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2005-06
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Medical Malpractice Damage Caps

Impacts of Limiting Noneconomic Damages

Prepared by Stephen Grover, Ph.D.

July 29, 2004

ECONorthwest

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Executive Summary

ECONorthwest was hired by the Oregon Medical Association (OMA) to evaluate the current state of medical malpractice liability in the State of Oregon. In particular, ECONorthwest was asked to provide a comprehensive, objective analysis of the impacts of capping payments for noneconomic damages. ECONorthwest has reviewed publicly available information as well as information provided by the OMA and insurance providers. Some of these data are confidential and proprietary.

The damages associated with a medical malpractice claim fall into two categories: economic damages that compensate for the monetary costs of an injury and noneconomic damages for items such as pain and suffering. The average physician in Oregon has had approximately one claim filed during his or her career. Approximately 20 percent of the claims filed in Oregon resulted in payment. While the number (claim frequency) has decreased by over 54 percent since the damage cap was imposed in 1987, the average payment (claim severity) has increased by 449 percent during the same period. While 20 years ago, payments of $1,000,000 or more constituted only 2 percent of paid claims, and 23 percent of the total dollars paid, in 2003, payments of $1,000,000 or more constituted 11 percent of paid claims and 52 percent of total dollars paid; or a 225 percent increase. The first quarter of 2004 continues this troubling trend where payments of $1,000,000 or more constituted 46 percent of the paid claims and over 85 percent of total dollars paid (see Figure 5). Since caps on non-economic damages were lifted following the Oregon Supreme Court's 1999 *Lakin v. Senco* decision, the average medical liability payment has grown by 90 percent from $247,000 to $470,000. Coincident with the growth in the amounts paid and the number of high-payout claims, medical malpractice premiums have grown by as much as 330 percent for some specialties (see Figure 2 and Figure 3).

From our research, we draw the following conclusions:

- **Oregon malpractice premiums and payments are well above the national average.** With an increase in malpractice premiums of 80 percent from 2001 to 2002, the U.S. department of Health and Human Services has identified Oregon as the state with the fourth-highest increase in premiums and the AMA has identified Oregon as one of 12 'crisis states'. Since 2000 (the year after the damage cap was lifted), Oregon's average payment on medical malpractice claims has risen well above the national average, while prior to 2000 the average malpractice payment in Oregon was consistently near the national average (see Figure 4).

- **Increasing medical malpractice premiums will ultimately reduce the number of physicians providing procedures that carry the higher premiums.** Increasing medical malpractice insurance rates have been associated with a declining number of physicians in Oregon, especially in rural areas and in those specialties experiencing the steepest premium increases. A 2002 OHSU survey of obstetrical clinicians in Oregon

showed that 34 percent of all those delivering babies have quit performing deliveries since 1999. Of these, 75 percent practice outside the Portland metropolitan area where more than one-half the state's women give birth. In addition, 31 percent of the obstetricians said they intended to quit deliveries within the next five years. An OMA survey of doctors within Oregon indicates that many are planning to or have stopped performing inherently high risk procedures and are considering retiring. Unless the situation changes, the current medical liability environment will discourage efforts to attract new physicians to the state.

- **Increasing claims payments account for nearly all of the increase in medical malpractice premiums.** Claims payments account for about two-thirds of insurers' total costs, and increase number of claims will increase overall insurance costs and ultimately increase premiums. Declining investment returns and reduced competition only account for a small portion of the increase in medical malpractice premiums both in Oregon and the nation.

- **Capping noneconomic damages would reduce medical malpractice premiums.** Evidence from Oregon's earlier experience and that of other states indicate that such limits reduce malpractice payments and, in turn, malpractice insurance premiums. Evidence in the literature also indicates that such limits can reduce health care costs.

Section I

Medical Malpractice Insurance In Oregon

Malpractice is defined as the failure to exercise that degree of care as is used by reasonably careful physicians in the same or similar community. This failure must be a substantially contributing cause of the injury.[1]

Generally, medical malpractice cases involve several stages: discovering the injury, loss, or damage; filing a claim; determining (through settlement or trial) payment responsibilities, if any; and paying the claim. The average physician in Oregon has had approximately one claim filed during his or her career.[2] The OMA estimates that only 20 percent of claims filed result in any payment.

The damages associated with a medical malpractice claim fall into two categories. *Economic damages* compensate a plaintiff for the monetary costs of an injury, such as medical bills or loss of income. *Noneconomic damages* are payable for items other than monetary losses, such as pain and suffering, loss of consortium, and loss of companionship. Punitive damages are a separate penalty (from economic and non-economic damages) that cannot be awarded unless there is proof by clear and convincing evidence that a health care provider acted with malice or reckless and outrageous indifference to an unreasonable risk of harm. There is a strong presumption that payments for pain and suffering are too high in the U.S. and that the resulting unpredictability of awards contributes to volatility in liability-insurance markets.[3] The Council of Economic Advisors (CEA) estimates that only 20 percent of the direct costs of torts actually go to claimants for economic damages such as lost wages or medical expenses.[4]

In Oregon, recent malpractice awards have had a substantial non-economic damage component. Of 15 plaintiff verdicts in Oregon malpractice cases from 1999-2002, economic damages totaled $9,670,677 while non-economic damages were $9,983,040, or 51 percent of the total damages awarded.[5]

Damage awards comprise only a fraction of the costs of liability. The CEA estimates that approximately 16 percent of tort costs are for defending claims.[6] The OMA calculated an average defense cost of $8,075 associated with a case closed without payment to the claimant. The defense costs of claims that result in

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[1] ORS 677.095.

[2] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

[3] Danzon, Patricia M., "Tort Reform: The Case of Medical Malpractice," *Oxford Review of Economic Policy*, March 1994.

[4] Council of Economic Advisors, *Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System*, April 2002.

[5] Gallagher, William J, Northwest Physicians Mutual Insurance Company, "Oregon Medical Liability Crisis", undated presentation.

[6] Council of Economic Advisors, *Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System*, April 2002.

payments are somewhat higher (average of $14,154) because of the added costs associated with the trial process. Cases in Oregon that are actually tried to verdict currently have average defense costs of more than $100,000.

Medical Malpractice Insurance

Most Oregon physicians not covered by hospital liability policies or employed by public entities but are served by one of two insurers: CNA or Northwest Physicians Mutual. Farmers Insurance was also a significant insurer for hospitals in the State but exited in 2003 because of declining profitability.

Medical malpractice insurers collect premiums from policyholders in exchange for an agreement to defend and pay future claims within the limits set by the policy. The insurer invests the premiums collected and income from the investments reduces the amount of premium income that would have been required otherwise. The insurer's expenses include claims against its policyholders as well as the insurer's estimates of future losses on those claims. The liability associated with the portion of incurred losses that have not yet been paid by the insurer is known as the insurer's *loss reserve*. Insurers must maintain assets in excess of total liabilities including loss reserves and reserves for premiums received but not yet earned. Together these make up what is known as the *insurer's surplus*. State insurance departments monitor insurers' solvency by tracking insurers' premiums, reserves, and surpluses.

