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Limiting Tort Liability for Medical Malpractice

The past few years have seen a sharp increase in premiums for medical malpractice liability insurance, which health care professionals buy to protect themselves from the costs of being sued *(see Figure 1 on page 2)*. On average, premiums for all physicians nationwide rose by 15 percent between 2000 and 2002—nearly twice as fast as total health care spending per person. The increases during that period were even more dramatic for certain specialties: 22 percent for obstetricians/gynecologists and 33 percent for internists and general surgeons.[1] (For a definition of malpractice and other terms used in this brief, *see Box 1 on page 3*).

The available evidence suggests that premiums have risen both because insurance companies have faced increased costs to pay claims (from growth in malpractice awards) and because of reduced income from their investments and short-term factors in the insurance market. Some observers fear that rising malpractice premiums will cause physicians to stop practicing medicine, thus reducing the availability of health care in some parts of the country.

To curb the growth of premiums, the Administration and Members of Congress have proposed several types of restrictions on malpractice awards. Bills introduced in the House and Senate in 2003 would impose caps on awards for noneconomic and punitive damages, reduce the statute of limitations on claims, restrict attorneys' fees, and allow evidence of any benefits that plaintiffs collect from other sources (such as their insurance) to be admitted at trial. Limits of one kind or another on liability for malpractice injuries, or "torts," are relatively common at the state level: more than 40 states had at least one restriction in effect in 2002.[2]

Evidence from the states indicates that premiums for malpractice insurance are lower when tort liability is restricted than they would be otherwise. But even large savings in premiums can have only a small direct impact on health care spending—private or governmental—because malpractice costs account for less than 2 percent of that spending.[3] Advocates or opponents cite other possible effects of limiting tort liability, such as reducing the extent to which physicians practice "defensive medicine" by conducting excessive procedures; preventing widespread problems of access to health care; or conversely, increasing medical injuries. However, evidence for those other effects is weak or inconclusive.

1. The figure for all physicians comes from survey data from the Centers for Medicare and Medicaid Services; the figures for various specialties come from annual surveys conducted by *Medical Liability Monitor* newsletter. Both sets of surveys collect data on base rates charged by insurers and thus do not reflect discounts or additional charges applied to individual policies. Moreover, the latter surveys do not incorporate the relative market shares of insurers, so the averages are not weighted. (Note that most of the numbers reported in this issue brief are for physicians; less information is available for other types of health care providers, but trends appear to be similar for them.)

