Has Medical Malpractice Tort Reform Worked?

In a new book for the Cato Institute, *Medical Malpractice Litigation: How It Works, Why Tort Reform Hasn't Helped*, a politically diverse group of health care and legal experts examine the track record of tort reform at fixing America's notoriously costly system of medical malpractice litigation and insurance. The book focuses in particular on the experience of Texas after a major overhaul in 2003. In June, Cato hosted a book forum moderated by Sen. Bill Frist (R-TN), himself a medical doctor and former Senate majority leader. Coauthor and Cato adjunct scholar **David Hyman** explained the book's findings, which were challenged by **Richard Anderson**, chairman and chief executive of The Doctors Company, the nation's largest physician-owned malpractice insurer.

DAVID HYMAN: First, to explain the background of our book a little bit, it focuses on Texas, which enacted major tort reform effective for cases filed in 2003 and later. And Texas is also one of the states that has a comprehensive database of medical malpractice claims. So we use that to study all of the surrounding malpractice litigation and insurance. And then we use other available data to analyze some of the same questions nationally, to see if the experience in Texas is representative.

So let me just start by flagging the real issue that physicians are concerned with, which is recurrent crises marked by sudden and dramatic increases in their malpractice premiums. The most recent one was around 2000–2001. If you look at the percentage increase in the malpractice premiums charged by basically every major company, you can see a dramatic increase. We're talking about a 100 percent increase over a relatively short period of time, and that causes real stress for physicians who are used to having premiums be at one level, and then they suddenly double. It can be even higher for certain specialties, especially high-risk specialties.

In 2003, Texas enacted a liability cap, which is the most popular reform idea, and what happened? Caps, it turns out, have a very substantial effect on both the number of paid claims and also the amount that's paid to resolve those claims. What you see is a pretty dramatic decline in both the number of claims and the payout per claim, after Texas enacts this cap, which wasn't a simple flat cap but did heavily constrain noneconomic damages. We saw a 60 percent drop in claims and a 42 percent drop in payout per claim, for a combined effect of 75 percent drop in per capita payouts. So, caps do work. They have a big impact. The question is, what else do they do besides reduce payouts? And at the end, will that fix the problems with the medical malpractice system?

One of the things you often hear in debates over tort reform is the claim that doctors are leaving the market, that we should enact the cap on damages to keep the doctors we have and attract new doctors. But in Texas, we don't find that effect. Basically, we see a continuation of the preexisting trends. You should obviously consider the possibility that a cap might have a different effect in other states, and it might have an effect on certain types of physicians, but not on others. We look at those issues as well and find similar conclusions.

We draw a series of lessons from all of that that I'd like to sketch out for you. The first is we don't find evidence that the medical malpractice system is doing a particularly good job. In fact, we think it's doing a pretty rotten job at the things that we would like it to do. It doesn't adequately compensate people who are entitled to it under our laws—that is, negligently injured patients—and the severely injured are the least well compensated. Second, it doesn't adequately deter negligence.

The current system doesn't send the right signals to physicians—it doesn't tell them "don't do this or that because it will cost you money," which is of course the whole point. That happens for a variety of reasons. Some of it has to do with people who are negligently injured not bringing claims, and some of it has to do with people who aren't negligently injured bringing claims and then being paid for those claims that shouldn't actually be paid.

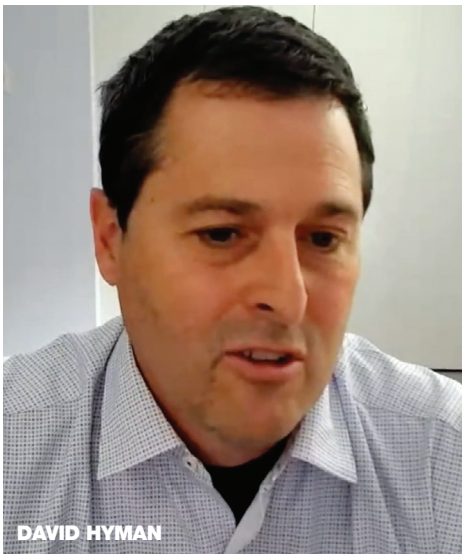
The process is also very expensive and time-consuming. It's disliked by everyone involved, pretty much across the board. Doctors especially hate it and with good reason. And so the obvious issue is that there's got to be a better way, and what is that? Well, based on this work, we don't think damage caps are the better way, because they don't fix any of the problems we just alluded to. They don't improve compensation. They don't improve deterrence. They don't make the system less expensive or time-consuming, except by making cases go away entirely. And it's not obvious why it would change people's dislike of the system. It makes some of those problems worse.