Medical malpractice insurers generally attempt to keep their surplus approximately equal to their annual premium income. They set premium base rates for particular medical specialties within a state and sometimes for particular geographic regions within a state. They may also offer discounts or add surcharges for the particular characteristics of policyholders, such as claim histories or participation in risk management programs.[7] In Oregon, the Insurance Division of the Department of Consumer and Business Services has the authority to approve or deny proposed changes to premium rates and may hold a hearing for any rate increase or decrease greater than 15 percent.

Their small number and long and variable nature make losses on medical malpractice claims difficult to predict accurately. Nationally, most medical malpractice claims take an average of more than five years to resolve from the time the alleged malpractice is discovered through the payment of the claim (if any malpractice is found). Some claims may not be resolved for as long as 8 to 10 years. Oregon, on the other hand, has one of the shortest lags, on average 18-36 months, among the states between the time of incident and trial.[8]

The potential losses may vary widely because individual claims with similar characteristics can result in very different losses for the insurer. Because the pool

[7] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[8] Wellington, Elizabeth A., *Loss Development Patterns in Medical Malpractice*, presentation, Casualty Actuarial Society, Seminar on Reinsurance, 2002.

of relevant policyholders is small, historical claims data is of little use in predicting future claims and payments, especially in a volatile market.[9]

Most physicians have policies that cover $1 million per claim and $3 million in aggregate.[10] On average, premiums for all physicians nationwide rose by 15 percent between 2000 and 2002. This increase was nearly twice as fast as total health care spending per person. The premium increases during that period were highest among obstetricians/gynecologists (22 percent) and internists and general surgeons (33 percent).[11]

Figure 1 shows the relative changes in premiums for CNA and Northwest Physicians Mutual. In this figure, we have indexed premium levels so that 1987=100 for both companies and changes in premium levels are more easily expressed as percentage changes. For example, a drop of 20 points in the graph corresponds to a 20 percent decrease in premiums. 1987 was chosen as the base year as this was the first year the damage cap was instituted in Oregon.

As shown in Figure 1, premiums for both companies decreased after 1987 and then remained relatively stable from 1991 to 1999. Following the lifting of the cap in 1999, premiums for both firms increased sharply. This large increase—particularly the 80 percent jump from 2001 to 2002—prompted the U.S. Department of Health and Human Services to identify Oregon as the state with the fourth-highest increase in medical malpractice premiums. The AMA has also designated Oregon as one of 12 "crisis states" due in part to high malpractice premiums.

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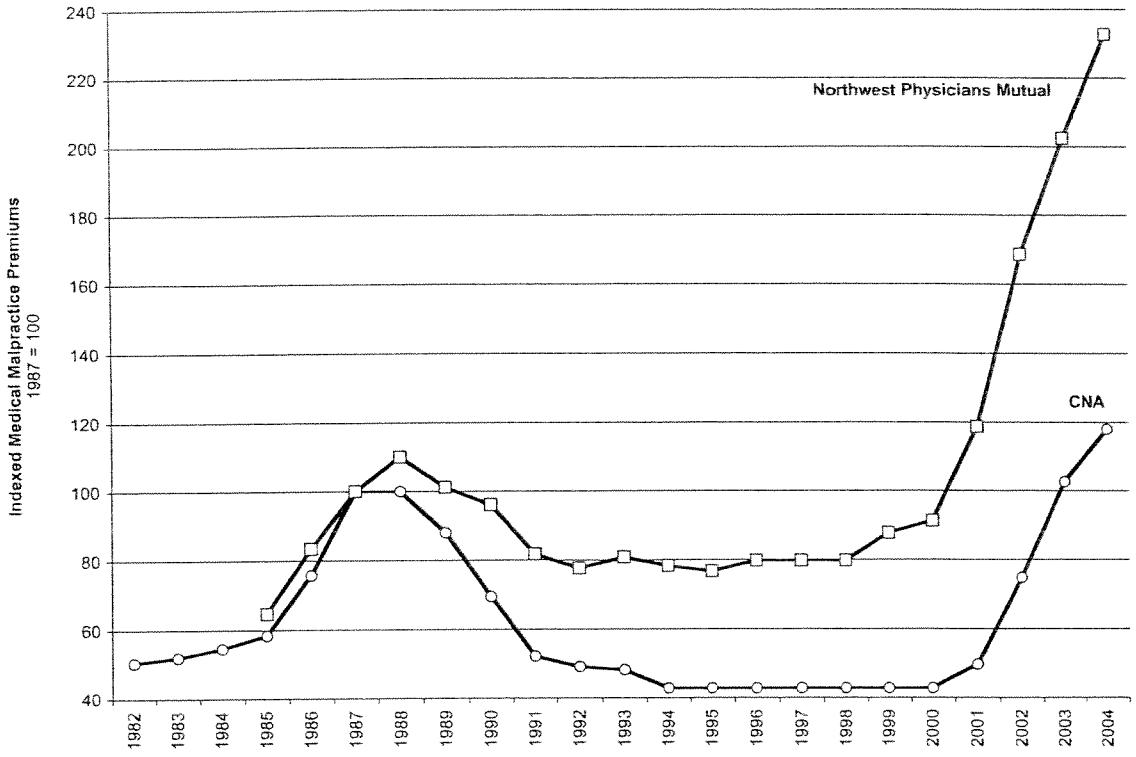
[9] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[10] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated; U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Care*, GAO-03-836, August 2003.

[11] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

Figure 1: Indexed Medical Malpractice Premiums for Oregon Physicians, 1982-2004 (1987=100)



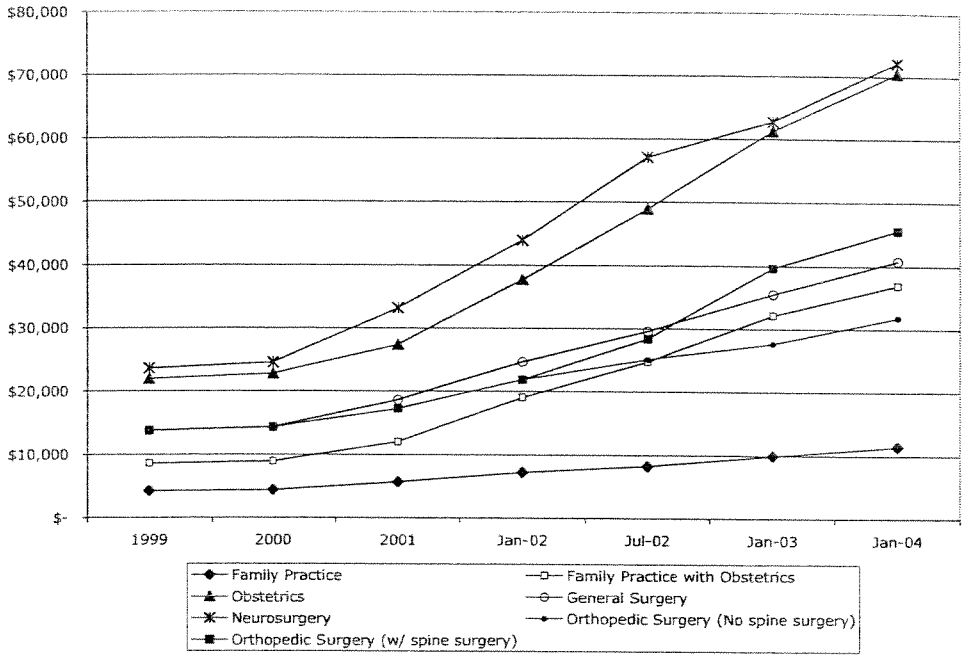
Source: CNA and Northwest Physicians Mutual

