Special Report

Physician medical malpractice

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Malpractice insurance premiums for physicians have increased at an average rate of over 30 percent per year. This rate is significantly higher than health care cost inflation and the increase in physician costs. Trends indicate that malpractice related costs, both liability insurance and defensive medicine costs, will continue to increase for the near future. Pressures to limit physician costs under Medicare raise a concern about how malpractice costs can be controlled. This paper presents an overview of the problem, reviews options that are available to policymakers, and discusses State and legislative efforts to address the issue.

Introduction

Medical malpractice costs are an important and increasing component of physicians' costs. More than two-thirds of malpractice awards are physician related. Trends indicate that malpractice costs will continue to increase for the near future. The American Medical Association (AMA) (1984-85) describes the problem as reaching "crisis" proportions. Pressures to limit physician costs under Medicare present a concern on how malpractice-related costs will be absorbed.

Physician malpractice costs include two parts—the cost of liability insurance premiums and defensive medicine costs. Malpractice insurance premiums are recognized as a part of physician overhead expenses, and the costs of increased premiums are passed on to patients and their insurers as part of the physician's fee. A recent study showed that for every 100-percent increase in premiums, physician fees are estimated to increase 9.1 percent. The fear of malpractice lawsuits also provides an incentive for physicians to order medically unnecessary services, such as an increased number of tests or confirming opinions. Such defensive medicine costs are difficult to measure, but the AMA (1984-85) estimates that $15 billion per year is added to the cost of health care. Defensive medicine costs are also passed on to patients and insurers.

Coverage of malpractice costs under Medicare Part B

In 1984, Medicare Part B paid $14.9 billion for physicians' services. The cost of physicians' services has increased at a rate of over 20 percent between 1979 and 1983. This rate is significantly higher than overall health care inflation and makes physician costs one of the faster growing components of the Medicare program.

Medicare pays for physicians' services on the basis of reasonable charges. A reasonable charge is a fee for each service that covers both the physician's medical costs and overhead expenses. Malpractice costs are one of the overhead expenses that a physician considers in determining his charges. Under Medicare, these charges may not exceed the lowest of: the physician's actual charge for the service, the physician's customary charge for that service, or the prevailing charges of physicians for similar services in the locality. Increases in prevailing charges are limited to an index, the Medicare Economic Index (MEI), which is based on changes in physician office practice and inflation in the general economy. The MEI has two components: changes in physicians' earnings and expenses. Medical malpractice premium costs are one of the physician expense items of the MEI. In 1983, malpractice insurance represented 10 percent of the expense item or 4 percent of the total MEI.

Because of the increase in costs during the early 1970's, physician malpractice premiums were identified as a separate expense item in the MEI calculation. (Prior to 1975, malpractice costs were included in a general overhead item.) The weight of the malpractice adjustment was initially determined through a survey of major malpractice insurers. This malpractice survey is conducted each year to account for changes in the costs of malpractice premiums.

The incorporation of annual changes in malpractice costs for the average physician in the MEI is the only way Medicare addresses physicians' malpractice costs.

During fiscal year 1985, Medicare imposed a freeze on physician payments. Because a revised MEI was not used, increased malpractice costs were not recognized. However, the estimated increase in the MEI that would have occurred without the freeze would have been small—a .14 percent maximum increase in prevailing charges for the malpractice component. Even on a $1,000 procedure, the prevailing charge would have been only $1.37 higher. This freeze is proposed for extension in fiscal year 1986.

Under the secondary payer authority, Medicare can recover costs of health services that are awarded as part of a malpractice insurance settlement. Medicare carriers are responsible for making these recoveries. Specific data on the amount of recoveries to Medicare are not available because carriers are not required to report this item separately. Such recoveries, according to general practice in the insurance industry, are limited to the costs of services delivered prior to the settlement. Costs of future health care are not included because of administrative difficulties in estimating the value and insurer reluctance to collect from injured parties.

Because Medicare deals with an aggregate payment for a service, physician malpractice insurance is effectively paid at the market rate. No effort to date has been made to determine if the market rate is the most efficient and cost effective method to cover malpractice liability under Part B. Studies of hospital malpractice claims and settlements by Westat (1978) and Rand (1982) suggest that Medicare beneficiaries are less likely to initiate a malpractice suit than patients under 65 years of age, and that settlements to Medicare beneficiaries are lower on average because of their shorter life expectancy and limited loss of earnings. Because physician malpractice claims experience may not be comparable to hospital claims experience, the Health Care Financing Administration (HCFA) is conducting a feasibility study to review Part B malpractice claims. The study will assess Medicare experience with malpractice claims against physicians, and will also consider whether Medicare is recouping from malpractice settlements the funds expended for health services for beneficiaries. If data are available, the study will be conducted in five States during the latter half of 1985.

