Health Cost Containment and Efficiencies
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Medical Malpractice Reform

Cost Containment Strategy and Logic

Medical malpractice reform, also known as tort reform, includes strategies to limit medical malpractice costs, deter medical errors and ensure that patients who are injured by medical negligence are fairly compensated.[1] Tort reform[2] has the potential to reduce health care expenditures by reducing the number of malpractice claims, the average size of malpractice awards and tort liability system administrative costs. It also may lead to fewer instances of defensive medicine where physicians order tests and procedures not primarily to ensure the health of the patient but as a safeguard against possible medical malpractice liability.

There is general agreement that the medical malpractice system is costly and inefficient. National estimates of medical liability system costs—including settlements, legal and administrative costs and defensive medicine—range from $55.6 billion annually (2.4 percent of total health spending) to $200 billion annually (10 percent of health care spending). Evidence indicates the system does not compensate all patients equitably, rapidly or efficiently; delivers compensation to a small share of injured people; does not appear to reduce medical errors; may hamper efforts to improve patient safety; and, in some cases, leads to unnecessary tests and procedures.[3]

Although medical malpractice premium rates nationwide began moderating in 2005 and fell an average of 4 percent in 2008 and 10 percent in 2009, this occurred after an extended period of sharply rising rates. Rates vary widely from state to state and by specialty; obstetricians and neurosurgeons pay among the highest rates—as much as $200,000 per year or more.

Medical malpractice reform proponents argue that tort reforms—such as limiting malpractice awards, tightening statutes of limitations for filing claims and screening cases before they go to trial—not only reduce overall medical care spending but also increase access to care. Opponents dispute these claims, arguing that "a nationwide crackdown on malpractice, not a campaign to roll back the rights of patients who are injured"[4] is needed instead.

Target of Cost Containment

Major medical malpractice reform targets include damage awards,[5] legal and administrative expenses and defensive medicine. Plaintiffs' attorney contingency fees average 35 percent of damage awards (Table 1).

According to the Physicians Insurance Association of America, the median claim payment in 2008 was $200,000, and the average was $350,000.

Some tort reforms have been shown to reduce medical malpractice premiums and may reduce overall health care expenditures.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, authorizes state demonstration projects to explore alternatives to current tort litigation to resolve malpractice claims (section 10607). The act authorizes $50 million (up to $500,000 per state) to be appropriated over five years, beginning in FY 2011, for state demonstration grants to develop, implement and evaluate alternatives. The president's 2012 budget proposal included $250 million for the U.S. Justice Department to help states overhaul their medical malpractice laws. It should be noted, however, that as of Oct. 1, 2011, the final 2012 budget had not been enacted.

Examples[6]

States use an array of strategies to control medical malpractice costs. The following section describes the major strategies, gives examples and includes opposing arguments. All data are current as of September 2010.

■ **Damage award limits.** Thirty-seven states and territories limit awards for non-economic damages, punitive damages or all damages. Non-economic damage caps typically range from $250,000 to $500,000 and may be adjusted for inflation. Several states with non-economic damage limits allow for higher payments under certain circumstances (e.g., substantial disfig-

Table 1. Medical Malpractice Payments and Plaintiff Legal Expenses Estimated National Costs, 2008

Damage payments, including plaintiff legal expenses	**$5.72 billion**	**100%**
Economic damages	$3.15 billion	55%
Noneconomic damages	$2.40 billion	42%
Punitive damages	$0.17 billion	3%
Plaintiff legal expenses—total and as a percent of damage payments	**$2.0 billion**	**35%**

Source: Michelle M. Mello et al., "National Costs of the Medical Liability System," *Health Affairs* 29, no. 9 (September 2010); http://content.healthaffairs.org/content/29/9/1569.abstract.

urement). A few states limit total damages—Colorado has a $1 million cap, Nebraska has a $1.75 million cap and Virginia has a $1.5 million cap. Some states (e.g., Illinois, Nebraska) and the U.S. Virgin Islands prohibit or cap punitive damage awards. Courts in several states (e.g., Alabama, Georgia, Illinois, New Hampshire, Oregon and Washington) have declared certain types of damage caps to be unconstitutional. Arizona, Kentucky and Wyoming specifically prohibit enactment of laws that limit medical malpractice damages. Opponents of non-economic damage limits argue they "punish the worst afflicted because the more pain and suffering that a plaintiff has endured, the more a cap deprives him of damages to which he would otherwise have been entitled."[7]

■ **More restrictive statutes of limitation** place stricter limits than historically has been the case on how long a plaintiff has to file a claim after an injury has been discovered or occurred. All states have statutes of limitation for medical malpractice claims. A state typically requires a claim to be filed within two to three years after the injury or one to three years after discovery, but in no event more than four to seven years after the injury. South Dakota has among the most restrictive provisions; it requires a claim to be filed within two years of the act or omission. States usually allow a longer period for cases filed on behalf of a child or for fraudulent concealment of information regarding malpractice. Opponents of statutes of limitation based on the date of injury argue the clock should start ticking only when the injury is discovered because it may take additional time after symptoms appear to discover that an injury was caused by medical malpractice.