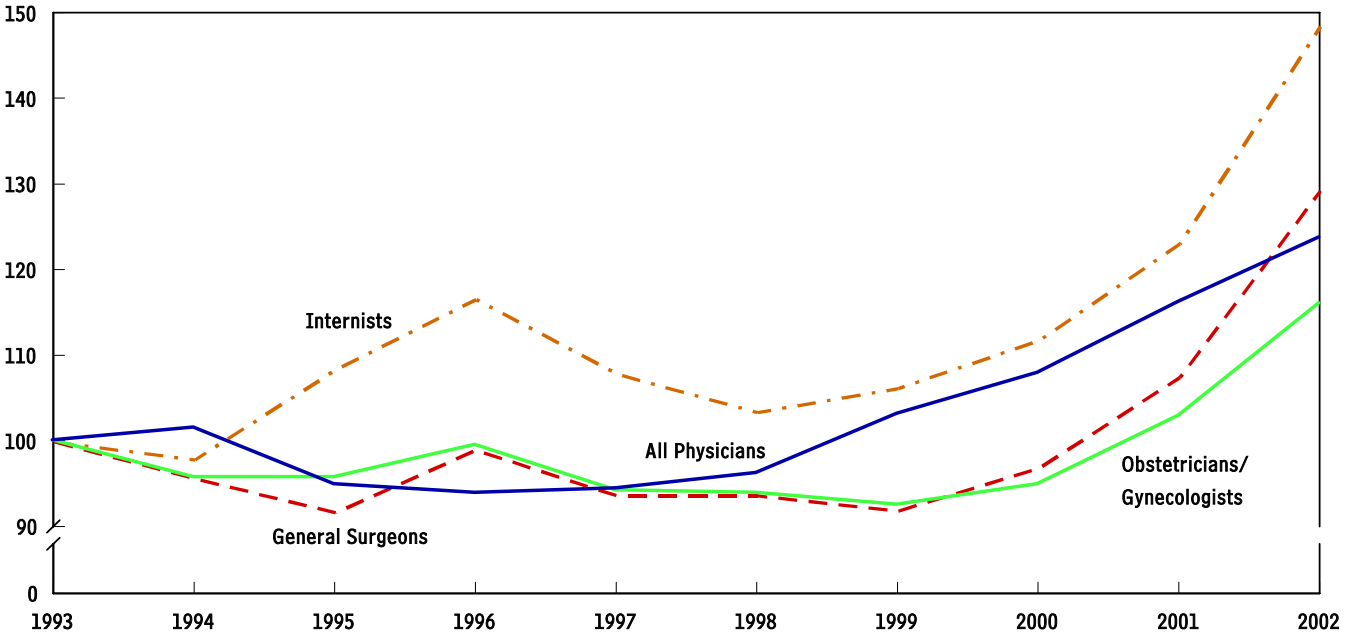
2. That number comes from the Congressional Budget Office's database of state laws on medical malpractice torts. The database includes information from the National Conference of State Legislatures, the American Tort Reform Association, and the law firm of McCullough, Campbell, and Lane. For a discussion of whether tort liability issues are better addressed at the federal or the state level, see Congressional Budget Office, *The Economics of U.S. Tort Liability: A Primer* (October 2003).

3. The 2 percent figure is a CBO calculation based on data from Tillinghast-Towers Perrin (an actuarial and management consulting firm) and the Office of the Actuary at the Centers for Medicare and Medicaid Services.

Figure 1.

Trends in Premiums for Physicians' Medical Malpractice Insurance, by Type of Physician, 1993 to 2002

(Index, 1993 = 100)



Source: Congressional Budget Office based on data from the Office of the Actuary at the Centers for Medicare and Medicaid Services (data for all physicians) and from annual premium surveys conducted by *Medical Liability Monitor* newsletter (data for physicians by specialty).

The Goals and Pitfalls of Tort Liability for Medical Malpractice

Issues surrounding the effects of the malpractice system and of possible restrictions on it can be viewed as questions of economic efficiency (providing the maximum possible net benefits to society) and equity (distributing the benefits and costs fairly).

Fairness is ultimately in the eye of the beholder. But the common equity-related argument for malpractice liability is that someone harmed by the actions of a physician or other medical professional deserves to be compensated by the injuring party.

The efficiency argument is that, in principle, liability (as a supplement to government regulations, professional oversight, and the desire of health care providers to maintain good reputations) gives providers an incentive to control the incidence and costs of malpractice injuries. In practice, however, the effect on efficiency depends on the standards used to distinguish medical negligence from appropriate care and on the accuracy of malpractice judgments and awards. If malpractice is judged inaccurately or is not clearly defined, doctors may carry out excessive tests and procedures to be able to cite as evidence that they were not negligent. Likewise, if malpractice is defined clearly but too broadly or if awards tend to be too high, doctors may engage in defensive medicine, inefficiently restrict their practices, or retire. Conversely, if doctors face less than the full costs of their negligence—because they are insulated by liability insurance or because malpractice is unrecognized or undercompensated—they may have too little incentive to avoid risky practices. For all of those reasons, it is not clear whether trying to control malpractice by means of liability improves economic efficiency or reduces it.

Box 1.

Definitions of Some Common Tort Terms

Collateral-source benefits: Amounts that a plaintiff recovers from sources other than the defendant, such as the plaintiff's own insurance.

