Medical Malpractice

A Physician's Sourcebook

Edited by

Richard E. Anderson, MD, FACP

15 The Case for Legal Reform

Richard E. Anderson, MD, FACP

SUMMARY

The rising cost of claims has fueled a dramatic rise in the cost of medical malpractice insurance in the United States. Increasing severity has driven malpractice tort costs beyond $20 billion per year. A significant percentage of America's doctors are defendants in malpractice litigation and more than 600 new claims are initiated daily. Malpractice claims do not reliably identify "bad" doctors. In high-risk specialties, virtually all physicians are potential litigation targets. Other factors contributing to the increased cost of malpractice insurance include falling interest rates, higher costs for reinsurance, shrinking capacity, and judicial nullification of existing legal reforms.

More than a quarter century's experience with California's Medical Injury Compensation Reform Act (MICRA) statutes provides ample evidence that reforms are well defined and effective. In the absence of these reforms, it is predictable that the current crisis will worsen and access to fundamental medical services will be increasingly imperiled.

Key Words: Legal reform; tort reform; Medical Injury Compensation Reform Act (MICRA); premiums; frequency; severity; "bad" doctor; Harvard Medical Practice Study; Institute of Medicine; collateral source; periodic payments; caps; contingency fee; defensive medicine.

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INTRODUCTION

The past few years have seen significant increases in the cost of malpractice insurance in many parts of the United States *(1)*, making legal reform an issue of great significance to both doctors and health care consumers. Many physicians have been forced to curtail their practices, move to other venues, or even retire from the practice of medicine *(2–5)*. The issue has been extensively discussed and debated in the medical and legal press, the media in general, a number of state legislatures, and nationally by both Congress and the president. This chapter reviews the nature and extent of the problem, the relevant attributes of medical malpractice insurance, and the evidence that legal reforms can ameliorate the problem.

EXTENT OF THE PROBLEM

The expansion of tort law into new arenas of potential liability grew throughout the 20th century, particularly the latter half.

> *"... Tort law has existed here and abroad for centuries, of course. But until quite recently it was a backwater of the legal system, of little importance in the wider scheme of things. For all practical purposes, the omnipresent tort tax we pay today was conceived in the 1950s and set in place in the 1960s and 1970s by a new generation of lawyers and judges. In the space of twenty years they transformed the legal landscape, proclaiming sweeping new rights to sue. Some grew famous and more grew rich selling their services to enforce the rights that they themselves invented. But the revolution they made could never have taken place had it not had a component of idealism, as well. Tort law, it is widely and passionately believed, is a public-spirited undertaking designed for the protection of the ordinary consumer and worker, the hapless accident victim, the 'little guy.' Tort law as we know it is a peculiarly American institution. No other country in the world administers anything remotely like it"* (6).

Peter Huber, author of a seminal treatise on the expansion of liability law, refers to the attendant costs as the tort tax:

> *"It is one of the most ubiquitous taxes we pay, now levied on virtually everything we buy, sell and use. The tax accounts for 30 percent of the price of a stepladder and over 95 percent of the price of childhood vaccines. It is responsible for one-quarter of the price of a ride on a Long Island tour bus and one-third of the price of a small airplane. It will soon cost large municipalities as much as they spend on fire or sanitation services"* (6).

Responding to the same issues, Philip Howard has referred to "the death of common sense" *(7)*. He founded an organization named Common Good, which is dedicated to reforming America's legal system (http://cgood.org/). Common Good has this to say about the expansion of medical liability and the provision of health care in the United States:

> *"The lawsuit culture in modern America is creating a crisis in American healthcare. The broad perception that anyone can sue for almost anything has fundamentally altered the practice of medicine, eroding the quality and availability of healthcare."*

- Doctors are abandoning obstetrics and other specialties, and many are quitting practice altogether, because of legal exposure and costs;
- Honesty and candor, vital to improving health care systems and to delivering humane care, have been supplanted by a culture of legal fear;
- Vast resources are squandered in unnecessary 'defensive' medicine at the same time..." *(8)*.

Catherine Crier, lamenting the explosion in litigation wrote: "Trial work has become a major stand-alone business within the legal community. What was once the place for good advice about the worthiness of a claim has become a gristmill for expanding rights and remedies. To enterprising attorneys, there are few unmerited lawsuits. Traditionally, lawyers were officers of the court who zealously represented clients within legal and ethical boundaries. The interests of justice were paramount, such that intentionally misleading a jury or using discovery simply to wear down an opponent or drain his pocketbook was degrading to the practitioner and unethical as well. Using court pleadings or the media as a litigation tactic to destroy an opponent was unacceptable. Attorneys now regularly solicit clients, conjure up creative and nuisance filing, and delay the trial process, all to line their own pockets" *(9)*.

To get a sense of the magnitude of this phenomenon, it is interesting to note that if plaintiff attorneys were employed as members of a single corporation, it would have 50% more annual revenue than Microsoft and would be double the size of Coca-Cola *(10)*.

In general, the last decade of the 20th century was a period of rapid change and we, as a society, became accustomed to unprecedented numbers preceded by dollar signs. We live in a trillion-dollar economy. Mass tort litigation produces judgments of hundreds of billions of dollars and attorneys demand and receive billion-dollar fees. Twenty-two-

year-olds who worked very hard for 18 months could find themselves Internet billionaires, and ballplayers could command hundred-million dollar contracts. Thus, the expansion of theories of liability has coincided with a significant monetary desensitization of the public mind. Jury verdicts in virtually all areas of the law have reached new heights with each succeeding year *(4,10)*.

