



## *Issue Brief I:*

# Malpractice Liability, Defensive Medicine & Health Care Costs

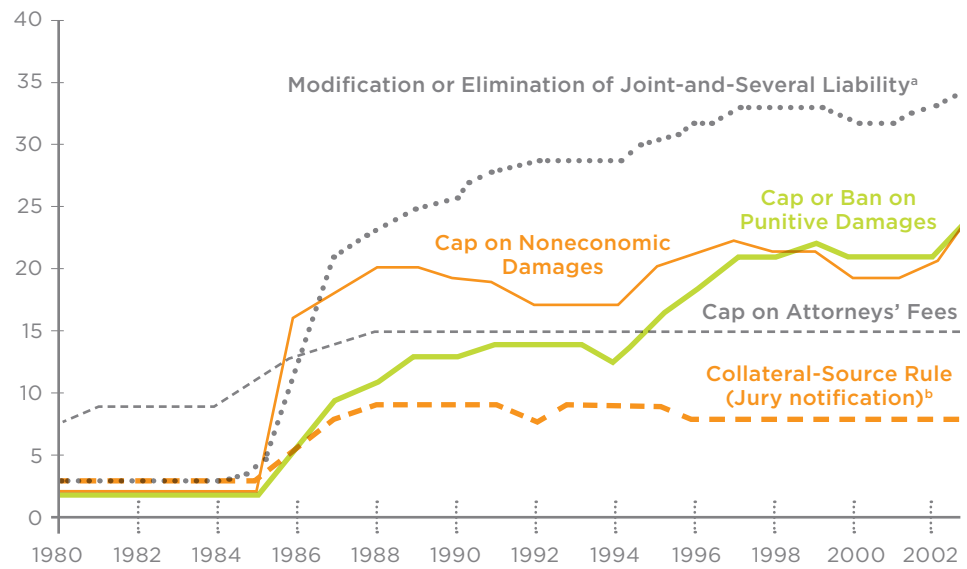
ONE OF THE MOST CONTENTIOUS ISSUES in discussions regarding limiting or controlling health care costs is the role of malpractice liability for providers. Malpractice premiums and payouts are themselves a relatively small contributor to total health care-related spending in the United States at less than 1%, but providers and others have asserted that a much higher amount of expense is attributable to the fear of being sued; a fear that causes physicians and other providers to adopt a defensive practice style that never overlooks any possible test, procedure or other service which they might be later second-guessed for not delivering or offering.<sup>1</sup>

Malpractice liability has regularly become a front-page issue when a series of premium jumps threatens to curtail the supply of doctors or access to health care. This occurred in the early 1970s, the mid-1980s, and again in the early part of this decade, each time sparking national headlines and a wave of state legislative reforms.<sup>2</sup> Though the issue has made national headlines and been raised in various forms in Congress, in practice tort reform has occurred at the state legislative level. According to a RAND overview of the issue, by 2005 all 50 U.S. states had enacted one or more statutory measures aimed at lowering the number of claims or the amount paid out in medical malpractice suits.<sup>3</sup> Common provisions include damage caps, attorney fee limits, expert witness requirements, and modification or elimination of joint and several liability.

California was an early adopter of tort reform, passing the Medical Injury Compensation Reform Act (MICRA) in 1975. MICRA's main provisions are a \$250,000 cap on non-economic damages, a sliding scale for plaintiff's attorney fees which reduces the percent going to the attorney as size of award increases, and allowing defendants to introduce collateral sources of recovery in court. Because of its early adoption and MICRA's relatively rigid provisions, California has been viewed as a proving ground for tort reform.

