



Medical Malpractice: Background and Legislation in the 112th Congress

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Summary

As a policy area, concerns about medical malpractice have often involved issues related to the market for provider liability insurance, the prevalence of malpractice in the health care system, and the resolution of malpractice complaints through the tort system. Medical malpractice has attracted congressional attention numerous times over the past decades, particularly in the midst of three “crisis” periods for the liability insurance market in the mid-1970s, the mid-1980s, and the early 2000s. These periods were marked by sharp increases in medical liability insurance premiums, difficulties in finding any insurance in some areas as insurers withdrew from providing coverage, reports of providers leaving areas or retiring following insurance difficulties, and a variety of public policy measures at both the state and federal levels to address these historic crises. Which public policy measures have been effective in addressing the difficulties in the medical malpractice liability market has been a matter of debate, in part because these difficulties have been at the intersection of the health care, tort, and insurance systems.

The overall medical liability insurance market is not currently exhibiting the same level of disruption as in the past. Nonetheless, concerns with the affordability and availability of malpractice insurance persist, especially in particular regions and physician specialties (e.g., obstetricians). In addition, the fear of claims for medical malpractice may impact individual provider decisions and drive up the overall cost of health care. In terms of *direct* costs, medical malpractice insurance adds relatively little to the cost of health care overall. According to the National Association of Insurance Commissioners (NAIC), medical malpractice premiums written in 2009 totaled approximately \$10.8 billion, while overall health expenditures are estimated by the Congressional Budget Office (CBO) to total \$2.6 trillion. *Indirect* costs, particularly increased use of tests and procedures by providers to protect against future lawsuits (“defensive medicine”), have been estimated to be much higher than direct premiums. CBO estimated that enacting federal tort reforms would reduce both health care spending by approximately 0.4% (roughly \$10.5 billion) and the federal budget deficit by \$40.1 billion over a 10-year period.

Even during a period of relative calm, the malpractice system experiences issues with equity and access. For example, some observers have criticized the current system’s performance with respect to compensating patients who have been harmed by malpractice, deterring substandard medical care, and promoting patient safety. Yet there are differing opinions as to the extent that each of these particular areas has been affected by the current malpractice system.

The President’s 2012 budget encouraged Congress to reform the medical malpractice system and requested \$250 million for the Department of Justice to test a variety of reform proposals. In the 112th Congress, the specific issue of medical liability reform was addressed by the House Committee on the Judiciary in a January 20, 2011 hearing. The committee marked up H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, on February 9 and February 16, 2011, and reported the bill on March 17, 2011. Among other things, the HEALTH Act would implement a cap on non-economic damages for health care lawsuits.

Contents

Introduction	1
Recent Action and Proposals on Medical Malpractice.....	1
During the 112 th Congress	1
The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 (H.R. 5).....	2
FY2012 President’s Budget	3
During the 111 th Congress	4
PPACA and Medical Malpractice	4
Costs of Medical Malpractice	4
Challenges in Medical Malpractice Policymaking	6
Health Care System.....	6
Tort System.....	7
Insurance System	7
Recent Experience	8
The Medical Malpractice Insurance Market.....	8
State Reform Efforts	10
Recent Experience Among Providers.....	13

Figures

Figure 1. Nationwide Direct Losses Incurred.....	9
Figure 2. Nationwide Loss Ratio	10
Figure 3. Change in the Average Paid Medical Malpractice Claim	13

Tables

Table 1. Percentage Change in the Number of Paid Medical Malpractice Claims (2003 – 2009) and Claims Per 100,000 Population (2009).....	11
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Contacts

Author Contact Information	14
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Introduction

Medical malpractice has attracted congressional attention numerous times over the past few decades, particularly in the midst of three “crisis” periods for medical malpractice liability insurance in the mid-1970s, the mid-1980s, and the early 2000s. These periods were marked by sharp increases in medical liability insurance premiums, difficulties in finding any liability insurance in some regions and among some specialties as insurers withdrew from providing coverage, reports of providers leaving areas or retiring following insurance difficulties, and a variety of public policy measures at both the state and federal levels to address the market disruptions. In each case, attention receded to some degree after a few years as premium increases moderated and market conditions calmed.

The overall medical liability insurance market is not currently exhibiting the same level of crisis as in previous time periods. Nonetheless, problems with the affordability and availability of malpractice insurance persist, especially in particular regions and physician specialties (e.g., obstetricians). In addition, the fear of claims for medical malpractice may affect individual provider decisions particularly through increased use of tests and procedures to protect against future lawsuits (“defensive medicine”) and drive up the overall cost of health care. The malpractice system also experiences issues with equity and access. For example, some observers have criticized the current system’s performance with respect to compensating patients who have been harmed by malpractice,¹ deterring substandard medical care,² and promoting patient safety.³

Which public policy measures have been effective in addressing the successive insurance market disruptions, and may be effective in the future, has been a matter of debate. Some proposals (such as the current Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, H.R. 5) have addressed the tort system, particularly limits on claims brought in medical liability cases; others have addressed the insurance system, particularly increased direct regulation of insurance companies, or removal of the existing partial exemption from federal antitrust laws for the “business of insurance.”

