AMERICAN ACTION FORUM

Primer: Medical Malpractice and Tort Reform

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Introduction

The impact of medical malpractice liability on American healthcare costs is a long-debated and contentious topic. As healthcare costs have risen astronomically in recent years, the contribution of the cost of malpractice claims is obscured by the difficulties in quantifying such costs as they include malpractice payouts, malpractice insurance premiums and hidden costs such as defensive medicine. Disagreements over the impact of these costs have led to conflicts over whether tort reforms are needed and the type of reforms most likely to be successful. In the debate over the Affordable Care Act (ACA) tort reforms were briefly taken up by the Obama administration, but dropped under increasing pressure from trial lawyer lobby groups.[i]

The costs of medical malpractice can go far beyond the costs of litigation, as reflected in medical malpractice insurance (an industry that has risen in response to the threat of medical lawsuits), but also can affect the day-to-day use of medical services through defensive medical practices. A 2010 *Health Affairs* study put the estimate of the total cost of medical malpractice at about $55 billion. At this point, the future of reform remains highly uncertain and both state and federal policymakers continue to put forth proposals to address the issue.

Malpractice Law

Medical malpractice law is a unique field, because while the proportion of successful claims (out of a large pool filed) is fairly low, damages can be huge: 80 percent of claims filed are unsuccessful, but of those that are paid, half pay out $25,000 or more.[ii] Medical malpractice's high potential for reward arises from the difficulties of monetizing malpractice damages. There are three major types of damages rewarded in malpractice cases:

Key Takeaways

Malpractice Law: A Unique Field

- From a lawyer's perspective, malpractice cases have a relatively low probability of success, but a huge potential for monetary reward.
- Main types of damages awarded in malpractice cases are *economic, non-economic, and punitive*.
- It is often hard to determine both error and the monetary cost of damages, making the issue highly contentious.

Defensive Medicine's Burden on Healthcare

- It is likely that the greatest economic cost of malpractice law is defensive medicine, where doctors practice unnecessary medicine to protect against potential lawsuits. However, quantifying that cost is very difficult.
- There is significant disagreement as to the magnitude of these costs between health policy analysts and health providers.

Exploitative Malpractice Lawyers

- Lawyer fees in malpractice cases have been going up, while total payouts have flat lined.

Promising Solutions for Reform

- Many states have experienced significant success with caps on non-economic damages, in effect lowering malpractice premiums and health spending.
- Similar Federal Programs have often been proposed, but have so far gained little traction.
- Many other types of tort reform have been proposed at the federal level to limit the incentive to bring frivolous lawsuits to the courts.

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economic, non-economic and punitive. Economic damages compensate a patient for medical costs resulting from the malpractice, and loss of quantifiable financial assets caused by being injured. Non-economic damages include pain, suffering, "inconvenience, emotional distress, loss of society and companionship, […] and loss of enjoyment of life."[iii] Punitive damages aim to punish the accused provider and deter him from further malpractice.

Table 1: Total Claims by Line of Insurance in 1995-2004 (Closed Claims)[iv]

Line of Insurance	Automobile	General Commercial	Multi-Peril	Other Professional	Medical Professional Liability
Total Claims	544,640	435,593	190,236	19,816	77,575
% With $0 Payout	44.3%	71.5%	60.5%	82.0%	81.9%
% With Payout from $1-$25,000	52.3%	26.7%	36.4%	15.4%	6.3%
% Large Paid Claims (payout ≥ $25,000)	3.4%	1.9%	3.1%	2.6%	11.8%
Mean Annual Payout on Large Real Claims (% of Total Payout)	73.8%	90.2%	86.6%	93.0%	98.7%

The exorbitant costs of malpractice (see Table 1) stem from a variety of sources, ranging from well-founded cases with huge (particularly non-economic) damages to cases with little evidence of doctor error. According to a recent study in the *New England Journal of Medicine*, ten percent of examined cases rewarded the plaintiff without clear evidence of medical error.[v] Well-founded cases also resulted in high payments. In 2011, average payout rates in successful malpractice cases varied dramatically by state from $34,754 in Indiana to $884,474 in Hawaii.[vi] The average payout for malpractice suits in the United States that year was $334,559. Although data on how much these payouts stem from non-economic damages is difficult to gather, the reduction in payouts from capping malpractice spending should give us some idea. States without caps on non-economic damages, in 2004, paid on average 26.4 percent more per malpractice payout than states with them,[vii] indicating that capping non-economic damages works to reduce total payouts.

