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Liability System Incentives to Consume Excess Medical Care

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Preface

This paper presents preliminary results of an Institute for Civil Justice analysis of liability system incentives to consume excess medical care. This draft has not been peer-reviewed, and some numbers and text may be revised before final publication. These results may be cited as preliminary findings, subject to revision.

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The Policy Issue

America's legal system provides significant incentives for excessive consumption of health care. Because damage awards for noneconomic losses, such as pain and suffering, are generally calculated as a multiple of medical and other out-of-pocket expenses, successful tort claimants can normally expect to recover several times their medical costs. For all practical purposes, the liability system offers potential claimants several dollars in compensation for every dollar they spend on medical care. Thus, an individual who claims to have been injured by another has substantial financial incentives to expend resources on medical treatment beyond the levels necessary to meet their health needs.

Moreover, financial self-interest is not the only force influencing claimants' medical care decisions. Claimants who feel they are entitled to the "full value" of their claims may exaggerate their medical costs to obtain enough additional compensation to pay their legal fees. And health care professionals, concerned about their own financial interests, may be more inclined to recommend excessive treatment when their patients are able to pass their costs on to a defendant or insurer.

Many accident victims, of course, do not respond to these incentives and seek only the health care they need or, indeed, sometimes less than they need. But, it is generally accepted that some, perhaps many, claimants obtain medical care for nonexistent injuries to gain access to compensation for pain and suffering. It is also generally accepted that some, perhaps many, claimants with valid injury claims consume more health care than appropriate either because they want to increase the amount of compensation they receive for pain and suffering or because a health professional recommended that treatment. However, there has been no empirical evidence about how excessive claims, in the aggregate, affect the costs of the health care system, or to what extent such claims impose other costs on society, such as claims handling, legal and other transaction costs, and increased prices and insurance costs.

This study provides a first-order estimate of these effects. Drawing on several Institute for Civil Justice (ICJ) analyses of claiming behavior, we characterize the nature of the liability incentives to exaggerate medical claims and develop estimates of the total costs of the excess medical care consumed.

Approach

We use the term *exaggerated or excess medical claiming* to refer to a broad range of activities, including claims based on staged or nonexistent accidents, claims for nonexistent injuries when the accidents were real, and buildup of claims for real injuries to leverage a larger settlement from an insurance company. To understand how much medical care is consumed unnecessarily by all of these forms of exaggeration, we take a two-pronged approach.

First, we examine the rate of excess medical claiming for automobile personal injuries. Automobile injuries are an appropriate starting point for the analysis because almost two-thirds of all the liability claims for personal injuries in the United States result from automobile accidents. In addition, the ICJ's extensive data base on automobile accident injuries allows us to examine claiming issues in the automobile arena in great detail. Using these data, we estimate what fraction of medical bills submitted to insurers for automobile injuries is excessive in one or another of the senses defined above. We then apply the rate of excess medical claiming to the total automobile injury medical costs to obtain an estimate of how many medical dollars are consumed unnecessarily in response to liability system incentives.

We then turn to all other injury liability claims, ranging from mundane "slip and falls" to medical malpractice and product liability claims. We estimate the amount of medical care resources that are consumed in those claims, then apply to that estimate the excess claiming rate derived from the analysis of automobile injuries. The result is an estimate of the cost of excess medical costs incurred for non-automobile injuries in response to liability system incentives. We combine this number with the estimated costs of excess medical claiming for auto injuries to estimate the total amount of excess medical care consumed.

Our calculations are based on a critical assumption: that the rate of excess claiming for non-automobile injuries ranging from slips and falls to medical malpractice is about the same as it is for automobile personal injuries. We believe this is a reasonable assumption on which to base a first-order estimate. Some studies indicate that individuals injured in non-automobile accidents are less likely to claim than those injured in auto accidents. However, these same

studies report claiming patterns suggesting that some of those who do claim are exaggerating their claims.[1] All of these claims are being brought within the context of the tort liability system. Therefore, the individuals bringing the claims are all responding to the same incentives inherent in the system.

Excess Claiming for Automobile Personal Injuries

Focused investigations, "sting" operations, and the like, routinely disclose examples of excessive claiming behavior. But at best these activities examine the validity of a specified group of claims. People submitting a false claim for compensation do not check a box that says, "This claim is fraudulent." Nor do they indicate the extent to which they consumed excess medical care in order to build their claims. As a consequence, we can't directly observe excessive claiming "globally" in the system.

