WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06

(session year)

Assembly

(Assembly, Senate or Joint)

Task Force on Medical Malpractice (ATF-MM)

Sample:

Record of Comm. Proceedings ... RCP
- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

- *Appointments* ... *Appt*
- **

- *Clearinghouse Rules* ... *CRule*
- **

- *Committee Hearings* ... *CH*
- **

- *Committee Reports* ... *CR*
- **

- *Executive Sessions* ... *ES*
- **

- *Hearing Records* ... *HR*
- **

- *Miscellaneous* ... *Misc*
- **05hr_ATF-MM_Misc_pt14**

- *Record of Comm. Proceedings* ... *RCP*
- **

United States General Accounting Office

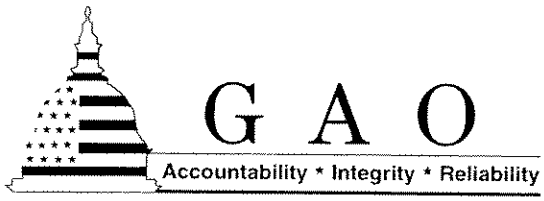
GAO

Report to Congressional Requesters

October 1999

MEDICAL MALPRACTICE

Effects of Varying Laws in the District of Columbia, Maryland, and Virginia



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Health, Education, and
Human Services Division

B-282171

October 15, 1999

The Honorable Dick Armey
The Honorable Charles H. Taylor
House of Representatives

In both the mid-1970s and mid-1980s, medical malpractice insurance premiums grew significantly, causing the medical profession to be alarmed by a crisis in the affordability and availability of insurance. As a result, many states adopted various tort reforms[1] designed to limit the number of malpractice claims and the size of payments. The states expected the changes to reduce insurance premiums—one component of medical liability costs. States took such actions as

- placing caps on the amount that could be awarded for damages for malpractice;
- amending "collateral source" rules that prevent providers from introducing evidence that the injured person's expenses have been reduced by payments from third parties, such as health insurers;
- modifying statutes of limitations to decrease the time injured people have to file a claim in court; and
- implementing alternative dispute resolution systems, such as arbitration, where forums other than the courts are used.

Furthermore, many tort reform advocates believed that by adopting tort reforms the costs associated with the practice of defensive medicine[2]—a second component of medical liability costs—would also decrease, thereby lowering overall health care costs and enhancing access to care.[3]

[1]Medical malpractice lawsuits are generally based on tort law (which includes both statutes and court decisions). A tort is a wrongful act or omission by an individual that causes harm to another individual. Typically, a tort claim of malpractice would be based on the claim that the provider was negligent and the injured party would seek damages. To reduce the cost of malpractice insurance and for other reasons, some have advocated changes to the states' tort systems. These changes are referred to as tort reforms.

[2]The Office of Technology Assessment defined defensive medicine as follows: "Defensive medicine occurs when doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily (but not necessarily solely) to reduce their exposure to malpractice liability . . . ."

[3]We previously reported that, in addition to costs associated with medical malpractice insurance and defensive medicine, medical liability costs include (1) liability-related administrative costs and (2) medical device and pharmaceutical liability costs. See Medical Liability: Impact on Hospital and Physician Costs Extends Beyond Insurance (GAO/AIMD-95-169, Sept. 29, 1995). As our work—both previous and current—only identified literature on malpractice insurance and defensive medicine costs, this report will focus on these two components of medical liability costs.

Unlike the neighboring states of Maryland and Virginia, the District of Columbia has not adopted multiple tort reforms. You expressed concern about the District's lack of significant tort reforms and the effect this may have on the quality, availability, and cost of health care in the District. As a result, you asked us to

- identify the rationale behind selected reforms states have made to their medical malpractice tort law;
- report on whether selected tort reforms have reduced malpractice insurance costs and the costs associated with defensive medicine;
- describe the extent to which the District, Maryland, and Virginia have adopted selected tort reforms; and
- compare malpractice claim payments, insurance premiums, and numbers of physicians in the District; Baltimore, Maryland; and Richmond, Virginia.

To meet these objectives, we reviewed health policy and legal literature, state tort law and reforms, and data on malpractice premiums and claim payments as well as data on the number of physicians in the District, Baltimore, and Richmond. Appendix I provides more detailed information on our methodology. We performed our work between February and September 1999 in accordance with generally accepted government auditing standards.

Results in Brief

During the last 25 years, many states have adopted various changes to their tort law, collectively referred to as tort reforms. Generally, states that adopted reforms were attempting to reduce malpractice insurance premiums. Each type of reform is viewed as having a number of possible benefits and negative consequences, as follows:

- Capping damages lowers the highest awards but could restrict payments to the most seriously injured people.
- Amending the collateral source rule may prevent double recovery but could shift payment of health care costs due to a malpractice injury from the malpractice insurer to the health insurer.
- Modifying statutes of limitations may reduce the number of malpractice claims but may prevent recovery by victims of malpractice who do not discover the injury until some time after it occurs.
- Implementing alternative dispute resolution systems may remove claims from the courts but could increase the costs associated with malpractice by encouraging more claims.

Limited evidence shows that tort reforms may have had some effect in reducing medical malpractice insurance premiums. A 1993 synthesis by the Office of Technology Assessment of six studies done in the 1980s and early 1990s concluded that, while damage caps and collateral source rule changes reduced malpractice payments, only caps were demonstrated to reduce premiums. However, this research did not study tort reforms' effect on a potentially larger medical liability cost—defensive medicine. A 1996 study did attempt to relate the effect of tort reforms on defensive medicine costs, but it had a limited scope. This study found that in states that imposed a package of tort reforms including caps on damages and collateral source rule amendments, hospital costs grew 5 to 9 percentage points less than in other states for Medicare patients with heart conditions without adverse effects on selected outcomes, such as mortality. Because this study was focused on only one condition and on a hospital setting, it cannot be extrapolated to the larger practice of medicine. Given the limited evidence, reliable cost savings estimates cannot be developed.