The next set of key lessons are also rather simple. Premium spikes are real, but we don't find evidence that they're driven by things happening inside the litigation system—that is, the number of claims and the payout per claim. Defense costs are

going up, but they're not going up enough to drive the sorts of premium spikes I mentioned earlier. We also find in Texas and elsewhere that paid claims have declined steadily since 2001, when the last malpractice crisis started, and they've been declining even in states that don't cap damages. And the smaller claims—smaller in terms of dollars, not necessarily in terms of severity of injury—have been steadily disappearing from the system, because they're no longer worth pursuing in a contingency recovery system, where the lawyers only get paid if they win. And medical malpractice insurance premiums, which went up a lot in the last malpractice crisis, have declined. They're now back to the level of the mid-1990s.

Given that we've had three malpractice crises in the last 40-plus years, you should expect another one reasonably soon. So what should we do? We think we should fix the real problems with the system. Doctors are very worried about the risk of personal bankruptcy. We think there's an easy fix to that: so long as the doctor maintains a reasonable amount of insurance, we don't think there should be any personal liability. We also suggest using a no-fault system for small claims. We think more experimentation, including what are sometimes called apology programs or Communication and Resolution Programs are worth experimenting with, along with enterprise liability rather than leaving individual physicians on the hook.

We think institutions ought to be more involved. Private contracts and safe harbors to keep people from being sued when they adhere to the standard of care strike us as plausible improvements. And finally, we think we need better incentives to deliver error-free care. This has little to do with malpractice insurance but a lot to do with how we pay for health care. Sometimes we pay more when physicians and health care institutions make mistakes. We pay them for the original job, and then we pay them to fix their mistakes. That's not something you would do if you were dealing with a car mechanic. It's not something you would see anywhere outside of the health care system. And it's part of the reason why our health care system has the problems that it does, which is the focus of our other book, *Overcharged: Why Americans Pay Too Much for Health Care*. The bottom line is that the proliferation of third-party payment and employer-based insurance creates a lot of these perverse incentives. They're not actually the product of the malpractice liability system, that's just one place where the symptoms show up.


DAVID HYMAN

> "We need better incentives to deliver error-free care."

RICHARD ANDERSON: The Texas tort reforms were extremely effective and did exactly what they were designed to do. The reams of data that were subjected to extensive statistical analysis by the authors and their colleagues basically leave us with a conclusion that the earth is flat. Their conclusions don't match the reality we've seen. Their data, in fact, do not comport with the real world and specifically the Texas professional liability environment before and after the tort reforms of 2003. So let's see where we can find common ground and where we might disagree. One thing, however, right at the start, which we can absolutely agree on is that the system of medical malpractice litigation is broken. Absolutely, we agree on that. And I'll show you some of the ways in which it's broken in just a minute.

One of the points Dr. Hyman and his coauthors make is that the medical malpractice system doesn't provide full compensation to some negligently injured patients and provides especially poor compensation to those with severe injuries. The answer to that from my point of view is yes, it overcompensates some and undercompensates others. The problem is that our adversarial legal system is a draconian combination of adventurism and the lottery.

The authors say our medical malpractice system doesn't create appropriate incentives for providers to exercise care. Yes and no. The shame-and-blame proceedings and the secrecy of many settlements incentivizes defensive medicine. There's no question about that. But the theory here is that the threat of litigation should lead doctors to practice better medicine. The aversion to medical malpractice litigation by physicians is so intense and so universal that if it were possible to stay out of court by practicing better medicine, doctors would do that universally. The real problem is, it's not possible to stay out of court in our system, regardless of how good the medicine you practice is.

Our medical malpractice system is expensive, time-consuming, and leads to hard feelings. The claim in this book is that damage caps don't fix any of these problems, and they make some worse. Well, actually, damage caps clearly do ameliorate the litigation lottery, and they lessen the disproportionate

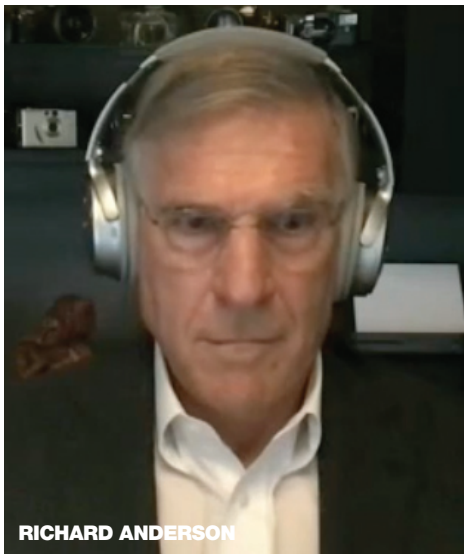
burden of premiums on practicing physicians. In our $4 trillion health care system, physicians pay about 50 percent of all the medical liability premiums—that is, doctors and not institutions. The burden falls very disproportionately on the physicians, and damage caps do help with that.

The authors state that premium spikes are real but can be caused by factors external to the litigation system. Well, the litigation system is what they are actually caused by. Premium spikes are caused by the number of claims, the payouts per claim as defense costs, the drawn-out length of malpractice litigation, and dysfunctional regulation of the insurance industry. These things all contribute to the steepness of the ups and downs. It takes three to five years from the day a physician pays a premium for protection before the average claim is settled, and yet insurance companies must predict in the premium what the cost of settlement of claims will be three to five years in the future.