Medical Context

It is not difficult to identify numerous factors affecting contemporary medical practice that have exacerbated medical malpractice liability within this broader cultural context. The foremost factor is managed care. Although ideally it offered the potential of cost savings, efficient medical practice patterns, and enhanced quality assessment and assurance, we have arrived at a place where virtually no major constituency is satisfied. Physicians and health care institutions are frustrated by reimbursement limitations, increased paperwork, and interruption of the traditional doctor–patient relationship. Patients decry access restrictions, reduced insurance coverage, and the need for frequent provider changes. Payors are unhappy with the resumption of significant increases in costs. Congress, seeing general dissatisfaction with the system, has attempted to pass legislation (i.e., 2001 Patients' Bill of Rights) that would have defined the public's rights under managed care and increased the potential for litigation directed against the managed care organizations themselves.

With virtually everyone disgruntled with significant aspects of their health care experience, the likelihood of malpractice suits increases. Because patient litigation against managed care organizations directly is limited by federal law (Employee Retirement Income Security Act [ERISA]), physicians often find they are targeted in litigation that might otherwise have been focused elsewhere. Suits alleging delayed diagnosis and failure to refer to appropriate specialists are especially potentiated because the real and imagined impediments of managed care in these areas resonate with juries.

Contemporary medical advances, especially in the realm of "medical miracles," are almost all technologically based. High-tech care is often low touch, and the skills needed to operate in this complex medical environment are not necessarily those that facilitate good bedside manner. Moreover, as the boundaries of possible medical intervention expand, expectations also rise. This produces potential litigation over adverse outcomes even in the most medically desperate circumstances.

Severity

Severity is an insurance term of art that refers to the cost of the average claim. By extension, it also connotes the range of potential adverse outcomes or the downside risk of taking a case to court. Since 1997, the increase in severity of medical malpractice litigation has been striking. The median malpractice verdict doubled from approx $500,000 to $1 million between 1997 and 2000 *(11)*, and the mean verdict increased from $1.97 million to $3.48 million over the same period *(12)*. The likelihood of a plaintiff's verdict exceeding $1 million increased from 34% in the period from 1994 to 1996 to 52% between 1999 and 2000 *(12)*. Therefore, it is not surprising that the total medical malpractice tort cost rose from $8.7 billion in 1990 to $20.9 billion in 2000—an increase of 140% *(13)*.

The amplification in the cost of the outlier verdict has been even greater. Texas recorded a judgment for $268 million. Several states have seen malpractice awards in excess of $100 million *(2)*. Until 2000, malpractice judgments were rarely, if ever, among the 10 largest in the United States in any given year. The Texas award made this list in 2000. In 2001, there were 2 medical malpractice claims among the top 10. Moreover, this list included a $312 million award against a nursing home for the care of a single patient, and a California jury returned a $3 billion verdict against the tobacco companies for the lung cancer death of a single smoker. Thus, 4 of the 10 largest judgments in the United States involved adverse health care outcomes for single individuals *(14)*. By 2002, fully half of the 10 largest awards in the United States involved health care outcomes of single individuals *(15)*.

Frequency

Frequency is another defined insurance term referring to the likelihood of a claim in a defined population of policyholders. For example, a frequency of 0.10 means that on the average, 10% of the group will report a claim every year or that each member will report a claim every 10 years. Frequency is very high among all physicians and averaged 15 to 16% in recent years, although the differences among specialties are significant (*see* Fig. 1). Approximately 55% of neurosurgeons report a claim (defined as a demand for payment) every year *(16)*. This means the average neurosurgeon would face a new claim every other year. For other high-risk specialties such as orthopedics, obstetrics, general surgery, and emergency medicine, frequency is around 30%. Even in "low-risk" specialties such as internal medicine,

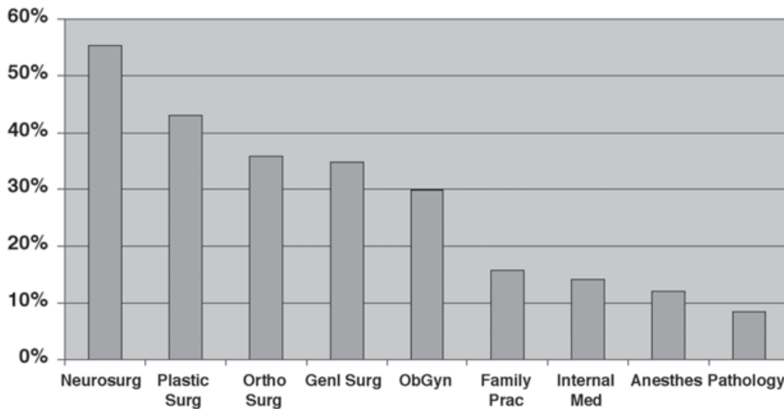

Fig. 1. Frequency by specialty from 1995 to 2001. (From The Doctors Company data on file.)

pathology, and anesthesiology, about 10% of policyholders will have a claim each year *(16)*.

Between 70 and 80% of all claims against physicians end without indemnity payment, meaning that the plaintiff receives nothing *(5)*. However, each claim requires a legal defense, and the attendant costs are high. In 2001, it cost a medical malpractice insurer an average of more than $23,000 in case-specific costs to close a nonmeritorious (zero pay) claim *(5)*. If such a claim had to go through a trial before a verdict for the defense, then the average cost was $85,718 *(5)*.

