Potential Impacts of Federal Medical Malpractice Interventions

An assessment based on available evidence

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There is an extensive body of empirical literature on the impact of medical malpractice (MM) on the U.S. health care system. Although direct payment of claims represents a small share of total health care costs, some argue that MM has a much larger impact on health care by giving physicians incentives to provide unnecessary treatment—a phenomenon termed “defensive medicine.” The evidence generally suggests that policy interventions that reduce MM liability tend to reduce health care costs to some degree, but the impact on patient care is mixed. Some studies have found that the threat of malpractice lawsuits promotes safer care and therefore better patient outcomes, but other studies have found no effect.

It is difficult to definitively answer the question of whether MM statutory tort interventions are effective in achieving their specific aims (e.g., in reducing the incidence of litigation, associated pay-outs, insurance premiums) or whether such laws produce unintended consequences (e.g., reducing the deterrence of negligence). In this memo, RAND researchers provide a thumbnail review of the empirical literature on the potential costs and benefits of several types of MM reform policies, specifically in connection with several potential and proposed aspects of federal tort interventions.

The proposals addressed in this memo include the Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2011, “The HEALTH Act,” (H.R. 5) and proposals made by the National Commission on Fiscal Responsibility and Reform and through the President’s Budget for Fiscal Year 2012. Because many of the reforms in H.R. 5 have been implemented at the state level, there is some empirical evidence on the potential effectiveness of at least some of its elements. By contrast, the alternative proposals have not been previously adopted or evaluated at the state level, so there is a more limited basis for evaluating the proposals’ effectiveness. This makes a direct, evidence-based comparison of the relative merits of the proposals impossible. In general, considerably more evidence is needed to fully understand the potential impact of any comprehensive reform of the medical liability system.

The RAND Corporation is a nonprofit institution that helps improve policy and decisionmaking through research and analysis. Consistent with that charter, RAND does not engage in advocacy work. The intent of this memo is not to advocate for a particular outcome. Rather, it is to provide a resource, rooted in objective research findings, to inform federal policymakers and other interested parties.

Additional background information, including a detailed discussion of the empirical literature on statutory tort reform, can be found on the RAND COMPARE website. Please contact Jesseca Boyer at Jesseca_Boyer@rand.org or 703-413-1100 x5196 with any questions or for further information.
Potential Impact of H.R. 5 Provisions

H.R. 5 would establish a new statute of limitations, caps on noneconomic and punitive damages, modification of the joint-and-several liability rule, and caps on attorneys’ contingency fees. Many of the provisions in H.R. 5 are similar in substance to the 1975 California Medical Injury Compensation Reform Act (MICRA).

Different versions of these proposals have been enacted by other states, usually with the common aims of reducing the occurrence of MM litigation and associated costs, curbing the practice of defensive medicine, and alleviating shortages in the supply of specialty services associated with higher liability risk. According to the National Council of State Legislatures, as of September 2010, 35 states had enacted caps on damages, 14 had enacted specific percentage limitations on attorney contingency fees, and 24 had enacted some alternative to the joint-and-several liability rule (NCSL, 2010). The liability restrictions in MICRA, particularly the $250,000 cap on noneconomic damages with no adjustment for inflation, are generally considered among the strictest in the country. Nevertheless, because a number of states already impose their own liability limitations, if enacted, H.R. 5 would have a more significant impact in states without similarly enacted laws.

In 2009, the Congressional Budget Office (CBO) estimated the potential impact of reforms such as those included in H.R. 5 on health care costs and predicted a 10-percent reduction in MM insurance premiums, a 0.2-percent reduction in direct aggregate health care expenditures, and a 0.3-percent reduction in expenditures related to defensive medicine (CBO, 2009a, 2009b). The most recent CBO projections, based on these estimates, suggest that H.R. 5 would reduce federal expenditures on health care by $40 billion from 2011 to 2021, a small share of health care costs overall but a non-negligible dollar amount (CBO, 2011).

Another potential effect of liability reforms is on access to healthcare, in the form of an impact on physician labor supply. A number of recent studies have concluded that reforms reducing the expected cost of liability increase the availability of physician services, particularly for high risk specialties such as obstetrics and for rural areas (Kessler et al., 2005; Klick & Stratmaan, 2007; Matsa, 2007; Helland & Showalter, 2009). While these studies mostly consider the impact of reforms more generally, it is likely that a package of reforms such as those introduced by H.R. 5 could generate a small increase in the supply of physicians and increase access to care.

