claims would be defended jointly. Incentives for hospitals and doctors would be aligned and directed at quality improvement. If hospitals were experience rated or liability insurance costs were related to their record on quality, it would provide further incentive to improve care. Caps on damages could be part of this system, but through a more flexible approach that ties the amount of the cap to a patient's age and level of injury.

No-Fault Insurance

Under a no-fault system, claims that fall into a category of avoidable adverse events would be automatically paid by an administrative compensation system that would not require a finding of negligence. This system would work similar to no-fault auto insurance, and would be similar to systems in Denmark, Sweden, Finland, and New Zealand. The advantages of this system are that it could more equitably compensate victims and provide incentives to reveal and correct system problems. The difficulty is that it runs counter to the historical emphasis on individual responsibility, and could also end up being more expensive if more people are compensated than under the current system.

Federal Provision of Malpractice Coverage for Doctors Participating in Medicare, Medicaid, and SCHIP.

Karen Davis suggested that the federal government assume liability for physicians participating in the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP). This would serve the dual purpose of providing incentives for practitioners to participate in these programs and ease the immediate crisis. These programs touch the majority of physicians and would have an immediate impact on the availability of obstetricians through the Medicaid and SCHIP program. Stuart Butler disagreed, and pointed out that this plan would make the federal government, the ultimate "deep pocket." Butler argued that such a policy would attract more, instead of less litigation, and that the government would eventually react by limiting compensation to victims.

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CONCLUSION

Stakeholders disagree about the causes of the current malpractice crisis and interpret statistics to support their own case. Politicians have largely limited their solutions to capping damages, which do not focus on the heart of the problem - deterring errors and fairly compensating victims. Although caps will likely provide some reduction in premium growth, they will not encourage error reduction or greater equity in compensating injured patients. There is a giant chasm between the political debate and the policy analysis in both identifying the problem and constructing solutions.

The current crisis is a result of both secular and cyclical factors. The secular rise in premiums and awards has not been particularly steep overall, but it has sharply impacted some medical specialties and geographic regions, and its effect has been greatly exacerbated by cyclical trends. This cycle is not substantively different from previous cycles, but it has been particularly harsh due to low interest rates and a reduced supply of companies offering insurance. The secular trends do reflect a changing health care system, but mostly because of a wider scope of liability. Congress may enact legislation to place caps on non-economic damages. However, this is a partial remedy that will probably not smooth the swings in the insurance cycle, and the problem will likely reoccur. A number of alternatives were offered that would address tort reform, equitable compensation, and quality improvement in a more systemic manner. As the IOM suggested, the individual states could provide a fertile testing ground for these kinds of reforms. The challenge for health policy analysts is to interject their perspectives back into the political debate. ▲

A meeting summary, background paper, speaker papers and presentations, webcasts and transcripts can be found on the Council website at sihp.brandeis.edu/council. The authors of this policy brief acknowledge the assistance of Stuart Altman and Katherine Kranz Lewis. Desktop Publishing by Lisa Andersen.

Council on Health Care Economics and Policy

The primary mission of the Council is to provide an independent, non-partisan deliberative body of recognized experts to identify critical issues generated by health system change, analyze the economic impact of such changes, and disseminate findings to national policy makers, health services researchers, industry leaders, and the general public.

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