To date, the District has not adopted any major changes to its tort law, while both Maryland and Virginia have adopted selected tort reforms with differing approaches. For example, Virginia has a $1.5-million cap on total damages, whereas Maryland caps nonmonetary damages at $575,000. For filing claims, Virginia provides 2 years from the date of the injury with some stated extensions, while Maryland provides 5 years from the date of injury or 3 years from discovery, whichever is earlier. Neither state has amended its collateral source rule. While the District does not have a specific arbitration program for malpractice cases, as do Maryland and Virginia, the courts can order nonbinding arbitration or the parties can agree to binding arbitration.

How these differences among the tort approaches of the District, Maryland, and Virginia have affected malpractice costs is unclear. However, limited data show the following:

- Median malpractice claim payments for District, Baltimore, and Richmond physicians from 1996 through 1998 were $200,000, $150,000, and $112,500, respectively.
- Malpractice insurance premiums for one traditionally high-cost specialty, obstetrics/gynecology, were higher in Baltimore than in the District in 1998 but lower for internal medicine and general surgery. Premiums for these specialties were lowest in Richmond.

- High malpractice claim payments or insurance premiums have not reduced the number of physicians in the District relative to Baltimore or Richmond. In fact, the number of physicians in the District per 100,000 people increased by about 24 percent between 1985 and 1997.

Background

In the United States, patients injured while receiving health care can sue health care providers for medical malpractice under governing state tort law, usually the law of the state where the injury took place.[4] The law governing malpractice varies from state to state, but among the goals of tort law are compensation for the victim and deterrence of malpractice. To prevail in court, the injured person must demonstrate that the injury was caused by a health care provider's negligence. In the context of malpractice, negligence means proving that the provider failed to meet the same standard of care expected of a member of the profession in good standing in the same circumstances, and that the provider's failure caused the injury that resulted in damage or loss.

Critics of the system of malpractice resolution through the courts doubt that it achieves any of the goals of the tort system in an efficient and effective manner—neither compensating victims fairly nor deterring future malpractice. Furthermore, the vast majority of patients injured by health care providers do not pursue claims,[5] and of those who do, most of the claims are either dropped or settled outside of court.

Nearly all health care providers buy medical malpractice insurance to protect themselves from claims. Under the insurance contract, the insurance company agrees to investigate claims, to provide legal representation for the health care provider if warranted, and to accept financial responsibility for payment of any claims up to a specific monetary level during an established time period. Therefore, in addition to medical malpractice claim payments, insurers incur costs for investigating and defending claims—even those closed without a payment. The insurer

[4]The Employee Retirement Income Security Act limits the ability of a person covered by an employer-based health care plan to sue the plan, instead of or in addition to the provider, for malpractice. The Act preempts state law related to employee benefit plans. The courts have generally interpreted this to prevent an employee's suit against an employer-based managed care plan for injury resulting, for example, from the plan's decision that a procedure is not medically necessary. For more information, see Employer-Based Managed Care Plans: ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice (GAO/HEHS-98-154, July 13, 1998).

[5]The findings of a comprehensive study conducted at New York hospitals showed that the number of negligent adverse outcomes was eight times the number of tort claims filed. See A. Russell Localio and others, "Relation Between Malpractice Claims and Adverse Events Due to Negligence," The New England Journal of Medicine, Vol. 325, No. 4 (1991), pp. 245-51.

agrees to do this in return for a fee—the medical malpractice insurance premium.[6]

Setting premium rates for malpractice insurance can be very complicated. The environment that influences premium rate-setting changes over time, affecting the number of claims or the amount of payments—the two factors most directly affecting premiums. For example, inflation and changes in legal theories can affect claims, payments, or both. The "long tail" of malpractice insurance—the long amount of time that can pass after the injury but before a claim is filed and closed—is a further complicating factor. In addition, premiums for malpractice and other insurance depend in part on projections of companies' investment income, which cannot be predicted with certainty.

States Adopted Tort Reforms in Response to Increasing Medical Liability Costs

Medical malpractice insurance premiums grew rapidly in the mid-1970s and mid-1980s. When costs increased several hundred percent for some specialties in the 1970s, health care providers became concerned either about the availability or affordability of medical malpractice insurance, or both. In response, the majority of states made some changes to their tort law. These tort reforms were adopted in part to limit the number of malpractice claims and the size of payments, thereby ultimately reducing malpractice insurance premiums. Also, tort reforms were intended to lower overall health care costs by getting health care providers to practice less defensive medicine as the threat of liability decreased. State tort reforms adopted during the malpractice insurance premium increases in the 1970s and 1980s included (1) capping malpractice damage amounts, (2) changing collateral source rules, (3) changing statutes of limitations, and (4) implementing alternative dispute resolution systems.[7] Proponents of malpractice reforms, including health care providers and insurers, offered rationales for why each reform would be generally beneficial and should be viewed positively. Conversely, opponents of tort reforms, including consumer advocates and trial attorneys, offered reasons intended to demonstrate the negative aspects of these reforms.

[6]Most policies are sold on a "claims made" basis. In this type of policy, the insurer is only liable for injuries that occur and claims that are filed while the policy is in effect. When changing or canceling coverage, the health care provider may purchase a "tail" policy to cover those injuries that occurred during the life of the "claims made" policy but for which claims were not yet filed.

[7]Other types of tort reforms adopted by the states include paying for damages through periodic rather than lump-sum payments, changing joint and several liability rules, controlling attorney fees, and establishing patient compensation funds and joint underwriting associations.