We take an indirect approach to estimating the extent of excessive medical claims for automobile personal injuries. Specifically:

- We develop a series of hypotheses as to how liability system incentives to exaggerate medical costs would affect claiming patterns.
- We draw on a large database of individual claims[2] to see if we observe the specific kinds of claiming patterns that would result from incentives to excess claiming.
- Finally, to the extent that we observe the specific kinds of claiming patterns that reflect excess claiming, we estimate the cost implications of the excess claims.

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[1]See, for example, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, Harvard Medical Practice Study, 1990.

[2]The All Industry Research Advisory Council, since renamed The Insurance Research Council (IRC), surveyed claims closed under the principal automobile injury coverages during 1987. Thirty-four insurance companies that together wrote nearly 60 percent of private passenger automobile insurance participated. We used these data to develop a database on the claimed injuries and losses and resulting compensation paid on a nationally representative sample of automobile insurance claims. *No-Fault Approaches to Compensating People Injured in Automobile Accidents*, S. J. Carroll, J. S. Kakalik, N. M. Pace, J. Adams, R-4019-ICJ, RAND: Santa Monica, CA, 1991, presents a detailed description of the database. We are now updating that database to include information obtained by The Insurance Research Council in another set of closed claim surveys in 1992. But that effort is not yet completed; the 1987 database is still the most recent comprehensive database on auto accident compensation available.

Opportunities and Incentives to Exaggerate Claims

Type of injury. The opportunity to exaggerate claims is influenced by the nature of the injuries themselves. Table 1 presents a categorization of injuries that is useful for exploring the ability to exaggerate claims.

Table 1

Characteristics of Injuries Affect Ability to Exaggerate Claims

	Hard Injuries	Soft Injuries
Examples	Death, loss of limb or sense, fracture, lacerations	Sprain or strain of neck or back
Objectively verifiable?	Generally	Usually not
Costly/serious?	Usually	Often not

Hard injuries are injuries that are objectively verifiable. For example, there is no debate about whether someone has lost a limb or suffered a fracture detected by x-ray. Moreover, hard injuries are usually relatively costly; hence, they probably attract attention from claims agents, who may review the evidence submitted in support of a compensation claim. We use the term *hard injury claim* to refer to a claim in which the injured party asserts some hard injury, whether or not he or she also claims to have incurred a soft injury as well.

Soft injuries are sprains and strains. They are not usually objectively verifiable; hence, they present an opportunity to exaggerate their existence or seriousness. And because they are often not costly injuries, claims based on them may not attract close scrutiny. We use the term *soft injury claim* to refer to a claim in which the injured claims to have incurred only a soft injury.

Type of insurance system. The incentive to exaggerate claims also depends on access to general damages, which is determined by the automobile insurance system functioning in each state.

Incentives under the tort system. When our data were collected, 36 states relied on the tort liability system to determine the compensation provided someone injured in an automobile accident. Under the tort system, an accident victim is entitled to seek compensation for both the economic loss incurred as a result of that injury (medical costs, for example) and for noneconomic losses, or general

damages. These are hurts the individual has suffered that are not directly measured in dollars--"pain and suffering," for example.[3] Because there is no objective measure of the magnitude of an accident victim's general damages, compensation for general damages is typically thought to be a multiple of the victim's economic loss.

This relationship between economic loss and general damages provides incentives for excess claiming.

Suppose an individual is injured in an accident and submits a claim for medical costs in the amount of $700. Under the tort system, that individual might reasonably expect to receive $700 as compensation for medical costs. (The amount of compensation would be reduced if the injured party was partially negligent. For simplicity, we neglect that concern; it has no bearing on the main point of the argument.) The injured party might also reasonably expect some amount of general damages. For purposes of this example, let us assume that general damages are twice the medical costs--in this case, $1,400.

This relationship between medical costs and general damages provides the incentive to bring a claim for nonexistent injuries. For example, driver A hits driver B's car. B is not injured but claims to be injured and finds a doctor who provides treatment and runs up $700 worth of medical bills. B can pursue a claim with A's insurance company and reasonably expect to be reimbursed for medical costs *and* to receive $1,400 in general damages, which B can pocket. By a similar argument, if B submitted a medical claim of $1,100, B could get paid $1,100 for medical costs and $2,200 in general damages.

The link between medical costs and general damages also provides the incentive to increase costs. For example, someone with a real injury, for which appropriate medical treatment would have cost $700, who manages to run up medical bills totaling $1,100, will end up with an extra $800 in his or her pocket.