The following charts provide additional detail on premium increases for individual practice areas for both insurance companies. Figure 2 shows the premium rates for various practice areas from 1999 to 2004 for Northwest Physicians Mutual. The table below the figure shows the percentage increase in premiums over time for each specialty. For all specialty areas, premiums increased only 4 percent in 1999-2000, the first year in which the damage cap was lifted in Oregon. Since then, all practice areas have seen sharp increases in premiums.

For family practice (the practice area with the lowest malpractice premiums), Northwest Physician Mutual premiums have increased 172 percent from 1999 to 2004. Riskier practice areas such as obstetrics and neurosurgery have correspondingly higher premium levels. These areas have also experienced the sharpest increases in premiums since 1999. Neurosurgery, for example, has seen premiums increase by 206 percent from 1999 to 2004. Higher increases are also observed for those practice areas that also include one of the high-risk components. For family practice that includes obstetrics, for example, premiums have increased 332 percent from 1999 to 2004, compared to a 172 percent increase for family practitioners that do not cover obstetrics. Similarly, orthopedic surgeons who do spinal surgery have experienced a 231 percent

increase in premiums from 1999 to 2004. In contrast, orthopedic surgeons who do not cover spinal surgery have had lower premium increases of 131 percent over the same period.

Figure 2: Medical Malpractice Premium Levels and for Northwest Physicians Mutual (Selected Specialties)

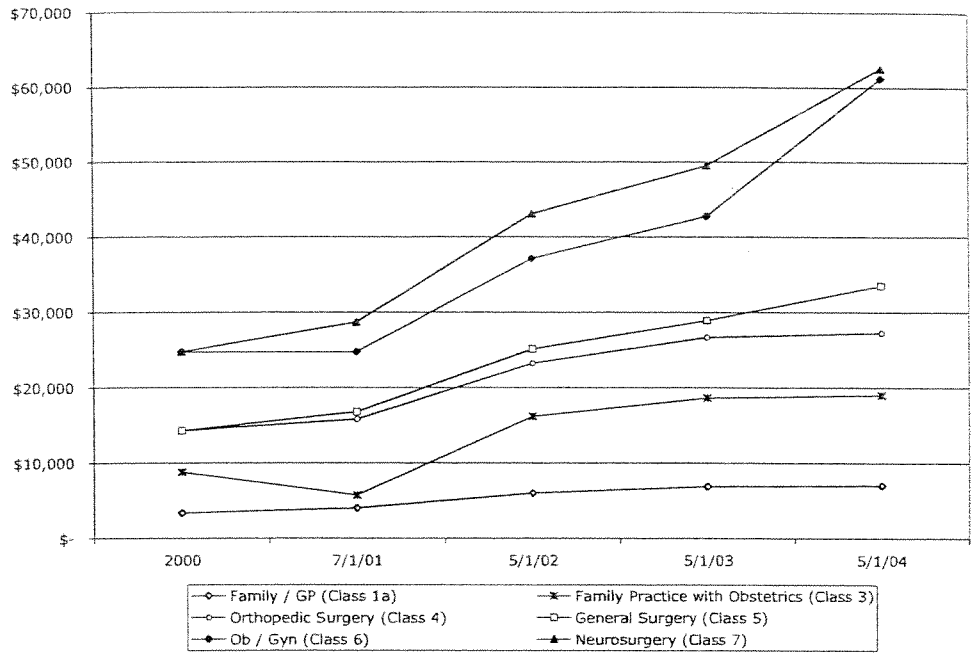


	Percentage Increase in Premiums Over Prior Years					Cumulative
Specialty	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	1999-2004
Family Practice	4%	30%	27%	38%	15%	172%
Family Practice with Obstetrics	4%	35%	59%	69%	15%	332%
Obstetrics	4%	20%	38%	63%	15%	221%
General Surgery	4%	30%	32%	44%	15%	196%
Neurosurgery	4%	35%	32%	43%	15%	206%
Orthopedic Surgery (No spine surgery)	4%	20%	27%	26%	15%	131%
Orthopedic Surgery (w/ spine surgery)	4%	20%	27%	81%	15%	231%

Source: Northwest Physicians Mutual

Figure 3 shows the same premium information from 2000 to 2004 for selected specialties for CNA insurance and demonstrate very similar trends. For general practitioners and family practitioners (Class 1a), rates have more than doubled with a 109 percent increase since 2000. As before, riskier practice areas have seen larger premium increases, with neurosurgery (Class 7) experiencing a 153 percent in crease in premiums and Ob/Gyn practices (Class 6) seeing a 147 percent increase in premiums from 2000 to 2004.

Figure 3: Malpractice Premium Levels and Increases for CNA (Selected Specialties)



	Percentage Increase in Premiums Over Pnor Years				Cumulative
Specialty	2000-2001	2001-2002	2002-2003	2003-2004	2000-2004
Family / GP (Class 1a)	19%	50%	15%	2%	109%
Family Practice with Obstetrics (Class 3)	-35%	185%	15%	2%	117%
Orthopedic Surgery (Class 4)	11%	47%	15%	2%	91%
General Surgery (Class 5)	17%	50%	15%	16%	135%
Ob / Gyn (Class 6)	0%	50%	15%	43%	147%
Neurosurgery (Class 7)	16%	50%	15%	26%	153%

Source: CNA

Section II Impacts of Increasing Medical Malpractice Insurance Rates

Increasing medical malpractice insurance rates have been associated with declining numbers of physicians and with increased diagnostic testing. Combined, these effects result in higher prices, longer waiting times, or longer travel times to receive physicians' services, and thereby reduce patient access to care.