Caps on Damages Have Been Controversial

Some states enacted laws to limit the amount of money that can be awarded as damages for injuries resulting from malpractice. Caps on damages were the centerpiece of many state tort reform packages.[8] States limited payments for damages in several ways—some, for example, capped the total amount that can be paid as monetary and nonmonetary damages; more commonly, states capped only the amounts payable to compensate for nonmonetary losses.[9] In some states, caps and other tort reforms have been challenged. These challenges have argued that tort reforms violate various provisions of federal and state constitutions, such as the guarantees of equal protection, trial by jury, and the separation of legislative and judicial powers.[10]

Cap proponents—health care providers and insurers—believed that adopting statutory caps on nonmonetary damages would result in several benefits that would help to reduce insurance premiums. For example, they believed that nonmonetary damage caps would

- help to prevent excessive awards and overcompensation. While monetary damages have specific dollar values that can be calculated, juries have considerable discretion and little guidance for nonmonetary damages.
- ensure consistency among jury verdicts. More consistency in awards would aid in setting insurance premiums because it is difficult for actuaries to calculate realistic premiums without knowing all the financial risks involved.
- provide incentives for the injured person to settle claims rather than pursue litigation. Caps help to eliminate the possibility of large jury verdicts, with the result that both injured people and attorneys paid on a contingency fee basis may have less incentive to go to trial.

[8]See Randall R. Bovbjerg, "Lessons for Tort Reform from Indiana," Journal of Health Politics, Policy and Law, Vol. 16, No. 3 (1991), p. 466.

[9]Monetary losses include medical bills, rehabilitation costs, and lost income. Nonmonetary losses include pain, suffering, and the loss of a spouse's companionship. (These are sometimes referred to as noneconomic damages.) Some states have also limited payments for punitive damages—damages to punish wrongdoers for egregious behavior. However, the literature on malpractice indicates that punitive damages are rarely awarded in medical malpractice cases.

[10]For example, Ohio's statutory cap on nonmonetary damages was found to have violated several provisions of the Ohio Constitution. See State ex rel Ohio Academy of Trial Lawyers v. Sheward, No. 97-2419, __ Ohio St. 3d __ (Ohio S.C. Aug. 16, 1999); Morris v. Savoy, 61 Ohio St. 3d 684, 576 N.E. 2d 765 (Ohio S.C. 1991). However, challenges to statutory caps on damages in some other states have not been successful. For example, Virginia's cap on total damages has been upheld, as has Maryland's cap on nonmonetary damages. See Etheridge v. Medical Center Hospitals, 237 Va. 87, 376 S.E. 2d 525 (Va. S.C. 1989) and Edmonds v. Murphy, 87 Md. App. 133, 573 A. 2d 853 (1990), aff'd 325 Md. 342, 601 A. 2d 102 (Md. S.C. 1992), respectively.

In contrast, cap opponents—trial attorneys and consumer advocates—believed that caps on nonmonetary damages created several disadvantages for people who were injured through medical malpractice incidents. For example, they believed that nonmonetary damage caps

- could restrict compensation for severe injuries. An injured person's damages based largely on pain and suffering could be undercompensated compared to damages for someone with little pain and suffering but large medical bills.
- hurt deterrence. Reducing health care providers' financial accountability for losses associated with their mistakes could also reduce providers' incentives to prevent mistakes and adverse outcomes.
- were a disincentive to attorneys accepting some malpractice cases because the potential for recovering a large amount of money is reduced. Therefore, injured patients with legitimate claims may find it more difficult to obtain legal counsel.

Furthermore, opponents stated that factors other than payment size affect the premiums charged by malpractice insurers. They stated that investment income changes also contributed to premium volatility.

Nonmonetary damage cap amounts vary among the states that have them. For example, in 1975, California adopted a $250,000 cap on nonmonetary damages, and the amount remains unchanged to date. Maryland, on the other hand, adopted a $350,000 cap on such damages in 1986 that has increased to $575,000 through legislation that included automatic annual adjustments.[11] Our review of the health and legal literature did not reveal any particular reasons for the cap amounts states adopted.

Collateral Source Rule Reforms Affect Payments, but Are Complicated by Subrogation Clause

A number of states modified or eliminated the collateral source rule. The collateral source rule provides that payments for medical malpractice damages may not be reduced to account for the benefits that an injured person received from other, unrelated sources such as health insurance. The rule prevents the provider being sued from introducing evidence in a trial that the injured person's insurance covers the health care costs arising from the injury. Generally, states that have changed their collateral source rule either permit or require malpractice payments to be reduced if there is evidence that related costs have been or will be covered by other sources.

[11]The law provides for the nonmonetary damage cap to increase $15,000 each October 1.

Reforming the collateral source rule may have the effect of reducing the size of a malpractice payment. Proponents of reform believed that the injured person should not be paid twice for the same harm. In addition, proponents believed that the rule undermines the jury's role by withholding information that it might use in calculating damages.

Opponents of reform, who support maintaining the collateral source rule, believed that the provider causing the malpractice injury should be held responsible for the full extent of the damages he or she caused. If not, the deterrent effect of the malpractice damages awarded is reduced. Also, opponents believed that allowing collateral sources to reduce the liability of the provider found at fault results in an unfair financial gain for the provider or his or her malpractice insurer. They contend that health insurance should not bear the financial risk of malpractice acts—rather, that is the purpose of malpractice insurance.

Health insurance contracts often contain a subrogation clause that can mitigate the effect of the collateral source rule. Under a subrogation clause, when the insurer has paid for health care needed by the insured person as a result of malpractice, the insurer is entitled to be reimbursed for that payment from whatever amounts the insured person collects from a liable third party.[12] Health insurance policies typically contain these clauses, and to the extent that health insurers exercise them there is already protection against double recoveries. However, if subrogation is not available or is not pursued and the collateral source rule is changed, the malpractice insurer of the provider at fault benefits at the expense of the injured person's health insurer.

Statutes of Limitations Establish Time Limits for Filing Lawsuits

Limiting the time to file medical malpractice lawsuits can help to reduce the number of malpractice claims. Statutes of limitations—the period of time during which lawsuits can be filed—help to protect health care providers and the courts from "stale" claims by providing an incentive to the injured person to file a timely claim. It can be difficult for the provider being sued to gather evidence if a long time passes between when an alleged injury occurs and when an injured person files a lawsuit. After a period of time, needed documents can be lost or destroyed.

