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Physician liability insurance reform

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Summary Rapidly rising medical malpractice insurance costs are causing reduced access to health care services. Physicians and other health care professionals are limiting or discontinuing high-risk procedures and services to reduce their malpractice insurance cost and potential liability; patients are forced to travel greater distances to obtain these health care services. The cause of the rapid rise in medical malpractice premiums and the effects of the tort system upon these increases continue to be debated among stakeholders. Nevertheless, studies have demonstrated that the current tort system fails in its goals to compensate victims of medical negligence and as deterrence to the occurrence of medical errors. A broad-based approach that includes insurance reform, enhancements to the physician peer review system, a protected system of reporting medical errors, and federally funded studies to determine alternate methods of resolving medical malpractice claims are required to restructure the current medical liability system.

The volatile nature of the medical malpractice market has created a crisis of affordability and availability for the third time since the 1970s. Investigative studies published in 2003 by the US Department of Health and Human Services (DHHS) and the US General Accountability Office (GAO) revealed reduced access to health care services in localized areas resulting from recent drastic increases in medical malpractice insurance premiums ranging as high as 165%.[1-3] Physicians, hospitals, and other health care professionals have either limited or discontinued certain services to curtail their risk of litigation and to reduce insurance costs.[1,2] Across the country, patients are forced to travel greater distances to receive emergency surgery or labor and delivery services.[1,2] A factor further exacerbating the crisis is that medical malpractice insurance is becoming increasingly difficult to obtain, regardless of price, because a number of major carriers have exited the market.[1]

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Although it is commonly accepted that the current medical liability system needs to be restructured, there is significant disagreement regarding the types of reforms that would provide a resolution to the present crisis. The Medical Injury Compensation Reform Act (MICRA) enacted by the state of California in 1975 is touted by proponents as a model for tort reform and is currently the subject of considerable debate. The most heated and often acrimonious discussions between stakeholders involve the limits on noneconomic damages.

Both promoters and opponents of tort reform point to the results of MICRA to support their respective arguments. The American Bar Association (ABA) contends that the increases in malpractice insurance are a result of a reduction of the insurance companies' investment income and the insurance underwriting cycle that causes periodic swings in premium rates.[4] They state that reforms similar to MICRA do not have a proven record of reducing malpractice rates and for this reason they oppose them. Countering these arguments are the American Osteopathic Association and American Medical Association, who maintain that rising jury awards and the high cost of defending against lawsuits are the primary causes of the unprecedented increase in

liability rates. They assert that states with caps of $250,000 on noneconomic damages have been successful in restraining the increases in malpractice premiums.[5,6] Both sides of the debate present conflicting statistical evidence in defense of their positions. The issues behind these opposing views include the origins of the escalating malpractice premiums, the frequency of malpractice claims and average jury award, and the effects of past tort reforms upon liability rates and their impact on access to health care. States have enacted various types and combinations of tort reforms (i.e., caps on noneconomic damages, limits on contingency fees, abolition of collateral source rule), which make the analysis of the performance of each type of reform across multiple states difficult at best.

Solving the medical malpractice crisis will involve a multilevel approach that includes both short- and long-term provisions. Short-term changes should include insurance reform, federal legislation for tort reform, a strict physician peer review system, and the establishment of methods to report medical errors confidentially, ultimately improving patient safety. Long-term restructuring of the current tort system would necessitate government-subsidized studies on the viability of proposed alternatives such as establishing specialized medical courts to review malpractice cases; instituting a specific damage award for a similar type of injury; implementing enterprise liability, a no-fault malpractice system, and a national reinsurance program; and possibly using private contracts between physicians and patients.

History and background

The legal system of torts was created to compensate victims of negligence and to deter acts of negligence. Medical malpractice is part of the tort system or personal-injury law. Insurance companies accept the financial responsibility for the payment of malpractice claims made against health care professionals covered by their policies. In this manner, the insurance companies provide professional liability insurance (PLI) to protect health care professionals from potential financial devastation stemming from malpractice awards.