Medical malpractice issue of the 1980's

During the mid-1970's, a medical malpractice crisis was identified based on large increases in malpractice insurance premiums and the difficulty of many physicians and hospitals in finding insurance coverage. In certain areas, physicians actually went on strike. The crisis was precipitated by the exodus of many insurance firms from the business as large underwriting and investment losses made medical malpractice insurance unprofitable. These losses were attributable to a number of factors:

- Actuarial estimates for malpractice insurance premiums are difficult to make because of the "long tail" of claims, i.e., many claims are not filed until several years after the service is delivered.
- Malpractice claims are settled in the legal tort system. During the last decade, the scope of medical liability and negligence was broadened resulting in an increase in frequency and severity of claims.
- New medical technology produced higher risk procedures, higher expectations, and undefined standards of quality.
- Public attitudes changed and there is a greater willingness to sue.

A number of changes were instituted to address the crisis of the 1970's. These included:

- State tort reforms were enacted to streamline the judicial process and decrease the amount of awards.
- Physicians formed their own insurance companies—these now constitute 50 percent of the insurance market.
- State governments established compensation funds to underwrite large awards.
- Insurance policies were redefined to limit claims to the period of coverage.
- Risk management programs to educate physicians on the ways to reduce malpractice situations were instituted to help prevent negligent occurrences.

Although these changes assured the availability of malpractice insurance, according to a study by the Rand Corporation (1982) they had a limited impact in reducing the growth in the number of claims between 1975-78. Overall, the reforms of the 1970's are widely regarded as unsuccessful in addressing the underlying factors that caused the increase in the number and severity of malpractice claims.

During the 1980's, a number of indicators or trends have emerged that suggest that another malpractice crisis may occur in the future.

- Insurance premiums for all physicians have continued to increase at an average rate of 30 percent per year, which is significantly higher than health care cost inflation and the increase in physician costs for the same period. During the last 9 years, physician liability insurance increased 221 percent compared to an increase in the Consumer Price Index for all goods and services of 107 percent.
- In 1984, malpractice insurance premiums increased dramatically in a number of States and for certain specialties. For example, the New York Insurance Commission approved a rate increase of 52 percent for the State's major malpractice insurers in 1984. In New York, policies for high-risk specialties such as a neurosurgeon increased to over $100,000 per year, thus threatening the ability of these physicians to continue to practice and posing potential problems for access to certain services.
- The frequency and severity of claims has also increased. The mean malpractice settlement was less than $400,000 in 1979 and by 1982 it had increased to almost $1 million. In 1979, there were 134 verdicts in the plaintiff's favor, 14 of which carried settlements of over $1 million. By 1982, there were 234 verdicts favorable to plaintiffs with 45 settlements in excess of $1 million.
- The number of physicians involved in malpractice suits has also increased. The AMA (1984-85) reports an increase of 3.3 percent of physicians to 8 percent involved in malpractice actions between 1979 and 1983.
- Several insurance companies in Florida and New York have recently notified physicians that they will no longer provide malpractice insurance.

However, analysis of these trends needs to consider other evidence in determining whether there is a new crisis in malpractice.

- Wide variation in malpractice premiums is built into the current insurance rating structure. This system includes specialty, locality, and limits of coverage. Physicians in high-risk specialties, and in States which have high health costs and malpractice actions, will always have rates

significantly higher than physicians in lower risk specialties and States. For example, a study by Rand (1981) revealed that in 1975 some physicians paid up to $50,000 and others paid as little as $75 for coverage.