Incentives under dollar threshold no-fault systems. When our data were collected, eleven states had significantly modified the rules for compensating automobile

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[3]Typically, the injuror's Bodily Injury (BI) insurance pays the compensation he owes the person he injured. Drivers can purchase Uninsured Motorist (UM) insurance to cover them for any compensation they cannot obtain from an uninsured motorist, up to the policy's limits. Under UM the insurer compensates its own policyholder in lieu of the compensation the insured would have received from an uninsured motorist if they had had BI insurance. The amount of compensation provided is governed by the rules that determine BI compensation--all types of losses are covered, but only to the extent the injuring party is responsible for the injury. Drivers can also purchase Medical Payments (MedPay) insurance, which covers their own medical expenses (and funeral costs), regardless of fault, typically with relatively low policy limits. MedPay does not cover other economic losses, such as lost earnings, or noneconomic losses, such as pain and suffering.

accident victims by introducing dollar threshold no-fault systems.[4] Under these systems, an individual injured in an automobile accident is compensated for all economic losses from his or her own insurer, without regard to fault. But the injured party can seek compensation for non-economic loss--general damages--from the other driver only if his or her medical costs exceed a specified dollar amount. The dollar no-fault system changes the incentives facing claimants.

Suppose the driver we were considering in the previous example was in a no-fault state in which the dollar threshold was $1,000. If the individual makes a claim for $700, he or she would receive reimbursement for that amount. But there will be no payment for general damages because the medical costs are under the threshold. On the other hand, making a claim for $1,100 (perhaps by obtaining unnecessary care) yields not only $1,100 in medical compensation, but because the dollar threshold has been exceeded, general damages as well. In sum, building the claim to get over the threshold in the dollar no-fault system has a substantial marginal effect on the amount of general damages someone might receive as a result of an auto accident.

Incentives under verbal threshold no-fault systems. When our data were collected, three states had adopted verbal no-fault systems.[5] In these systems, the law contains an explicit list of injuries for which one is allowed to seek general damages. If an injury is not on that list, the injured party may not seek general damages, no matter how high the medical bills are. The listed injuries tend to be serious: death, dismemberment, loss of a bodily part or sense, fracture.[6]

Suppose the driver we have been considering was in a verbal no-fault state and incurred an injury that was not "over the threshold." If the individual makes a claim for $700, he or she would receive reimbursement for that amount. But there will be no payment for general damages because the injury did not surmount the threshold. Making a claim for $1,100 (perhaps by building the medical costs) would yield $1,100 in medical compensation. But, because the injury did not exceed the threshold, there would be no general damages paid. In

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[4]Kentucky offered drivers the choice between the tort system or a dollar threshold no-fault plan. Because virtually all insureds opted for the no-fault plan, Kentucky was, for all practical purposes, a dollar threshold state when our data were collected. Since then, Connecticut and Georgia repealed dollar threshold no-fault plans and New Jersey switched from a dollar threshold plan to a choice plan offering drivers the choice between the tort system or a verbal threshold no-fault plan.

[5]Pennsylvania and New Jersey have since adopted choice plans offering drivers the choice between the tort system or a verbal threshold no-fault system.

[6]Michigan and New York have strong verbal thresholds--that is, the types of injuries that qualify an individual to seek general damages are all serious injuries. In contrast, the verbal threshold in Florida allows an individual to claim general damages if he or she has a permanent partial disability, no matter how small. Since this threshold is not as stringent as the thresholds in Michigan and New York, in subsequent discussions of verbal threshold states, we focus on Michigan and New York.

sum, verbal no-fault systems eliminate the incentives to submit excess medical claims for injuries that do not surmount the threshold. Because an accident victim cannot obtain compensation for general damages for below-threshold injuries, there is no return either to claiming a nonexistent injury that doesn't meet the threshold or to building costs on a below-threshold injury. In either case, the injured will receive only his or her medical costs and nothing else.

Expected Claiming Patterns. The combination of the potential for exaggeration inherent in injury types and the opportunity to pursue general damages available under different insurance systems yields a series of hypotheses about how incentives to various kinds of exaggeration will affect claiming patterns. Figure 1 summarizes these hypotheses.

		Insurance System		
		Verbal no-fault	Dollar no-fault	Tort
Claims for nonexistent	Hard injuries	---	---	---
	Soft injuries	---	+	++
Cost buildup	Hard injury claims	+	++	+
	Soft injury claims	---	++	+

Fig. 1–Insurance System Incentives to Exaggerate Medical Claims

The first row of the figure shows blanks--there is no incentive to claim nonexistent hard injuries under any insurance system. Because hard injuries are objectively verifiable, it is very difficult to fake a claim for one. Thus, except for instances of out-and-out fraud--which we have no reason to believe vary with insurance systems-- we would not expect to see claims for nonexistent hard injuries anywhere.