Declining Numbers of Physicians

Increasing medical malpractice insurance rates have been associated with a declining number of physicians, especially in rural areas and in specialties experiencing the steepest premium increases. An OMA survey found that 12.0 percent of physicians in eastern Oregon reported that they already have or definitely will close or sell their practices.[12] While much of the extant literature focuses on anecdotal—rather than statistical—evidence,[13] one nationwide statistical study found that states with medical malpractice damage caps experienced a more rapid increase in their supply of physicians than states without such caps.[14]

A 2002 OHSU survey of obstetrical clinicians in Oregon showed that 34 percent of all those delivering babies have quit performing deliveries since 1999. Of these, 75 percent practice outside the Portland metropolitan area where more than one-half the State's women give birth. In addition, 31 percent of the then current obstetricians said they intended to quit deliveries within the next five years.[15]

An additional factor affecting physician supply in Oregon is the low rate of reimbursement, particularly for the care of Medicare and Medicaid patients. In a statement to Congress in May of 2004, the American Medical Association reported that from 1991 through 2005, medical practice costs will have increased by 41 percent; during the same time period, Medicare payments to physicians will only have increased by about 18 percent.

The medical liability environment may also have an impact on the number of new physicians practicing in Oregon, especially in those fields at a higher risk of medical malpractice liability. An AMA survey found that 96 percent of medical

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[12] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

[13] See for example, U.S. Department of Health and Human Services, *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care*, March 3, 2003 and *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System*, July 24, 2002.

[14] Hellinger, Fred J. and William E. Encinosa, "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians," July 3, 2003.

[15] Smits, Ariel K., Elizabeth C. Clark, Mark Nichols, and John W. Saultz, "Factors Influencing Cessation of Pregnancy Care in Oregon," *Family Medicine*, Vol. 36, No. 7, pp. 490-5, July-August 2004.

school students believe the current medical liability environment to be a major problem or a crisis; 39 percent said that the medical liability environment affected their decision about the state in which they would complete their residency and 48 percent stated that liability affected their choice of specialty.[16] The impact of increasing premiums on these younger physicians contemplating the profession or entering practice in the state may be substantial. Unlike sales/closures of practices or retirements where announcements are made and the news gets out, the failure of new physicians to enter specialties within the state is difficult to monitor and evaluate. Ultimately this trend manifests itself in slow or negative growth in the physician population.

Reduced Access to Care

In general, a decline in the number of physicians offering services has resulted in reduced access to care. The OMA survey found that nearly one in eight physicians already has or definitely will close or sell his or her practice and 13.2 percent already have or definitely will stop providing direct patient care. Statewide, 26.1 percent of those in neurological surgery either have or will stop providing direct patient care.[17] Analysis by the OMA shows that in 2001, eastern Oregon had 56 head injuries but no neurosurgeons in the areas of the State where the injuries occurred. In contrast, central Oregon had 117 head injuries and 5 neurosurgeons.[18]

Other physicians are unable to get insurance because one of the two remaining insurers will not underwrite new policies for certain specialties. For example, the mayor of John Day, Oregon recently wrote a letter stating that the inability to get malpractice insurance—not a lack of physicians—would likely result in the loss of obstetrics services at the local hospital. If such services are lost, John Day patients would have to travel 75 miles to the nearest hospitals.[19]

Some physicians remaining in practice have stopped performing high-risk procedures in order to reduce their exposure to liability. The OMA's workforce assessment found that 21.2 percent of physicians in eastern Oregon intend to stop providing certain services. Statewide, 27.4 percent of those in obstetrics/gynecology and 23.1 percent in neurological surgery expect to stop providing certain services.[20]

The OMA survey found that the average surgeon rated the cost or availability of professional liability insurance as their most important factor regarding changes to their practices. Among eastern Oregon physicians, 29.2 percent already have or definitely will stop providing certain services because of changes to liability

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[16] American Medical Association, *AMA Survey: Medical Students' Opinions of the Current Medical Liability Environment*, November 2003.

[17] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

[18] Oregon Medical Association, *Oregon's Neurosurgeon Shortfall*, April 24, 2003.

[19] Letter from Roger Simonsen to Greg Walden, May 10, 2004.

[20] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

insurance. Among all surgeons in the State, 23.5 percent already have or definitely will stop providing certain services because of changes to liability insurance.[21] This is consistent with a BlueCross Blue Shield survey: 56 percent of the plans surveyed in AMA-designated "crisis" states say physicians are refusing some high-risk procedures, versus 32 percent for non-crisis states.[22]

The GAO found instances of reduced access to hospital-based services affecting emergency surgery and newborn deliveries in scattered, often rural, areas where providers identified other long-standing factors that also affect the availability of services.[23] In addition to increasing medical malpractice premiums, Oregon's relatively low rate of Medicare reimbursement further reduces incentives for physicians to practice in Oregon, particularly in rural Oregon.[24]

Increased Health Care Costs

Increased medical malpractice insurance can lead to higher health care costs in three ways: pass-through of premium increases to patients and health insurers, reduced supply of health care services, and increased testing and procedures, i.e., *defensive medicine.*

Reduced supply of physicians and physician services

To the extent increased medical malpractice insurance premiums result in fewer doctors entering higher risk specialties, more early retirements, and fewer services offered, basic economics suggests that health care costs will increase. We are aware of no studies that empirically measure the impact of reduced supply on health care costs. Anecdotal evidence suggests that consumers bear higher costs through increased travel or waiting time to see a physician. For example, the GAO reported that pregnant women in a central Mississippi rural county that closed its obstetrics unit must travel about 65 miles to the nearest obstetrics ward to deliver.[25] The GAO made several attempts to verify longer wait times associated with reduced physician supply but found that the longer wait times cited by provider organizations were likely caused by factors other than malpractice pressures.[26]

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[21] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

[22] BlueCross BlueShield Association, *The Malpractice Insurance Crisis: The Impact on Healthcare Cost and Access*, 2003. The American Medical Association has designated 12 states—including Oregon—in which rising medical malpractice insurance premiums have created a "crisis" situation.

[23] U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Care*, GAO-03-836, August 2003.

[24] Office of Health Policy and Research, *Oregon's Health Care Trends*, Bruce Goldberg, January 21, 2004.

[25] U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Care*, GAO-03-836, August 2003.

[26] U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Care*, GAO-03-836, August 2003.

Increased practicing of defensive medicine

Defensive medicine is defined as medical care that is primarily or solely motivated by fear of malpractice claims and not by the patient's medical condition. The effect can manifest as the prescription of increased diagnosis and treatment procedures beyond what is needed form a purely clinical perspective, and the avoidance of procedures which might be appropriate from a clinical standpoint but whose risk level discourages their use.[27]

Proponents of limiting malpractice liability have argued that much greater savings in health care costs would be possible through reductions in the practice of defensive medicine.[28] In a study for the National Bureau of Economic Analysis, Stanford University researchers Daniel Kessler and Mark McClellan found that malpractice reforms that directly reduce clinician liability pressure lead to reductions of 5 to 9 percent in health care costs,[29] which translates to annual savings of about $60 billion. Within Oregon, an OMA survey reports that 25.2 percent in general surgery and 27.6 percent in orthopedic surgery have already increased the diagnostic procedures that they perform or plan on doing so. Over 20 percent of Oregon physicians surveyed have increased their referrals of complex cases or plan on doing so.[30]

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[27] *Liability for Medical Malpractice: Issues and Evidence,* Joint Economic Committee Study, May 2003 at 12.