A 2005 report studying the effect of MICRA on access to healthcare in California concluded that the cap successfully improved access to healthcare, reduced the incentive to bring weak cases to court, lowered total loss costs, and discouraged unnecessary medical

NUMBER OF STATES WITH TORT LIMITS IN PLACE BY YEAR, 1980-2003



Source: Congressional Budget Office

procedures.<sup>4</sup> A RAND analysis of medical liability cases since MICRA agreed that the reform has been successful in reducing costs for defendants (by 30%), but also noted that plaintiffs' recoveries have decreased by 15% due to the cap on non-economic damages.<sup>5</sup>

Texas is another state often held up as a success story for liability reform. In 2003 Texas voters passed a constitutional amendment based on MICRA. Five years later, Texas has seen a 25% overall drop in liability insurance rates since the amendment's passage. The largest liability insurance carrier in the state experienced a 50% reduction in lawsuit filings from 2003-2008, medical license applications have increased, and the supply of specialists has risen.<sup>6</sup>

Many studies have attempted to quantify the impact, if any, of state medical malpractice tort reform on both malpractice liability costs and health care spending. A literature review and evaluation finds papers with varying conclusions. Born,

Viscusi and Baker (2006)<sup>7</sup> studied the aggregate medical liability losses suffered by insurers as reflected in compulsory year-end statements and concluded that states with caps saw decreased ultimate (vs. incurred) malpractice losses. Kilgore, Morissey and Nelson (2006)<sup>8</sup> concluded that internal medicine premiums are 17.3% less in states with caps on non-economic damages. In certain specialties the impact is even greater: general surgery 20.7% less, gynecology 25.5% less. The authors found that a \$100,000 increase in a state's damages cap was associated with a 3.9% rise in malpractice premiums, suggesting that enacting \$250,000 caps in states currently without any, or with a higher cap, could save \$1.4billion, or 8%, compared to current premiums. Waters et. al ranked each state's tort law provisions based on stringency and concluded that caps on non-economic damages were associated with lower and fewer payments, but that overall, changes to tort law had only a "limited," though measurable, impact.<sup>9</sup>

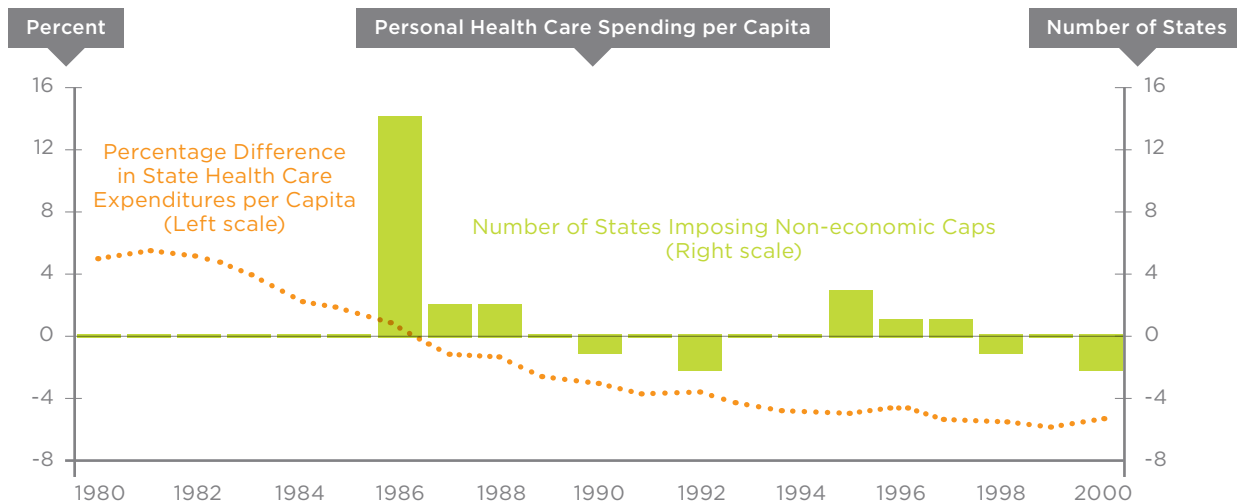
Similarly, studies attempting to examine the impact of providers practicing “defensive medicine” have reported differing results. Kessler and McClellan’s seminal 1996 paper<sup>10</sup> using Medicare fee-for-service spending in the mid-late 1980s

found that expenditures were lower in states with tort reforms. No significant differences in health outcomes were observed, so the difference in spending was attributed to defensive medicine. More recently, a Congressional Budget Office study from 2006 found that while Part A spending (hospital) was 5% lower in cap states, there was no relationship between part B (physician) spending and caps. This seems unusual, as one might expect more of an impact on physician costs than hospital costs. While the overall Medicare spending impact was 4% lower per beneficiary in reform states, the relationship was only marginally significant and small in magnitude for the general

“The CBO estimated that the enactment of comprehensive nationwide tort reform would result in a lowering of premiums that would reduce spending by only 0.5%, or approximately \$13 billion in 2009.”