Economic damages: Funds to compensate a plaintiff for the monetary costs of an injury, such as medical bills or loss of income.

Joint-and-several liability: Liability in which each liable party is individually responsible for the entire obligation. Under joint-and-several liability, a plaintiff may choose to seek full damages from all, some, or any one of the parties alleged to have committed the injury. In most cases, a defendant who pays damages may seek reimbursement from nonpaying parties.

Malpractice: "Failure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss or damage to the recipient of those services or to those entitled to rely upon them."[1]

Negligence: A violation of a duty to meet an applicable standard of care.

Noneconomic damages: Damages payable for items other than monetary losses, such as pain and suffering. The term technically includes punitive damages, but those are typically discussed separately.

Punitive damages: Damages awarded in addition to compensatory (economic and noneconomic) damages to punish a defendant for willful and wanton conduct.

Statute of limitations: A statute specifying the period of time after the occurrence of an injury—or, in some cases, after the discovery of the injury or of its cause—during which any suit must be filed.

1. Bryan A. Garner, ed., *Black's Law Dictionary*, 6th ed. (St. Paul, Minn.: West Group, 1990), p. 959.

The costs of court-imposed awards and out-of-court settlements for malpractice are reflected in the premiums charged for malpractice insurance. If those costs are inefficiently high (or low), premiums will tend to be too, on average. But premiums can also be a source of inefficiency themselves. The amounts that physicians pay for malpractice coverage are generally based on broad aggregates, which reflect factors such as doctors' medical specialties and locations but neglect relevant differences in the quality of their services. Thus, even if premiums are correct on average, they may be too high for the large majority of physicians and too low for a minority who are less careful or competent.

Why Have Malpractice Premiums Risen So Sharply?

Premiums for malpractice insurance are set so that over time, insurers' income from those premiums equals their total costs (including the cost of providing a competitive return to their investors) minus their income from investing any funds they hold in reserve. In the short term, however, premiums may be above or below that equilibrium level, with profits fluctuating or reserves rising or falling as a result.

A full analysis of the reasons for the recent rise in premiums is beyond the scope of this brief. But the available evidence suggests that higher costs for insurers (particularly from increases in the size of malpractice awards), lower investment income, and short-term factors such as cyclical patterns in the insurance market have all played major roles.

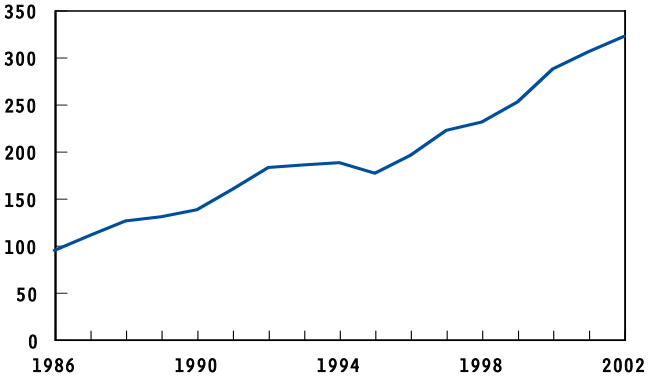
Increased Costs

Payments of claims are the most significant costs that malpractice insurers face, accounting for about two-thirds of their total costs. The average payment for a malpractice claim has risen fairly steadily since 1986, from

Figure 2.

Average Insurance Payment for Closed Malpractice Claims, 1986 to 2002

(Thousands of dollars)



Source: Physician Insurers Association of America.