[28] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[29] Kessler, Daniel and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, May 1996. It is uncertain the extent to which these results can be generalized, see U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004. See also, Kessler, Daniel and Mark McClellan, "How Liability Law Affects Medical Productivity," *Journal of Health Economics*, 21 (2002) 931-955 at 935.

[30] Oregon Medical Association, Preliminary Report of the 2003 Physician Workforce Assessment, undated.

Section III

Causes of Increasing Medical Malpractice Insurance Rates

Increasing claims payments account for nearly all of the increase in medical malpractice premiums. Claims payments account for about two-thirds of insurers' total costs. Declining investment returns and reduced competition only account for a small portion of the increase in medical malpractice premiums and reinsurance costs are virtually irrelevant in Oregon.

Increased Claims Payments

Payments of claims are the most significant costs that malpractice insurers face, accounting for about two-thirds of their total costs.[31] Substantial increases in paid claims have a direct effect on the premiums paid by physicians. In Oregon, the average amount paid on claims has increased by 90 percent since damage caps were lifted in 1999 (Figure 4). The steepest increases have occurred in neurology/neurosurgery and obstetrics/gynecology. As shown in Figure 4, the average paid claims in Oregon surpassed the national average since 1999. During the time in which Oregon capped noneconomic damages, the average medical malpractice claim paid in Oregon was lower than the national average in all but three years.

The recent increase in the number of large payments accounts for the 90 percent growth in average claims payments in Oregon since 1999. Figure 5 shows claims payments of $1,000,000 or more, both as a share of the number of all paid claims and as the share of total dollars paid. As shown in this figure, 20 years ago payments of $1,000,000 or more constituted only 2 percent of paid claims and 23 percent of the total dollars paid. In first quarter of 2004 payments of $1,000,000 or more already constitute 46 percent of the paid claims and more than 85 percent of total dollars paid.

In addition to indemnity payments, costs of defending both Oregon paid claims and those claims closed without any payment have risen dramatically since 1982. Paid claim defense costs currently average $14,154 while closed without payment defense costs average $8,075. Since 1982, average defense costs for paid claims and claims closed without payment have risen 482 percent and 191 percent respectively.[32]

Oregon's experience is consistent with a national trend of increasing numbers of high-cost claims payments. Annual paid losses and incurred losses for the national medical malpractice insurance market began to rise more rapidly

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[31] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[32] OMA Department of Medical-Legal Affairs

beginning in 1998.[33] The CBO noted that nationwide, the cost per successful claim has increased, but the rate of such claims has remained relatively constant.[34]

As noted above, Oregon has one of the shortest lags among the states between the time of incident and trial. This reduces the time during which premiums collected from physicians can earn a return in the insurance company's portfolio. In other words, Oregon faces a shorter lag between the collection of premiums and the payment of claims, which means that all other things equal, Oregon premiums are higher.

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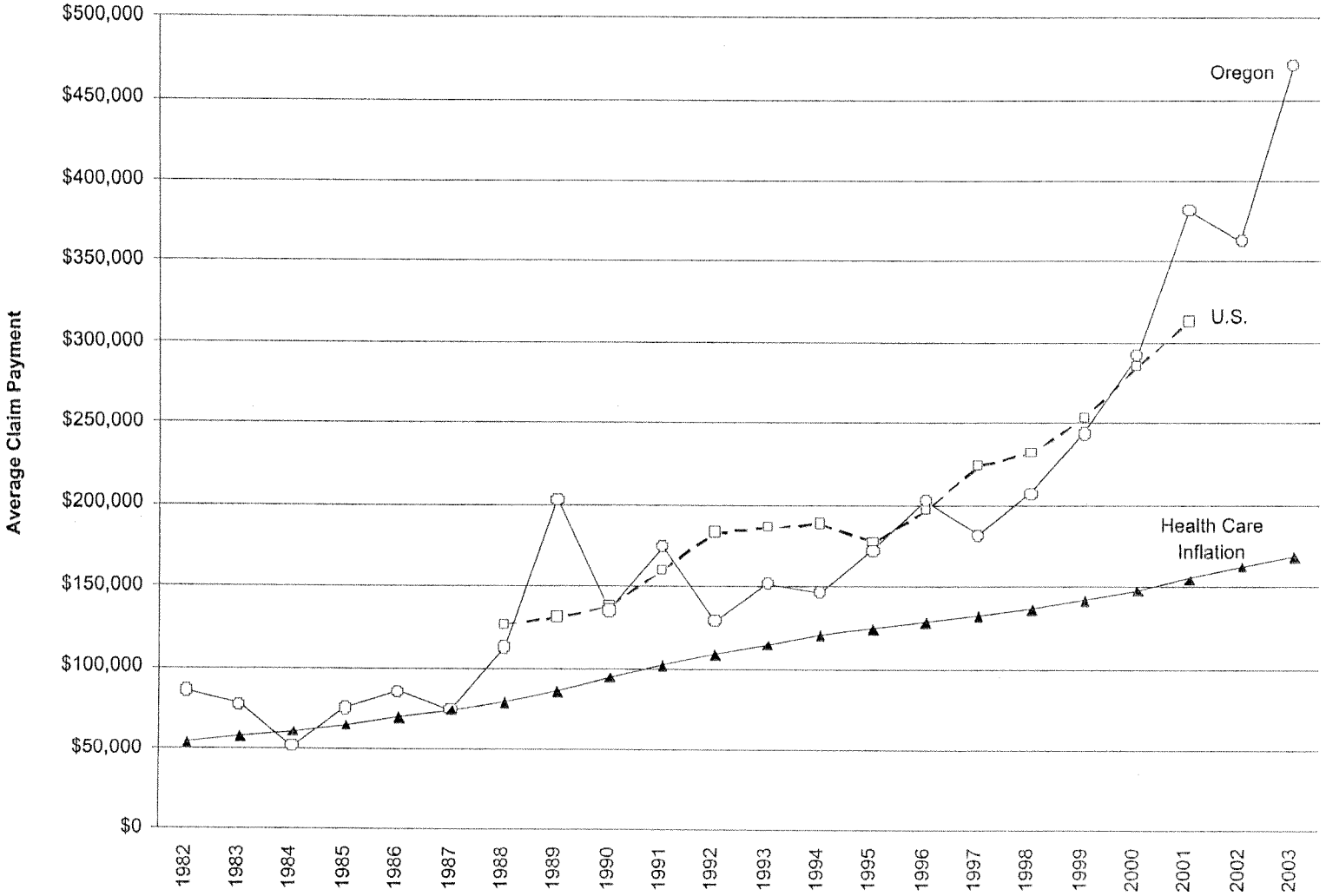
[33] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[34] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

