INTRODUCTION

Medical malpractice costs are increasingly being targeted in the political debate on health care reform. The direct costs of medical malpractice, measured by insurance premiums paid by physicians, hospitals, HMOs, and other providers, account for less than 1 percent of the health care budget. However, many physicians and policy makers believe that a potentially large hidden cost of the malpractice liability system is the practice of "defensive medicine." Definitions of defensive medicine differ, but most include the practice of ordering extra tests and procedures primarily in response to a perceived threat of a future medical malpractice claim.

OTA is currently studying defensive medicine, its costs, and the potential impact of medical malpractice reform on defensive medicine. The final report of this study will be published in early 1994. This background paper reviews the medical malpractice reforms that have been implemented in the States and the limited evaluations of their success in reducing three indicators of direct malpractice costs (hereinafter referred to as "malpractice cost indicators"):

- Claim frequency (the number of claims per 100 physicians);
- Payment per paid claim (the average dollar amount awarded to plaintiffs for claims that result in payment); and
- Malpractice insurance premiums.

The paper also provides a summary of the leading new reform proposals, highlighting some of their possible strengths and weaknesses.

Trends in Malpractice Cost Indicators

Malpractice insurance premiums, claim frequency, and average payment per paid claim increased rapidly in the mid-1970s and have since followed a fluctuating and more moderate upward path, marked by a relatively sharp increase during the mid- 1980s. Since 1988, premiums and claim frequency have declined. Data on payment per paid claim are difficult to obtain because insurance companies hold most of these data. (Approximately 80 percent of medical malpractice claims are settled through private negotiations between the physician's insurer and the plaintiff.) One measure of malpractice claims payment that captures both actual and projected damages per claim is direct insurance losses, a measure that combines trends in both payment per paid claim and the probability of a claim resulting in payment. Between 1979 and 1985, direct insurance losses increased by 25 percent per year and then declined by 2.7 percent annually from 1985 and 1991. suggesting that either mean payment per paid claim or the probability of payment, or both, have declined in recent years.

It is not known whether these recent declines are part of a cycle or indicate a secular change in the medical malpractice environment. In addition, national averages obscure the sometimes pronounced changes across regions of the country and physician specialties.

Approaches to Medical Malpractice Reform

Over the past 20 years, almost every State has passed some type of medical malpractice reform. Most of the legislative activity occurred during the mid-1970s and mid-1980s in response to two malpractice "crises" marked by rapid increases in medical malpractice insurance premiums (Bovbjerg 1989). The "crisis" during the mid-1970s was more dramatic, because in some States physicians found themselves unable to obtain insurance. Most reforms

have had the goal of limiting the number of malpractice suits and payments per paid claim, in the hope that such limits would lower insurance rates.

Reforms to limit the number of suits or payment per paid claim include:

- Shortening the statute of limitations (i.e., the time period in which a suit can be brought);
- Limiting attorney fees;
- Requiring pretrial screening of suits;
- Setting specific dollar limits on payments per paid claim ("caps on damages");
- Requiring the plaintiff's health or disability insurer be the first payer of medical and related expenses (amending the "collateral source rule"); and
- Permitting the malpractice insurer to pay future damages as they come due, rather than in lump sum ("periodic payment" of damages).

To date, reforms that aim to promote access to the malpractice liability system by injured patients have not been a priority, Some recent reform proposals are designed to increase patients' access to the legal system, either by expanding the scope of injuries for which compensation will be provided or by removing the dispute from the courts and using alternative dispute resolution procedures or an administrative tribunal, With the exception of limited no-fault programs for birth-related injuries in Florida and Virginia, few of these proposals have been adopted by the States or used to any extent in medical malpractice actions.

Finally, clinical practice guidelines have received considerable attention as a potential tool for determining the standard of care in medical malpractice trials. Maine and Minnesota have just begun programs to use clinical practice guidelines in medical malpractice litigation.

Impact of State Medical Malpractice Reforms

During the past decade, a handful of rigorous empirical studies has examined whether the medical malpractice reforms implemented by the States have had their predicted effects of reducing claim frequency, payment per paid claim, or malpractice insurance premiums. These studies have used multi-State data and multiple regression analysis to assess the specific impact of individual medical malpractice reforms after controlling for other factors that might be responsible for such differences.

The one reform consistently shown to reduce malpractice cost indicators is caps on damages. Requiring collateral source payments to be deducted from the plaintiff's malpractice award has also been shown to reduce certain malpractice cost indicators. Pretrial screening panels and limiting the statute of limitations show conflicting results. Finally, statutes that restrict attorney fees, require periodic payment of awards, and codify the standard of care have not been shown to have the intended result of reducing malpractice cost indicators.

Although the finding that both caps on damages and mandatory collateral source offsets reduce certain malpractice cost indicators is strong, one cannot conclude that the other reforms have no impact. Contradictory results in different studies may reflect different models and assumptions. The failure to find an effect may be a result of factors unrelated to the

effectiveness of the reform. Certain reforms have not been studied sufficiently to draw conclusions. In addition, a number of reforms were modest and might not be expected to have large effects. For example, periodic payment of awards is triggered in a very small number of suits with large future damages, so the savings gained by paying awards on a periodic basis may be very modest. Legal challenges to statutory changes may have also delay the actual implementation of the reform. Finally, due to data limitations, no conclusions can be drawn regarding the impact of medical malpractice reform on claim frequency.

Conclusion

Caps on damages and mandatory collateral source offsets should reduce the direct costs of the medical malpractice compensation system, The studies are not detailed enough to conclude anything about the level of the cap necessary to achieve this effect, but caps on noneconomic damages alone appear to reduce direct malpractice costs. It should be noted, however, that these savings are likely to come by reducing the payments per paid claim received by a small number of most severely injured plaintiffs.

The studies did not examine the impact of any of the reforms on access to compensation by patients injured by negligent care. While not addressing the access issue directly, some State courts have found certain medical malpractice reforms, most notably caps on damages, to violate their State constitutions, because they singled out medical malpractice plaintiffs for a reduction in their ability to recover damages. Other kinds of injuries (e.g., those resulting from other types of malpractice accidents) were not covered in the laws that have been struck down.

Analysis of the impact of most reforms is 1imited, especially of reforms that move malpractice disputes outside the civil litigation system. The lack of uniform national data on claim frequency, payment per paid claim. and insurance premiums limit opportunities for strong empirical research on the potential for medical malpractice reforms to reduce malpractice costs.

Even if a given reform reduces direct malpractice costs significantly, the direct savings (i. e., from reductions in malpractice premiums) would represent only a very small portion of the national health care budget. Medical malpractice reform can be expected to generate significant savings in overall health care costs only if it can be shown that physicians order a significant number of extra tests and procedures and that these defensive practices are indeed influenced by the level of malpractice claim activity.

The impact of changes in malpractice cost indicators on physician behavior is not known. Although reducing malpractice cost indicators through medical malpractice reform might encourage physicians to limit defensive ordering of tests and procedures, it may also dampen whatever beneficial effects of the medical malpractice system has in deterring negligent medical practice. The advisability of such changes under a new health care payment regime--particularly one with greater incentives to reduce costs--is a policy issue that deserves careful consideration.