These costs are important drivers of premium rates. Although most malpractice claims end in vindication for the physician, the costs of the legal process are high. Allocated loss adjustment expense (ALAE) is the specific cost associated with an individual claim. The most important components are fees for defense attorneys and expert witnesses. ALAE does not include the overhead of the insurer in general or even the cost of running a claims department. It is important to note this cost driver. Ironically, all of these nonmeritorious claims have the paradoxical effect of driving down the cost of the average claim and increasing total claims expenses. The size of the average claim is best measured by specifying average paid claims. Without this seemingly obvious distinction, the large volume of nonmeritorious litigation can be distorted to appear to lower the cost of malpractice claims *(17)*.

THE ROLE OF MEDICAL MALPRACTICE INSURANCE COMPANIES

Claims Losses

Although rising frequency and severity account for the dramatic increase in the annual cost of medical malpractice tort cases cited earlier *(13)*, there has been debate about whether this is adequate justification for the attendant increase in malpractice insurance premiums *(17,18)*. Because this issue has been central to legislative debate on the desirability of legal reform, it has been well studied from a number of viewpoints.

Conning & Co., a national insurance indemnity analyst, estimates that malpractice insurers will pay out approx $1.40 for every premium dollar collected in 2001 and 2002 *(19)*. Even with rate increases, Conning & Co. projects insurers will pay out $1.35 for each dollar collected in 2003 *(19)*. Similar figures have been presented by Tillinghast-Towers Perrin using data from A.M. Best *(20)*.

The preponderance of this loss comes from increased claims losses. Losses per doctor, the figure that would track individual physician premiums most closely, have risen considerably more than inflation, medical costs, or premiums themselves *(21)*. No relationship between premium costs and the general state of the economy was detectable *(21)*. To return to the medical malpractice insurance industry's 27-year average loss ratio (claims costs divided by premium), premiums would have required an increase of 59% in 2003 *(21)*. In every year since 1995, the cost of claims losses alone (without any accounting for expenses) has exceeded the total premium collected by malpractice insurers *(20)*.

In 2002, faced with a malpractice crisis in Florida, the governor appointed a blue ribbon commission to analyze the root causes of the problem and suggest solutions. The panel was chosen in a manner that assured impartiality and did not include physicians, attorneys, or insurers. It was composed of five university presidents who submitted a unanimous and unequivocal report.

> *"The primary cause of increased medical malpractice premiums has been the substantial increase in loss payments to claimants caused by increases in both the severity of judgments and the frequency of claims."*
>
> *"The Task Force finds that the lack of predictability in the market, combined with a trend toward increased damage judgments, has caused instability in the market which, in turn, has led to insurance*

carriers either increasing their premiums (often to a level above what independent doctors can afford) or withdrawing from the marketplace" (22).

The nonpartisan General Accounting Office (GAO), in its 2003 report to Congress on the cause of the rising cost of malpractice insurance, reached similar conclusions:

"Multiple factors have combined to increase medical malpractice premium rates over the past several years, but losses on medical malpractice claims appear to be the primary driver of increased premiums rates in the long term. Such losses are by far the largest component of insurer costs, and in the long run, premium rates are set at a level designed to cover anticipated costs" (23).

The US Department of Health and Human Services issued a comprehensive report on the medical liability system and the quality of health care in the United States *(2)*. The department found: "Americans spend proportionately far more per person on the costs of litigation than any other country in the world. The excesses of the litigation system are an important contributor to 'defensive medicine'—the costly use of medical treatments by a doctor for the purpose of avoiding litigation. As multimillion-dollar jury awards have become commonplace in recent years, these problems have reached crisis proportions. Insurance premiums for malpractice are increasing at a rapid rate, particularly in states that have not taken steps to make their legal systems function more predictably and effectively" *(2)*. The report detailed rising claims losses as the main driver of increased premium rates and a threat to both quality and access in the health care system.

Accounting for Rate Increases: The Perfect Storm

Although claim costs comprise nearly 80% of an insurer's expenses *(23)*, there are additional factors that have contributed to the increase in malpractice premiums. Insurers must collect premium today to pay for the cost of claims in the future. In the case of malpractice claims, this gap may be long, because the average claim requires 3.5 years to resolve, and some claims are pending for as long as 10 years. It is the fiduciary responsibility of the insurance company to invest premium dollars prudently so that funds will be available to pay claims when needed. Approximately 80–90% of the average malpractice carrier's portfolio is invested in investment grade bonds, so investment income is heavily dependent on prevailing interest rates *(5,23)*. These have fallen considerably over the same period of time claims losses have been increasing. Therefore, there has been reduced income from

investments to subsidize the cost of claims. Although virtually no malpractice insurer has suffered net negative investment returns, reduced investment income means that premium must cover a greater share of insurers' costs. The GAO has calculated that in the period from 2000 to 2002, premium rates would need to rise approx 7.2% to compensate for the fall in investment income *(23)*. However, this is a small percentage of overall rate increases, emphasizing the primary role played by rising claims losses.

In fact, the high returns of the 1990s enabled insurers to sell coverage for less than its actual cost by making up the difference with investment income. This worked well for the companies, which were able to grow despite intense price competition, and directly benefited policyholders, who received their insurance for less than cost. Unfortunately, when interest rates declined, the deficit created by the lost investment income added to premium increases necessitated by the rising cost of claims.

Faced with large losses, a number of malpractice insurers were forced into bankruptcy (notably PHICO, PIE, and Frontier, among others), and many more electively withdrew from the market, refusing to offer professional liability coverage at any price. St. Paul, a market leader in this field for more than two decades, was the largest and most important of these *(2)*. This shrank the capacity of the market as a whole to provide insurance for physicians and other health care providers.