Three medical malpractice crises have occurred over the last 30 years (early 1970s, mid-1980s, and early 2000s), all of which were marked by an acute rise in insurance premiums and departure of major insurance carriers from the market. As a consequence, physicians and other health care professionals were left scrambling to obtain insurance coverage.[7] In response to the crisis of the 1970s, the state of California enacted the Medical Injury Compensation Reform Act (MICRA) in 1975. Key provisions under MICRA are listed in Table 1.[8]

Over the years, all states have enacted a mix of MICRA-like tort reform measures. During each of the malpractice insurance crises, much debate ensued regarding the reasons for the sharp increases in liability premiums. The most divisive discussions revolved around the role of the insurance cycle during economic downturns, losses of investment income, frequency of claims filed, and jury awards. These very issues are still being debated.[7,8]

Table 1 Medical injury compensation reform act–key provisions

Noneconomic damages	Limited to $250,000
Periodic payments	Permitted for awards greater than $50,000
Collateral source rule	Permits juries to be informed of compensation from other sources
Joint and several liability	Multiple defendants are liable only for their share of noneconomic damages
Contingency fees	Places limits on attorneys fees

On the surface, the current crisis may seem like a repeat of the previous ones. However, many events between then and now have changed the climate. What is different about the current medical malpractice crisis of the 2000s? A recent article published in the *New England Journal of Medicine* highlights two significant differences: (1) The inability of the health care industry to absorb abrupt increases in malpractice premiums and (2) recently heightened concerns about patient safety. In the 1970s and 1980s, health care professionals were able to increase their billing for services to cover the increased premiums. The advent of managed care, fee-for-service set by insurers, and the Medicare strict price control policy have virtually blocked this avenue of cost recovery for health care professionals.[7] The 1999 Institute of Medicine report "To Err is Human" estimated the number of deaths per year caused by medical error to be 44,000 to 98,000.[9] The release of this report brought patient safety to the front pages and with it medical malpractice and patient safety have become inseparable, adding another facet to the malpractice debate.[7] As a result, any provisions proposed for the resolution of the malpractice crisis must address patient safety concerns as well. Finally, access to health care in localized regions is being affected during the current medical malpractice crisis in contrast to those of the 1970s and 1980s.[1,2]

Another factor confounding the analysis of the present medical malpractice crisis is that the insurance market underwent gradual modifications since the 1970s and 1980s. The medical malpractice insurance market transformed from traditional large property and casualty insurers to companies primarily owned and operated by physicians. In addition, the types of malpractice policies underwritten by insurance companies changed from mainly occurrence-based claims (covers incidents that occur, but are reported after the policy period ends) to claims-based (covers incidents that occur and are reported during the policy period). These changes make it difficult to determine the extent to which past tort reforms have limited the increase in malpractice premiums. Moreover, all of the states have passed different

combinations of tort reform since the 1970s, further fueling the debate on the impact of each type of reform.[2] The combination of these factors are fertile grounds for the conflicting evidence presented by interested parties and make it difficult for policy makers to sort through the different proposals for solutions that have been brought to the table.

Adding yet another dimension to the medical malpractice liability debate is evaluating the performance of the current tort system concerning the compensation of victims of negligence and the deterrence of acts of negligence. According to the results obtained in the Harvard Medical Practice Study III, only 1.53% of persons injured by medical negligence file a claim.[10] In contrast, a large percentage (up to 70%) of malpractice claims filed result in no payment to the plaintiff.[3,11] In light of these facts, the system as it stands performs poorly with regard to compensation of victims. It appears that the performance of the tort system is just as inadequate as a form of deterrence of medical errors. Medical malpractice premiums are sold on a non–risk rated basis. As a result, the cost of premiums is not entirely assumed by the doctor who committed the act of negligence, but rather it is spread to all of the physicians in his/her specialty. This type of arrangement greatly undermines the deterrent effect that the current tort system is alleged to exert.[1] The striking failure to compensate most victims of medical negligence and its meager deterrence effect highlights the need for a reformation of the current medical malpractice tort system.