Unlike traumatic injuries that may occur in automobile accidents, for example, medical malpractice injuries may not become apparent until

[12]The federal government requires that medical expenses paid by Medicare and Medicaid be reimbursed from medical malpractice awards.

years after they occur. To allow for this, the limitation period in some states does not begin to run until after the injured person has discovered, or should have discovered, the injury. However, this "discovery rule" makes writing malpractice insurance more difficult actuarially because of the long period of time over which claims could be filed.[13] Therefore, one of the most common tort reforms states have undertaken has been to change their statutes of limitations for malpractice claims. Many states shortened the time during which lawsuits could be filed by either setting an overall time limit or by modifying their discovery rule. However, shortened statutes of limitations can prevent some injured people who had no way of knowing that they were the victims of malpractice from having a legal remedy.

Alternative Dispute Resolution Offers the Possibility of Avoiding Litigation

Critics have long charged that litigation—ending with trial by jury—is slow, inefficient, inconsistent, and expensive. States have established several ways to resolve medical malpractice claims other than through litigation. Included among these alternative dispute resolution systems are arbitration, mediation, and no-fault programs, described below:

- Under arbitration, malpractice claims are submitted for resolution to one or more professional arbitrators who generally are not bound by rules of evidence and procedure that would apply in court. Depending on state law and the agreements of the parties, the arbitrators' decisions may not be binding: a party who does not like the outcome may be able to take the matter to court where the outcome of the arbitration may not be taken into account.
- Under mediation, a neutral third party helps the parties involved come to an agreement.
- Under no-fault programs, the injured person can be compensated for the expenses associated with the injury without proving that the injury was caused by someone's negligence or other wrongful conduct.

Proponents of alternative dispute resolution generally say that these systems can resolve claims in a faster, less costly manner. For example, they contend that less severe malpractice claims may be resolved in a relatively inexpensive manner, any excessive jury verdicts may be eliminated, and claims may be settled quickly. Therefore, medical liability costs, including premium costs, could be lower.

[13]If the injured person is a minor or is otherwise not legally competent to sue, the statute of limitations may also begin to run only when the person becomes competent.

Opponents believe that litigation alternatives may encourage injured people to pursue claims that they might not take to court, either because the amount is not substantial or the evidence is weak, thereby increasing liability costs. On the other hand, if voluntary, alternatives may seldom be used. Also, if the decisions reached through alternative systems are nonbinding, claims can still be filed in the courts, thus extending claim resolution times and increasing overall liability costs. Furthermore, the deterrent effect provided by the threat of litigation may be removed if no-fault approaches are adopted.

Limited Evidence Shows That Some Tort Reforms May Reduce Premiums and Defensive Medicine Costs

While evidence on reduced premiums and defensive medicine costs is limited, a review of studies done as of the early 1990s indicated that while two tort reforms—caps on damages and collateral source offsets—may reduce medical malpractice payments, only caps were shown to reduce insurance premiums. Recent companion studies also found that these two reforms may have some effect on reducing defensive medicine costs. However, these studies provide only a weak basis for estimating the specific dollar savings associated with these two components of medical liability costs.

Damage Caps Found to Reduce Malpractice Insurance Premiums

A 1993 Office of Technology Assessment synthesis of six empirical studies found evidence which demonstrated that some tort reforms we reviewed had either direct or indirect effects on medical malpractice insurance premiums—one component of medical liability costs.[14] However, according to the synthesis, only damage caps were shown to reduce malpractice insurance premiums. For example, a 1990 study reviewed in the synthesis found that caps on total damages reduced premiums by one-third.[15] None of the six studies demonstrated that collateral source offsets directly reduced insurance premiums. However, the synthesis did find that both caps and offsets reduced medical malpractice claim payments, which in turn can affect premiums. According to a 1989 study, damage caps reduced malpractice payments about 38 percent and collateral source offsets reduced them by 21 percent.[16] According to the

[14]U.S. Congress, Office of Technology Assessment, Impact of Legal Reforms on Medical Malpractice Costs, OTA-BP-H-119 (Washington, D.C.: U.S. Government Printing Office, 1993).

[15]Stephen Zuckerman, Randall R. Bovbjerg, and Frank Sloan, "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums," Inquiry, Vol. 27 (1990), pp. 167-82.

[16]Frank A. Sloan, Paula M. Mergenhagen, and Randall R. Bovbjerg, "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis," Journal of Health Politics, Policy and Law, Vol. 14, No. 4 (1989), pp. 663-89.

synthesis, by lowering claim payments, damage caps and collateral source offsets could also indirectly reduce premiums. Studies assessing the effect of shorter statutes of limitations on malpractice premiums showed mixed results—one study found that they did reduce premiums while another found that they did not. And, due to the limited amount of use, the synthesis found that the effect of alternative dispute resolution systems on premiums could not be assessed.

Estimating the actual savings generated by tort reforms from reductions in malpractice premiums is difficult. Neither the synthesis nor more recent studies have developed dollar-savings estimates. Moreover, insurance premium costs are estimated at less than 1 percent of the total cost of health care in the United States, a small component of overall health care costs. Other tort reform studies have focused more on another component of medical liability costs—defensive medicine.

Tort Reforms' Effect on Defensive Medicine Cost Savings Cannot Be Reliably Estimated

Medical liability costs include a potentially more expensive component than insurance premiums—defensive medicine. While several studies done in the 1990s indicate that defensive medicine practices exist, the extent of defensive medicine and the effects of tort reform on defensive medicine have been difficult to quantify. For example, one 1993 study found that obstetricians and gynecologists practicing in New York hospitals with high malpractice insurance premiums and claims frequency performed more cesarean sections than did physicians in hospitals with lower premiums and claim frequency.[17] The Office of Technology Assessment concluded that this study presented strong evidence that hospitals with the excess cesarean sections were practicing defensive medicine.[18] The Office's broader study of defensive medicine, published in 1994, estimated that less than 8 percent of diagnostic procedures might be caused by liability concerns.[19] However, the study stated that it is not possible to estimate the level and cost of defensive medicine. There may be a number of other reasons why a provider performs a particular service, including local standards of care, academic training, or requirements of managed care organizations. This study could not determine the primary motivation for a provider's decisions.