When those numbers turn out to be excessive (that is to say, the claims costs are higher than anticipated by the companies and actuaries and so forth), in most states, one must get regulatory approval from the state department of insurance to raise rates. That is a politically fraught process; it's an incremental process and adds years before the risk and liability can match the premium. So you may be looking at a five-to-seven-year gap between a surge in claims or excess claims costs, or costs of defense, and the time when rates can catch up, creating a very steep up-and-down picture.

Yes, nationally, malpractice litigation premiums have been falling since 2005 and are now back to levels of the mid '90s. But why? The reason is that real tort reforms have worked. And because they have worked, and because insurance carriers know that, premiums have gone down to reflect that reduced risk. Insurance companies base rates on the risk and cost of litigation, and in fact, have lowered premiums as that risk has declined.

The average neurosurgeon spends about a quarter of their career defending active claims. Think about that. A quarter of their career is spent in active litigation. When you take out the claims that were ultimately paid, you still get 20 percent. That is a fifth of a neurosurgeon's career spent defending claims that ultimately are found by the legal system to be without merit.


RICHARD ANDERSON

> "Malpractice premiums have been falling since 2005."

This is really very important context, and it brings us to the point of defensive medicine, the distinction between supposedly high risk and low risk. The reality is that there's virtually no such thing as low-risk medicine, in terms of facing malpractice claims. High-risk specialties over the course of a physician's career have statistically a 100 percent likelihood of producing a claim. So-called low-risk specialties over the course of a physician's career have an 80 percent chance of producing a claim. So when this book says, "The medical malpractice system is broken," I couldn't agree more.

If we focus on Texas, we can put its tort reform in context. In the 10 years between 1989 and 1999, the average noneconomic damage award in Texas quadrupled from $318,000 to $1,379,000. Between 1995 and 2002, which is the period just before the tort reforms were implemented, Texas doctors were sued about twice as frequently as doctors in other states, on average. Some counties in Texas averaged more than one claim for every doctor every year. Whole counties had more claims than doctors on an annual basis for a number of years in a row. And again, how much of this is valid medical error that's found to be the case by the courts themselves? Fourteen percent. Eighty-six percent of all claims against Texas doctors in that period were ultimately found to be without merit, and that is still true today.

But of course, going through the litigation system has enormous costs, and all of these claims have costs with them. In the four years before the 2003 reforms, 50 percent of Texas nursing homes were uninsured because they couldn't find or afford the coverage that was available. In fact, 13 physician liability insurers left the state or went bankrupt prior to 2003.

Of course, tort reforms weren't designed to solve all the problems of Texas health care. That is a Herculean task, and Texas had some particular problems that made it one of the worst states in the country by several metrics. But what the tort reforms were designed to do was to reduce the cost of claims and ultimately to reduce the number of fruitless claims. And were they successful at that? I would say they were extraordinarily successful. Physician insurance premiums have fallen by more than 50 percent after the reforms. And much of that decline came within two years of the reforms. My conclusion is the tort reforms did exactly what they were intended to do. They reduced rates,

they decreased the frequency of fruitless litigation, and they increased access to care.

DAVID HYMAN: I think the objective fact is that medical malpractice crises have been marked not by an increase in malpractice but by an increase in medical malpractice premiums. That causes all sorts of distress for physicians over and above the distress of being sued or worrying about being sued. It's what has prompted legislative campaigns to enact tort reform. And now about 30 states have caps on damages, 9 of them originating in the most recent 2001–2002 crisis.

In terms of what causes it, I should say that the book is about the litigation system. It's not about the insurance system, except sort of incidentally. We talk a little bit about premiums because we have some evidence on that. That's the focus of the book because we're lawyers and law professors writing about what's going on in the courts. But from what we can see on the legal side of things, claims about how the litigation system is driving up insurance premiums don't seem to hold much water.

> "Insurers are rational actors within a system."

If we had seen a sudden increase in the number of claims or a sudden increase in the payout per claim or runaway jury verdicts, then it would be much more plausible that the litigation system was driving what's going on in the insurance system. But we don't see that. We don't see that in states that already had caps going back many decades. We don't see that in states that didn't have caps and still don't. The states that enacted caps in response to recent spikes in premiums, such as Texas, are a sort of intermediate group. So, it's less plausible to us that the litigation system is driving the premium increases. We do see that there are factors that are internal to the insurance market, some of which Dr. Anderson has alluded to, that we think are powerful explanations that don't involve the litigation system.

I'll also just address one specific issue Dr. Anderson raised: we never say anything in the book that suggests that insurance companies are profiteering or are charging more than what the state of the market would imply. Nor do we make any suggestions that they should be regulated to prevent what some people would call profiteering. Insurers are rational actors within a system, and they are working to provide an important and necessary service. So imputing bad motives like that is certainly not what we set out to do. ■