The second row shows the incentives to claim nonexistent soft injuries under each insurance system. Because soft injuries generally do not exceed the verbal threshold, accident victims who claim these injuries will not have access to general damages. Hence, there is no incentive to claim a nonexistent soft injury in a verbal threshold no-fault state. We can anticipate some claims for

nonexistent soft injuries in dollar threshold no-fault states if the medical claim can be pushed over the threshold, thus providing the potential for general damages. Of course, in tort states, where general damages can flow from the first dollar of one's medical claim, we expect to see comparatively more claims for nonexistent soft injuries.

Where do we expect to see cost buildup on true claims? Hard injuries will generally exceed a verbal threshold, so we can anticipate some building of claims for hard injuries in that insurance environment. We can expect even more cost buildup on hard injuries in dollar no-fault states because some hard injuries that normally would not exceed the threshold can be built to exceed a dollar threshold, thus providing the claimant with general damages. Tort states should have levels of cost buildup on hard injuries comparable to verbal no-fault states.

Finally, what about cost buildup on soft injury claims? It makes no sense to build medical costs for soft injuries in a verbal no-fault state because these injuries don't provide access to general damages. Dollar threshold systems offer a strong incentive to build medical costs for soft injuries because doing so can bring the claim over the threshold, providing access to general damages. The tort system also offers incentives to build medical claims for soft injuries, but these incentives are less strong than in dollar threshold systems.

Observed Claiming Patterns

Having stated our expectations about where nonexistent or exaggerated claiming will occur, we analyzed data for every state to see whether they support the hypotheses reflected in Figure 1.[7] We illustrate our analysis with three examples.

Example 1: Claims for Nonexistent Injuries. We assume that hard injury claims are generally valid, and that claims for nonexistent soft injuries are rare in Michigan and New York (the strong verbal threshold states), occasional in dollar threshold states, and more frequent in tort states. Based on these assumptions, the ratio of the number of soft claims to the number of hard claims in a state is an index of the frequency of claims for nonexistent soft injuries.

Michigan and New York have an index of 0.7. That is, in these states there are 7 soft injuries claims for every 10 hard injury claims. In Hawaii, a dollar-threshold state, we see 9 soft injury claims for every 10 hard injury claims--an index value

[7]This analysis is described in detail in *The Costs of Excess Medical Claims for Automobile Personal Injuries*, Stephen Carroll, Allan Abrahamse, and Mary Vaiana, DB-139-ICJ, RAND: Santa Monica, CA, 1995.

of 0.9. That's 25 percent more than in the verbal threshold states, but much less than in California, a tort state, where we expect to see, and indeed find, evidence of many claims for nonexistent injuries. California's index is 2.5--that is, 25 soft claims for every 10 hard claims.

Figure 2 shows the index for all fifty states. The solid line shows the average value for Michigan and New York, which we use as our "baseline" in the sense that we expect few claims for nonexistent injuries given the insurance systems in these states. The pattern of the data across all states is consistent with our predictions about where claims for nonexistent injuries would occur. Michigan and New York are at the very bottom of the claiming distribution. The dollar threshold states, shown in hatched gray, are scattered, but by and large they cluster toward the lower end of the distribution. All of the top 19 states are tort states.

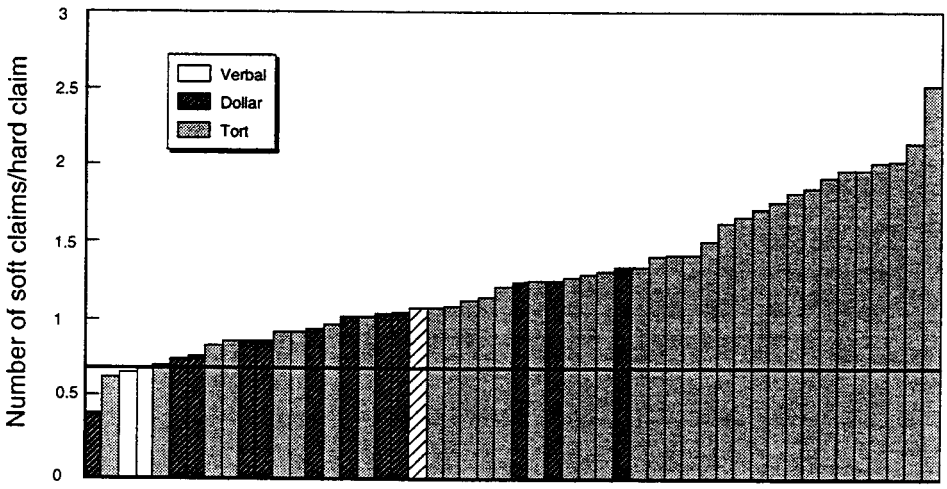

Fig. 2–State Pattern Is Consistent with Many Claims for Nonexistent Injuries

Using the Michigan-New York line as a base point, we can interpret the claims above the line are an indication of the degree to which claims are being submitted for nonexistent injuries.