Hidden Costs of Defensive Medicine

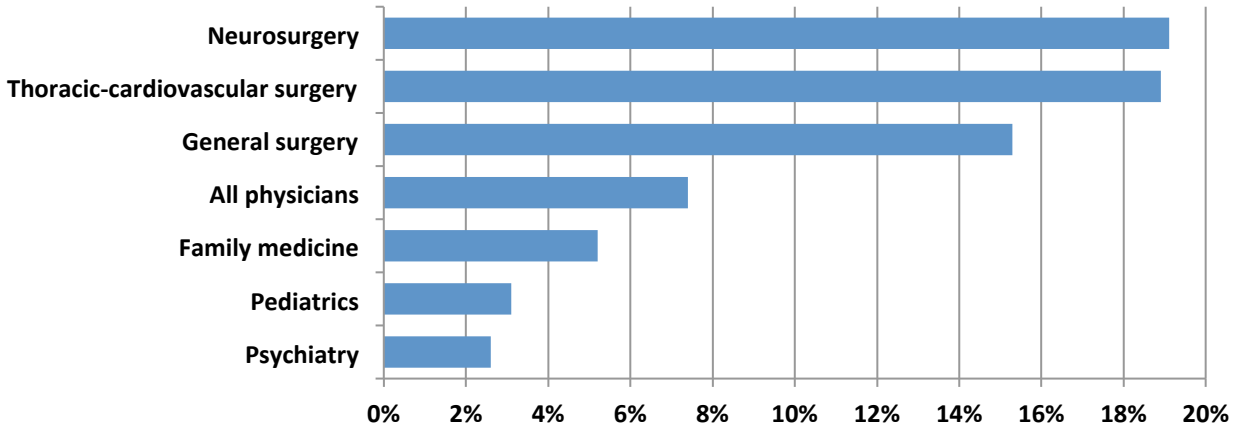
While the courtroom costs of malpractice are easy to quantify, they are dwarfed by the repercussions on the way medicine is practiced. According to an oft-cited 2010 study in *Health Affairs*, an estimated 81.9 percent of the medical cost impact of malpractice arises from defensive medicine. The study defines 'defensive medicine' as "when doctors order tests, procedures, or visits, or avoid certain high-risk patients or procedures, primarily (but not solely) because of concern about malpractice liability."[viii] The study acknowledges the difficulty of measuring the effects of defensive medicine, but the authors' estimate of $38.8 billion in potential savings through tort reform is conservative compared to previous estimates by health policy experts.

While the study concluded that only 2.4 percent of American health spending was attributable to malpractice, there is a common conception in the medical community that the costs of defensive medicine could be far greater. According to a 2008 report from the Massachusetts Medical Society, malpractice costs (primarily defensive

medicine) account for 12% of all American healthcare expenditures.[ix] An article from the American Academy of Orthopedic Surgeons also touts a physician poll in which providers estimated the cost of defensive medicine to be 34 percent of total American medical costs.[x]

The practice of defensive medicine also has a varying impact on different specialties. Not surprisingly, high-risk specialties, particularly in surgery, are more likely to face malpractice litigation. For example, specialists in neurosurgery and thoracic surgery, on average, will experience litigation once every five years.[xi] This persistent threat, besides increasing malpractice premiums in these specialties, can dissuade medical students from entering them. For a comparison between liabilities in select specialties, see Figure 1.

Figure 1: Proportion of Physicians Facing a Malpractice Claim Annually, According to Specialty