[17]A. Russell Localio and others, "Relationship Between Malpractice Claims and Cesarean Delivery," The Journal of the American Medical Association, Vol. 269, No. 3 (1993), pp. 366-73.

[18]U.S. Congress, Office of Technology Assessment, Defensive Medicine and Medical Malpractice, OTA-H-602 (Washington, D.C.: U.S. Government Printing Office, 1994).

[19]U.S. Congress, Office of Technology Assessment, Defensive Medicine and Medical Malpractice, 1994.

A more recent study found that a package of reforms including damage caps and collateral source rule changes may decrease some defensive medicine costs. This 1996 study found the cost of annual hospital treatment for newly diagnosed Medicare heart patients grew 5 to 9 percentage points less after states implemented this package of reforms compared to other states.[20] The slowdown occurred 3 to 5 years after tort reform passed. Despite these reductions in treatment costs in the reform states, there was no difference for selected adverse outcomes (such as mortality) between patients in states with and without tort reforms. The authors concluded that the reduced costs measure the size of defensive medical practice and demonstrate the power of certain tort reforms to reduce defensive medicine costs; in a follow-up study, they found similar results.[21] However, the limits of the study—focusing only on heart patients with Medicare between 1984 and 1990—make generalization to overall medical practice impossible and offer limited opportunities for estimating cost savings resulting from tort reform.[22]

Tort Reforms' Effect on Other Medical Liability Costs Unknown

We found no studies of tort reforms' effect on the two other categories of medical liability costs GAO previously identified—liability-related administrative costs and medical device and pharmaceutical liability costs.[23] Furthermore, we found no studies specifically demonstrating how the presence or absence of tort reform in the District, Maryland, or Virginia affects any of the four components of medical liability costs.

[20]Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" The Quarterly Journal of Economics, Vol. CXI, Issue 2 (1996), pp. 353-90.

[21]This latter study using nationally representative American Medical Association physician surveys for the same period found that physicians' perceptions of reduced malpractice pressure corresponded to the tort reforms and reduced practice costs in the original study. See Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," Law and Contemporary Problems, Vol. 60, Nos. 1 and 2 (1997), pp. 81-106.

[22]The authors took several steps to assure that tort reform rather than any other factors explained the pattern of reduced treatment costs. First, a simple comparison of states that reformed and states that did not found similar baseline expenditures and outcomes. Second, they controlled for several other factors, including proxies for regional differences that might have influenced trends in treatment costs, and dismissed them as explanatory factors.

[23]Liability-related administrative costs include certain risk management activities, time and travel associated with litigation, and creating and maintaining records subject to discovery or required for defense. Medical device and pharmaceutical liability costs include manufacturers' insurance and liability-related production and warning costs passed on in the price of their products.

Different Approaches to Tort Reform Found Among the District, Maryland, and Virginia

Each state and the District determines whether to adopt tort reforms and what forms they take. As a result, the law under which medical malpractice claims are resolved varies considerably among states. For example, there is considerable variation between malpractice reform in the District, Maryland, and Virginia. The District has not adopted any major tort reforms, whereas the two neighboring states have adopted various tort reforms. Even though Maryland and Virginia have implemented similar types of reforms, they vary in their specific design.

The District Has Not Adopted Any Major Tort Reforms

The District has not adopted any major tort reforms during the past 25 years. As shown in table 1, the District's tort law

- has no limits on the amount of damages that may be recovered,
- has a collateral source rule that prohibits introducing evidence that can be considered in reducing the amount of an award,
- provides for a 3-year statute of limitations for filing claims that begins after the injured person discovers the injuries, and
- makes arbitration available.[24]

[24]District law provides for court-sponsored arbitration in all civil cases, not specifically for malpractice or other torts. In addition, the District has adopted the Uniform Arbitration Act, which establishes arbitration procedures to be followed when parties have an arbitration agreement.

Table 1: Implementation Status of Selected Tort Reforms

Tort reform	District	Maryland	Virginia
Caps on damages	None	Nonmonetary damage cap of $575,000[a,b]	Total damage cap of $1.5 million[c,d]
Collateral source rule	Collateral source rule followed	Collateral source rule followed	Collateral source rule followed
Statute of limitations	3 years from date of injury or discovery, whichever is later	5 years from date of injury or 3 years from discovery, whichever is earlier (statute deals exclusively with medical malpractice cases)	2 years from date of injury; for malpractice cases involving foreign objects—for example, sponges left in the body—or fraud or concealment, time is extended for 1 year from discovery but no longer than 10 years
Arbitration	The District does not have a specific arbitration program for malpractice or for torts. However, court-sponsored arbitration is available in all types of cases, including medical malpractice; unless parties agree otherwise, arbitration is not binding.[e] Any of the parties may initiate court trial after nonbinding arbitration.[e]	All malpractice claims over $2,500 must be arbitrated by state-appointed health claims panel, unless one of the parties waives arbitration. Arbitration is not binding; any of the parties may initiate court trial.[e]	Health care provider being sued for malpractice may request review by a court-appointed panel. Review panel issues nonbinding opinion; parties may proceed with trial.[e]

[a]Nonmonetary damage cap increases $15,000 each October 1.

[b]Does not include punitive damages, which are not capped.

[c]Effective August 1, 1999, the cap increased from $1 million to $1.5 million. Under the law, it is to increase annually by $50,000 through 2006 and by $75,000 in 2007 and 2008.

[d]Punitive damages are capped at $350,000 within the overall $1.5 million limit.

[e]In addition, the Uniform Arbitration Act, which establishes arbitration procedures to be followed when parties have an arbitration agreement, has been adopted.

Source: GAO analysis of District, Maryland, and Virginia tort law.