Example 2: Cost Buildup on Soft Injury Claims. In estimating cost buildup on soft injury claims, we again take Michigan and New York as a reference point because there is no incentive to build claims in these states. However, there are incentives to build them in other states, especially in dollar threshold states as claimants inflate claims to get over the threshold and gain access to general damages. To measure the extent of cost buildup on soft injury claims, we take the average cost of a soft injury claim in each state and adjust for interstate

differences in medical costs (for example, what doctors and nurses cost) and treatment modalities (for example, how often an MRI is used). We compute the average cost of a soft injury in Michigan and New York and normalize the result to a level of 1. We then index each other state's averages by a ratio to the Michigan and New York average. If we apply this index to Hawaii and California, the two example states we discussed above, we would obtain a value of 2.8 for Hawaii, where the dollar threshold provides strong incentives to build medical claims, and 1.1 for California, a tort state where we expect less buildup.

Figure 3 shows why the average adjusted medical cost of a soft injury is so much higher in Hawaii than in Michigan and New York. It presents the distribution of adjusted medical costs for soft injury claims in each state. Note that the horizontal axis in the figure is a logarithmic scale: Equal intervals show equal percentage differences.

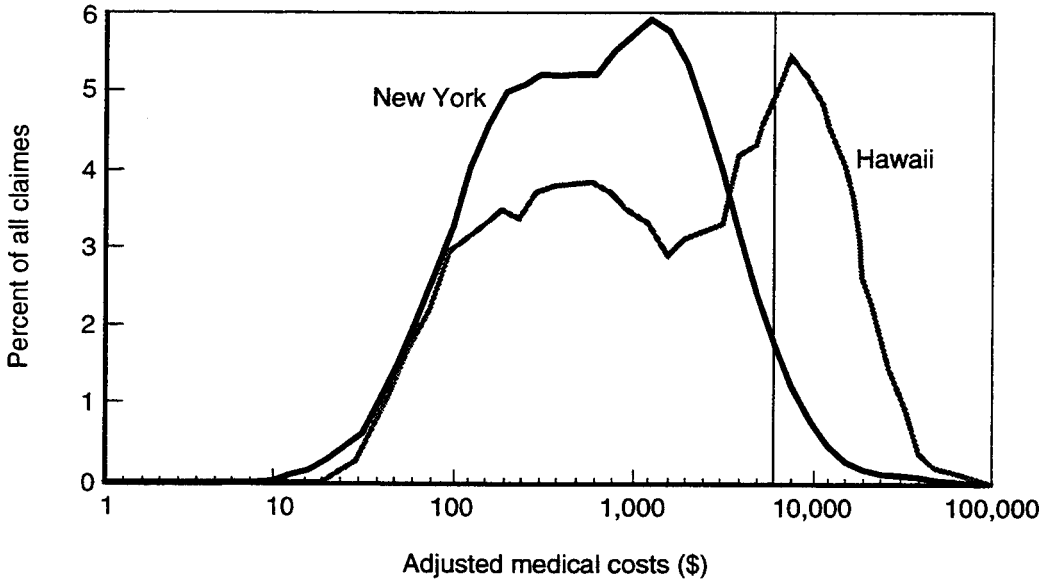

Fig. 3–Distribution of Adjusted Medical Costs for Soft Injury Claims in Hawaii and New York

The distribution of claims in New York looks very much like a normal distribution. The distribution rises sharply, peaks, and then tails off sharply to the right. The large majority of claims are for relatively small medical costs.

The bold vertical line on the figure shows Hawaii's dollar threshold. (To allow comparisons between the distribution of New York's claimed medical costs and Hawaii's threshold, we also adjusted the threshold for interstate differences in

medical costs and treatment patterns.) The distribution of New York claims begins to decline well below the Hawaii threshold and continues to fall, without interruption, past the threshold. New York has very few claims for medical costs that exceed Hawaii's threshold.

Hawaii's distribution also rises sharply in a pattern very similar to the New York distribution, and it flattens out at about the same place as New York's but at a lower level. It then turns up again and rises sharply through the dollar threshold. The Hawaii distribution peaks above the threshold, and finally falls off. A substantial fraction of Hawaii's claims are for medical costs above the threshold.

Adjusting for interstate cost differences, the fraction of Hawaii claims that is above the Hawaii threshold is much greater than the fraction of New York claims that exceeds that number. It is clear that, compared to New York, the distribution of adjusted medical costs in Hawaii is shifted substantially to the right, exactly as we predicted, given the incentives built into the state's insurance system to build medical costs to get over the threshold.