Note: These averages exclude closed claims that did not result in payments.

about $95,000 in that year to $320,000 in 2002 *(see Figure 2)*. That increase represents an annual growth rate of nearly 8 percent—more than twice the general rate of inflation.[4]

Although the cost per successful claim has increased, the rate of such claims has remained relatively constant. Each year, about 15 malpractice claims are filed for every 100 physicians, and about 30 percent of those claims result in an insurance payment.[5]

The other one-third of malpractice insurers' costs comprise legal costs for policyholders who are sued and underwriting and administrative expenses. Those types of costs have also increased. Like claims payments, legal-defense costs grew by about 8 percent annually during the 1986-2002 period, from around $8,000 per claim to more than $27,000.[6] In addition, the many malpractice insurers who buy reinsurance to protect themselves from large losses have seen that part of their underwriting costs rise significantly over the past decade. (Those increases are not related solely to medical malpractice but reflect a general tightening of the reinsurance market in the wake of such catastrophic events as Hurricane Andrew in 1992, the Northridge earthquake in 1994, and the terrorist attacks of September 11, 2001.)[7]

Reduced Investment Income

Insurers generally base the malpractice premiums they charge in a given year on the future payments they expect to make for claims filed in that year. On average, claims are settled five years after the premiums for them were collected, and the income that insurers earn from investing premium receipts in the meantime is an important source of funds for them.

Insurance companies' investment yields have been lower for the past few years, putting pressure on premiums to make up the difference. According to the General Accounting Office (GAO), annual investment returns for the nation's 15 largest malpractice insurers dropped by an average of 1.6 percentage points from 2000 to 2002—enough to account for a 7.2 percent increase in premium rates.[8] That figure corresponds to almost half of the 15 percent increase in rates estimated by the Centers for Medicare and Medicaid Services.

Short-Term Factors

Premium increases in recent years may also reflect temporary adjustments in the reserve levels and profit rates of insurance companies. Premiums rose sharply for a few years in the late 1980s because of insurers' expectations of

4. Those figures are based on data collected by the Physician Insurers Association of America. Malpractice claims typically include a component to compensate plaintiffs for additional medical costs they incur because of their injuries, so one factor contributing to the growth in the average value of claims since 1986 has been increases in health care spending—which, on a per-person basis, has risen at an average rate of 6.9 percent a year during that period.

5. Kenneth E. Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms" (paper presented at the Council on Health Care Economics and Policy conference, "Medical Malpractice in Crisis: Health Care Policy Options," Washington, D.C., March 3, 2003); and CBO calculations based on data from the Physician Insurers Association of America.

6. Claims that did not lead to payments incurred average defense costs of $22,000 in 2002, compared with $39,000 for claims that did result in payments.

7. For a discussion of the dynamics of the reinsurance market, see Congressional Budget Office, *Federal Reinsurance for Disasters* (September 2002).

8. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (June 2003), p. 27.

future claims, which proved to be too high. The result was an accumulation of reserves, which were drawn down in the 1990s during a period of relative stability in premiums. If insurers' current expectations of future claims also turn out to be too high, the same thing could happen again.

The recent increases may also be a self-limiting response to insurers' low profits. In some states, premiums have been significantly affected when major insurers have decided to withdraw from the malpractice market, either locally or nationally. For example, in West Virginia and Nevada, the St. Paul Company had market shares of 43 percent and 36 percent, respectively, when it stopped renewing policies in August 2001 and then left the market entirely.[9] Such a reduction in the supply of malpractice insurance can help drive premiums up sharply in the short run. But those higher premiums encourage other malpractice insurers to expand their insurance offerings in those markets and thus tend to moderate future price increases (all other things being equal).

Potential Effects of Some Restrictions Under Consideration

In theory, the kinds of limits on malpractice liability that are being considered in the Congress could either enhance or detract from economic efficiency, depending on the current state of the liability system. For example:

- Capping or otherwise restricting awards for noneconomic losses and punitive damages might improve efficiency if such awards are now frequently arbitrary or excessive. It would do so by reducing the extent to which disproportionate awards distort the incentives for providers to practice medicine safely. Conversely, that change might undermine incentives for safety and reduce efficiency if current awards are generally appropriate.
- Allowing evidence of benefits that patients receive from collateral sources to be presented at trial might improve efficiency if today judges or juries sometimes wrongly find health care providers negligent out of (perhaps subconscious) concern that plaintiffs would otherwise be in dire financial straits. Or again, it might reduce efficiency if it encouraged carelessness by providers.
- Capping "contingent" fees (those set by a plaintiff's attorney as a percentage of any damages awarded to the plaintiff) could improve efficiency by reducing nuisance suits. Conversely, such a change could reduce efficiency by making it harder for some patients with legitimate but difficult claims to find legal representation.