In recent years, several MICRA-type legislations have been presented for consideration at the federal level in an effort to stabilize the malpractice insurance market. The latest bill H.R. 5, the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011" was introduced on January 24, 2011 to the 112th US Congress. In contrast to some of the legislative bills previously presented to the US congress, the HEALTH Act of 2011 includes a provision for an early offer program in which the defendant may make a reasonable offer to the claimant to settle the health care claim. If the claimant rejects the offer, the amount of any noneconomic damages awarded to the claimant in a lawsuit may not exceed $350,000. In addition, the HEALTH Act of 2011 includes provisions to protect current and future state liability reforms. The bill was referred to the House Committee on the Judiciary and the House Committee on Energy and Commerce. To date, no further actions on this bill have been taken by the US Congress and is pending consideration by these committees.

Stakeholders

The American Bar Association and Public Citizen (a large consumer advocacy group) oppose MICRA-type tort reforms.

They contend that this type of medical malpractice reform would not have the effect of reducing the cost of obtaining liability insurance and limits the rights of patients to receive just compensation for adverse events from acts of medical negligence. These groups place blame upon the insurance companies for the rise in malpractice premiums. Their argument is that the decrease in investment income propelled the insurance companies to markedly increase the rates for liability insurance.[4,12]

Their greatest concerns regarding the MICRA-type provisions included in the HEALTH Act of 2011 are as follows[4,12]:

- **Noneconomic caps:** Compensate injured parties for human suffering, pain, or negligence that lead to loss of child bearing, disfigurement, and paralysis. These damages are not easily measured in monetary terms, yet the losses are real. A cap on noneconomic damages affects victims of severe permanent injuries who are in the greatest need of financial protection.
- **Joint and Several Liability:** In the case of more than one defendant, this provision allows a plaintiff to collect the full amount of the award from either defendant in the case that the other is unable to pay. Abolishing this provision would leave the injured party with no recourse to recover compensation in the event of an uninsured or bankrupt defendant.
- **Limits on attorneys' fees**: Attorneys take risks in terms of expenses in preparation for representing a malpractice lawsuit. Placing caps on attorney fees potentially decreases the benefit of taking on malpractice cases and therefore may prevent many victims from being able to obtain legal representation.

The American Osteopathic Association, American Medical Association, and American Hospital Association have declared medical malpractice reform as a top priority issue on their legislative agendas.

These associations favor MICRA-type reforms and state they have a proven record of restraining the elevations in malpractice premiums. They further state the primary cause of the medical liability crisis is the escalating and unrelenting rise in jury awards. As a consequence of the crisis, physicians and other health care professionals have limited their scope of practice to avoid risky services that may place them at risk for litigation. Emergency and obstetric services have been the most affected and patients are being left without needed services that are readily obtainable.[5,6,13]

Their arguments in favor of tort reform include the following:

- **Limits on noneconomic damages:** Noneconomic damages have no precise monetary value; as a result awards are erratic. Placing a cap of $250,000 on these damages has a proven record of reducing the rate at which insurance premiums rise and increases the availability of medical malpractice insurance. In addition, patients will be able to recover fully any and all economic damages.
- **Abolishment of Joint and Several Liability:** The current system imposes a hardship on defendants who are minimally at fault in a malpractice case. Eliminating this provision would ensure that the defendants are liable only for their share of the plaintiff's injury.

■ **Limits on contingency fees:** Maximizes the award that a plaintiff may receive by making certain that a large portion of the award is not taken up in attorney's fees.[5,6,13] According to the American Bar Association, the most common contingency fee rate is one third of the recovery award.[14]

The National Association of Health Underwriters and the American Insurance Association are in favor of tort reform.