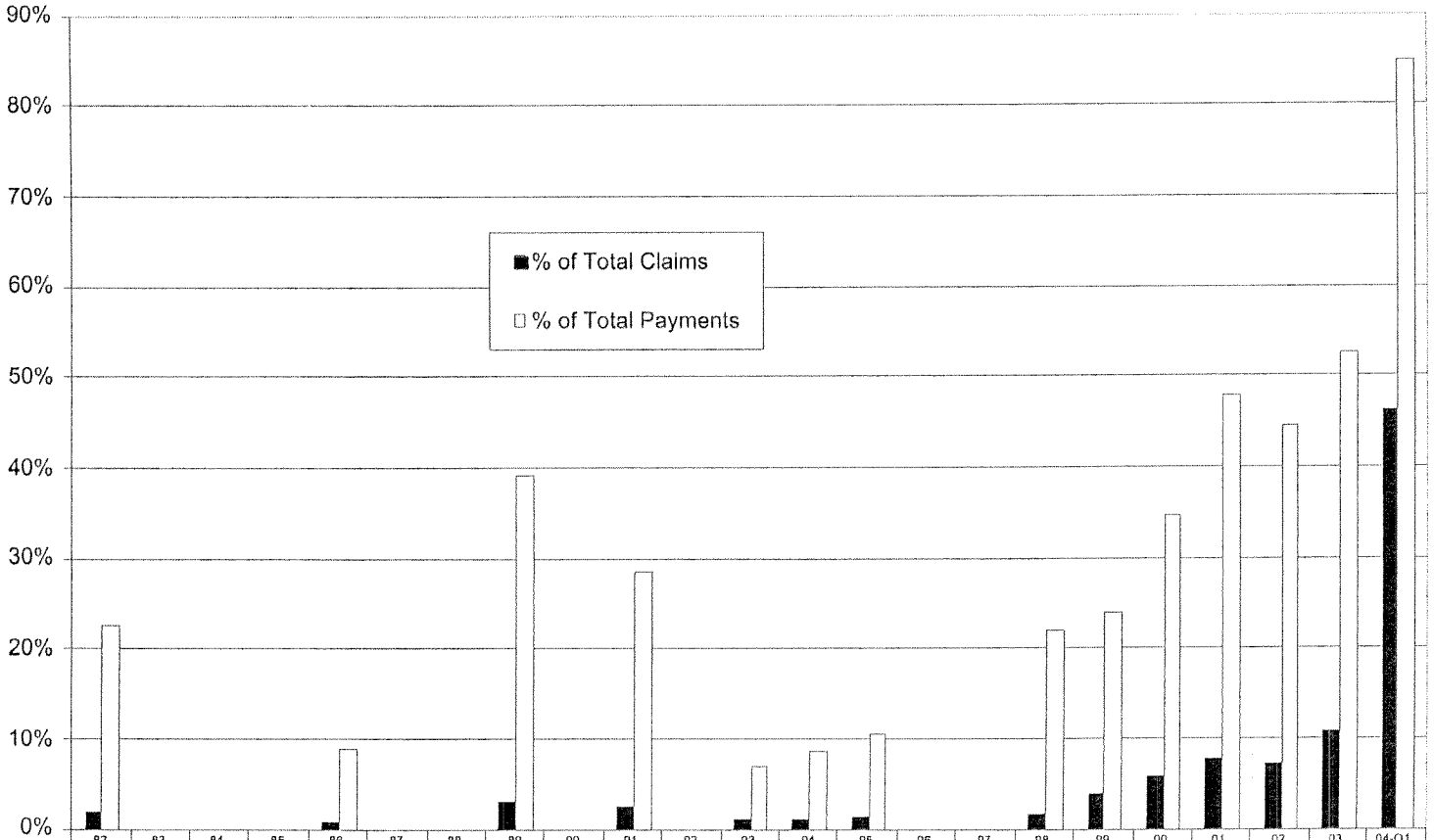
Figure 4: Average Payment on Medical Malpractice Claims, U.S. and Oregon, 1982-2003



Sources: PIAA; OMA

Figure 5: **Annual** Medical Malpractice Claims Paid in Oregon, 1982-2004

Total Oregon Million Dollar Paid Claims and Total Milion Dollar Payments as a Percentage of All Payments 1982-2004 (Q1)



	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04-Q1
% of Total Claims	2%	0%	0%	0%	1%	0%	0%	3%	0%	3%	0%	1%	1%	1%	0%	0%	2%	4%	6%	8%	7%	11%	46%
% of Total Payments	23%	0%	0%	0%	9%	0%	0%	39%	0%	28%	0%	7%	9%	11%	0%	0%	22%	24%	35%	48%	44%	53%	85%

Sources: PIAA; OMA

Reinsurance

Some insurers purchase *reinsurance*, or excess loss coverage, to protect themselves against large unpredictable losses. Medical malpractice insurers, particularly smaller insurers, depend heavily on reinsurance because of the potentially high payouts on medical malpractice claims. Increases in medical malpractice premium rates have been attributed to the increased cost of reinsurance that, in turn, increases the total expenses that premiums and other income must cover.[35] The increased costs of reinsurance, in turn, have been attributed to the increased severity of claims payments.

In Oregon, the costs of reinsurance are not a component of premiums. Moreover, many insurers, including CNA, do not purchase reinsurance.

Reduced Investment Income

Medical malpractice insurers are required by state insurance regulations to reflect *expected* investment income in their premium rates. Opponents of tort reform have erroneously asserted that premium increases are driven by insurers' efforts to recoup stock market losses. These assertions are incorrect for the following reasons.

- Oregon insurance regulations prohibit calculation of insurance rates to recoup past losses or restore capital.[36]
- Most insurers' assets are in bonds. Medical malpractice insurers' portfolios, on average, held less than 10 percent in equities.[37]
- In the last 15 years, no Oregon insurance providers have experienced any losses in their portfolios.[38]

For these reasons, the impact of reduced investment income is indirect in that it adjusts providers' *expectations* of future investment income.

In Oregon, changes in investment returns likely provide little explanation for the increases in medical malpractice premiums. Empirically, a 1 percentage point decrease in investment income has been associated with a 2 to 4 percent increase in premiums.[39] The rate of return of one Oregon insurer peaked in 1997 at 6.51

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[35] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[36] Stegeman, Ronald and Sharon Robinson, *Medical Liability Insurance: Statement of CNA Insurance Companies*, Oregon House of Representatives Judiciary Committee, March 10, 2003.