- H.R. 5 §3—Limiting time to sue (speedy resolution of claims)

Using data from state MM closed-claims databases, the Bureau of Justice Statistics estimated that medical malpractice claims are reported within 15–18 months, on average, although the median reporting lag for cases involving surgeons is almost two years (Cohen & Hughes, 2007). In Florida, a state that has a publicly available closed-claim database, almost 5 percent of MM cases resolved during 1999–2004 took longer than three years to report. By inference, a new federal statute of limitations would presumably reduce some fraction of MM claims and associated costs, perhaps approximating the rate in Florida from 1999 to 2004. To the best of our knowledge, adjustment to the statute of limitations has not been evaluated as frequently as other types of tort reform, so the empirical evidence for its effectiveness as a cost-control device in MM litigation is lacking.
• **H.R. 5 §4—Damage caps (compensating patient injury)**

Caps on noneconomic damages are among the most commonly proposed statutory interventions to MM liability. Empirical evidence is stronger concerning the ability of caps to lower MM costs, and thus health care costs, than for most other forms of tort intervention. Even if these caps succeed in lowering MM costs, however, they may raise some concerns. There is evidence to suggest that cases with the greatest percentage reductions in total awards are those with small economic losses but in which juries found great damage to the plaintiff’s quality of life. One major study found, for example, that the effect of noneconomic damage caps tend to be most pronounced in cases involving elderly plaintiffs (whose wage losses are likely to be smaller) or wrongful deaths (Pace et al., 2004).

• **H.R. 5 §4—Fair share rule (compensating patient injury)**

Modification of the joint-and-several liability rule in MM litigation would make each defendant to an MM claim liable only for his or her proportional share of fault in connection with the injury. This has an important legal effect of making the plaintiff responsible for joining all relevant defendants at the beginning of MM litigation, or else risk losing some compensation for injuries. According to RAND COMPARE, empirical evidence concerning the effectiveness of eliminating joint-and-several liability in reducing MM litigation or its associated costs has been weak and mixed. CBO commented on joint-and-several liability reform specifically in its 2009 letter to Orrin Hatch and observed that this kind of reform might actually increase utilization and defensive medicine costs in some circumstances (CBO, 2009).

• **H.R. 5 §5—Contingency fee limits (maximizing patient recovery)**

Attorney fee limits (AFLs) are another key feature of MICRA-style statutory tort intervention. The direct impact of this reform is to increase the share of a given award that is recovered by the plaintiff and decrease the share that is recovered by the plaintiff’s attorney(s). Pace (2004) found that the contingency fee schedule adopted by MICRA significantly increased potential compensation to plaintiffs, offsetting about half of the decline that was imposed by the adoption of the noneconomic damage cap. This suggests that contingency fee limits possibly play a key role in minimizing the adverse impact of other tort reforms on the compensation awarded to plaintiffs.

However, it is also possible that contingency fees could reduce the ability of potential plaintiffs to obtain the services of an attorney. It is intuitive that a plaintiff attorney’s willingness to take a case on a contingency basis may decline if contingency fee percentages are significantly reduced, and at least one survey study of plaintiff attorneys supports this assertion (Garber et al., 2009). If attorneys are less willing to take cases, that may reduce the volume of MM litigation overall. Whether the impact on attorney representation is a net negative or positive from a social standpoint depends on whether the impact is felt on meritorious or non-meritorious claims. Helland and Tabbarok (2003) found that caps on contingency fees tend to lower the number of low quality cases—cases that are less likely to result in a positive judgment or settlement for the plaintiffs. More generally, evidence on the net impact of contingency fees on social welfare is inconclusive.
• H.R. 5—Other provisions

Additional provisions under H.R. 5 include caps on punitive damages, revisions to the collateral source evidence rule, and periodic payment of future damages. Recent scholarly reviews (including RAND COMPARE and Mello, 2006, 2011) suggest that there is no strong empirical evidence that these forms of tort intervention have been effective in states that have adopted them, either in reducing litigation costs or in reducing the volume of MM litigation.


The President’s Budget for FY 2012 calls for a $250 million grant program to fund the states in implementing new legal MM reforms.

