

Medical Liability Reforms

Issue

Sharp increases in medical liability insurance premiums in recent years, and the withdrawal of some insurers from this market have focused the attention of health care providers, patients, and policymakers on reform of the medical liability system. Of additional concern is that the fear of liability causes physicians to practice medicine in ways that raise costs. The key issues being debated this election season are how to assure the availability of affordable liability coverage in the future while maintaining access to care, and the impact medical liability has on rising health care costs. There are varying opinions of how medical liability reform should be addressed, including whether it should remain a state issue or be addressed at the federal level, and, if so, how.

Background

According to a recent study on medical liability by the Congressional Budget Office (CBO), medical liability insurance premiums for all physicians nationwide increased an average of 15 percent between 2000 and 2002. Those for some specialties rose even faster, with premiums for obstetrician-gynecologists increasing an average of 22 percent and those for internists and general surgeons growing an average of 33 percent during the same period. The same study indicated that malpractice costs account for less than 2 percent of health spending and that significant reductions in these costs would only modestly affect overall health spending growth. Concern has also been raised over spending related to the practice of defensive medicine. However, based on existing research and its own analysis, the CBO found that savings from reducing this practice would be "very small."¹

Premium hikes have also varied substantially from one area to another. In a 2003 survey of seven states, the General Accounting Office (GAO) found that "premium levels varied greatly not only from state to state, but...even among areas within states."² For example, it found that the largest professional liability insurer in Florida raised annual premiums for general surgeons in Dade County by 75 percent between 1999 and 2002 (to \$174,300), while the largest such insurer in Minnesota hiked premiums for the same specialty during the same period by 2 percent (to \$10,140). Outside Dade County, the Florida insurer's annual premium rate for general surgeons for 2002 was \$89,000.

This surge in premiums is only the latest episode in an insurance cycle that produced similar increases in the second half of the 1970s and again in the mid-1980s. These upswings in premiums are thought by most experts to be caused by higher-than-expected financial outflows from insurers, lower-than-expected financial inflows to them, or a combination of the two.

A number of factors may increase liability insurers' spending, including growth in the size of payouts to patients, an increase in the number of lawsuits, the rising cost of health care for injured parties, and increased premiums for reinsurance (insurance that they purchase from other companies to protect themselves against extremely costly cases).³ While evidence on the role

played by most of these factors is mixed, the available data suggests that the costs of malpractice lawsuits have risen significantly over time. For example, CBO has determined that average pay-outs to patients and average legal defense costs per case have both risen at annual rate of 8 percent between 1986 and 2002.⁴

Aside from premiums, the main factor affecting the financial inflows or revenues of liability insurers is income from the investment of their reserves. While agreeing that other factors play a role in determining liability premiums, the GAO has found that lower-than-expected investment income for 15 large insurers between 2000 and 2002 probably played an important role in their rate-setting.⁵ Likewise, an analysis by the American Academy of Actuaries also found that liability insurers' investment income decreased as a percentage of premiums between 1995 and 2001, and it suggested that each one percent decrease in interest rates would require insurers to increase premiums 3 to 4 percent to offset the reduced investment income.⁶

Another factor contributing to the current round of premium hikes is that a number of insurers have withdrawn from the market, thereby limiting competition on premiums as well as the number choices for coverage available to physicians. In 2001, the St. Paul Company, which provided about 10 percent of all medical malpractice insurance nationally, withdrew from the market altogether. Some physician-owned insurance companies have also exited the market or restricted where they offer coverage.⁷

In response to current and past surges in premiums, many states have refashioned their laws governing medical liability lawsuits, which have traditionally been a state issue. As of October 2002, 28 states had adopted limits on the amount of non-economic damages (pain and suffering) that can be awarded to an injured party⁸. California led the way with the adoption of the Medical Injury Compensation Reform Act of 1975, (MICRA) which, among other things, capped such damages at \$250,000. Similar legislation is pending in most of the states that have not yet acted. California also has approved a referendum rolling back premiums on many types of insurance (including medical liability insurance) and instituted state regulatory review of proposed premium increases.

Options for Assuring Access to Affordable Liability Coverage

Federal limits on liability lawsuits. Although there are a number of policy prescriptions for remedying the problem of rising medical liability insurance premiums, most of the attention in Congress has focused on legislation that would limit medical malpractice lawsuits and awards. Preferred by most Republicans, such legislation has been passed twice by the House of Representatives in the past two years. While Republicans in the Senate have tried to bring similar legislation up for consideration, most Democrats (joined by two Republicans) have blocked these attempts.