They argue that the main cause of the dramatic increases in malpractice premiums is the losses sustained on medical malpractice claims.[15,16] This fact was confirmed by the investigational study conducted by the GAO dated June 2003.[3] Although the study did acknowledge that other factors such as declines in the insurer's investment income and increased reinsurance rates had an impact on malpractice premium rates, it concluded that the major part of the insurer's cost are the losses on malpractice claims and thusly the chief culprit in rate increases.

Recommendations

The current tort system has been criticized for its inability to compensate victims of medical negligence and as a form of deterrence of medical errors.[8] In recognition of the need for medical malpractice liability reform, the Patient Protection and Affordable Care Act (H.R. 3590), which was signed into law on March 23, 2010, authorized the Secretary of Health and Human Services (HHS) to award grants to states for the development, implementation, and evaluation of alternatives to the current system of tort litigation.[17] Nevertheless, providing solutions to the medical malpractice crisis will require a multilevel approach.

Health care professionals' distrust and fear of litigation must be addressed to improve **patient safety**. In an era in which medical malpractice premiums are drastically rising, and obtaining coverage is becoming increasingly difficult, it is not surprising that health care professionals are fearful of error disclosure. Open yet confidential disclosure of medical errors will lead to the establishment of methods to prevent the same errors from recurring. Enactment of the Patient Safety and Quality Improvement Act of 2005/S544 in July 2005 was a positive step in identifying and preventing medical errors. Physicians must take an active role in adopting measures toward reduction of medical errors that would ensure patient safety. In addition, they should implement an effective peer review policing system to identify and swiftly remove from practice physicians who provide substandard care and are negligent in their practices. These measures could potentially improve patient confidence in the services provided by physicians.

Passage of all of the **MICRA key provisions** at the federal level is an essential short-term provision to curtail the current malpractice crises. MICRA has been successful in providing a more stable malpractice market in California compared with other states. Graphs presented in the GAO report of June 2003 demonstrate this stability.[3] Moreover, in an October 2009 analysis of the MICRA tort reform provisions, the Congressional Budget Office reported that enactment of these provisions at the federal level would reduce total national health care expenditures by 5%; reduce national medical liability premiums by 10%; reduce mandatory spending on Medicare, Medicaid, and other federal health insurance programs by $41 billion over 10 years; and reduce the federal deficit by $54 billion over the next 10 years.[18]

The following **insurance reforms** should be enacted to increase the availability of malpractice insurance: (1) Place limits on the ability to cancel malpractice policies, (2) require a mandatory review of rates charged by the insurance company before approving a premium increase, and (3) call for full disclosure to insurance regulators of the disposition of all claims filed against malpractice policies. The review of premiums ought to be conducted by an appropriate government agency.

Finally, long-term provisions should include **government-funded studies** on the feasibility of other proposed reforms such as[8,19]:

■ Formation of a specialized tribunal, which according to Common Good, would provide predictability to the litigation process. One advantage is that the judges would have enough medical training to be able to interpret standards of care.[19]

■ Formation of an agency to predetermine the compensation for specific types of injuries that would provide consistency and uniformity for similar injuries.

■ Establishment of a national reinsurance program to stabilize swings in insurance premiums.

■ Establishment of enterprise liability whereby the large institutions would bear the weight of the liability in a malpractice case instead of individual health care professionals. Proponents favor this type of arrangement because it could improve the deterrence effect of the malpractice system.

■ Adoption of a no-fault approach to medical malpractice claims. By eliminating the determination of negligence, such a system could potentially facilitate the filing of claims, streamline awards of injured parties, and augment reporting of medical errors.

In summary, the present medical malpractice tort system fails to deter medical errors, compensates only a small percentage of patients affected by negligent care, and is driving shortages in specialty and primary care services through rapidly rising insurance rates. New approaches, including those suggested here may address these issues and improve patient safety.

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