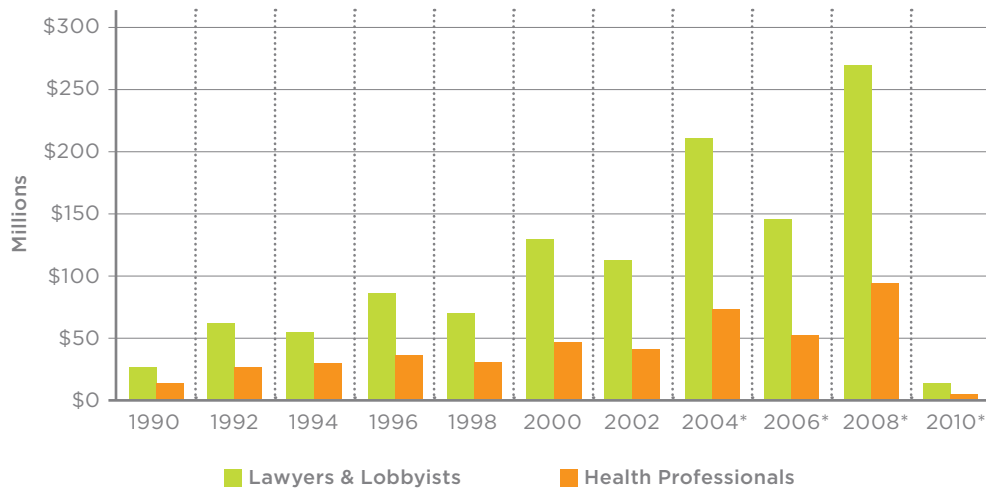
population. On the other hand, Baicker, Fisher and Chandra (2007)<sup>11</sup> observed that a 10% increase in average physician indemnity payments was linked to a 1% increase in spending on Part B services in their study of malpractice costs and health care expenditures for Medicare fee-for-service beneficiaries. A 10% increase in indemnity payments was also linked to a 1.5-1.8% rise in utilization of some procedures (diagnostic, imaging), suggesting that the 60% rise in liability premiums between 2000 and 2003 is responsible for increased Part B Medicare spending of \$7.1 billion. Similarly, Roberts and Hoch (2007)<sup>12</sup> studied patterns of litigation and Medicare spending

PERCENTAGE SPENDING DIFFERENCE IN HEALTHCARE BETWEEN STATES WITH CAPS ON NON-ECONOMIC DAMAGES AND STATES WITH NO CAPS, 1980-2000



Source: Congressional Budget Office

### CAMPAIGN CONTRIBUTIONS BY LAWYERS, LOBBYISTS AND HEALTH PROFESSIONALS, 1990-2010 ELECTIONS



Data from The Center for Responsive Politics (opensecrets.org)

put it, “medical liability accounted for nearly 6% of tort costs in 1975 and more than twice that percentage in 2006. Lawyers have a lot to lose.”<sup>14</sup> Providers also perceive that they have a lot to lose in the malpractice struggle and have devoted substantial sums and time to reform.

Perhaps the most important aspect of malpractice liability and defensive medicine in regard to current

in Mississippi and determined that 0.9-1.6% of spending was due to the litigation climate; in the worst (most litigious) county 15.9% of spending was attributed to lawsuits (or fear of them).