Recent Action and Proposals on Medical Malpractice

During the 112th Congress

The 112th Congress has acted early to address health reform generally and medical malpractice issues specifically. H.R. 2, which would repeal P.L. 111-148 in its entirety, including the medical malpractice provisions discussed below (under the section “During the 111th Congress”), was introduced by Representative Eric Cantor on January 5, 2011. This bill was passed by the House

¹ E. Thomas et al., “Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado,” *Medical Care*, vol. 38, no. 3, (March 2000); T. Brennan et al., “Incidence of Adverse Events and Negligence in Hospitalized Patients,” *New England Journal of Medicine*, vol. 324, no. 6, (February 7, 1991).

² Michelle M. Mello and Troyen A. Brennan, “Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform,” 80 *Tex. L. Rev.* 1595 (2002).

³ L. Sato et al., “Legal Liability and Protection of Patient Safety Data,” Harvard Risk Management Foundation, 2005.

on January 19, 2011. Medical liability reform was the topic of the first committee hearing in the House Committee on the Judiciary for the 112th Congress, held on January 20, 2011, and the Committee has acted on H.R. 5 as discussed below.

The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 (H.R. 5)

H.R. 5 was introduced by Representative Phil Gingrey on January 24, 2011.⁴ The House Committee on the Judiciary marked up the bill on February 9, and February 16, 2011, and reported the bill on March 17, 2011. The bill has also been referred to the House Energy and Commerce Committee for further consideration ending not later than May 13, 2011.

H.R. 5 would, with certain exceptions, preempt some aspects of existing state medical malpractice laws. Although H.R. 5 seeks to address both medical malpractice and product liability, this report is limited to provider medical malpractice. The bill defines a “health care lawsuit” to encompass not only suits between a provider and patient, but also any claim against a health care organization, manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product and any claims concerning health care goods and services or medical products affecting interstate commerce. Among other things, H.R. 5 would mandate a uniform statute of limitations for health care lawsuits and set parameters and caps for non-economic damages,⁵ punitive damages,⁶ and attorneys fees. However, it would also grant states flexibility in that it would not preempt any state law that imposes greater procedural or substantive protections for health care providers and organizations from liability, loss, or damages. It would also not preempt any state law that specifies a particular monetary amount of compensatory or punitive damages, regardless of whether the state’s monetary amount is greater or lesser than is provided for in the act.

In the February 16, 2011, markup of the bill, an amendment to eliminate a provision in H.R. 5 that would have allowed juries to hear evidence of “collateral source benefits,” such as workers’ compensation payments or long-term disability insurance payments, was adopted by voice vote. The amendment also struck a provision that would have prohibited providers of collateral source benefits from recovering any amounts paid after a court award is made to a plaintiff.⁷

⁴ Prior versions of this bill have been introduced in past Congresses. See H.R. 4600, 107th Cong. (2nd sess., 2002); H.R. 5, 108th Cong. (1st sess., 2003); H.R. 4280, 108th Cong. (2nd sess., 2004); H.R. 5/H.R. 534 (1st sess., 2005); H.R. 2580, 110th Cong. (1st sess., 2007); H.R. 1086, 111th Cong. (1st sess., 2009).

⁵ Non-economic damages typically compensate for intangibles, such as pain and suffering and capacity to enjoy life, as opposed to economic damages, which compensate for more tangible elements, such as medical expenses and loss of earnings.

⁶ Punitive damages are damages in excess of those needed to compensate an individual for injuries or loss and are designed to punish the alleged wrongdoer for bad behavior.

⁷ See also CRS Report R41661, *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys on Tort Reform Proposals*, by Vivian S. Chu.

FY2012 President's Budget

The President's FY2012 budget made general reference to reforming medical malpractice:⁸

To do more to restrain health care costs, the President is ... :

Calling for a more aggressive effort to reform our medical malpractice system to reduce defensive medicine, promote patient safety, and improve patient outcomes. The President encourages Republicans to work constructively with him on medical malpractice as part of an overall effort to restrain health costs.

In addition, the President's budget "makes available \$250 million in grants to states to reform the way they resolve medical malpractice disputes." These grants would be awarded in consultation with the Department of Health and Human Services.⁹

According to information from the Justice Department,¹⁰

[S]tates could use the grant money to test out reforms such as:

Health courts which use specially-trained judges and medical experts to review medical liability cases, rather than the traditional trial-by-jury approach.

Safe harbors, which would provide physicians, hospitals, and other medical providers a legal safety net; those who adhered to best-practices standards of care would be considered non-negligent. Funding could be used toward identifying and certifying practice guidelines.

Early disclosure and offer, which would require doctors and hospitals to follow a protocol after a medical error occurred that could include disclosing the error to a safety officer and the patient, apologizing to the patient, and offering fair compensation. If the patient decided to sue, the provider's disclosure and apology could not be used as evidence of liability.

