FREQUENTLY ASKED QUESTIONS
ABOUT MEDICAL MALPRACTICE INSURANCE
FEBRUARY 2005

Are high insurance rates driving obstetricians and gynecologists out of business or reducing access to health care?

The Congressional Budget Office noted in a January 2004 study: "On the one hand, [the U.S. General Accounting Office] confirmed instances of reduced access to emergency surgery and newborn delivery, albeit 'in scattered, often rural, areas where providers identified other long-standing factors that affect the availability of services.' On the other hand, it found that many reported reductions in supply by health care providers could not be substantiated or 'did not widely affect access to health care.'"[1] Moreover, a 2001 study by noted management specialist Professor Vasanthakumar Bhat found that although the "supply of physicians and specialties is extremely uneven, the medical malpractice system is not a significant factor in this supply. Malpractice insurance premiums do raise charges for normal deliveries but they do not reduce the supply of obstetricians and gynecologists and family physicians who practice obstetrics and gynecology."[2] Bhat also noted that, "Obstetricians and gynecologists do pass on increased malpractice costs to their patients through increased fees. However, they also increase their time in patient visits and spend more time per visit."[3]

Are lawsuits against doctors driving up their medical malpractice premiums?

There is no evidence that the tort liability system has caused medical malpractice insurance premiums to increase, or that caps on damages would reverse the trend. Consumer groups interested in protecting consumers have made it clear that they do not believe that tort reform will reduce insurance premiums.[4] A July 2003 General Accounting Office study of the causes of malpractice insurance increases found that, while malpractice awards have contributed to increased premiums, "a lack of comprehensive data at the national and state levels on insurers' medical malpractice claims and the associated losses prevented us from fully analyzing the composition and causes of those losses."[5] Insurers have not promised lawmakers that medical malpractice caps on damage awards and other limitations on recoveries will reduce premiums.

Would capping non-economic awards reduce doctors' insurance premiums?

No. According to data provided by the American Medical Association, 22 states that are considered by proponents of a federal cap to be "in crisis" or "showing problem signs" already have caps in place. This follows a June 2003 report by Weiss Ratings, Inc., which found that "Caps on non-economic damages have failed to prevent sharp increases in medical malpractice

[1] Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice,* Economic and Budget Issue Brief (Jan. 8, 2004), p. 7
[2] Vasanthakumar N. Bhat, *Medical Malpractice: A Comprehensive Analysis,* (Auburn House, 2001) p. 173.
[3] Ibid.
[4] See, for example, www.consumersunion.org, centerjd.org, and www.citizen.org.
[5] General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates,* GAO-03-702 (June 2003)

insurance premiums, even though insurers enjoyed a slowdown in their payouts."[6] A similar, earlier study on the impact of tort reforms conducted in 1999 found that states with caps in place had experienced the same increases in liability insurance rates as the states that did not.[7] What these caps would do, however, is hurt the people who are most severely injured by medical malpractice.

What has caused doctors' insurance premiums to increase?

Because the insurance industry is exempt from federal antitrust laws, it is difficult to get a clear understanding of how insurance premiums are set; but several studies show that the primary cost driver is insurance companies' diminished investment returns. When the markets cool and interest rates fall, the profitability of insurance companies' investments plunge, prompting insurers to increase rates and abandon lines of insurance with unappealing claims histories. Premiums are driven up by several additional factors, as well. These include: medical inflation, which has driven medical costs up 75 percent since 1991; the need for insurance companies to replenish diminished cash reserves; basic supply and demand issues caused by a significant decline in the number of companies providing medical malpractice insurance, particularly in certain geographic areas; and insurers' increased vulnerability to financial difficulties, which has pressured many medical malpractice insurers to increase rates despite new laws in many states capping payouts.[8]

Would capping damages reduce national health care costs?

While limiting medical malpractice awards would have a dramatic and severe impact on injured people, it would have only marginal impact on national health care costs. According to the Congressional Budget Office, malpractice costs make up less than 2 percent of overall health care spending. As a result, caps would have only a very minor effect on health care costs. The CBO also reports that even if malpractice costs were reduced by 25 to 30 percent, it would only lower health care costs by 0.4 to 0.5 percent and would likely have a comparably small effect on insurance premiums.[9] In addition, since malpractice insurance premiums account for only around 3.2 percent of the average physician's expenditures,[10] the impact of caps on on those expenses would be nominal.