Evidence About the Effects of Restricting Malpractice Liability

Several studies have found that various types of restrictions on malpractice liability can indeed reduce total awards and thereby lead to lower premiums for malpractice insurance. By themselves, however, such changes do not affect economic efficiency: they modify the distribution of gains and losses to individuals and groups but do not create benefits or costs for society as a whole. The evidence for indirect effects on efficiency—through changes in defensive medicine, the availability of medical care, or the extent of malpractice—is at best ambiguous.

Effects on Malpractice Premiums

In 1993, the Office of Technology Assessment issued a report summarizing the first wave of studies on the experience of states that set limits on malpractice liability in the 1970s and 1980s. The report concluded that caps on damage awards consistently reduced the size of claims and, in turn, premium rates for malpractice insurance. Further, it found that limiting the use of joint-and-several liability, requiring awards to be offset by the value of collateral-source benefits, and reducing statutes of limitations for filing claims were also effective in slowing the growth of premiums.[10]

More-recent studies have reached similar conclusions. A 2003 study that examined state data from 1993 to 2002 found that two restrictions—a cap on noneconomic

9. The St. Paul Company had been the largest or second-largest malpractice insurer in nine other states as well; see Thorpe, "The Medical Malpractice 'Crisis'."

10. Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs* (September 1993), p. 66.

damages and a ban on punitive damages—would together reduce premiums by more than one-third (all other things being equal).[11] And based on its own research on the effects of tort restrictions, the Congressional Budget Office (CBO) estimated that the provisions of the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003 (H.R. 5) would lower premiums nationwide by an average of 25 percent to 30 percent from the levels likely to occur under current law. (The savings in each state would depend in part on the restrictions already in effect there.)

Savings of that magnitude would not have a significant impact on total health care costs, however. Malpractice costs amounted to an estimated $24 billion in 2002, but that figure represents less than 2 percent of overall health care spending.[12] Thus, even a reduction of 25 percent to 30 percent in malpractice costs would lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums would be comparably small.[13]

Effects on Defensive Medicine

Proponents of limiting malpractice liability have argued that much greater savings in health care costs would be possible through reductions in the practice of defensive medicine. However, some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients. On the basis of existing studies and its own research, CBO believes that savings from reducing defensive medicine would be very small.

A comprehensive study using 1984 data from the state of New York did not find a strong relationship between the threat of litigation and medical costs, even though physicians reported that their practices had been affected by the threat of lawsuits.[14] More recently, some researchers observed reductions in health care spending correlated with changes in tort law, but their studies were based on a narrow part of the population and considered spending for only a few ailments. One study analyzed the impact of tort limits on Medicare hospital spending for patients who had been hospitalized for acute myocardial infarction or ischemic heart disease; it observed a significant decline in spending in states that had enacted certain tort restrictions.[15] Other research examined the effect of tort limits on the proportion of births by cesarean section. It also found savings in states with tort limits, though of a much smaller magnitude.[16]

However, when CBO applied the methods used in the study of Medicare patients hospitalized for two types of heart disease to a broader set of ailments, it found no evidence that restrictions on tort liability reduce medical spending. Moreover, using a different set of data, CBO found no statistically significant difference in per capita

11. Thorpe, "The Medical Malpractice 'Crisis'."

12. U.S. health care spending totaled about $1.4 trillion in 2002 (excluding spending on public health and capital improvements), according to data from the Office of the Actuary at the Centers for Medicare and Medicaid Services.