Another factor adding to the upward pressure on malpractice premiums was a changed reinsurance market. Insurance companies buy reinsurance to prevent individual large losses from distorting results and to further spread the risk inherent in providing professional liability coverage in the first place. After September 11, the cost of this reinsurance rose significantly as reinsurers sought to recover from the estimated $75- to $100-billion cost of the tragic event. This meant that reinsurers demanded higher profit margins and more restricted coverages before they were willing to accept risk.

Finally, judicial nullification and threats to existing legal reforms contributed to the problem. State supreme courts in approximately a dozen states held the tort reforms approved by their respective state legislatures unconstitutional *(24)*. The loss of these reforms worsened the medical-legal environment for physicians and their insurers and is still another factor contributing to the rise in severity.

The Fallacy of the Bad Doctor

There would be less concern over the increase in malpractice premiums if the additional costs were born only by unqualified or negli-

gent physicians. Indeed, one of the arguments for preserving the current system is that malpractice suits accurately identify these substandard doctors, thus performing an important societal function. However, the available data argue to the contrary. First, 70 to 80% of all malpractice claims today are found to be without merit (i.e., they close with no payment to the plaintiff) *(5)*. So it cannot be reasonably argued that the existence of claims against a doctor is evidence of poor medical practice. This notion is underscored by the frequency data (Fig. 1) reviewed earlier, which indicate that 33 to 50% of all high-risk specialists face a claim every year. Expressed differently, the majority of malpractice claims in the United States today are filed against good doctors.

Further evidence that rising malpractice premiums are not caused by bad doctors can be found in a review of additional data. It is a reasonable rule of thumb in any given year that about 2% of physician-policyholders will account for approx 50% of the claims losses *(16)*. This leads some to argue that eliminating these offenders would dramatically reduce premium rates. For this to be true, the same 2% of doctors would have to account for half the losses in succeeding years, and this is not the case. Although the rule of thumb is reliable enough, the doctors involved are different each year. Were this not true, other physicians would not practice with them, and insurance companies would certainly not insure them. This ratio is driven by the reverse causation: 2% of the plaintiffs receive 50% of all indemnity, and the 2% of doctors involved are not predictable, or in most cases even culpable (*see* below). This is not unexpected in a system so subject to the effects of outlier verdicts.

A review of the files of a national medical malpractice insurer indicates that less than 1% of its physician-policyholders have two paid claims over a 10-year period of time *(16)*. The likelihood that a physician who has one paid claim will have a second in the succeeding decade is only one in five *(16)*. Therefore, even paid claims do not reliably identify a group of physicians practicing substandard medicine.

Finally, the Harvard Medical Practice Study *(25)* looked at the actual litigation that arose from the more than 32,000 medical records they reviewed and concluded that there was no relationship whatever between the presence or absence of medical negligence and the outcome of malpractice litigation *(26)*. The only variable correlated with the outcome of litigation was the degree of injury. Plaintiffs with the most serious injury were more likely to be successful in court, irrespective of whether the injury was caused by negligence.

Because the majority of malpractice claims are found to be without merit and the extent of injury is more strongly correlated with litigation outcome than with medical negligence, insurance companies cannot predict with any certainty the likelihood that an individual physician will incur malpractice liability in the future. This means premium rates must be predicated primarily on group, rather than individual, experience. In this context, medical specialty and geography (location of the practice) are more important determinants of rates than a physician's personal experience. Of course, there are exceptions (e.g., impaired physicians, extreme practice profiles, etc.), but exceptions are not the rule.

Using the extremes as an example, it is easy to see the limits of experience rating in the context of medical malpractice insurance. A physician with no claims could argue that his or her premium should be close to zero. On the other hand, following a single million-dollar claim, the physician's rate the following year could be many hundreds of thousands of dollars. Given the facts above, this would be illogical as well as unfair and would undermine the very notion of insurance. Therefore, in most cases the premium burden is evenly divided among physician groups with only modest experience-based discounts or surcharges actuarially creditable.

The Settlement Issue

Personal injury attorneys sometimes argue that outlier jury verdicts could be avoided if insurance companies settled claims more readily *(27)*. There are several reasons that this is wrong. First, physician defendants win approx 80% of malpractice trials *(5)*, making it difficult to argue that those claims should have been settled. Second, the physician, not the insurance company, is the defendant and usually retains the right to make any decision on settlement. In our legal system, the defendant is entitled both to the presumption of innocence and the right to a day in court. It is disingenuous for plaintiff attorneys to suggest that the courtroom has become too dangerous a venue for the exercise of one's legal rights. The alternative to a forced settlement should not be an unreasonable jury verdict. Finally, so-called "nuisance settlements" only encourage more litigation.

Insurance Companies and Markets

The plaintiff bar argues that the sharp rise in the cost of malpractice insurance is principally caused by exploitation of physicians and management incompetence by the companies that provide coverage. The facts do not support these allegations. Sixty percent of physicians are

insured in mutual companies owned by the policyholders themselves *(5)*. The remainder find coverage with commercial carriers, many of which insure other risks unrelated to professional liability. The physician-owned companies are dedicated to providing malpractice coverage for their policyholder-owners. These companies tend to be state-based, although several have expanded regionally and a few nationally.

Several hundred companies write medical malpractice insurance in the United States, but that figure may be misleading because only a fraction of these are actively writing and the 20 largest medical liability insurers accounted for 56% of malpractice premium in 2002 *(28)*. The 60% of physicians insured in physician-owned mutuals are spread among approx 40 companies. When insurers perceive the medical-legal environment as poor, they will be forced to reduce insurance writings or leave the state entirely. A poor environment is basically defined as one where premium rates fail to cover the risk of liability and a reasonable return on investment. Forty-six companies, primarily commercial carriers but some mutuals as well, ceased writing this business between 2000 and 2002 *(28)*, typically for one of the following three reasons:

1. The company felt the business to be unprofitable, or more generally, that the practice of medicine had become uninsurable.
2. State regulators prohibited additional writing because of the precarious financial position of the company or regulatory violations.
3. Actual bankruptcy.