Would capping malpractice awards reduce the practice of defensive medicine?

Incidents of "defensive care" are not common. Doctors order tests to ensure that they have all the information they need to provide patients with the best possible care. In fact, a 1992 Congressional Budget Office report concluded that most of the care commonly referred to as

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[6] Weiss Ratings, Inc., *Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage,* June 2, 2003.
[7] Hunter, p. 2.
[8] Weiss Ratings, Inc., *Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage,* June 2, 2003.
[9] Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice,* Economic and Budget Issue Brief (Jan. 8, 2004), p. 6
[10] See Federal Register, December 31, 2002, Part II, Department of Health and Human Services, Centers for Medicare and Medicaid Services Regulations, at p. 80023, 80024.

"defensive medicine" would have been provided anyway, for reasons other than concerns about medical malpractice.[11] More recently, a 2004 CBO study noted that, "Some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients. On the basis of existing studies and its own research, CBO believes that savings from reducing defensive medicine would be very small."[12]

Would caps on damages save the federal government money?

Some have cited enormous dollar figures to suggest that it would, but these claims rest almost entirely on a single 1996 study by two Stanford economists who focused exclusively on hospitalized heart patients and then projected their findings to the entire health-care system. Both the GAO and the CBO question their sweeping conclusion, with the CBO arguing, "In short, the evidence available to date does not make a strong case that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency."

In fact, there are some reasons that current proposals could actually cost the government more money. Under the current system, if Medicare or Medicaid pays someone's medical expenses and that person prevails in a medical malpractice matter, Medicare and Medicaid must be reimbursed from the award. If current proposals for caps on medical malpractice awards are enacted, the limits on damages could make it unfeasible for injured patients to pursue expensive medical malpractice lawsuits. Medicare and Medicaid programs would then not be able to recover what they had paid out.

Is there an insurance "crisis" today?

Insurance premiums in a number of areas are up significantly, even while the number of lawsuits filed each year has remained constant. The question is why. The U.S. insurance market is intensely competitive, which has caused both dramatic increases and dramatic decreases in insurance rates over time. For example, competition caused insurance rates to be comparatively lower in the United States from 1979 through 1983 than in other countries. When increases occurred in the U.S. between 1984 and 1986, they appeared more dramatic because they occurred against the background of artificially low rates.[13] That same cycle seems to be operating today.[14]

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[11] See Congressional Budget Office, *The Economic Implications of Rising Health Care Costs*, October 1992, p. 27.

[12] Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice,* Economic and Budget Issue Brief (Jan. 8, 2004), p. 6

[13] See Werner Pfennigsdorf & Donald G. Gifford, *A Comparative Study of Liability Law and Compensation Schemes in Ten Countries and the United States,* 159 (Donald G. Gifford & William M. Richman, eds., commissioned by the Insurance Research Council) (1991).

[14] See Edward Wasserman, "Blaming the Victim: Why are Liability Insurance Rates Soaring Again?", Miami Herald, December 30, 2002 and J. Robert Hunter, *Premium Deceit, 1999, 2002;* Zimmerman, Rachel and Oster, Christopher*, Insurers' Price Wars Contributed to Doctors Facing Soaring Costs; Wall Street Journal, June 24, 2002.*

Why do these cycles seem to affect doctors and hospitals more than some others?

Increases in medical malpractice insurance rates appear more dramatic because, unlike most businesses, doctors and other medical providers operate under fee schedules mandated by Medicare, health insurers and other third-party payers. With such inflexibility in this "ceiling" for revenues, large increases in malpractice insurance over short durations of time are now extremely difficult to accept and incorporate into one's medical practice. This makes the current increase in premiums much more difficult to handle than was the case in earlier cycles. Moreover, a July 2003 GAO report found that, "Cycles in the medical malpractice market tend to be more extreme than in other insurance markets because of the longer period of time required to resolve medical malpractice claims."[15]

What are "non-economic" damages, and why should people get them?

Pain and suffering awards – so-called "non-economic" damages – compensate victims for losses sustained when they suffer a serious injury such as paralysis, disfigurement, blindness or deafness as a result of negligent behavior. In many cases, "economic damages" such as lost wages and medical expenses simply do not reflect the true price of a defendant's negligence. The most devastating damages are often the pain and suffering that can be endured daily for the rest of an injured person's life, and which can result in permanent changes in the lives of injured persons and their families. Since 1975 proponents of caps on non-economic damages have argued that these victims are entitled to $250,000 – a number that continues to dominate caps proposals. Keeping pace with inflation, that $250,000 would be worth $891,284.77 today. Conversely, $250,000 today was worth $70,123.49 in 1975.[16]

How serious a problem is medical malpractice?

