



# Medical malpractice: Impact of the crisis and effect of state tort reforms

Claudia H. Williams and Michelle M. Mello, J.D., Ph.D., M.Phil., based on a Research Synthesis by Mello.

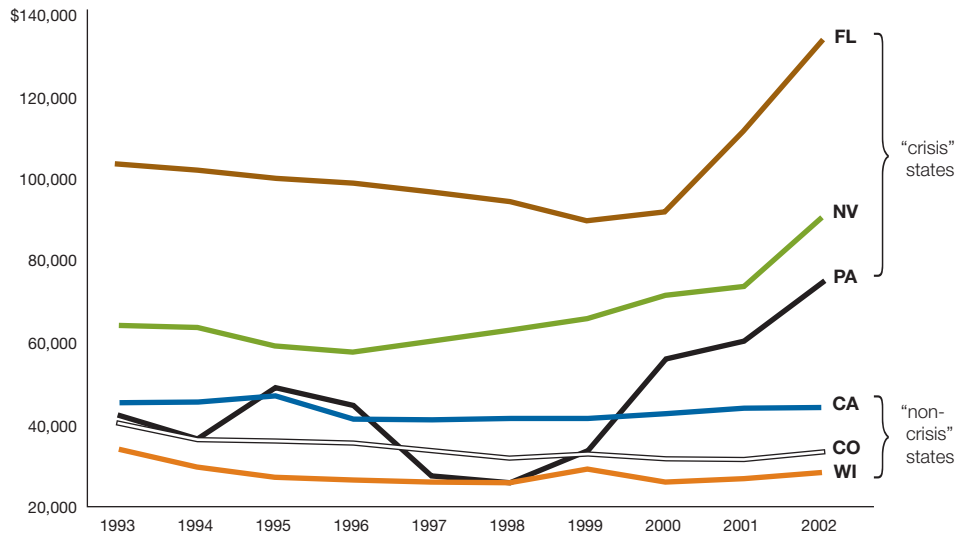
## SUMMARY OF KEY FINDINGS

- > **Over the last 30 years there have been three periods of rapidly rising malpractice premiums.**
- > **In response, states have adopted a range of tort reforms.** Among the most common are caps on noneconomic damages, which limit awards in more than half the states.
- > **Caps on noneconomic damages reduce average award size by 20 to 30 percent.** They also constrain premium growth and increase physician supply, but the effects are modest in size. Additionally, caps disproportionately burden the most severely injured patients.
- > **Other reforms have had little impact.** Joint-and-several liability reform does constrain the growth of insurance premiums, and some studies suggest that shorter statutes of limitations/ repose have an effect on claims frequency and premiums.

## What is a medical malpractice crisis, and are we in one?

- **A medical malpractice crisis is a period of volatility in the malpractice insurance market** characterized by above-average increases in premiums, contractions in the supply of insurance and deterioration in the financial health of insurance carriers. In a crisis, medical specialties at high risk for claims, such as obstetrics and orthopedic surgery, experience the largest premium increases.
- **Many states are now in their fifth straight year of malpractice crisis.** Today as in prior years, the situation varies by state (Figure 1).

Figure 1. Average liability premiums for OBGYNs in select "crisis" and "non-crisis" states, 1993 to 2002



Source: Weighted average premiums based on author calculations from data reported in the Medical Liability Monitor Annual Rate Survey. All amounts in 2003 dollars.

- **Recent signs suggest that premium growth has leveled off, but premium volatility is a recurring problem.** Over the last 30 years there have been three periods of rapidly rising premiums, each sparking policy-maker concerns about affordability and accessibility of coverage and the effectiveness of policy solutions.
- **Stakeholder groups disagree on whether the crisis affects access to care,** but there is agreement that insurance has become less affordable and available.

State policy-makers have implemented a range of reforms in response to these crises, but their effectiveness is not well understood. This policy brief summarizes the results of research on the impact of these reforms on premium growth, claims frequency, award size and physician supply.

# States have implemented a range of tort reforms, building on experience from the 1980s.

## TORT REFORMS COMMONLY ADOPTED BY STATES

**Caps on damages** limit the amount of money that the plaintiff can take as an award in a malpractice suit.

**Joint-and-several liability reforms** limit each defendant's liability for a judgment to that defendant's percentage fault.

**Statutes of limitation/statutes of repose** limit the amount of time a patient has to file a claim.

**Attorney contingency-fee reforms** limit the amount of a malpractice award an attorney may take as a fee.

**Collateral-source rule reforms** allow the defendant to deduct payments to the plaintiff from other sources (such as health insurance) from the amount due to a plaintiff.

**Periodic payment reforms** allow or require insurers to pay out the award over time, rather than in a lump sum payment.

**Pretrial screening panels** review cases at an early stage and give an opinion about whether they have enough merit to go to trial. A negative decision doesn't generally end the case, but defendants can introduce the panel's opinion as evidence at trial.