We compared the distribution of adjusted medical costs for soft injury claims in each of the dollar threshold states to the combined distribution for Michigan and New York--the two strong verbal threshold states. All of the dollar threshold states were "right-shifted" relative to the reference states; the magnitude of the shift was statistically significant in eight of the dollar threshold states. (The exceptions were Kansas, North Dakota, and Utah.)

Example 3: Cost Buildup on Hard Injury Claims. Figure 4 illustrates cost buildup on hard injury claims. Recall that there are incentives to build costs on hard injury claims everywhere. These incentives are particularly strong in dollar threshold states, as claimants are induced to inflate claims to get over the threshold and gain access to general damages. Figure 4 shows the distributions of adjusted medical costs for hard injury claims in New Jersey, a dollar threshold state, and New York. The vertical line in the figure shows New Jersey's (adjusted) threshold.

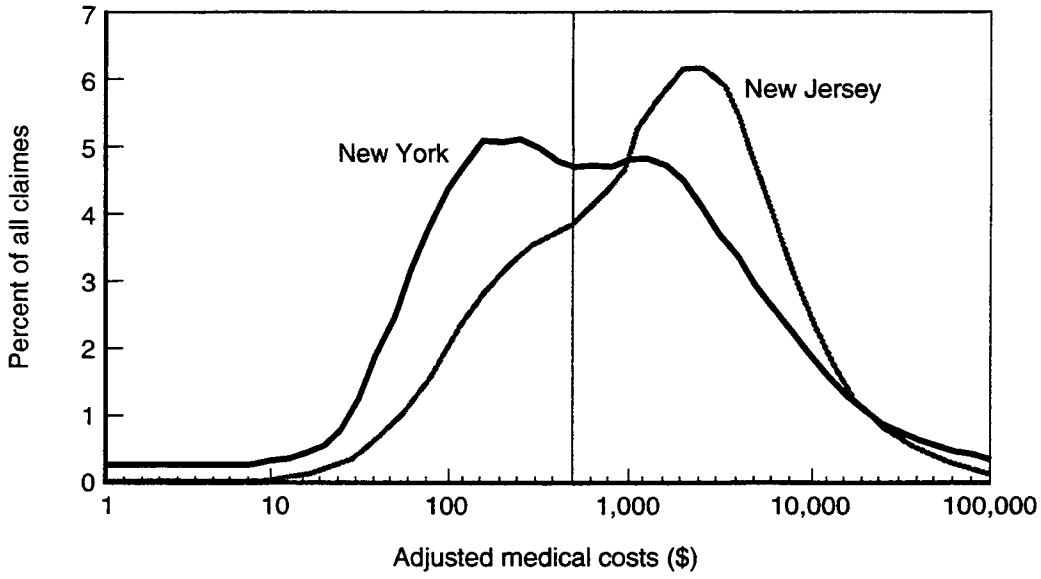

Fig 4–Distribution of Adjusted Medical Costs for Hard Injury Claims in New Jersey and New York

As was the case for soft injury claims, the distributions are as expected, given the incentives in these two insurance systems. New York's distribution rises sharply, flattens out, and then tails off to the right. New Jersey's distribution is distinctly right-shifted, compared to New York's. The fraction of New Jersey claims that are above the New Jersey threshold is much greater than the fraction of New York claims that exceed that number.

We compared the distribution of adjusted medical costs for hard injury claims in each of the states to the corresponding distribution for Michigan and New York combined. Four of the dollar threshold states--Hawaii, Massachusetts, New Jersey, and North Dakota--were significantly right-shifted relative to the reference states. The distribution of adjusted medical costs for hard injury claims

in Florida and in eleven of the tort states was significantly right-shifted compared to the combined Michigan/New York distribution.

Estimated Cost of Excess Claiming for Automobile Personal Injuries

Based on the detailed analysis illustrated above, we concluded that approximately 35-42 percent of all the medical bills submitted to automobile insurers by people who claim to have been injured in an automobile accident are excess in one or another of the senses defined earlier. We translated that percentage to dollar amounts as follows.

In 1993, the most recent year for which complete data are available, medical bills paid by auto insurers for people injured in automobile accidents totaled $11 billion.[8] If 35-42 percent of these medical costs are excessive, then the amount of health care we consumed unnecessarily in auto claims is approximately $4 billion.

Excess Claiming for Non-Automobile Injuries

We now turn our attention to estimating the amount of excess claiming for non-automobile personal injuries. The most comprehensive study of the claiming behavior of injured Americans is a congressionally requested survey funded by the Department of Health and Human Services and conducted by the Institute for Civil Justice in 1989.[9] We surveyed 26,000 randomly selected households comprising more than 70,000 individuals to measure the incidence of injury, health care utilization, and liability claiming. In detailed interviews with 2,800 injured household members, we gathered data about accident circumstances, the nature and severity of the injury, economic loss, compensation, and claiming.