According to several media accounts, key types of state reforms that might be supported by the new federal grant program include health courts, establishing safe harbors from MM liability based on best clinical practice guidelines, establishing hospital-based early apology and compensation programs, and possibly other sorts of legal reforms (such as instituting a “fair share” rule in MM litigation). These specific proposals correspond closely to those suggested in the December 2010 report of the bipartisan National Commission on Fiscal Responsibility and Reform. We briefly comment on each of these points in turn.

• Establish health courts in which judges, rather than juries, determine liability and damages

At present, there is little empirical literature to document the impact of health courts on MM litigation or costs, mainly because no state has yet enacted such a system. It seems plausible that a health court system that eliminated jury trials and awarded damages based on a predetermined schedule of damages might be able to reduce aggregate MM payouts and legal expenses. However, the impact would depend on the details of how such a health court is organized, what its procedural rules are, and what kinds of rights litigants would have in such a court. To reduce aggregate payouts and expenses, any hypothetical health court system would need to be more administratively efficient than the current litigation scheme, reduce payments made to attorneys, or reduce awards paid to plaintiffs. Each of these possibilities for savings would involve similar trade-offs to those with the provisions discussed above.

• Create a legal safe harbor to MM for doctors and hospitals based on best practice guidelines

Such a safe harbor is not a new idea, several states experimented with safe harbors in the 1990s but those four states (ME, FL, MN and VT) abandoned them. There is no empirical evidence to document the litigation or cost effects of a safe harbor statute. The simplest version of a safe harbor, which would permit best practice guidelines to be entered as evidence for the standard of care in an MM trial, might not represent much of a departure from the status quo in many states. Stronger versions of a safe harbor could have more dramatic effects on physician liability and the practice of “defensive medicine,” but this cannot be proven without real-world evidence. As is true with the concept of health courts, implementation details and varying approaches among states could be very important. The details of
how a particular safe harbor statute is structured will be influential in determining its effects on MM litigation and associated costs.

- **Encourage or mandate early apology and compensation programs in health care facilities**

There is some empirical evidence to suggest that early apology programs can reduce the incidence of MM litigation (Gallagher, Studdert & Levinson, 2007). Due to the many possible variations of hospital-based early apology and compensation programs, and of state laws designed to protect, facilitate, or incentivize those programs, the details of the programs and laws will be very important in determining their ultimate effects on MM litigation and related costs.

- **Change legal rules to substitute a “fair share” rule in place of joint-and-several liability**

Similar to the H.R. 5 §4 provision, according to RAND COMPARE, empirical evidence concerning the effectiveness of eliminating joint-and-several liability in reducing MM litigation or its associated costs has been weak and mixed. CBO commented on joint-and-several liability reform specifically in its 2009 letter to Orrin Hatch and observed that this kind of reform might actually increase utilization and defensive medicine costs in some circumstances (CBO, 2009).

**Summary**

There are long-standing concerns about the medical malpractice system that have made it a common target of reform efforts. There is evidence that the system is inefficient, costly, does a poor job of targeting true negligence and increases healthcare costs (Localio et al., 1989; Kessler & McClellan, 1996; Thomas et al., 2000; Mello et al., 2006; Lakdawalla and Seabury, 2009). This memo summarizes what is known about the potential effects of current proposals to reform the malpractice system at the federal level based on the current state of empirical evidence. Many of the proposed changes introduced by H.R. 5 have been introduced previously at the state level, offering the opportunity to evaluate their potential impact. Based on the experiences of states introducing reform, these provisions are likely to reduce healthcare costs and increase access to care, though potentially at the cost of restricting access to justice, lowering compensation for the victims of negligent care and possibly even worsening patient safety. It is possible that some alternative positions could achieve the same goals of lowering costs without the same adverse effects, but a true evaluation cannot be made without more empirical evidence demonstrating the relative cost and benefits of different types of reforms.
References


Congressional Budget Office. (2009a, October 9). Letter to the Honorable Orrin G. Hatch regarding effects of proposals to limit costs related to medical malpractice.

Congressional Budget Office. (2009b, December 10). Letter to Senator John D. Rockefeller IV regarding questions about CBO’s analysis of the budgetary effects of proposals to limit costs related to medical malpractice.


NCSL—see National Conference of State Legislatures.