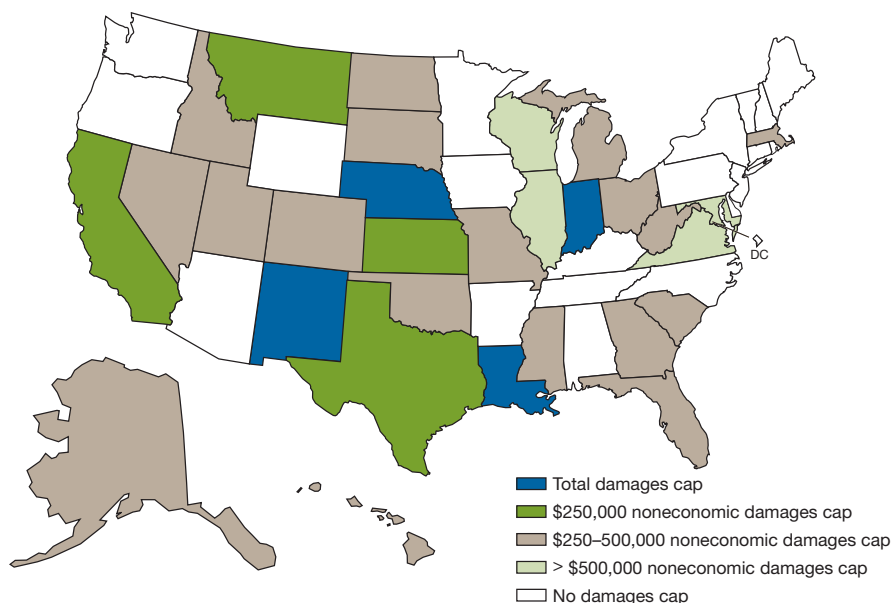
## What are the effects of a malpractice crisis on physician services?

- **No hard evidence indicates that access to high-risk services has declined significantly due to the malpractice crisis.** While several surveys have reported that physicians are less willing and available to perform these services, no study has linked the liability climate to differences in rates of high-risk procedures across geographic areas.
- **Although defensive medicine is difficult to quantify, good evidence indicates that physicians often engage in defensive behaviors, especially in environments of high liability risk.** Within crisis states, physicians who are not confident of their malpractice coverage or who face high premiums are more likely to report frequently ordering unneeded diagnostic procedures, referrals or prescriptions (Reference 1).

## How have states responded to malpractice crises?

- **In response to recent crises, states have implemented a range of reforms.** Many states adopted tort reforms in response to the 1980s malpractice crisis; recently, other states have adopted similar reforms. The goal of these reforms is to reduce costs of malpractice litigation and thus lower premiums. Caps limiting noneconomic damages are among the most common reform, enacted by 26 states (Figure 2). Some states have also imposed tighter regulation of insurance premium rate changes.

Figure 2. Caps on damages by state, April 2006



Source: Mello MM. "Medical malpractice: Impact of the crisis and effect of state tort reforms." Research Synthesis Report, 2006. Maine and Oregon have caps that only apply in cases of wrongful death; Alaska, Florida, Massachusetts and Ohio have caps that increase or can be waived in severe cases.

# Caps on damages reduce average awards and have modest effects on premium growth and physician supply. Other reforms have little impact.

## What is the impact of caps on noneconomic damages?

- Researchers have examined the impact of caps on damages and other reforms on four outcomes of interest: premium levels, claims frequency, average award size and physician supply.
- **Much of the available evidence is not based on rigorous analysis.** Many reports rely on simple descriptive analyses, inappropriate data on insurance premiums and inappropriate comparison groups. Findings from simple state-to-state comparisons are not reliable because they do not control for many important ways in which states differ.
- **Strong evidence shows that caps on noneconomic damages reduce the average size of awards by 20 to 30 percent** (References 2, 3). Caps do not appear to affect claims frequency, though only one study has examined this issue (Reference 4). Most of the evidence on these points comes from relatively old studies using data from the 1980s.
- **Caps on noneconomic damages have a modest impact on premium growth.** While studies indicate that caps did not significantly affect premiums in the 1970s and 1980s, good evidence shows that caps have reduced the growth of premiums in more recent years by six to 13 percent (References 5, 6). The total impact is not immediate but takes place over several years, and while the rate of growth is lower after cap adoption, premiums do still rise in absolute terms.
- **Although evidence is emerging and mixed, the best study shows that caps are associated with a small rise in physician supply** (Reference 7). Five controlled studies have shown mixed results, but the strongest shows that state reforms that directly limit malpractice awards—including caps on damages—are associated with a modest increase in physician supply (three percent over three years).

## What is the impact of other state tort reforms?

- **Aside from caps on damages, state tort reforms have had little impact.** Nevertheless, state policy-makers, anxious for solutions, continue to turn to these reforms. Joint-and-several liability reforms constrain the growth of premiums, but have no significant effect on claims payouts or physician supply. Some strong studies have found that shorter statutes of limitations or repose have an effect on claims frequency and premiums, but not on claims payouts (effects on physician supply have not been tested). The remainder of the reforms have no significant effects (Reference 4).

## MALPRACTICE RISK AND PHYSICIAN SUPPLY

The recent rise in malpractice premiums has prompted concerns about patient access to care. These concerns are fueled by anecdotal reports about physicians retiring early, relocating, or restricting their scope of practice to reduce their malpractice risk.