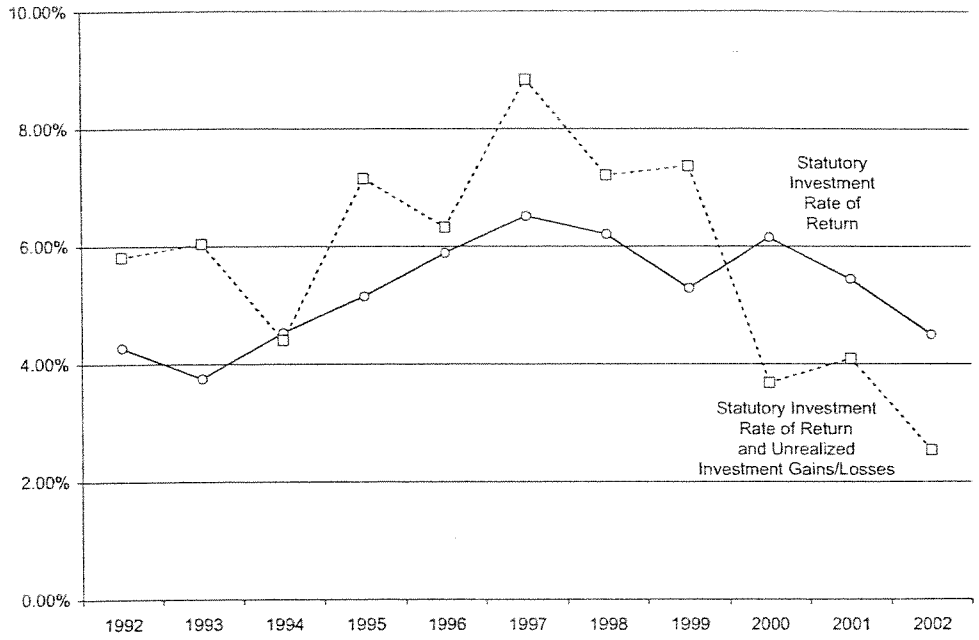
[37] Ramachandran, Raghu, *Did Investments Affect Medical Malpractice Premiums?*, January 21, 2003.

[38] Governor's Medical Professional Liability Task Force, 2002

[39] Hurley, James, Assessing the Need to Enact Medical Liability Reform, U.S. House of Representatives Subcommittee on Health, Committee on Energy and Commerce, February 27, 2003; Thorpe, Kenneth, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms," *Health Tracking*, January 21, 2004.

percent, and declined by 1.07 percentage points to 5.44 percent in 2002 (Figure 6). Over that same period, premiums increased by 111 percent, or 25 to 50 times more than explained by changes in investment income.

Figure 6: Investment Returns of Northwest Physicians Mutual, 1992-2002



Source: Northwest Physicians Mutual

Reduced Competition

Declining profitability among insurers has caused some large insurers either to stop selling medical malpractice policies altogether or to reduce the number they sell. For example, the St. Paul Companies—previously the second-largest medical malpractice insurer in the United States—stopped writing all medical malpractice insurance beginning in 2002 because of declining profitability.[40] Oregon has seen ten insurers leave the State; one former insurer – Farmers Insurance – sold policies to hospitals under the Truck Insurance Exchange name. With the exit of Farmers in 2003, AIG is now the only insurance provider to Oregon hospitals. Other insurers have restricted the writing of new business. For example, Northwest Physicians Mutual has stopped writing most new obstetrician/gynecologist or family practice/obstetrician business.[41]

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[40] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[41] Oregon Department of Consumer and Business Services, *Target Report of Financial Examination of Northwest Physicians Mutual Insurance Company*, June 30, 2002.

The reduced competition associated with firms exiting the business does not necessarily result in above-competitive pricing. In Oregon, CNA and Northwest Physicians Mutual together have comprised approximately 70 percent of the market since 1984.[42] Because they comprise such a large portion of the market, and have for some time, the exit of some of the smaller firms likely placed little upward pressure on pricing. Evidence suggests that medical malpractice premiums are not generating above-competitive profits for insurers for the following reasons.

- If the higher premium rates were above what was justified by insurers' expected losses, profitability would be increasing. But profits are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates.[43] For example, Northwest Physicians Mutual has had four years of unprofitability since 1999.[44]

- Physician-owned insurers have little incentive to overcharge their policyholders because those insurers generally return excess earnings to their policyholders in the form of dividends.[45]

- Insurance regulators in most states—including Oregon—have the authority to deny premium rate increases they deem excessive. The Oregon Department of Consumer and Business Services allows for a public hearing for any rate increase or decrease of 15 percent or more.[46]

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[42] The Business Journal of Portland, "Insurers' pain symptom of state wide problem", June 14, 2004.

[43] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[44] Northwest Physicians Mutual, "Did Mismanagement Cause This Crisis?" undated.

[45] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[46] Oregon Revised Statute §737.207.

Section IV

The Effects of Capping Noneconomic Damages

As of 2002, more than 40 states had at least one restriction on medical malpractice liability in effect.[47] Available evidence indicates that such limits reduce malpractice payments and, in turn, malpractice insurance premiums. Available evidence also indicates that such limits likely have no impact on the incidence of malpractice.

Reduced Medical Malpractice Insurance Premiums

Figure 5 shows the number of million dollar claims in Oregon since 1982, and the share these claims comprise of the total number of claims and total claim payments. With the lifting of caps in 1999, both the number and amount of million dollar claims as a share of the total has increased dramatically. As shown in Figure 4, the average amount of paid claims also increased substantially during this period, with Oregon rising well above the national average. Premiums in Oregon reflect this trend; premiums decreased substantially after 1987, remained stable throughout the 1990s, and increased substantially after 1999 (see Figure 1, Figure 2 and Figure 3).

In addition to the reduced exposure to payments, caps provide insurers greater predictability in what they will have to pay out in noneconomic damages because they can more easily estimate potential losses. Therefore caps reduce the uncertainty that can give rise to premium rate increases. The GAO reported that, according to insurers, economic damages are more predictable than noneconomic damages because damages for things such as pain and suffering are very difficult to quantify.[48]

From 1987 to 1999, Alabama established three sets of caps on noneconomic damages against health care providers in all other civil litigation matters. Through a series of court decisions, each of the caps was removed. During the period in which all three caps were in place, the average medical malpractice payout was $23,300 lower than the period before the caps were in place. During the period in which all the caps were removed, the average medical malpractice payout was approximately $49,400 higher than the period in which all three caps were in place.[49]

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[47] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[48] U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003.

[49] Yoon, Albert, "Damage Caps and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the South," *American Law and Economics Review*, 2001, pp. 199-227.

In 1993, the Office of Technology Assessment concluded that caps on damage awards consistently reduced the size of claims and consequently premium rates for malpractice insurance. Its conclusions were based upon a summary of studies on the experience of states that set limits on malpractice liability in the 1970s and 1980s.[50]

A 2003 study examining state data from 1993 to 2002 found that two restrictions—a cap on noneconomic damages and a ban on punitive damages—would together reduce premiums by more than one-third (all other things being equal). The Congressional Budget Office (CBO) estimated that the provisions of the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003 would lower premiums nationwide by an average of 25 percent to 30 percent.[51]

A Caltech dissertation completed in 2003 concluded that damage caps reduce medical malpractice insurance premiums. The results were derived from data on medical malpractice insurance premiums per physician in the 50 states for the period 1991-2001.[52]

A 2004 study concludes that states that enacted caps on noneconomic damages at or below $500,000 and set limits on joint and several liability have had significantly lower premium increases than states without such caps.[53]

During the period in which Oregon capped noneconomic damages, the State's medical malpractice premiums declined by more than 50 percent (Figure 1). Since the caps have been lifted, premiums have more than doubled for most specialties.