■ **Joint and several liability limits.** Joint and several liability is a common-law doctrine that holds that, if more than one defendant is found liable for the plaintiff's injuries or losses, then each defendant may be held 100 percent liable. Eighteen states provide for several liability, which requires damages to be apportioned according to each defendant's percentage of fault. Seven states apply several liability to non-economic or punitive damages only. Fourteen states have modified joint and several liability laws. In Missouri, for example, a defendant who bears 51 percent or more of fault is joint and severally liable, but defendants who are less than 50 percent at fault are only severally liable. Opponents of joint and several liability limits argue that, if the individual actions of multiple defendants are together necessary for the injury to occur, then all defendants are jointly and fully responsible and should face the full value of the plaintiff's losses.

■ **Expert witness standards** establish minimum qualifications for expert witnesses in tort actions. At least 29 states have standards specific to medical liability cases. Expert witnesses may be required to be licensed or board certified in the same field as the defendant; practice or teach in the same field; and be knowledgeable about accepted standards of care that are the subject of the case. Expert witness standards are unconstitutional under New Hampshire's constitution. Opponents of strict medical malpractice expert witness standards argue that physicians and hospitals should not have special status as defendants, legislatures should not regulate what plaintiffs present to a jury without an overwhelming public policy necessity, and strict standards may discourage innovative science and diminish medical care.

■ **Modified collateral source rules**. The collateral source rule allows an injured party to recover damages from the defendant even if the plaintiff is also entitled to receive damages from a third party (e.g., auto or workers' compensation insurance). Modified collateral source rules allow some or all of an award to be offset by the amount the plaintiff receives from collateral sources. At least 26 states have modified collateral source rules. The rules may apply to medical malpractice actions only (e.g., Illinois, Utah), all personal injury actions (e.g., Indiana, Montana) or all tort actions (e.g., Alaska, Minnesota). Illinois' modified collateral source rule allows an award to be reduced by 50 percent of the lost wages or disability income paid or payable to the claimant by a third party and 100 percent of the health care charges paid or payable by a third party. There are, however, limits to the offsets (e.g., the judgment cannot be reduced by more than 50 percent). Modified collateral source rule opponents argue that injured people are entitled to the full value of the injury from those who perpetrated the wrong.

■ **Attorney contingent fee limits** cap the amount attorneys can receive as a percentage of an award to pay for legal services**.** In most malpractice cases, a lawyer agrees, in return for representing a plaintiff, to accept a percentage of the award but to receive nothing if the plaintiff loses. Nearly half the states limit attorneys' fees. Thirteen states, Guam and Puerto Rico have sliding fee schedules. Delaware has among the lowest limits; attorney fees may not exceed 35 percent of the first $100,000 in damages, 25 percent of the next $100,000 and 10 percent of all damages exceeding $200,000. At least six states authorize courts or an arbitration panel to review the reasonableness of attorney fees but do not set specific limits. Courts in Pennsylvania have ruled attorney fee limits unconstitutional. Opponents of attorney fee limits say they limit the ability of injured people, particularly those faced with medical bills and lost wages, to finance lawsuits they otherwise could not afford.

■ **Periodic payment provisions** allow or require insurers to pay damage awards over time, rather than in a lump sum. Thirty jurisdictions have periodic payment laws. Among states that set a specific threshold above which damages must be paid in whole or in part periodically rather than as a lump sum, $100,000 is the most frequent threshold. The threshold in California and Nevada is $50,000. Periodic payment laws in Alabama, Arizona, Arkansas and Georgia have been held unconstitutional. Opponents of periodic payment requirements argue this decision should be the plaintiff's, some of whom may prefer to invest the awards themselves or may be concerned about the solvency of the entity that provides the annuity coverage.

■ **Other medical liability-related reforms.**[8] States have considered —and a few have adopted—other laws to contain medical malpractice litigation costs. Examples include patient compensation and injury funds, pre-trial alternative dispute resolution and screening panels, affidavits or certificates of merit, frivolous lawsuit penalties, and non-economic damage award schedules. States also have considered safe harbor rules, which make adherence to evidence-based medical practice guidelines a presumptive defense; and health courts, where cases are decided by specially trained judges, assisted by neutral expert advisers, instead of a jury.

Evidence of Effectiveness

Some tort reforms have been shown to reduce medical malpractice premiums and may reduce overall health care expenditures. The following sections review evidence of the combined effect of multiple reforms and the effect of specific reforms that have been in place long enough and adopted widely enough to be evaluated.