The exodus of such a large percentage of insurers from the market has substantial costs for doctors, injured plaintiffs, and all health care consumers. When a given market will not support enough insurers to cover all doctors, the physicians will be unable to practice in that venue and patients will be forced to travel long and potentially hazardous distances to receive medical care. The insolvency of a malpractice insurer is the worst possible outcome for both policyholders left uninsured and injured plaintiffs left uncompensated.

The following examples illustrated how this comes to pass. Between 1991 and 2000, malpractice insurers paid out $1.60 in losses and expenses for each dollar of premium earned in Florida *(29)*. In 1999, there were 66 active malpractice insurers in the state. By 2002, that number had decreased to 12, and only 4 were accepting general new business *(22)*. In Texas, where insurers paid out $1.35 for each dollar of premium earned between 1991 and 2000 *(22)*, the number of active insurers was reduced from 11 to 4 in 2002 *(30)*. No market can be sustained very long by requiring its participants to lose money.

Table 1
Principal Provisions of MICRA

MICRA provisions	*What they mean*
$250,000 limit on noneconomic damages (i.e., pain and suffering).	No limit on actual damages. Limits only payment for pain and suffering.
Periodic payment of awards in excess of $50,000.	Damages are paid over the time period they are intended to cover, rather than as a lump sum.
Collateral source rule.	Prevents duplicate collection of damages already paid by a third party.
Contingency fee limitation.	Controls the size of contingency fees using a sliding scale. For a $1 million award, an attorney is limited to $221,000, plus expenses.

The value of legal reforms in stabilizing insurance markets will be discussed in the next section.

THE VALUE OF LEGAL REFORMS

Although legal reform has been endlessly and repetitively debated in professional, legislative, and media forums across the United States in recent years, in truth we have more than a quarter century of experience and data, and relatively clear answers are available *(2,5,22,27, 31–34)*.

The first malpractice crisis crystallized in California in 1975. Between 1968 and 1974, the number of malpractice claims doubled and the number of losses in excess of $300,000 increased 11-fold *(35)*. Insurers were paying out $180 for each $100 of premium they collected *(35)*. Most commercial insurers concluded that the practice of medicine was uninsurable, and they refused to provide malpractice coverage at any price. Faced with the prospect of either no malpractice insurance at all or premiums that were not affordable, physicians selectively withheld medical services, and access to care was threatened throughout the state. Doctors marched on the state capital. A special session of the California legislature was called to deal with the crisis. The result was the Medical Injury Compensation Reform Act of 1975 (MICRA; *see* Table 1).

The most important of the MICRA reforms is a $250,000 cap on noneconomic damages. California does not limit awards for economic damages, but capping pain and suffering awards takes the lottery aspect out of malpractice litigation. Economic damages are defined broadly and include lost wages, medical and nursing care, and rehabilitation.

The second major MICRA reform is the provision for periodic payments. This allows damage awards to be paid over the period of time that they are intended to cover. Such a rule means injured patients will actually receive payment in the timeframe in which it is needed. Moreover, the time value of money allows the insurance system to accommodate even very large judgments without facing insolvency.

The third major MICRA reform is the collateral source rule. This prevents duplicate collection for the same damages. For example, if an injured patient has already had lost wages or medical costs covered by disability or medical insurance, recovery may not be duplicated in a malpractice award. This is not only equitable but also avoids using the tort system, with its 72% transaction tax *(2)*, as a mechanism for funding basic services that have already been covered.

Fourth, there are modest limits on attorneys' contingency fees. MICRA provides for a sliding scale: a plaintiff attorney keeps 40% of the first $50,000 of an award but "only" 21% (plus expenses) of a $1 million judgment. This rules protects patients, allowing more of an award to actually reach the injured patient. The difference is significant. A patient with a $1 million award in a state with a contingency fee of 40% must give $400,000 (plus expenses) to his or her attorney as compared to $221,000 (plus expenses) under MICRA.

These reforms have reduced California malpractice premiums by 40% in constant dollars since 1975, or less than 3% per year uncorrected for inflation *(16)*. On average, California's malpractice premiums have risen at a rate of only one-third the national average (Fig. 2 *[29]*).

There are considerable data that a $250,000 cap on noneconomic damages reduces malpractice premiums by 25 to 30% *(2,28,36)*, and experience in California, Colorado, and other states is confirmatory.

The mirror image of the positive effect of real reform can be seen in the experience of states that had caps on noneconomic damages that were invalidated by their state supreme courts. Ohio enacted MICRA-like reforms in 1975, but the Ohio Supreme Court nullified these in 1985. Malpractice insurance rates fell steadily until 1982, when the law was challenged in the courts. Since 1985, Ohio malpractice premiums have once again increased significantly and the state is dealing with a

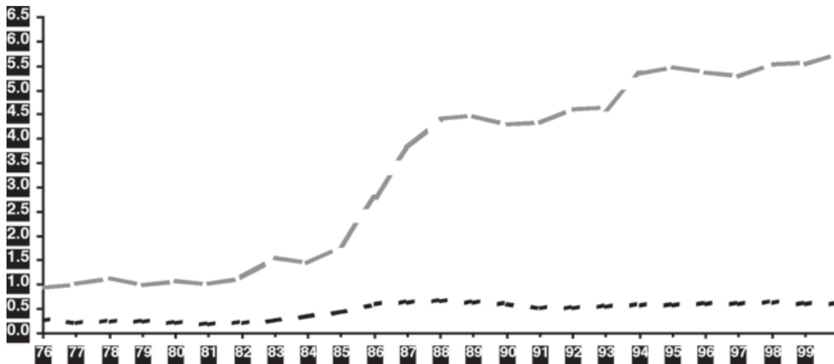

Fig. 2. Savings from MICRA reforms: California vs US premiums for 1976–2000. (From ref. *5*.)

new malpractice crisis *(33,37)*. In 2003, Ohio approved a new set of reforms in an effort to ameliorate the growing problem.