- Insurance companies claim they need a 20 percent spread between income and claims paid to remain profitable. During the last several years, the insurance companies have not realized this margin. Recent premium increases are higher to compensate for these past shortcomings.
- Insurance costs have remained relatively constant as a portion of physician's gross income during the last decade and have decreased as a portion of total health costs. Physician malpractice insurance premiums represent $2 billion per year. This is less than 1 percent of total health care costs. Malpractice insurance represents only about 3 percent of average physician gross income (5 percent for high-risk specialties such as obstetrics, neurological, or thoracic surgery), and 1–3 percent of overhead costs. Physicians with high premium costs (e.g., obstetricians) have higher gross incomes. A recent survey conducted by *Medical Economics* (1983) revealed that a typical physician paid premiums of $4,170 in 1983 or an increase of 14 percent from the 1981 median of $3,650. In 1984 the average physician paid $6,200 for malpractice premiums. This increase was in line with the national inflation rate. The cost of the average insurance premium for New York physicians is $12,000.
- The cost of malpractice premiums varies dramatically among States and among companies. Differences can be attributed to factors such as insurance management; frequency and outcome of litigation; and judicial climate.
- Availability of malpractice insurance is not a problem generally, although these are problems in certain States and specialties. The commercial insurers who are in the business intend to stay. Physician-sponsored companies are seeking ways to improve their viability and competitiveness.
- Increasing health care costs have contributed to larger settlements.
- A Rand study (1982) indicated that the 40 percent increase in the number of physicians between 1960 and 1978 may account for part of an increase (24 percent) in the frequency of malpractice claims for the same period.
- Part of the recent rate increase is because physicians broadened their coverage to include more comprehensive policies.

At the 1985 National Medical Malpractice Conference convened by the Urban Institute, evidence of a malpractice crisis was provided by members of the insurance industry, legal profession, physician and hospital industry, and the academic community. The preliminary conclusion was that there is no immediate crisis, but there are some short-term problems that need addressing, and some longer-term reforms that should be considered. The conclusions were:

- There is not a general problem of availability of malpractice insurance coverage.
- There is an affordability problem for 1–5 percent of the physicians; however, it is not a problem for most physicians.
- Accessibility to services is not yet a problem, but this needs to be monitored.
- Recent increases need to be reviewed for fairness.
- Defensive medicine costs are prevalent but it is not clear that malpractice is the only cause. For example, fee-for-service payment systems encourage unnecessary utilization.

The conference highlighted the need for further study to define the problem and determine the objectives of reform, and the need for an incremental approach to reform.

State experience

Since 1975, over 300 tort reforms have been enacted by the States. Every State except West Virginia has enacted some reform proposals. In 1984, 33 malpractice reform laws were enacted in 17 States. In addition, 92 bills to reform malpractice were introduced but not enacted. The National Conference of State Legislatures has identified 40 bills that States plan to introduce during the 1985 legislative sessions. Virginia, Florida, Illinois, and Rhode Island have created special commissions to recommend legislation. In addition to tort reforms, there has been some limited State experience with alternatives to the tort system to handle professional liability claims.

Most States focused their reforms on changes in the tort system (see technical note). Early tort reforms were designed to make it more difficult for plaintiffs to bring groundless suits and to limit the costs of successful lawsuits. Recent State legislation is designed to extend or strengthen these tort reforms, as well as to implement new reforms such as improved reporting of malpractice claims and settlements; establishment of compensation guidelines for malpractice awards, (e.g., New York); establishment of a malpractice system that does not determine fault, for example, the workmen's compensation model proposed in Florida.

A number of studies have reviewed the experience of the early tort reforms. The AMA Task Force on Professional Liability (1984-85) concludes that tort reforms have not been successful in reducing litigation. They also conclude that professional liability claims are actually more frequent and jury verdicts against physicians are higher. Many of the most effective tort reforms have been successfully challenged in the courts, in particular pretrial

screening panels and limits on liability. Already there have been 12 States that have repealed previously enacted tort reforms or let the authorities expire.

The following tort reforms have been assessed as being most effective in reducing the number of claims and/or malpractice awards:

Pretrial screening panels—Nonjudicial panels are used to screen nonmeritorious claims from the lengthy judicial process. Mandatory panels are considered effective in terms of speedy disposition of claims, however, mandatory systems are more vulnerable to being struck down by State supreme courts. A study by George Washington University (1980) found voluntary panels to be underutilized or inactive. In many cases, these panels add a further layer to the claim resolution process and have been abandoned by some States, e.g., Virginia. A study by Rand (1982) found that screening panels have no significant effect in reducing the number of claims.

Repeal of the collateral source rule—This rule prevents a jury from learning that the plaintiff has been compensated from another source. Reforms include either jury discretion to consider other sources of compensation or mandatory offset. A Rand study (1982) found the mandatory offset to be one of two tort reforms with the greatest impact on the size of the awards, resulting in a drop of up to 50 percent in awards. The insurance industry suggests that this reform would reduce premium rates by 11 percent.

Attorney fee regulation—Reforms include either court review of the reasonableness of attorneys' fees or fixed limits on the percent of award paid. The evidence of the effectiveness of this reform is mixed, but may result in more equitable allocation of awards among plaintiffs and attorneys.