Reduced Health Care Costs

A 2002 study found that physicians from states adopting malpractice liability reforms that directly limit awards—such as caps on noneconomic damages—saw a 1.4 percent point reduction in claims rates. Such a decrease was associated with a 3.9 to 4.2 percent reduction in hospital expenditures.[54] This study supported an early study by the authors that found that direct limits led to statistically

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[50] U.S. Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs*, OTA-BP-H-119, September 1993.

[51] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[52] Zeiler, Kathryn, *Medical Malpractice and Contract Disclosure: A Study of the Effects of Legal Rules on Behavior in Health Care Markets*, dissertation, May 20, 2003.

[53] Danzon, Patricia M., Andrew J. Epstein, and Scott Johnson, "The 'Crisis' in Medical Malpractice Insurance," Presented at the Brookings-Wharton Conference on Public Policy Issues Confronting the Insurance Industry, December 2004.

[54] Kessler, Daniel and Mark McClellan, "How Liability Affects Medical Productivity" *Journal of Health Economics*, November 2002. It is uncertain the extent to which these results can be generalized, see U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

significant reductions in medical expenditure growth.[55] A 1999 study examining the effect of tort limits on the proportion of births by cesarean section found cost savings of 0.27 percent.[56]

According to the CBO, malpractice costs nationally amounted to an estimated $24 billion in 2002, or less than 2 percent of overall health care spending. It concluded that, all other things held constant, a reduction of 25 percent to 30 percent in malpractice costs would lower health care costs about 0.4 percent to 0.5 percent, with comparable effects on health insurance premiums.[57]

For Oregon, higher medical malpractice rates are impacting the cost of care both directly and indirectly through higher taxes needed to provide services through the Oregon Health Plan. In 2002, the Oregon Department of Human Services (DHS) estimated that the average cost of baby deliveries covered by the OHP would increase by $300 (31 percent) due in part to the increases in medical malpractice insurance premiums.[58] In response, the 2002 DHS budget request proposed increases for both fee-for service rates and capitation payments to increase reimbursements to obstetricians and family practitioners that provide prenatal care and deliver babies. The requested increase totaled $1.9 million in General Funds ($4.7 million total when funds from other sources were included.) The increase in medical malpractice insurance premiums was cited as the primary reason for requesting the additional funds.[59]

No Change in the Incidence of Malpractice

Opponents of caps argue that restrictions on malpractice liability could undermine the deterrent effect of such liability and thus lead to higher rates of medical injuries. The CBO did not agree with this argument and concluded that "it is not obvious" that the current tort system provides effective incentives to deter medical injuries for the following reasons.[60]

- Malpractice insurance itself dampens health care providers' exposure to the financial cost of their own malpractice risk. The premiums for such insurance tend not to reflect the records or practice styles of individual providers but reflect more general factors such as location and medical specialty.

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[55] Kessler, Daniel and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, May 1996.

[56] Dubay, Lisa, Robert Kaestner, and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics*, August 1999.

[57] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[58] Crawford, Herschel, email to Scott Gallant OMA, August 19, 2002.

[59] Oregon Department of Human Services, Request to Oregon Legislature to Approve DHS 2001-03 Rebalance Plan, November 7, 2002.

[60] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

- Very few medical injuries ever become the subject of a claim. A 1984 New York study cited by CBO estimates that 1.5 percent of cases of medical negligence that occurred in hospitals throughout the state that year led to claims.[61]

The scant evidence available so far does not indicate that restricting malpractice liability would have a significant effect, either positive or negative, on the incidence of malpractice.[62]

As stated in a 2002 study by Kessler and McClellan, only one in fifteen patients who suffer an injury due to medical negligence receives compensation, and five sixths (83 percent) of the cases that receive compensation have no evidence of negligence. Rather, the primary determinant of whether an injury will receive compensation is the extent of the injury, not the extent of fault.[63]

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[61] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[62] U.S. Congressional Budget Office, *Economic and Budget Issue Brief: Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

[63] Journal of Health Economics 21(2002) 931-955 "How Liability Law Affects Medical Productivity," Daniel B. Kessler, Mark B McClellan.

Section V

Conclusions

Medical malpractice insurance premiums for Oregon physicians have seen enormous increases in recent years, and rates for doctors performing inherently high risk procedures have increased the most. Although there are several factors that have contributed to the sharp increase in medical malpractice insurance premiums, claims payments are the largest component of insurer costs and increases in malpractice damage awards will increase premiums accordingly.

As our analysis of claims data shows, the number of claims has decreased by more than 54 percent since Oregon imposed a damage cap in 1987 and remained at or below this figure even after the damage cap was removed; the average payment (claim severity) has increased by 449 percent during the same period. Twenty years ago, payments of $1,000,000 or more constituted only 2 percent of paid claims, and 23 percent of the total dollars paid, in first quarter of 2004, payments of $1,000,000 or more constituted 46 percent of the paid claims and more than 85 percent of total dollars paid. Since caps on non-economic damages were lifted following the Oregon Supreme Court's 1999 *Lakin v. Senco* decision, the average medical liability payment has grown by 90 percent from $247,000 to $470,000.

Based on our research of healthcare trends within Oregon, experience in other states with limits on malpractice damage awards, and studies conducted nationally and in other regions, it appears that capping non-economic damages in medical malpractice cases will reduce medical malpractice insurance premiums. Reduced premiums should reduce the cost of health care and increase the supply of health care services offered in Oregon over time.

From our research, we draw the following conclusions:

- **Increasing medical malpractice premiums will ultimately reduce the number of physicians providing procedures that carry the higher premiums.** Increasing medical malpractice insurance rates have been associated with a declining number of physicians in Oregon, especially in rural areas and those specialties experiencing the steepest premium increases. A survey of doctors within Oregon indicates that many are planning to stop performing inherently high risk procedures and are considering retiring. Unless the situation changes, the current medical liability environment will discourage efforts to attract new physicians to the State.

- **Increasing claims payments account for nearly all of the increase in medical malpractice premiums.** Claims payments account for about two-thirds of insurers' total costs, and increases in claims will increase overall insurance costs and ultimately increase premiums. Declining investment returns and reduced competition only account for a small portion of the increase in medical malpractice premiums.

- **Capping noneconomic damages would likely reduce medical malpractice premiums.** Evidence from Oregon's earlier experience and that of other states indicate that such limits reduce malpractice payments and, in turn, malpractice insurance premiums. Evidence in the literature also indicates that such limits can reduce health care costs.