The experience in Oregon is even more dramatic. The state legislature capped noneconomic damages at $500,000 in 1987. The Oregon Supreme Court nullified this law in 1998. By 2000, malpractice indemnities in the state had increased 400% compared to 1998 *(38)*.

Alabama, Georgia, Illinois, Kansas, New Hampshire, North Dakota, and Washington have also had tort reforms nullified by their state supreme courts *(4)*. Today, Georgia, Illinois, Oregon, and Washington are among the 19 states facing a professional liability crisis *(4)*.

Other states have passed reforms that did not include damage caps. New York did so in 1975, 1981, and 1986 with no observable improvement in the malpractice insurance situation *(33)*. Florida and Texas have repeated similar experiences *(24)*, and in 2003 both state legislatures attempted to remedy the deteriorating medical-legal climate in their state with new reforms that do include caps on noneconomic damages.

A work group of the American Academy of Actuaries concluded that to be effective, a package of medical malpractice reforms must include a $250,000 per injury limit on noneconomic damages and a collateral source offset *(33)*. They found that reforms worked best when implemented together as a comprehensive program. Most significantly, they confirmed that porous caps with built-in exceptions or multipliers and peripheral reforms that do not include the fundamental elements of MICRA are predictably ineffective.

Beyond this, there is considerable additional evidence bearing on the effectiveness of legal reform in reducing malpractice premium rates. States with $250,000 or $350,000 limits on noneconomic damages had average premium increases only one-third as large as those in states without caps between 2000 and 2001 *(2,39)*. California's experience over the preceding quarter century stands as firm testimony to these data.

In 2002, the nonpartisan Congressional Budget Office estimated that the MICRA-based reforms contained in House Resolution 4600 (which failed to pass the Senate) would have lowered malpractice insurance premiums by 25 to 30% *(40)*.

Milliman USA analyzed medical malpractice claims in the 15 largest states from 1990 to 2001 and concluded that caps on noneconomic damages reduced medical malpractice loss costs for physicians *(41)*. In this study, reform states like California and Colorado saw loss costs reduced 48 and 31%, respectively. In contrast, New York's loss cost per physician stood at 300% compared to California, and Pennsylvania's stood at 328%. In an earlier study, Milliman had estimated that a $250,000 cap on noneconomic damages in New York would reduce premium levels by 29% *(32)*.

Perhaps the most comprehensive study of this issue ever undertaken was that delivered by the Governor's Select Task Force on Healthcare Professional Liability Insurance in Florida in 2002 *(22)*. Testimony ran to 13 volumes and included physicians, lawyers, insurance industry representatives, regulators, legal scholars, professional organizations, and concerned citizens. The final report exceeds 300 pages and contains more than 1300 citations. However, its conclusions were clear and unanimous. The report takes note of Florida's past history of unsuccessful reform and concludes that:

> *"A cap on non-economic damages of $250,000 per incident limited only to healthcare professional liability cases is the only available remedy that can produce a necessary level of predictability ... without the inclusion of a cap on potential awards of non-economic damages in the package, no legislative reform plan can be successful in achieving a goal of making medical malpractice insurance affordable and available, and thereby controlling increases in healthcare costs and promoting improved access to healthcare"* (22).

The authors noted that Florida's unsuccessful previous attempts at reforms that did not include such a cap "are nothing more than a failed litany of alternatives" *(22)*.

The National Association of Insurance Commissioners (NAIC) studied the market for medical malpractice insurance to evaluate the current crisis in 2003 *(28)*. Its conclusions, made independently and with access to the considerable state statutory data and experience, are in accord with those detailed previously. It found rising premium rates to be primarily a function of increasing claims costs. In addition, they found these problems were impeding public access to essential health care. They made six recommendations for states to consider when addressing these issues, including a $250,000 cap on noneconomic damages, a periodic payments provision, and collateral source reform. In addition, they recommended consideration of reforms to limit nonmeritorious claims, “bad faith” claims (*ex post facto* litigation alleging failure to make a timely settlement), and exploration of mechanisms that would add more predictability to insurers’ loss costs *(28)*.

There is ample evidence that the MICRA reforms have had a substantial impact on the availability and cost of malpractice insurance. In assessing the cost of the current crisis, we should also review the impact of defensive medicine and reduced access to care.