■ **Effect of multiple reforms.** A study published in 2010 found that the 15 states with the lowest levels of malpractice payments and claims between 1999 and 2003 had low damage caps, restrictive statutes of limitation and stringent expert witness requirements.[9]

Most studies have found that caps on non-economic damages are associated with fewer and lower awards.

An analysis of Medicare expenditures and medical liability costs between 1993 and 2001 found an association between increased average malpractice payments per physician and higher total physician services expenditures, most notably for imaging services.[10] Other studies have reported weak or no evidence of a relationship between malpractice premiums and health care costs or malpractice reforms and health care costs.

According to the Congressional Budget Office, evidence of the effect of tort reform on patient health is mixed.[11] Some studies have found an association between caps on non-economic damages and poorer health and between lower malpractice costs and increased mortality. Others have found no significant association between malpractice costs and adverse outcomes for patients.

■ **Damage award limits.** Most studies have found that caps on non-economic damages are associated with fewer and lower awards.[12] Research indicates that limits on pain and suffering awards reduce the average payment per claim, modestly constrain liability premium growth and reduce defensive medicine for some services. One study documented a $15,000 average claim payment reduction from capping non-economic damage awards.[13] A 2011 article in *The New England Journal of Medicine* reported some evidence that caps on damages modestly increase the supply of physicians in a state, although other study findings have been mixed."[14] Another study found that caps on noneconomic damages "disproportionately affect compensation for the most severely injured patients, which raises equity issues."[15]

A study of a 1975 California law that capped pain and suffering awards at $250,000 and limited attorney fees found the law led to a 30 percent reduction in damage awards.[16] Compensation to injured patients declined by 15 percent, while the fees for plaintiffs' attorneys fell by 60 percent. Plaintiffs with the highest percentage loss as a result of non-economic caps were often those with injuries that caused relatively little economic loss but a significantly lower quality of life. One of the law's major effects was to make plaintiffs' lawyers bear more of the cost of the litigation.

■ **Expert witness standards.** A comprehensive analysis of state tort reforms reported the "striking finding" that expert witness standards are strongly correlated with reductions in the average medical malpractice claim size, total number of paid claims, and the number and average size of paid claims per physician.[17]

■ **Joint and several liability limits.** Some researchers have found that limits on joint and several liability constrain the growth of premiums and reduce the number of annual payments, but do not significantly affect average awards or physician supply.[18] Others have found that restrictions do not lead to lower claims frequency, claims costs, overhead cost, malpractice premiums or defensive medicine.[19]

■ **More restrictive statutes of limitation.** Evidence indicates shortening the period for filing a malpractice claim reduces the frequency of claims and may help constrain malpractice premium growth.[20]

■ **Modified collateral source rules.** Evidence of an association between changes in collateral source rules and lower malpractice costs is mixed. One study reported the "counter-intuitive" finding that states with more restrictive collateral source rules had slightly higher average payments and number of claims payments per physician.[21]

Challenges

■ A slower growth or actual reduction in malpractice insurance premiums may not translate to overall health care savings. This occurs only if providers pass along their savings to patients, insurers and other payers in the form of lower medical care prices or if their practice included fewer instances of defensive medicine.

■ Malpractice reforms should be designed not only to control medical liability system costs but also to ensure that patients injured by medical negligence are fairly compensated. As noted above, however, evidence suggests that some reforms may constrain the ability of plaintiffs with legitimate claims to be fairly compensated. Medical record reviews indicate that only between 1.5 and 10 lawsuits are filed for every 100 cases of negligent injury.

■ Some reforms may face constitutional challenges. Examples of medical malpractice laws that have been found to be unconstitutional in some states include damage award caps, attorney contingent fee limits and periodic payment provisions.

Complementary Strategies

The cost savings potential of medical malpractice liability reforms may be enhanced when offered with complementary cost containment strategies. Examples include patient safety initiatives and global payments to providers, which are the subject of other briefs in this series. Other complementary strategies include providing adequate or enhanced funding for state medical boards to expeditiously investigate complaints about and discipline doctors; developing robust data-collection efforts to track and analyze medical errors and instances of malpractice; and supporting efforts to make clinical best practice guidelines widely available to, and a safe harbor in malpractice cases for, clinicians.

NCSL's **Medical Liability/Medical Malpractice Laws** website is the nation's in-depth public resource on this topic. Visit www.ncsl.org/?tabid=18516.

For More Information

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Mello, Michelle M.; Allen Kachalid; and Sarah Goodell. *Medical Malpractice—Update*. Princeton, N.J.: The Robert Wood Johnson Foundation, April 2010; http://www.rwjf.org/files/research/042011.72097.synthesis.medmal.update.pdf.