Overall, there is not much direct evidence that access to care has been significantly affected. Two groups of studies have examined access by looking at a proxy measure, the number of practicing physicians.

The first group of studies examined the impact of caps on damages—which lower malpractice risk—on supply. One strong study showed that caps do increase physician supply, presumably by reducing claim size and premiums.

The second group of studies directly examined the relationship between measures of malpractice cost—premiums and claims—and physician supply. The strongest of these studies showed no relationship between malpractice cost and physician supply.

Studies show that overall physician supply in most states has not decreased in recent years. Even if decreases in supply were identified, this would not necessarily imply an access-to-care problem. Whether a drop in supply results in access problems depends on how many physicians there were initially, as well as how demand for physician services changed over the same period.

# Policy Implications

- > **Policy-makers are likely to face malpractice crises again.** The factors contributing to the recent three crises (in the mid-1970s, the mid-1980s, and the last five years) remain. So although the current crisis appears to be abating, insurance premium volatility is likely to recur.
- > **Of reforms adopted by states, caps on damages have the greatest impact on important outcomes, but also pose problems.** Caps modestly constrain premiums, reduce average awards and exert a positive influence on physician supply. But they also disproportionately affect compensation for the most severely injured patients, which raises equity issues.
- > **Malpractice crises highlight deeper problems in our current liability system and the need for better solutions.** The liability system does not compensate patients in an equitable way nor does it effectively deter medical errors or encourage participation in patient safety initiatives such as adverse event reporting. It is also inefficient: only about 40 percent of the dollars spent on malpractice insurance go to injured patients. Several efforts are underway to develop alternative approaches that would offer prompter, more efficient and/or more equitable payment to injured patients, and encourage patient safety efforts. These include:
  - Schedules of damages.* A schedule of noneconomic damages—essentially a series of dollar ranges that vary with injury severity—might deliver the benefits of flat caps on noneconomic damages, without the same equity concerns.
  - Disclosure and “early offer” programs.* Prompt and candid disclosure of errors with offers of reasonable compensation would address two reasons patients file suits: the need for compensation and anger because of the lack of candor about errors.
  - Administrative compensation systems, or health courts.* An administrative tribunal would use independent medical experts and established guidelines on preventable injuries to make faster, more consistent compensation decisions.

**THE SYNTHESIS PROJECT** (Synthesis) is an initiative of the Robert Wood Johnson Foundation to produce relevant, concise, and thought-provoking briefs and reports on today’s important health policy issues.

## PROJECT CONTACTS

David C. Colby, Ph.D., the Robert Wood Johnson Foundation, Claudia H. Williams, AZA Consulting

## SYNTHESIS ADVISORY GROUP

Linda T. Bilheimer, Ph.D., U.S. Department of Health and Human Services

Jon B. Christianson, Ph.D., University of Minnesota

Jack C. Ebeler, The Alliance of Community Health Plans

Paul B. Ginsburg, Ph.D., Center for Studying Health System Change

Jack Hoadley, Ph.D., Georgetown University Health Policy Institute

Haiden A. Huskamp, Ph.D., Harvard Medical School

Julia A. James, Independent Consultant

Judith D. Moore, National Health Policy Forum

William J. Scanlon, Ph.D., Health Policy R&D

Michael S. Sparer, Ph.D., Columbia University

The Synthesis Project  
The Robert Wood Johnson Foundation  
Route 1 & College Road East  
P.O. Box 2316  
Princeton, NJ 08543-2316  
E-mail: [synthesisproject@rwjf.org](mailto:synthesisproject@rwjf.org)  
Phone: 888-719-1909  
[www.policysynthesis.org](http://www.policysynthesis.org)

## REFERENCES

Figure 1: Medical Liability Monitor Annual Rate Survey and Author’s calculations.

Figure 2: Author’s research.

Reference 1: Studdert D et al. “Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment.” *JAMA*, vol. 293, no. 21, 2005.

Reference 2: Danzon PM. “The Frequency and Severity of Medical Malpractice Claims: New Evidence.” *Law and Contemporary Problems*, vol. 49, no. 2, 1986.

Reference 3: Sloan FA, Mergenhagen PM, Bovbjerg RR. “Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis.” *Journal of Health Politics, Policy and Law*, vol. 14, no. 4, Winter 1989.

Reference 4: Zuckerman S, Bovbjerg RR, Sloan F. “Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums.” *Inquiry*, vol. 27, no. 2, Summer 1990.

Reference 5: Thorpe KE. “The Medical Malpractice ‘Crisis’: Recent Trends and the Impact of State Tort Reforms.” *Health Affairs, Supplement Web Exclusives*, Jan-Jun 2004.

Reference 6: Danzon PM et al. “The ‘Crisis’ In Medical Malpractice Insurance,” in *Brookings-Wharton Papers on Financial Services*, R. Harris and R. Litan, Editors. 2004, Brookings Institution Press: Washington, DC.

Reference 7: Kessler DP et al. “Impact of Malpractice Reforms on the Supply of Physician Services.” *JAMA*, vol. 293, no. 21, Jun 1, 2005.