Statute of limitation changes—Reforms set a specific time period in which claims have to be brought, e.g., 2 years from the injury or point at which the injury should have been discovered. This change may limit the open-endedness of professional liability suits, but evidence is not available.

Limitations on liability—Reforms either limit certain kinds of damages, e.g., pain and suffering, or limit a physician's liability. The Rand study (1982) found liability caps are one of the two tort reforms with the greatest impact on the size of awards, with States realizing an average drop of 1 percent in amount of awards.

Periodic payment of damages—The AMA (1984-85) reports that schedules of payment may reduce malpractice costs because insurance companies can purchase annuities at a lower-cost than lump sum payment methods. Studies in New York and Pennsylvania identify potential savings of up to 14 percent.

Reforms other than tort reforms have had limited testing. There are 11 States that have arbitration statutes that permit voluntary agreements between physicians and health care providers to submit any medical liability claims to binding arbitration as an alternative to trial by jury. Arbitration methods have generally been upheld by the courts (except in Nevada) and have resulted in speedier resolution of claims and lower transaction costs. Arbitration has resulted in more awards; however, the average amount of the award is lower. Arbitration is more favorable to the providers and appears to be an attractive alternative for group arrangements, e.g., HMO's.

Private contracts, where a prior agreement is established between the physicians and the patient on the extent of liability or method of appeal, have been tried in a small number of cases but have typically been overturned by the courts because many of the cases involve emergency situations. No-fault systems for medical malpractice have not been tested.

Alternative malpractice reforms

A number of reforms are currently being considered to address the malpractice problem. These include:

Extension and expansion of the tort reforms initiated during the 1970's—Reforms would address inequities identified in the current legal system. Proponents feel that there is a new judicial climate and that tort reforms will not be struck down in the courts. In particular, California reforms, which recently survived constitutional challenges, are potentially wide-reaching. Changes include limitation on attorneys' fees, periodic payments, and limit on payments for pain and suffering to $250,000. Preliminary evidence suggests that these reforms have had a significant impact on malpractice costs: premium increases in 1984 were less than half the national average; the number of awards dropped; and the average award of $649,000 was well below the national average of $888,000. Critics of tort reform indicate that these reforms have been tried and have not solved the problem.

No-fault insurance system—This system would eliminate the costly process of determining negligence. A no-fault system would benefit consumers because more claims would be paid. (The current judicial process deters many cases from being initiated. At the Urban Institute Conference (1985) findings of 17 percent of cases revealed negligence but less than 3 percent were litigated.) Supporters argue that a no-fault system would result in lower average settlements, and thus reallocate the existing malpractice pool. Opponents feel that the total cost of settlements would increase significantly.

Arbitration or other alternative dispute resolution systems—This approach offers an alternative to the tort system to resolve differences, e.g., binding arbitration, use of mediators. The advantages include lower costs, emphasis on problem solving, speedier resolution, and reduction of adversarial relationship.

Private arrangements—This system would involve negotiation of contracts between the physician and patient to define rights and responsibilities associated with medical accidents, e.g., to define fault, limit recoveries, give up the right to sue, or restrict appeal

to a certain process such as binding arbitration. Private contracts can be negotiated on an individual or group basis. These arrangements are generally supported as feasible in a competitive health care marketplace where consumers and providers have a choice of structure, treatment, and payment methods.

No action—Some argue that the health care industry is changing and that new payment systems, e.g., prospective payment, will provide incentives for improved medical care, reduce the number of services and the related risks. The malpractice problem will resolve itself. Others argue that new systems will result in lower quality of care and increase malpractice suits.

Education—Most malpractice cases stem from accidents or preventable occurrences. Medicare patients, in particular, are more likely to be injured as a result of institutional errors such as a fall. Thus, an injury prevention program could be effective in eliminating many of the major causes of malpractice suits. Consumer and physician education initiatives could also be undertaken to produce a more realistic expectation of the services and risks, thus reducing the adversarial environment.

Improved reporting—Reporting of malpractice claims and resolutions could be improved within the legal and health industry. Malpractice outcomes could be linked to professional licensure and discipline systems in the States.

Study and evaluation—Recent and objective data on the malpractice problem is not available. Studies could be funded to further define the dimensions of the malpractice problem and evaluate the reforms currently underway.

Insurance reform—Of the malpractice claims filed, 50 percent are against 5 percent of insured physicians. However, malpractice insurance premiums are not experience rated. For example, physicians' insurance premiums could be based on individual loss experience to deter negligence and create incentives to prevent injuries.