According to the Institute of Medicine, a 1999 study showed that at least 44,000 – and as many as 98,000 – patients die in hospitals each year as a result of preventable medical errors.[17] Even if the lower estimate is used, deaths as a result of medical errors are the eighth leading cause of death in America.

Should Congress write medical malpractice laws?

No. States have been writing medical malpractice and other tort liability laws for more than 200 years. This arrangement is a hallmark of our American justice system. Congress should not substitute its judgment for systems that have thoughtfully evolved in each state. Efforts to do so would likely be challenged on constitutional separation-of-powers grounds because health care has traditionally been an area left for states to regulate.[18]

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[15] General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates,* GAO-03-702 (June 2003)

[16] On-line Consumer Price Index inflation calculator based upon *Statistical Abstracts of the United States* and located at www.westegg.com/inflation

[17] Institute of Medicine, *To Err is Human: Building a Safer Health System* (November 1999)

[18] Recent Supreme Court decisions – including *Pegram et al v. Herdrich,* 120 S.Ct. 2143 (2000), and *Rush Prudential HMO, Inc. v. Moran***,** 122 S.Ct. 2151 (2002) – have continued to recognize that it is appropriate for the states to handle health accountability matters because health care is an area traditionally left to the states to regulate.

Are jurors biased against doctors, or overly generous in cases involving severely injured patients?

Not according to extensive studies of these questions. Despite what many people believe, jury damage awards in fact are not based on the depth of defendants' pockets, sympathy for plaintiffs, malice, or excessive generosity.[19] Physicians typically win cases in which their care met community standards,[20] and the severity of a patient's injury has little bearing on whether a physician wins or loses a case. There appears to be no evidence that juries are biased against doctors or that they are prone to ignore legal and medical standards in order to decide in favor of plaintiffs with severe injuries. In fact, studies of juries indicate a correlation between jury verdicts and doctors' ratings in negligence. Juries may even have a slight bias in favor of doctors.[21] And on those occasions in which juries do grant exorbitant awards, there are numerous post-verdict legal mechanisms that tend to correct the anomalies.

Should the collateral source rule be eliminated?

No. "Collateral sources" are usually health and disability insurers, including Medicare and Medicaid, that pay medical and disability costs up front when someone is injured. When an award is made against a negligent doctor, the collateral source rule allows those sources to recover their money from the victim's award. Eliminating the collateral source rule would mean that collateral sources would not be able to get the money back because the award would have been reduced by exactly that amount, unfairly favoring medical professional liability insurers at the expense of injured patients, their health or disability insurers, or consumers of health or disability insurance (if those insurers pass the cost on to their customers in the form of increased premiums).

How can states improve their medical malpractice laws?

Tort laws – including medical malpractice laws – that work for everyone by protecting the rights of patients, doctors, and insurers alike are essential. To this end, the ABA supports a number of improvements states should consider making in their tort laws if they have not already done so.

- State courts should be encouraged to make greater use of their powers to set aside verdicts involving pain and suffering awards that are disproportionate to community expectations.
- There should be rigorous enforcement of professional disciplinary codes that prevent the filing of lawsuits that lack merit. Sanctions should be imposed when those provisions are violated.
- Tort commissions should be created to annually review tort awards and publish suggested guidelines to encourage uniform awards.

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[19] See *Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets, and Outrageous Damage Awards*, by Neil Vidmar, at page 259, 1995. See also Daniels, Steve, and Martin, Joanne, *Civil Juries and the Politics of Reform*, (American Bar Association, 1995).

[20] See Taragin, et al., "The Influence of Standard Care and Severity of Injury on the Resolution of Medical Malpractice Claims," *Annals of Internal Medicine*, November 1992, Vol. 117, No. 9, p. 780.

[21] *Ibid* Vidmar at 182.

- There should be a “clear and convincing” evidence standard for punitive damages, which should be awarded only when there is a conscious or deliberate disregard by the defendant of his or her obligations.
- Joint and several liability should be limited to economic losses when a defendant is less than 25 percent responsible for an injury.