13. Moreover, one of the restrictions in H.R. 5—changing the rules for collateral-source benefits—would in some cases merely shift costs from malpractice insurers to providers of such collateral benefits (who in most cases are health insurers) rather than reduce costs overall. As a result, the total dollar impact on health insurance premiums would be smaller than the impact on malpractice premiums. Conversely, the total benefit to the federal Treasury would be larger than the savings in federal spending on health care, because tax revenues would increase to the extent that employers passed on part of their savings in health insurance premiums to their workers in the form of higher taxable wages.

14. Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (Boston: Harvard University School of Public Health, 1990), Chapter 10, pp. 2-3.

15. Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics* (May 1996), pp. 353-390. Specifically, the study estimated that states with any of four restrictions (caps on noneconomic or total damages, prohibitions on punitive damages, no automatic addition of prejudgment interest, and offsets for collateral-source benefits) lowered spending for inpatient care by between 5 percent and 9 percent in the year following the patients' initial admission for either diagnosis. However, the study also found that a second set of tort restrictions (caps on contingent fees for plaintiffs' attorneys, deferred payment of some or all damages, restrictions on joint-and-several liability, and public compensation funds for patients) tended to increase spending by between roughly 2 percent and 3 percent, at least in the short run. Those results were unexplained.

16. Lisa Dubay, Robert Kaestner, and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics*, vol. 18 (August 1999), pp. 518-519. Estimated cost savings were 0.27 percent.

health care spending between states with and without limits on malpractice torts. Still, the question of whether such limits reduce spending remains open, and CBO continues to explore it using other research methods.

Effects on the Availability of Physicians' Services

Some observers argue that high malpractice premiums are causing physicians to restrict their practices or retire, leading to a crisis in the availability of certain health care services in a growing number of areas. GAO investigated the situations in five states with reported access problems and found mixed evidence. On the one hand, GAO confirmed instances of reduced access to emergency surgery and newborn delivery, albeit "in scattered, often rural, areas where providers identified other long-standing factors that affect the availability of services." On the other hand, it found that many reported reductions in supply by health care providers could not be substantiated or "did not widely affect access to health care."[17]

Effects on Malpractice

Defenders of current tort law sometimes argue that restrictions on malpractice liability could undermine the deterrent effect of such liability and thus lead to higher rates of medical injuries. However, it is not obvious that the current tort system provides effective incentives to control such injuries. One reason for doubt is that health care providers are generally not exposed to the financial cost of their own malpractice risk because they carry liability insurance, and the premiums for that insurance do not reflect the records or practice styles of individual providers but more-general factors such as location and medical specialty.[18] Second, evidence suggests that very few medical injuries ever become the subject of a tort claim. The 1984 New York study estimated that 27,179 cases of medical negligence occurred in hospitals throughout the state that year, but only 415—or 1.5 percent—led to claims.[19]

In short, the evidence available to date does not make a strong case that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency. Thus, choices about specific proposals may hinge more on their implications for equity—in particular, on their effects on health care providers, patients injured through malpractice, and users of the health care system in general.

Related CBO Publications: *The Economics of U.S. Tort Liability: A Primer* (October 2003) and *Cost Estimate for H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003* (March 10, 2003), available at www.cbo.gov.

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17. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (August 2003), unnumbered summary page ("What GAO Found") and p. 5. GAO's study also included a comparison group of four states without reported access problems.

18. However, providers incur other financial and psychic costs (in time, loss of reputation, and so on) when they are sued for malpractice. Moreover, in some cases, they lose their insurance coverage.

19. A. Russell Localio and others, "Relation Between Malpractice Claims and Adverse Events Due to Negligence," *New England Journal of Medicine*, vol. 325, no. 4 (July 25, 1991), pp. 245-251. Many acts of negligence are undoubtedly too minor to justify filing a tort claim. But the 27,179 estimated cases of negligence in 1984 included 5,396 with strong evidence that the negligence contributed to patient disabilities of six months or more—and the estimated 415 claims actually filed correspond to just 7.7 percent of that smaller number of cases.