A number of these reforms are included in bills proposed for consideration by the 99th Congress. These include:

Inouye plan—S.175 was introduced in the Senate on January 3, 1985. This bill would encourage States to require pretrial screening panels that meet minimum Federal standards including provisions for periodic payment, limitations on attorneys' fees, and improved reporting of malpractice awards. The bill would encourage States to establish risk management programs for health care facilities. The bill authorizes $25 million to be available to States that are certified by the Attorney General as meeting the provisions of the bill.

Moore-Gephardt-Durenberger plan—"Alternative Medical Liability Act." A modified version of the 1984 bill is scheduled to be introduced in the 99th Congress. This plan proposes a modified no-fault system that would offer out-of-court settlements for economic losses (e.g., health costs, lost wages) in cases with medically adverse results. In exchange for an early settlement, the plaintiff would agree not to sue for punitive damages and pain and suffering. Claims would proceed to court in cases where settlement is not offered or when settlement is grossly inadequate. The plan includes model State legislation that would become mandatory for Federal health programs (e.g., Medicare/Medicaid) if States failed to act.

Wyden plan—A bill is planned to be introduced in the 99th Congress. This plan proposes a limited number of tort reforms and mandates further study of the malpractice problem. It includes specific provisions to structure awards in excess of $100,000 to plaintiffs; limit attorney fees; require the Department of Health and Human Services (DHHS) to develop a mechanism to collect malpractice data; and require DHHS to conduct a study of the best way to determine economic value of damages resulting from malpractice.

The AMA (1985) has recommended an action plan to address the malpractice problem. The major provisions include:

- A program to improve awareness of the malpractice problem through education and public affairs activities.
- Support of Federal legislation with incentives for States to reform their tort systems, such as limits on payments; structured settlements; restricted attorneys' fees; and mandatory pretrial screening panels.
- Provision of legal assistance to States in developing tort reforms.
- Study of alternatives to tort reform.
- Assistance to physicians in defending lawsuits.
- A program to address quality of care through risk management, peer review, improved reporting to State licensure boards, and education.

The AMA (1985) support of Federal legislation represents a shift in position from prior support of local initiatives for tort reform.

The Association of Trial Lawyers (1985) defends the existing tort system to resolve malpractice claims and states that there is no malpractice crisis. They argue that the cause of claims is negligence, and that the insurance industry does not reflect investment income in their premium calculations, thus charging more than economically necessary. They defend the contingency fee system as a protection to permit all patients access to redress, and emphasize the deterrent features of the tort system. Informally, attorneys acknowledge that some reforms of the tort system are warranted.

The Government Accounting Office (GAO) (1985) has initiated a major study of the medical malpractice problem. The study is scheduled to be completed by December 1986 and will focus on the following areas: the extent of the problem, proposed alternatives, and the need for Federal intervention; effectiveness of alternative approaches to resolve malpractice claims such as the tort system, arbitration; identification of the economic costs (cost of liability insurance coverage and defensive medicine) of medical

malpractice; case studies of six States; and characteristics of claims closed in 1984. Early GAO study (1985) efforts have indicated that data may not be available in all areas.

Conclusion

Although malpractice costs may be a problem for some physician specialties, overall the problem in the short-term is limited. For Medicare, the problem is less acute than for other health insurers because less than 6 percent of Medicare costs for physicians' services is spent for services from high-risk physicians such as obstetricians, neurological surgeons, and thoracic surgeons. High defensive medicine costs and the trend toward increasing malpractice premiums suggests that longer term restructuring may be a concern, particularly at the State level.

Technical note

The following reforms were most widely adopted by the States during the 1970's:

- Shortening of the statute of limitations for filing medical liability claims—41 States.
- Elimination of "ad damnum" clauses in complaints, i.e., statements which specify, sometimes in inflated terms, the amount sought in damages—32 States.
- Pretrial screening panels (the use of non-judicial panels to screen non-meritorious claims from the lengthy court process)—30 States.
- Limitations on attorney fees—24 States.
- Clarification of standards of care—20 States.
- Elimination of the collateral source rule (prevents a jury from learning that a plaintiff has been compensated from another source, e.g., health insurance)—19 States.
- Limitations on physician liability or amount of damages—17 States.
- Establishment of patient compensation funds that require physician participation and provide insurance coverage for awards over a certain limit, e.g., $200,000—17 States.
- Periodic payment of awards in installments rather than in lump sums—17 States.

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