The House-passed legislation, which would not limit damages for any economic losses (such as medical costs and lost wages) sustained by a patient, would:

- cap non-economic damages (pain and suffering) at \$250,000;
- limit punitive damages to cases involving malicious intent to injure or deliberate failure to avoid unnecessary injury;

- cap punitive damages at the greater of \$250,000 or two times economic damages;
- end joint and several liability (under which, in lawsuits with multiple defendants, one defendant can be responsible for paying all of the damages if other defendants lack the resources to pay);
- reduce damage awards by the amount available to an injured party from collateral sources (such as workers compensation and health insurance);
- limit contingency fees (the share of any award that a lawyer can claim to cover fees and expenses);
- limit how long after an injury a lawsuit may be brought; and
- permit future damages (e.g., future lost wages, health care costs, etc.) to be paid in installments instead of one lump sum.

These reforms would apply not just to lawsuits against physicians, but also to cases involving other health care providers, health plans, and the manufacturers, distributors, and sellers of medical products, such as drugs and devices. The bill would allow more restrictive state laws to stand.

Those who favor such reforms view rising premiums as primarily the product of frivolous lawsuits and overly generous juries. For this reason, they tend to view the \$250,000 cap on non-economic damages as perhaps the most important reform. They argue that, while economic damages are relatively easy to determine, non-economic damages are subjective and difficult to quantify and predict. In their view, this creates a sort of lottery that drives up premiums, while also producing widely differing pay-outs for similarly situated patients. In support of their view that such a cap would limit future premium increases, many of them point to the fact that premiums increases in California have been less than in many other areas of the country.

Alternative Approaches. Opponents of such reforms tend to see other factors, such as efforts by insurers to offset lower-than-expected investment income, as more likely causes of the recent surge in premiums. In their view, a \$250,000 cap on non-economic damages will have little impact on premium increases, but instead will unfairly penalize those whose injuries are not solely financial (e.g., people suffering permanent disfigurement) or patients (e.g., women, children, and older Americans) for whom the lost wages component of any economic damages will be lower. They also point out that, because of inflation, a \$250,000 cap in 2004 is significantly lower than the cap included in MICRA in 1975, thereby devaluing the pain and suffering of injured parties today in relation to that of their counterparts in the past. In addition, they argue that since the impact of premium increases varies so much from one part of the country to another, the problem is more appropriately addressed by the states, which have traditionally regulated insurance as well as medical liability lawsuits. Finally, they point out that, in addition to capping non-economic damages at \$250,000, the California referendum rolling back premiums on many types of insurance (including medical liability insurance) and ongoing state regulatory review of proposed premium increases, have been at least partly responsible for lower premiums there.

Opponents of federal liability limits have not coalesced around an alternative proposal, but have offered several potential remedies. Some have proposed eliminating the federal antitrust

exemption for liability insurers under the McCarran-Ferguson Act, which permits insurers to share information on losses through an organization known as the Insurance Services Office. Proponents of this approach argue that such information-sharing facilitates collusion in setting premium rates. Others have advocated a reinsurance program under which the federal government would relieve liability insurers of some of the costs associated with particularly costly cases by insuring them against losses above a specified amount. Still, others have suggested increasing sanctions on plaintiffs' lawyers for frivolous lawsuits or requiring parties to use alternative dispute resolution mechanisms, such as binding arbitration. Finally, some favor the use of tax incentives, such as a credit for the purchase of medical liability insurance or an exclusion from taxable income of amounts awarded in binding arbitration.

Promoting Patient Safety. Although divided largely along partisan lines on the question of federal medical liability limits, Congress is now working on a more bipartisan basis to craft legislation that would attack the medical liability issue from another angle—by encouraging changes in the health care delivery system to prevent medical errors and promote patient safety. Spurred on by a series of reports by the Institute of Medicine, large majorities in both the House and the Senate have passed legislation (H.R. 663 and S. 720) to encourage providers to report medical errors to organizations that would identify patterns and help providers learn from these mistakes. As an incentive to participate, information held by these organizations would be protected from disclosure in most circumstances. The House and Senate are currently resolving their differences on the two bills.

Assessing Candidate Positions

Included below are a series of questions to help evaluate the positions of policymakers and candidates this election season.

- Is there a crisis in the cost of medical liability insurance?
- If so, what is causing the high premiums?
- What should be done to make medical liability insurance more affordable?
- Should this be addressed by the federal government or the states?
- What can be done to promote patient safety?

Prepared by Health Policy Alternatives, Inc.

¹ Congressional Budget Office, "Limiting Tort Liability for Medical Malpractice," Economic and Budget Issue Brief (January 8, 2004), p. 6.

² General Accounting Office, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," (June 2003), p. 8.

³ Rosman, "Background Paper: Medical Malpractice in Crisis," Council on Health Care Economics and Policy (March 3, 2003), pp. 6-10.

⁴ CBO, "Limiting Tort Liability for Medical Malpractice," pp. 3-4.

⁵ GAO, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," (June 2003), p. 47.

⁶ Rosman, "Background Paper: Medical Malpractice in Crisis," p.10.

⁷ Schactman, Doonan, and Rosman, "Policy Brief: Medical Malpractice in Crisis," Council on Health Care Economics and Policy, (May, 2003), p. 5.

⁸ Rosman, "Background Paper: Medical Malpractice in Crisis," p. 4.

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