In a recent report the CBO echoed its earlier statement that it has not found sufficient evidence that defensive medicine has a substantial cost. It estimated that the enactment of comprehensive nationwide tort reforms including a \$250,000 non-economic damages cap, a \$500,000 punitive damages cap, a 1 year statute of limitations, and the replacement of joint and several liability with the “fair share” rule would result in a lowering of premiums that would reduce total health care spending by only 0.5%, or approximately \$13 billion in 2009.<sup>13</sup>

This issue has a significant political component. Providers and trial lawyers are major campaign contributors at the state and federal level. These heavy-weight groups tend to stymie each other, although as discussed above, providers have had some success with malpractice reform at the state level. As one source

reform efforts which include attempts to rein in cost growth is that an ongoing threat of significant tort liability provides cover for providers who may be inclined to maximize their revenue whenever possible. They can justify excessive use of various services in marginal situations by claiming to be concerned about liability exposure. Removing that actual fear or pretext may be helpful in getting providers to practice more appropriate medicine. ■

## End Notes

<sup>1</sup> RAND, “Overview of Medical Malpractice Policy Options.” [http://www.randcompare.org/analysis/mechanism/medical\\_malpractice](http://www.randcompare.org/analysis/mechanism/medical_malpractice)

<sup>2</sup> American Medical Association, “Medical Liability Reform Now!” Feb. 5, 2008. <http://www.ama-assn.org/ama1/pub/upload/mm/1/mlrnow.pdf>

<sup>3</sup> RAND, “Overview of Medical Malpractice Policy Options”

<sup>4</sup> Hamm, William G., C. Paul Wazzan, H.E. Frech III. MICRA and Access to Healthcare. February 2005. <http://cap-action.com/pdfs/HAMM%20LECG%20Report%2011-08.pdf>

<sup>5</sup> Pace, Nicholas Daniela Golinelli, Laura Zakaras. “Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA.” RAND, 2004.

<sup>6</sup> “Five years of tort reform: Lone Star success story.” AMA Editorial, Sept. 15, 2008. <http://www.ama-assn.org/amednews/2008/09/15/edsa0915.htm>

<sup>7</sup> Born, Patricia, W. Kip Viscusi, and Tom Baker. “the Effects of Tort Reform on Malpractice Insurers’ Ultimate Losses.” NBER Working Paper 12096 (Cambridge, MA: National Bureau of Economic Research, March 2006) <http://www.nber.org/papers/w12086>

<sup>8</sup> Kilgore, Meredith L, Michael E. Morrisey and Leonard J. Nelson. “Tort Law and Medical Malpractice Insurance Premiums.” *Inquiry* 43 (Fall 2006):255-270

<sup>9</sup> Waters, Teresa, Peter Budetti, Gary Clazton and J. Lundy “Impact of State Tort Reforms on Physician Malpractice Payments.” *Health Affairs* 26:2 (2007):500-509.

<sup>10</sup> Kessler, Daniel and Mark McClellan, Do Doctors Practice Defensive Medicine?, 445 *Q. J. of Econ.* 353-390 (1996)

<sup>11</sup> Baicker, Katherine, Elliott S. Fisher and Amitabh Chandra, “Malpractice Liability Costs and the Practice of Medicine in the Medicare Program.” *Health Affairs* 26:3 (2007): 841-852.

<sup>12</sup> Roberts, Brandon and Irving Hock. “Malpractice Litigation and Medical Costs in Mississippi.” *Health Economics* 16 (August 2007): 841-859

<sup>13</sup> Congressional Budget Office. “Budget Options Vol. 1: Health Care.” December 2008. <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>

<sup>14</sup> Tillinghast-Towers Perrin, 2006 Update on US Tort Cost Trends. [http://www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2006/200611/Tort\\_2006\\_FINAL.pdf](http://www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2006/200611/Tort_2006_FINAL.pdf)



---

*ABOUT VITA ADVISORS, LLC: VITA Advisors is a research-based merger & acquisition and strategic advisory firm serving the health care industry. The VITA founders have significant industry experience and relationships and have earned reputations for success with integrity.*

---



VITA ADVISORS, LLC | 10400 Viking Drive | Suite 150 | Minneapolis, MN 55344

[contact@vitaadvisors.com](mailto:contact@vitaadvisors.com) | 952 942 3377 | [vitaadvisors.com](http://vitaadvisors.com)