We drew on this rich database for the current analysis. We estimated the medical costs on liability claims for both automobile personal injuries and for all other types of injuries. We distinguished automobile claims from all others in this

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[8]The National Association of Insurance Commissioners, *State Average Expenditures & Premiums for Personal Automobile Insurance in 1993*, Kansas City, MO, Jan. 1995, reports that private passenger automobile insurance premiums were $90 billion in 1993. The Insurance Information Institute, *Executive Letter*, New York, NY, Nov. 30, 1994 reports that health care compensation to injured persons accounted for 12 percent of automobile insurance premiums that year. This amount does not include what injured parties may have collected from first party health care insurance because in this analysis we are concerned only with costs within the liability system.

[9]See *Compensation for Accidental Injuries in the Unites States*, Deborah R. Hensler, Susan Marquis, et. al, R-3999-HHS/ICJ, RAND: Santa Monica, CA, 1991.

national sample so that we could compute the ratio of medical expenditures on automobile liability claims to medical expenditures for other liability claims. Given this ratio, we can use our estimate of excess claiming derived from the auto arena to estimate the cost of excess claiming for all other liability claims. Any action to obtain compensation from another takes place in the context of the tort system. Because the tort system is the ultimate recourse for an injured party who seeks compensation from another, the discussions between the parties are shaped by their expectations of how the injured party's claim would be resolved if brought to the tort system.

Claiming for Accidental Injuries in the United States

Figure 5 summarizes the pattern of liability claiming across all of the accident claims in the ICJ compensation study.

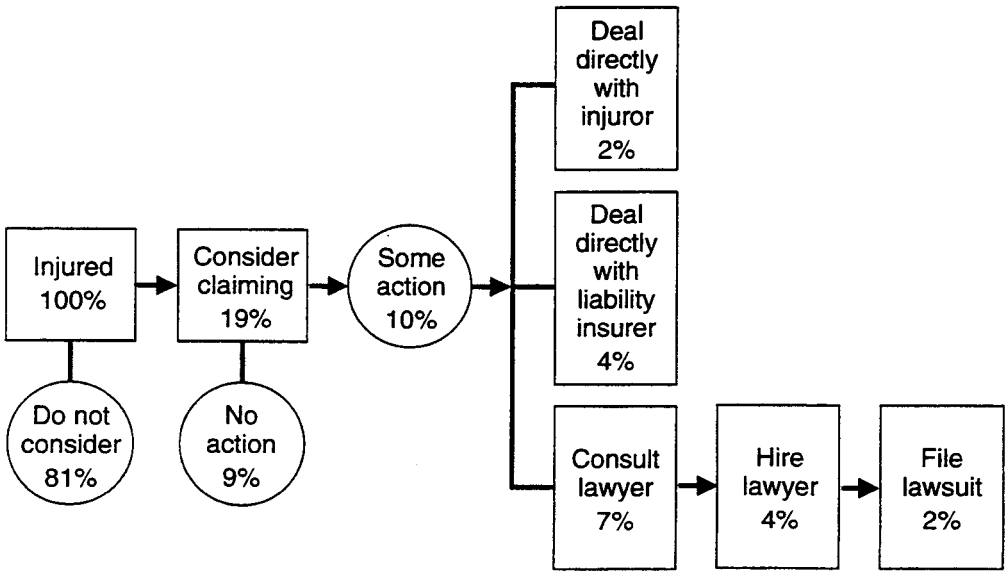

Fig. 5–Across All Accidents, Liability Claiming Is Infrequent

More than three-quarters of all those injured do not even considering seeking compensation for their injuries. About twenty percent consider claiming, but only ten percent take some action. Of those who do attempt to claim, the majority choose the legal route. (Some try more than one strategy.)

People injured in automobile accidents are much more likely to pursue claims against others than are people injured in other circumstances. Figure 6 shows the

distribution of all accident victims, the rates at which people injured in various types of accidents pursue claims for compensation, and the resulting distribution of all claimants. People injured in automobile accidents are almost four times as likely to pursue claims against another as are people injured in work-related accidents and almost 10 times more likely to pursue a claim as someone injured in any other type of accident. (We refer to non-automobile, non-work-related injuries as "other" injuries.) Consequently, although automobile accidents account for only 19 percent of all injuries, about 61 percent of all claims are brought by automobile accident victims. Conversely, the 60 percent of all injuries that result from "other" types of accidents give rise to only one-fifth of all claimants.