Waters, Teresa M. et al. "Impact of State Tort Reforms on Physician Malpractice Payments." *Health Affairs* 26, no. 2; http://content.healthaffairs.org/content/26/2/500.full.

The latest information on this topic is available in an online supplement at www.ncsl.org/?tabid=19941.

Notes

1. This brief focuses on reforms designed to reduce medical malpractice litigation costs. Other types of reforms are primarily intended to reduce the incidence of medical negligence (e.g., by improving hospital patient safety or giving patients access to reports of hospitals' and doctors' adverse incidents).

2. A "tort" is defined as a wrongful act other than a breach of contract that injures another and for which the law imposes civil liability.

3. Ariel Winter,*The Medical Malpractice System: Review of the Evidence,* PowerPoint presentation to MedPAC meeting, Washington, D.C., April 1, 2010, http://www.medpac.gov/transcripts/medical%20malpractice%20April%202010_public.pdf.

4. Bob Herbert, "Malpractice Myths," *The New York Times*, June 21, 2004; http://www.nytimes.com/2004/06/21/opinion/21HERB.html.

5. There are three types of damage awards. Economic damage awards compensate plaintiffs for direct costs incurred because of medical negligence, including medical expenses and loss of income. Non-economic damage awards provide compensation for non-monetary damages such as pain and suffering or loss of consortium. Punitive damage awards are intended to punish a defendant for willful and wanton conduct.

6. Most of the information presented in this section is from National Conference of State Legislatures, Medical Liability/Malpractice Laws Web page, Aug. 15, 2011, www.ncsl.org/?tabid=18516. See the Web page for updates.

7. Henry Cohen, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages (Washington, D.C.: Congressional Research Service, April 11, 2005);* http://opencrs.com/document/RL31692/2005-04-11/. Also see Peter Perlman, "Don't Punish the Injured," *American Bar Association Journal,* May 1, 1986.

8. For more information on these approaches, see U.S. Senate Committee on Health, Education, Labor and Pensions, *Medical Liability: New Ideas for Making the System Work Better for Patients,* Senate Hearing 109-710, June 22, 2006 (Washington, D.C.: U.S. Government Printing Office, 2007); http://www.gpo.gov/fdsys/pkg/CHRG-109shrg28417/html/CHRG-109shrg28417.htm.

9. Teresa M. Waters et al., "Impact of State Tort Reforms on Physician Malpractice Payments," *Health Affairs* 26, no. 2 (2007); http://content.healthaffairs.org/content/26/2/500.full.

10. Katherine Baicker, Elliott S. Fisher, and Amitabh Chandra, "Malpractice Liability Costs and the Practice of Medicine in the Medicare Program," *Health Affairs 26, no. 3* (2007); http://content.healthaffairs.org/content/26/3/841.full.

11. Letter from Douglas M. Elmendorf, director, Congressional Budget Office, to the Honorable Bruce L. Braley, U.S. House of Representatives, Dec. 29, 2009; http://www.cbo.gov/ftpdocs/108xx/doc10872/12-29-Tort_Reform-Braley.pdf.

12. Ronen Avraham, "An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Settlement Payments," *Journal of Legal Studies* 36, no. 2 (2007); http://ideas.repec.org/a/ucp/jlstud/v36y2007is2ps183-s229.html.

13. Teresa M. Waters et al., "Impact of State Tort Reforms on Physician Malpractice Payments."

14. Allen Kachalia and Michelle M. Mello, "New Directions in Medical Liability Reform," *The New England Journal of Medicine* 364, no. 16 (April 21, 2011); http://www.nejm.org/doi/full/10.1056/NEJMhpr1012821.

15. Michelle M. Mello, Allen Kachalid and Sarah Goodell, *Medical Malpractice—Update* (Princeton, N.J.: The Robert Wood Johnson Foundation, April 2010); http://www.rwjf.org/files/research/042011.72097.synthesis.medmal.update.pdf.

16. Nicolas M. Pace et al., *Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts under MICRA* (Santa Monica, Calif.: RAND Corporation, 2004); http://www.rand.org/pubs/monographs/2004/RAND_MG234.pdf.

17. Teresa M. Waters et al., "Impact of State Tort Reforms on Physician Malpractice Payments."

18. Claudia H. Williams and Michelle M. Mello*, Medical Malpractice: Impact of the Crisis and the Effect of State Tort Reforms, Synthesis Project Policy Brief No. 10* (Princeton, N.J.: The Robert Wood Johnson Foundation, May 2006); http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_policybrief.pdf.

19. Michelle M. Mello, Allen Kachalid and Sarah Goodell, M*edical Malpractice—Update.*

20. Ibid.

21. Teresa M. Waters et al., "Impact of State Tort Reforms on Physician Malpractice Payments."

About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher and author of most of the briefs. Thanks go to Heather Morton for her contributions to this brief.

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