While the District has not adopted any major tort reforms, its law, as in neighboring states, contains procedures to help prevent the filing of

frivolous lawsuits. Attorneys filing a lawsuit, whether for medical malpractice or any other cause of action, certify that it is evidence-based and not frivolous.[25] Attorneys can be disciplined by the courts for violating these requirements. Other procedures, such as pretrial conferences, pretrial discovery, and the need for expert testimony to support malpractice claims, also seek to discourage frivolous legal actions in the District.

Legislation to change the District's tort law has been introduced but major changes have not been adopted.[26] In 1991, for example, the Council of the District of Columbia considered but did not adopt any major reforms. Changes considered at that time included capping nonmonetary damages at $350,000 and amending the collateral source rule. More recently, the House version of the District of Columbia appropriations bill for fiscal year 1998 (H.R. 2607) contained provisions which would have, among other things, capped nonmonetary damages at $250,000, amended the collateral source rule, and eliminated the right of subrogation by collateral sources. However, the District's appropriation as adopted into law did not contain these provisions.[27]

Though it did not include the tort reform provisions in its version of the District's fiscal year 1998 appropriations bill, the Senate Appropriations Committee did direct the District's Financial Responsibility and Management Assistance Authority to study the need for malpractice reform in the District. In reports issued in March 1998 and February 1999, the Authority found that District-specific evidence did not support the need to adopt tort reforms.[28] On the contrary, the Authority found evidence that malpractice premiums in Baltimore, with tort reforms in place, were often as high as or higher than in the District.

[25]Under District court rules, by filing a lawsuit an attorney certifies that it is (1) not being presented for any improper purpose, (2) warranted by existing law or a nonfrivolous argument, and (3) based on evidentiary support.

[26]The District has adopted certain limited tort reform measures. For example, the District provides limited civil immunity from damages for a health care professional who provides voluntary health care or treatment at one of the city's free health clinics.

[27]See P.L. 105-100, Nov. 19, 1997.

[28]See District of Columbia Financial Responsibility and Management Assistance Authority, Report on Medical Malpractice Liability (Washington, D.C.: 1998) and District of Columbia Financial Responsibility and Management Assistance Authority, 1999 Report to Congress on Medical Malpractice (Washington, D.C.: 1999).

Maryland and Virginia Adopted Tort Reforms but Chose Different Approaches

In contrast to the District, its two neighboring states have adopted changes to their tort law, but each in somewhat different ways. For example, while both states have limited the size of malpractice payments, Virginia capped total damages, including punitive damages, whereas Maryland capped nonmonetary damages but not monetary or punitive damages. Furthermore, Virginia established a no-fault program to provide a mechanism for resolving some of the most expensive malpractice claims outside the court system—those resulting from very severe birth-related neurological injuries.[29] Also, Virginia has a different time period for filing medical malpractice claims than Maryland. Neither state has chosen to amend its collateral source rule.

Limited Data Show Mixed Results of Tort Law for the District, Baltimore, and Richmond

Comparisons of malpractice claim payments, liability insurance premiums, and number of practicing physicians in the District, Baltimore, and Richmond provide some indications of the effects of the varying tort law in each jurisdiction. However, results are inconsistent across these indicators. Moreover, any differences in these indicators cannot be fully attributed to differences in malpractice law; other legal, social, and economic factors also influence the indicators.

Malpractice Claim Payments Made for Physicians

Reported payments for claims against physicians varied among the District, Baltimore, and Richmond. Table 2 shows that the District had higher median and average cumulative claim payments than the other two cities for the years 1996 through 1998, as reported to the National Practitioner Data Bank. Five of the claims closed during this 3-year time period by the largest malpractice insurer of physicians in the District were for $1 million or more. Such high claims, though relatively infrequent, contribute to the higher average claim payments in the District. These payments would have exceeded the total damage cap in effect in Virginia until August 1, 1999. See appendix II for more information on malpractice claim payments as reported by the District's largest physician insurer.

[29]Under the Virginia Birth-Related Neurological Injury Compensation Act, which was passed in 1987, claimants in cases involving birth-related neurological injuries may recover compensation awards, covering enumerated losses, without having to prove that the health care provider caused the injury.

Table 2: Physicians' Paid Medical Malpractice Claims and Payments

Cumulative for 1996, 1997, and 1998	District	Baltimore	Richmond
Number of paid claims[a]	190	203	49
Median payment[b]	$200,000	$150,000	$112,500
Average payment[b]	$425,813	$299,058	$218,843

[a]These data represent the years that the insurance company considered the claims to be closed and reported them to the National Practitioner Data Bank. They do not represent the years in which the medical malpractice incident occurred or when the claim was filed.

[b]Data do not include allocated loss adjustment expenses unless they are included in a medical malpractice payment. These expenses include, but are not limited to, fees for legal services, expert witnesses, court reports, and medical records. Medical malpractice claims closed without any payments can incur significant allocated loss adjustment expenses.

Source: Unpublished special analyses by the National Practitioner Data Bank, Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services, at the request of GAO.

Malpractice Insurance Premiums Vary for Three Physician Specialties

Medical malpractice insurance premiums, another possible indicator of the effect of tort reforms, varied by physician specialty in the District, Baltimore, and Richmond in 1998. Table 3 shows that the Richmond insurer had the lowest medical malpractice insurance premiums compared to the premiums of the District and Baltimore insurers. However, the insurance rating territory that includes Richmond includes some rural areas as well, which may lower rates. While the District's premiums for internal medicine and general surgery, which are traditionally relatively low-cost specialties, were higher than were those in Baltimore City and County, the premiums for obstetrics/gynecology, a traditionally high-cost specialty, were lower. These premium variations also occur for 1999 premiums for several specialties when comparing the District's and Baltimore's largest malpractice insurers of physicians. Appendix III shows 1999 medical malpractice insurance premiums for selected physician specialties as written by the leading physician malpractice insurers in the District and Maryland.

Table 3: Medical Malpractice Insurance Premiums for Three Physician Specialties, 1998

	District[a]	Baltimore[b]	Richmond[c]
Internal medicine	$11,051	$8,109	$2,585
General surgery	$36,467	$32,414	$10,340
Obstetrics/gynecology	$75,143	$77,619	$18,094

[a]Shows premiums for the National Capital Reciprocal Insurance Company.