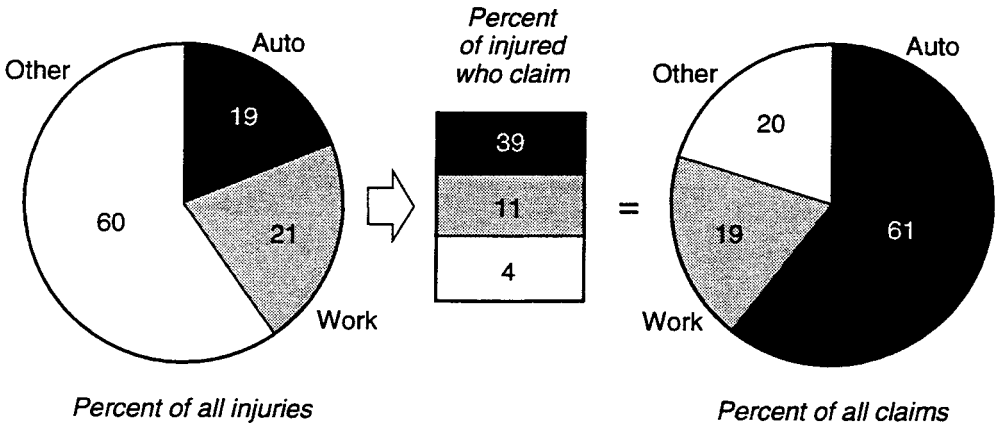

Fig. 6 – Tort Liability Claiming Rates Vary Dramatically by Accident Circumstances

The Costs of Excess Claiming for Non-Automobile Personal Injuries

We analyzed the responses of each of the 2,800 individuals who incurred some injury to identify which path they took through the claiming process. We included all those who took some action to obtain compensation from another, whether they dealt directly with either an injuror or a liability insurer or consulted a lawyer. We divided them into two groups, those injured in an automobile accident and those injured in some other form of accident, and estimated the medical costs for automobile accident victims and for all other accident victims. We then computed the ratio of the medical costs incurred by non-auto accident victims to the medical costs incurred by auto accident victims.

Based on this ratio, we estimated that 73-85 cents was spent on medical care by a claimant injured in a non-automobile accident for every dollar spent on medical care by a claimant injured in an automobile accident. Given the $11 billion insurers spent in 1993 on medical care associated with automobile accidents, we estimate that $8-9 billion dollars in health care was consumed by individuals injured in some other way.

How much of that $8-9 billion results from excess claiming? Although claiming rates for people injured in different circumstances differ, as we noted earlier other data suggest that those injured in non-auto accidents do respond to incentives provided by the tort system to exaggerate claims.

Based on this assumption, we can obtain a first-cut estimate of the extent to which people injured in non-automobile accidents exaggerated their medical claims by applying the auto excess claiming rate to the total health care dollars spent in non-auto injuries. Doing so, we estimate that $2.8 - $3.8 billion of medical care was consumed unnecessarily by people injured in non-automobile accidents.[10]

Estimated Excess Medical Costs of Liability Claims, 1993

We combine these two analyses to estimate the total amount of excess medical care consumed (see Table 2).

Table 2

Estimated Excess Medical Costs of Liability Claims (1993)

	$ Billion
Auto	3.8 - 4.6
All other	2.8 - 3.8
Total	6.6 - 8.4

Combining the estimate of excess claiming in the automobile arena with the estimate for excess claiming for all other injuries, we estimate that roughly $7-8

[10] As with the automobile excess claiming estimates, these estimates are for 1993, the most recent year for which data are available.

billion worth of health care resources were consumed solely to leverage larger settlements through the liability system.

Solution Directions

What kind of policy responses might reduce this excess consumption of health care resources? This analysis is not sufficiently definitive to provide a clear answer, but our work and conversations we have had with others suggest three directions in which we might look for solutions.

(1) *Examine our auto insurance systems.* Although automobile injuries account for only 19 percent of all injuries, more than half of the estimated excess health care consumption is attributed to them. Verbal no-fault systems appear to eliminate the incentives driving excess claiming while dollar no-fault systems appear to exacerbate them.

(2) *Schedule general damages for some or all cases.* For example, establishing a schedule for general damages based on the nature of the injury--similar to the schedule embedded in disability policies--would eliminate the incentive to inflate medical costs in order to leverage general damages.

(3) *Change the rules governing admissibility of medical cost information in courts.* Currently, juries may be told the cost of a claimant's medical treatment. Participants in an Institute for Civil Justice conference on interactions between our health care and liability systems argued that claimants inflate costs to impress the jury or to stimulate a favorable settlement in the shadow of the jury. Modifying admissibility rules about medical costs could eliminate the incentive to build medical costs.