Malpractice Lawyers Exploit the System

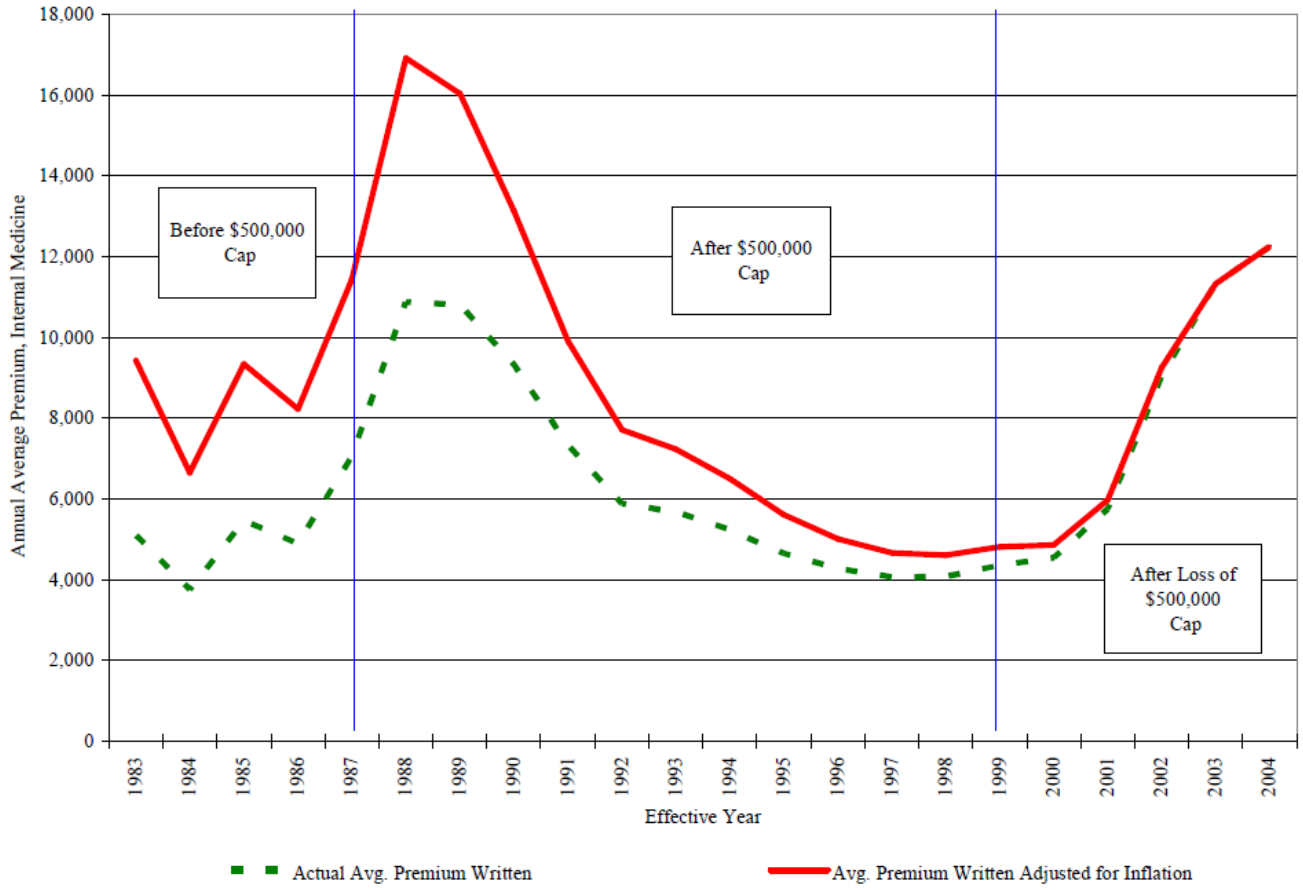
Another unique aspect of malpractice law is the role of lawyers, both in choosing which cases reach court and in setting incredibly high rates of reward. Many personal injury plaintiff law offices offer to represent clients without a fee if there is no malpractice awarded.[xii] This popular practice of waiving legal fees puts greater emphasis on the case itself as a source of revenue for the prosecuting lawyer. In recent years, plaintiff lawyers' share of the rewards in personal injury cases has been consistently rising, even as the reward amounts have not.[xiii] In Texas in 2007, for every dollar awarded to plaintiffs in malpractice cases, lawyer fees claimed a dollar.[xiv] Because of the increasing influence of trial lawyers over the malpractice caseload, it is common for ambiguous but more lucrative cases to be aggressively pursued, while less advantageous cases where damages and acts of doctor error are apparent are overlooked.

Approaches and Benefits for Reform

Several policy solutions have been proposed and tested in attempts to bring the force of the legal system in balance with the needs of physicians and patients. The most frequently implemented approach for state-based tort reform has been to cap non-economic awardable damages or to impose a cap for total damages. While caps have the direct effect of limiting payouts, they also discourage lawyers from accepting cases with weak claims but potentially large rewards.[xv] This both prevents the success of weak lawsuits and helps redirect attention to patients who have legitimately suffered as a result of medical error. Such an approach, as of 2004, was the law in just under thirty states. The results are impressive both on malpractice insurance premiums and eventually trickling down to

overall medical costs. The drastic changes in malpractice premiums can be seen in Oregon, which implemented a $500,000 cap on non-economic damages in 1987, only to remove it twelve years later in 1999. Figure 2 shows the impact of the cap on liability insurance premiums: a decrease after the cap was implemented, and an increase after it was removed.