[b]Shows premiums for the Medical Mutual Liability Insurance Society of Maryland. Premiums are for the rating territory that includes Baltimore City and Baltimore County.

[c]Shows premiums for the Mid-Atlantic Medical Insurance Company (Medical Mutual of Maryland). Premiums are for the rating territory that includes Richmond and counties such as Henrico, Goochland, and Chesterfield.

Source: "Trends in 1998 Rates for Physicians' Medical Professional Liability Insurance," Medical Liability Monitor, Vol. 23, No. 8 (1998), pp. 2, 5, and 12.

Number of Physicians per 100,000 People

The total number of active, nonfederal physicians in the District, Baltimore, and Richmond increased between 1985 and 1997. The number of physicians per 100,000 people in each of the three cities either increased or stayed the same for all categories, as shown in table 4. Overall, the number of physicians per 100,000 people increased by about 24 percent in the District, and by about 29 and 14 percent in Baltimore and Richmond, respectively. Appendix IV provides information for more physician specialties in the three cities in 1997.

Table 4: Number of Physicians per 100,000 People for Three Specialties, 1985 and 1997

	District		Baltimore		Richmond[a]	
	1985	1997	1985	1997	1985	1997
Active physicians	567	704	672	864	464	528
Internal medicine	125	149	158	197	92	103
General surgery	47	47	57	57	29	33
Obstetrics/ gynecology	39	45	46	52	27	31

[a]Shows the number of physicians in Richmond and neighboring Henrico County.

Source: GAO analysis of the Area Resource File, Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services, February 1998 and February 1999.

As agreed with your offices, unless you announce the report's contents earlier, we plan no further distribution of it until 10 days after the date of this letter. At that time, we will make copies available upon request. If you or your staff have any questions, please call me or Kathryn Allen at (202) 512-7114. Other major contributors to this report are listed in appendix V.

William J. Scanlon
Director, Health Financing
and Public Health Issues

Contents

Letter 1

Appendix I Methodology 22

Appendix II Medical Malpractice Payment Data for the Largest Physician Insurer in the District of Columbia 24

Appendix III Medical Malpractice Insurance Premiums for Selected Physician Specialties in the District of Columbia and Baltimore, 1999 26

Appendix IV Number of Physicians by Specialty in the District, Baltimore, and Richmond per 100,000 People in 1997 27

Appendix V GAO Contact and Staff Acknowledgments 28

Tables

Table 1: Implementation Status of Selected Tort Reforms 14
Table 2: Physicians' Paid Medical Malpractice Claims and Payments 17
Table 3: Medical Malpractice Insurance Premiums for Three Physician Specialties, 1998 18
Table 4: Number of Physicians per 100,000 People for Three Specialties, 1985 and 1997 18
Table II.1: Number of Medical Malpractice Claims and Claim Payments for Physicians at the Largest Insurer in the District of Columbia 24
Table III.1: Medical Malpractice Insurance Premiums by Specialty, 1999 26
Table IV.1: Number of Physicians per 100,000 People by Specialty, 1997 27

Appendix I

Methodology

The objectives of our study were to (1) identify the rationale behind selected reforms states have made to their medical malpractice tort law; (2) report on whether selected tort reforms have reduced malpractice insurance costs and the costs associated with defensive medicine; (3) describe the extent to which the District, Maryland, and Virginia have adopted selected tort reforms; and (4) compare malpractice claim payments, insurance premiums, and numbers of physicians in the District with those in a large city within each of the two neighboring states: Baltimore, Maryland; and Richmond, Virginia.

Literature Review

To identify the rationale behind selected reforms states have made to their medical malpractice tort law, we reviewed health policy and legal literature. We identified the literature to be reviewed by searching 17 different databases. We searched such databases as MEDLINE, HealthStar, Social SciSearch, Sociological Abstracts, Social Sciences Abstracts, Legal Resource Index, and Westlaw. We selected, reviewed, and synthesized more than 100 health policy and legal articles found through the literature search and published since 1990.

We also used information obtained through our literature search and through contacts with experts and affected parties to report on whether selected tort reforms have reduced malpractice insurance costs and the costs associated with defensive medicine. To ascertain whether selected tort reforms reduced medical malpractice insurance premiums, we primarily relied on the results found in a 1993 literature synthesis published by the Office of Technology Assessment. This Office synthesized the results of all six known studies published in the 1980s and early 1990s. We relied on more recent literature to show the relationship between tort reforms and defensive medicine costs.

Statute Review

To describe the state of tort reform in the District and to compare selected provisions of its law to those of Maryland and Virginia, we reviewed applicable state statutes, law review articles, and relevant case law.

Claim Payment Data

We used medical malpractice claim payment data obtained from the National Practitioner Data Bank. The Bank, administered by the Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services, collects data on medical malpractice payments made for physicians, dentists, and other types of

health care practitioners. Malpractice payment data must be reported to the Bank when an insurance company or a self-insured entity makes a payment of any amount for these health care providers to settle or satisfy a judgment on any malpractice action or claim. We asked the Bank to provide data on the number of malpractice claims and median and average malpractice payments reported for physicians during calendar years 1996 through 1998 in the District, Baltimore, and Richmond.

Insurance Premium Data

We used insurance premium data published in the Medical Liability Monitor, which annually compiles a comprehensive premium rate overview. The Monitor obtained malpractice insurance premium data for three specialties—internal medicine, general surgery, and obstetrics/gynecology—through a survey of 47 companies writing insurance in 49 states in 1998. Premiums were reported by the insurers' rating territories within each state. While the District has only one insurance rating territory, Maryland and Virginia have multiple rating territories. These premiums represent rates for mature (generally defined as having been in force with the insurer for 5 or more consecutive years) claims made coverage of $1 million per claim/$3 million in total. Almost all members of the Physician Insurers Association of America participated in this survey.