Defensive Medicine

In addition to its obvious direct impact, the tidal wave of malpractice litigation extracts a severe indirect toll on practicing physicians *(42,43)*, forcing many doctors to regard patients as potential adversaries and leading to the practice of defensive medicine. By definition, defensive medicine is unnecessary and consists of interventions that do not benefit the patient but are meant to protect the physician from litigation. Therefore, defensive medicine is always wasteful. The facile argument that perhaps a degree of defensive medicine would be salutary for our health care system is thus clearly invalid. Unfortunately, one can argue that virtually all medicine in the United States is to some degree defensive *(43)*. Medical standards of care have been replaced by medical-legal standards, physician judgment has been devalued, and the value of medical chart documentation set above the actual benefit to the patient. The standard of care in the community is not necessarily the most rational or the one with best supporting evidence but rather the one that keeps physicians out of court. Two examples of this phenomenon nationally are the high rate of Cesarean sections (C-sections) and high percentage of mammograms interpreted as suspicious for breast cancer *(43)*. The United States has a much higher C-section rate than any other developed country, with no improvement in birth outcomes. This phenomenon is clearly caused by litigation pressure. Similarly, the rate of false-positive

mammograms in the United States is twice that in other developed countries, again without improving the cancer detection rate. In another example of litigation-biased decision making, cardiac surgeons have been accused of gaming risk selection of patients to improve outcome data, limiting surgical access for the highest risk patients *(44)*.

Even ignoring the emotional burden and the damage caused by litigation-scared physicians practicing angry or hurt, the dollar costs are enormous. In 1996, Kessler and McClellan *(45)* estimated the cost of defensive medicine at $50 billion and argued that extending current malpractice reforms to all the states would reduce health care costs by 5 to 9%. More recently, the Department of Health and Human Services calculated the savings at $60 to $108 billion per year *(2)*. Although these may be the best estimates available, they are extremely conservative. These numbers reflect the reduced cost of health care in states with effective tort reform compared to states lacking such reforms. California, inherently a litigious state, has a frequency of malpractice litigation that is about 50% above the national average *(16)*, despite MICRA. Although the data indicate that effective tort reforms reduce the practice of defensive medicine, it is clearly not eliminated. This would suggest that the true costs are considerably higher than indicated by this methodology.

Because financing the cost of health care in the United States today is a zero-sum game, these direct and indirect costs of the malpractice crisis must be subtracted from funds available to fund the care of the uninsured and underinsured *(2,5,31)*, and for medical research and innovation. Reasonable limits on noneconomic damages, by reducing both the direct costs of malpractice insurance and the cost of defensive medicine, would save enough money to fund a prescription drug benefit for Medicare beneficiaries and facilitate insurance coverage for millions of uninsured Americans *(2)*.

Access to Care

As direct and indirect cost drivers increase the price of health care, it becomes unaffordable for an incremental number of patients. As the cost of malpractice insurance increases, it becomes unaffordable for an incremental number of doctors, other health care providers, and medical institutions, effectively preventing them from delivering medical services. As the fear of malpractice litigation and the consequent increase in malpractice insurance rates affect physician behavior, doctors become incrementally more averse to high-risk procedures, difficult patients, and more litigious venues. They also become incre-

mentally more susceptible to practices with more benefit in litigation avoidance than patient care. The same pressures will incrementally affect the choice of specialties by medical students and investment in medical facilities and medical research *(46)*.

None of this would appear to be particularly controversial; however, for several reasons it is difficult to be precise about the magnitude of these effects or to define the exact tipping point for individual physicians, specialties, facilities, or communities. First, "affordability" is a relative concept. Second, there are many contributors to the price of health care. Third, there are no adequately defined and scaled metrics for analysis as costs and their consequential pressures continue to rise. Moreover, there is an important personal factor in evaluating the access to care issue that goes beyond statistical analysis. If it is your obstetrician who is unavailable, then you have an access to care crisis. If the trauma center closest to the scene of your accident is closed, then you have an access to care problem. If there is no neurosurgeon available in your community following your head injury, then you have an access to care issue.

The Florida Select Task Force looked carefully at access to care because they felt it to be the most important reason for reform of laws governing medical malpractice litigation. The Task Force Report provides 33 pages (pp. 69–102 in ref. *22)* of examples where the cost of malpractice insurance threatens or has already reduced access to care. Again, their conclusion was unequivocal:

> *"The concern over litigation and the cost and lack of medical malpractice insurance have caused doctors to discontinue high-risk procedures, turn away high-risk patients, close practices, and move out of the state. In some communities, doctors have ceased or discontinued delivering babies and discontinued hospital care"* (22).

On the other hand, with effective tort reform:

> *"Physicians and hospitals will not be compelled to reduce or eliminate services, particularly those involving high risk. High-cost and low-income groups in particular will benefit. Lower malpractice insurance rates increase the willingness of physicians and hospitals to provide treatments that carry a relatively high risk of failure but offer the only real prospect of success for seriously ill patients"* (22).

Three separate arms of the federal government reached similar conclusions. The Agency for Healthcare Research and Quality found that

states with caps on noneconomic damages had 12% more physicians per capita than states without these reforms *(47)*.

The US Department of Health and Human Services found:

> *"This is a threat to health care quality for all Americans. Increasingly, Americans are at risk of not being able to find a doctor when they most need one because the doctor has given up practice, limited the practice to patients without health conditions that would increase the litigation risk, or moved to a state with a fairer legal system where insurance can be obtained at a lower price"* (2).

The GAO compared health care access in five states with rapidly rising medical malpractice premiums to four states with more stable medical-legal environments *(3)*. The GAO found:

> *"Actions taken by health care providers in response to rising malpractice premiums have contributed to localized health care access problems in the five states reviewed with reported problems. GAO confirmed instances in the five states of reduced access to hospital-based services affecting emergency surgery and newborn deliveries in scattered, often rural areas where providers identified other long-standing factors that also affect the availability of services. Instances were not identified in the four states without reported problems"* (3).

There are many specific examples of compromised health care caused by our litigation system. This list is not meant to be comprehensive but rather to show both the widespread nature of the problem as well as its immediacy.