Figure 2: Impact of Non-Economic Damages Caps on Medical Liability Insurance Premiums in Oregon[xvi]



A study conducted by H.E. Frech calculated both the amount saved on malpractice payouts by states with caps and the potential savings for states without them. The values for 2004 were $471,798,900 and $251,384,457 respectively. The authors of the study concluded that while caps have the effect of shifting the caseload and saving money, they do not seem to reduce the actual numbers of lawsuits filed against physicians.[xvii]

While calculating the effect of reforms on overall healthcare costs is an inexact science, it is common sense that the reduction of a major cost of money and risk for health providers will trickle down to patient care. After the success of cap programs at the state level, there were abundant proposals for a federal version under the Bush Administration, but no such proposal has yet become law.[xviii] President Obama also considered tort reform but eventually dropped such a measure from the Affordable Care Act of 2010 under pressure from certain lobby group like the American Association for Justice, an organization of trial lawyers.[xix] Several approaches for tort reform tried at the state level are detailed in Table 2.

Table 2: Examples of Tort Reform Success at the State Level[xx]

State	Year Enacted	Type of Reform	Effect
New Jersey	1995	Plaintiff required to provide defendant(s) with an Affidavit of Merit from an appropriately licensed person stating that the physician acted outside acceptable professional standards for treatment	From 1997 to 2004, the number of medical malpractice suits filed decreased by nearly 500 or about 24 percent
Texas	2003	Limits on noneconomic damages and punitive damages; medical liability, joint and several liability and class action reform	Doctors have saved about $50 million after the five largest insurance companies cut their rates in 2005.
West Virginia	2003	$250,000 cap put on noneconomic damages	In 2005, 377 more physicians were licensed, the most since 1999. The State's largest private malpractice coverage provider also lowered rates by 3.9 percent in 2005.
Mississippi	2004	Reforms relating joint and several liability; medical liability; noneconomic damages; etc.	The Medical Assurance Company of Mississippi, which provides malpractice insurance, reduced premiums by 5 percent in 2006.

Many proposals for federal medical malpractice liability reform take a more comprehensive approach. One example is the National Commission on Fiscal Responsibility and Reform (NCFRR) recommendation for a federal ban on collateral source collection (the practice of reaping damages for medical costs when those costs have already been reimbursed by insurance). Such a ban already exists in many states.[xxi] Another proposal suggests imposing a federal statute of limitations on malpractice cases. However, enacting such a statute invites questions as to what constitutes the 'start' of a condition – whether one can bring suit, for example, after suddenly 'discovering' the complications of a surgery decades after the alleged injury. To alleviate the pressures on doctors found liable who are normally required to pay damages in a lump sum, 30 states have adopted laws to divide the damages according to a court-specified payment schedule.[xxii]

The NCFRR also suggests the creation of a system of "health courts" made up of health experts, under the auspices of the federal government to adjudicate malpractice cases. Prominent health policy experts Michelle Mello and Troyen Brennan commented that, "…this approach is attractive on its merits; it would address several fundamental problems with the current system, in which juries make decisions with scant guidance on complex scientific issues and what constitutes reasonable damages awards."[xxiii] Such courts would certainly decrease the practice of "doctor shopping," in which patients seeking damages are able to cherry-pick an expert witness who would be willing, with little knowledge of the context, to plead their case.[xxiv]

Conclusion

While medical malpractice litigation has long been a problem in the American healthcare system, states are constantly generating and experimenting with new solutions. Although state caps and a trend against litigation in recent years may have led to a leveling off in awards to plaintiffs, lawyers' shares of those awards continue to grow, indicating that there are several competing interests driving the industry. By capping non-economic damages, states (and potentially the federal government) can potentially shift the caseload from lucrative but questionable cases to those that really need attention. The possibility of huge payouts in malpractice cases continues to influence the way doctors practice medicine in America. Though these costs are hard to quantify, there is little doubt that they have a profound effect on medical costs and medical practices. Both doctors and patients stand to gain a great deal from implementing tort reform in terms of lower costs and higher quality of care. If successful, reform will help refocus physician efforts from the practice of defensive medicine to effective, individualized, evidence-based health care.

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