Physician Data

We analyzed physician data obtained from the Area Resource File. This file, maintained by the Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services, centralizes several kinds of health-related and other data obtained from different sources. Included on the file are physician data from the American Medical Association. While specific data are reported for the District and Baltimore City, Richmond data are reported along with Henrico County. Among the categories of physicians reported, we analyzed active, nonfederal physicians practicing in 1985, 1990, 1995, and 1997 in total and by selected specialties.

Other Information

We contacted several other sources including (1) the primary physician malpractice insurer in the District, (2) malpractice insurers of physicians in Maryland and Virginia, (3) the Physician Insurers Association of America, (4) the District's Financial Responsibility and Management Assistance Authority, and (5) the Association of Trial Lawyers of America.

Medical Malpractice Payment Data for the Largest Physician Insurer in the District of Columbia

The National Capital Reciprocal Insurance Company is the largest malpractice insurer of physicians in the District of Columbia in terms of market share. Table II.1 shows that between 16 and 22 percent of the claims closed in the District by this insurer were closed with a payment in each year between 1996 and 1998. When paid, about 46, 62, and 48 percent of the payments were for $250,000 or more in 1996, 1997, and 1998, respectively. Even though the percentage of paid claims stayed relatively consistent over the 3-year period, median and average medical malpractice claim payments changed each year.

Table II.1: Number of Medical Malpractice Claims and Claim Payments for Physicians at the Largest Insurer in the District of Columbia

	1996	1997	1998
Number of claims closed[a]	129	130	124
Percentage of closed claims paid	22	16	19
Median payment[b]	$221,000	$348,486	$237,500
Average payment[b]	$314,442	$450,475	$219,228
Number and (percentage) of payments $250,000 or more[b]	13 (46)	13 (62)	11 (48)
Number and (percentage) of claims $1 million or more[b]	2 (7)	3 (14)	0 (0)

[a]Data are shown for the year in which the insurance company considered the claim to be closed. These data do not show when the incident occurred or when the claim was filed.

[b]Payment data do not include allocated loss adjustment expenses. These expenses include, but are not limited to, fees for legal services, expert witnesses, court reporters, the court, and medical records.

Source: National Capital Reciprocal Insurance Company, Inc.

The National Capital Reciprocal Insurance Company closed 11 medical malpractice claims with payments of $250,000 or more in 1998 in the District. As shown in the following list, these 11 claims involved several different types of physician specialties, including internal medicine, pediatrics, and orthopedic surgery. Almost half of the injuries occurred because of the physician's failure to diagnose a problem:

- General surgery—Improper performance of a surgical procedure
- Internal medicine—Failure to diagnose disease
- General surgery—Failure to treat malignant mass
- Internal medicine—Medication error

- Obstetrics and gynecology/traumatic surgery—Improper performance of a surgical procedure
- Cardiothoracic surgery—Improper management/monitoring of condition
- Pediatrics—Failure to diagnose disease
- Obstetrics/gynecology—Failure to diagnose malignant mass
- Internal medicine—Failure to diagnose disease
- Pediatrics—Failure to diagnose disease
- Orthopedic surgery—Improper performance of a surgical procedure.

Medical Malpractice Insurance Premiums for Selected Physician Specialties in the District of Columbia and Baltimore, 1999

Medical malpractice insurance premiums vary by specialty and by area of the country. For example, areas like the District of Columbia and Baltimore, which are close to each other in distance, can have very different premiums. Table III.1 shows that for several specialties in 1999, medical malpractice insurance premiums are higher in Baltimore than in the District of Columbia. Of particular note are premiums for obstetrics/gynecology, a specialty long associated with among the most expensive medical malpractice claim payments. Higher premiums in Baltimore occur even though Maryland adopted a cap on nonmonetary damages more than a decade ago.

Table III.1: Medical Malpractice Insurance Premiums by Specialty, 1999

Specialty	District premiums[a,c]	Baltimore premiums[b,c]
Internal medicine	$11,051	$8,325
Ophthalmology	12,156	13,190
General surgery	36,467	33,334
Anesthesiology	16,576	20,152
Obstetrics/gynecology	75,143	79,850

[a]Premiums written by the largest physician malpractice insurer in the District.

[b]Premiums written by the largest physician malpractice insurer in Maryland. These premiums are for the rating territory that includes Baltimore City and Baltimore County.

[c]Premiums represent a mature claims made policy with coverage limits of $1 million/$3 million. In a claims made policy, the insurer is only liable for injuries that occur and claims that are filed while the policy is in effect. A mature claims made policy is generally defined as having been in force with the insurer for 5 or more consecutive years.

Source: District premium data are from the National Capital Reciprocal Insurance Company, Inc. Baltimore premium data are from Medical Mutual of Maryland.

Appendix IV

Number of Physicians by Specialty in the District, Baltimore, and Richmond per 100,000 People in 1997

The number of physicians in total and by specialty per 100,000 people varies for each of the three urban areas—the District, Baltimore, and Richmond. However, table IV.1 shows that, with the exception of general practitioners, Baltimore had more physicians per 100,000 people in total and in each specialty than either the District or Richmond in 1997.

Table IV.1: Number of Physicians per 100,000 People by Specialty, 1997

	District	Baltimore	Richmond[a]
Active physicians	704	864	528
General practitioners	30	33	46
Cardiologists	15	24	19
Internists	149	197	103
Pediatricians	74	80	46
Surgeons	47	57	33
Neurosurgeons	7	9	6
Obstetricians/ gynecologists	45	52	31
Anesthesiologists	20	32	20
Diagnostic radiologists	15	19	17
Emergency medicine	12	20	7
Gastroenterologists	9	11	10

[a]Shows the number of physicians in Richmond and neighboring Henrico County.

Source: GAO analysis of the Area Resource File, Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services, February 1999.

Appendix V

GAO Contact and Staff Acknowledgments

GAO Contact

John Dicken, (202) 512-7043

Staff Acknowledgments

In addition, Barry Bedrick, Barbara Chapman, Robert Crystal, Joseph Petko, and Roger Thomas made key contributions to this report.

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