- Access to Pap smears for the detection of cervical cancer is threatened because lawsuits demand an impossible to achieve zero error rate *(48)*.
- More than 12% of obstetricians/gynecologists across the country have ceased delivering babies, and nearly twice that number have reduced their exposure to high-risk obstetric care *(48)*.
- Abbott Laboratories withdrew its participation in a National Institutes of Health clinical trial designed to test a vaccine to prevent HIV-positive mothers from infecting their unborn children because of fear of liability *(48)*.
- Dupont restricted the sale of raw materials to manufacturers of artificial blood vessels, heart valves, and sutures to avoid litigation over the use of these devices *(48)*.
- The northern panhandle of West Virginia lost all neurosurgical services for about 2 years when the neurosurgeons who served the area

either left or stopped providing services because of malpractice pressures *(3)*.

- Pregnant women in parts of Mississippi had to travel 65 miles to deliver after the local hospital was forced to closed its obstetrical unit *(3)*.
- The only Level I trauma center in Nevada was forced to close for nearly 2 weeks when 60 orthopedic surgeons refused to provide services to protest the cost of malpractice insurance *(3)*.
- Parts of Pennsylvania have suffered a significant physician exodus because of high malpractice insurance costs; 44 occurred in Delaware County in 1 year alone *(2)*.
- In Ohio, a urologist would have had to spend 7 months of his yearly income simply to cover the cost of malpractice insurance *(2)*.
- Sixty-five percent of New Jersey hospitals report that physicians are leaving because of the cost of malpractice insurance *(2)*.
- Community clinics report increasing difficulty finding volunteer physicians because of liability fears *(2)*.

Finally, it is instructive to review California's quarter century experience with MICRA to measure its effect on health care access. William Hamm, the former legislative analyst for the California Assembly, analyzed the effect of MICRA on health care costs for safety net providers and Medi-Cal *(49)* (California's version of Medicaid for low-income Californians). He found that MICRA:

- Provided significant cost savings to teaching and safety net hospitals.
- Saved as much as $826 million for Medi-Cal.
- Reduced the practice of defensive medicine, which otherwise increases medical costs.
- Produced significant savings for nonprofit and community clinics, which otherwise would find it necessary to reduce services or increase fees.

Looking at California's health care system more generally *(31)*, he found the following:

- MICRA played a critical role in promoting access to health care for high-cost and low-income groups.
- MICRA's favorable impact on losses and malpractice insurance premiums reduced the cost of health care in California.
- Cost-savings are reflected in health insurance premiums, making health insurance benefit programs more affordable to businesses, particularly small businesses.
- Reduced "malpractice pressure" will increase the supply of physicians in California.

- Lower malpractice insurance premiums contribute to the viability of community hospitals.
- Lower malpractice insurance rates increase the willingness of physicians and hospitals to provide treatments that carry a relatively high risk of failure but offer the only real prospect of success for seriously ill patients.
- MICRA has improved California's access to health care by reducing provider fees, discouraging treatment that inflates costs but does not improve outcomes, and dampening malpractice pressure that tends to reduce the supply of physicians—particularly in key specialty areas, such as obstetrics, and underserved communities, such as rural areas and inner cities.

What can we conclude about rising malpractice premiums and access to care? Eighty-four percent of Americans believe availability and quality of health care is threatened by rising malpractice premiums *(50)*. This is a strikingly high figure for any poll. It is also a particularly sharp counterpoint to the notion that malpractice suits are effective in identifying substandard medical care (*see* The Fallacy of the Bad Doctor section on p. 209).

Until the entire health care system breaks down completely under the pressure of malpractice litigation, the threat to health care access will be incremental, felt differently by individual doctors, patients, and communities. However, it is clearly a significant problem. This is especially true if it is your family's health that is compromised.

SUMMARY AND CONCLUSIONS

The crisis in medical malpractice insurance has arisen in a context of a dramatic increase in the overall scope and cost of litigation in the United States. However, there are a number of factors specific to medicine that have accelerated this event. They have in common an undermining of the doctor–patient relationship and include dissatisfaction with managed care, the increased use of technology in medicine, weakening the personal bonds between physician and patient, and rising expectations for medical interventions.

Increasing severity has led to an unprecedented increase in the cost of malpractice claims, now surpassing $20 billion per year and still rising rapidly. A high percentage of America's physicians are currently in litigation and 600 new claims are opened daily. In the highest risk specialties, 33 to 50% of all practitioners report a claim every year. Even worse, there is no evidence that malpractice suits reliably identify "bad"

doctors. Indeed, we have considerable data to the contrary. Litigation outcomes are correlated with patient injury rather than medical negligence, and even paid claims are only weakly predictive of future litigation problems for individual physicians. Certain specialties have become repetitive targets for malpractice suits because of the serious nature of the clinical problems rather than the quality of the medicine being practiced.

Although several factors have contributed to the increased cost of malpractice insurance, the rising cost of claims is by far the most important. Falling interest rates, higher costs for reinsurance, shrinking capacity, and judicial nullification of existing legal reforms are also issues.

Since 1975, we have had direct experience with various legal reforms and clear knowledge of which of these are effective and which are not. It is best to effectuate legal reform as part of a comprehensive package based on California's MICRA experience. A $250,000 cap on noneconomic damages is most important, but collateral source reform, a periodic payments rule, and control of attorney contingency fees are also important. Other reforms may be appropriate and useful, but a quarter century of experience indicates they will have much less impact than the MICRA statutes.

In the absence of these reforms, it is predictable that the cost of malpractice insurance will continue to rise, as will the cost of medical care in general, defensive medicine will increase, and access to fundamental health care will be increasingly imperiled.

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