States could also use the money to try out other reforms, such as a "fair share" rule that would allocate responsibility for malpractice payments that are in proportion to responsibility for the damages.

These grants are ultimately dependent on further legislative action by Congress.

⁸ The White House Office of Management and Budget, *Fiscal Year 2012 Budget of the United States Government*, p. 25, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/budget.pdf>.

⁹ The White House Office of Management and Budget, *Fiscal Year 2012 Budget of the United States Government*, p. 737, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jus.pdf>.

¹⁰ Emily P. Walker, "Obama's Budget Includes \$250M in Malpractice Grants," *MedPage Today*, February 16, 2011, <http://www.medpagetoday.com/PracticeManagement/Medicolegal/24904>.

During the 111th Congress

PPACA and Medical Malpractice

The Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as amended, included two provisions related to medical malpractice reform.

PPACA, § 6801, expressed the Sense of the Senate that (1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; (2) states are encouraged to develop and test litigation alternatives while preserving an individual's right to seek redress in court; and (3) Congress should consider establishing a state demonstration program to evaluate alternatives to the existing civil litigation system with respect to medical malpractice claims.

PPACA, § 10607, authorized \$50 million for a five-year period beginning in FY2011 for the HHS Secretary to award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or organizations. States that receive a grant are required to develop an alternative that (1) allows for the resolution of disputes caused by health care providers or organizations, and (2) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to the resolved disputes.

Prior to receiving a grant, a state will have to demonstrate that its alternative (1) increases the availability of prompt and fair resolutions of disputes, (2) encourages the efficient resolution of disputes, (3) encourages the disclosure of health care errors, (4) enhances patient safety by reducing medical errors and adverse events, (5) improves access to liability, (6) informs the patient about the differences between the alternative and tort litigation, (7) allows the patient to opt out of the alternative at any time, (8) does not conflict with state law regarding tort litigation, and (9) does not abridge a patient's ability to file a medical malpractice claim.

The demonstration grant provisions do not limit any prior, current, or future efforts of any state to establish any alternative to tort litigation. Monies for this demonstration have not been appropriated as of this time.

Costs of Medical Malpractice

In terms of direct costs, medical malpractice insurance adds relatively little to the direct cost of health care relative to total health care spending, but medical malpractice tort reform could still save, as noted below, a not insignificant amount of money over time. Medical malpractice premiums written in 2009 totaled approximately \$10.8 billion,¹¹ while health expenditures estimated by CBO total \$2.6 trillion.¹² Indirect costs, particularly increased use of tests and procedures by providers to protect against future lawsuits ("defensive medicine"), have been

¹¹ NAIC, "Countrywide Summary of Medical Malpractice Insurance, Calendar Years 1991-2009," provided to CRS on December 16, 2010.

¹² Douglas Elmendorf, "Expanding Health Insurance Coverage and Controlling Costs for Health Care," testimony provided to the Senate Budget Committee, February 10, 2009, http://www.cbo.gov/ftpdocs/99xx/doc9982/02-10-HealthVolumes_Testimony.pdf.

estimated to be much higher than direct premiums. These conclusions, however, have been controversial, in part because some synthesis studies have claimed that national estimates of defensive medicine are unreliable.¹³ A recent analysis on the subject estimated that the total costs of defensive medicine in 2008 were \$45.6 billion.¹⁴

Prior to the passage of the health care reform law, CBO conducted its own analysis, as well as synthesized and analyzed previous studies on the relationship between medical malpractice and health care costs.¹⁵ The most recent CBO analysis estimated that federal tort reforms would reduce national health care spending by about 0.4% in 2009 (equivalent to approximately \$10.5 billion).¹⁶ This estimate is the cumulative impact of tort reform on both lowering medical malpractice insurance premiums and reducing use of health care services, and takes into account the fact that because many states have implemented tort reforms, a significant proportion of potential cost savings already has been realized. Other earlier studies have estimated the reduction of health care spending attributable to state tort reforms. These studies compared pre- and post-reform spending within each state that implemented such reforms, and found varying impact (e.g., a set of studies found 4%-9% reduction in hospital spending for Medicare patients with heart disease; another study found that state tort reforms reduced personal health care expenditures by 3%-4%).¹⁷

CBO also estimated the effect of malpractice tort reform on the federal budget. In its latest analysis, CBO estimated that such reforms would reduce spending under Medicare, Medicaid, the State Children's Health Insurance Program, and the Federal Employees Health Benefits Program by approximately \$34 billion from 2011 to 2021. In addition, Congress's Joint Committee on Taxation (JCT) estimated that such reforms would lead to an increase in federal revenues of \$6 billion over the same 10-year period.¹⁸ By combining the impact of tort reform on mandatory health spending and tax revenues, CBO estimated that tort reforms could reduce the federal budget deficit by approximately \$40.1 billion over 10 years.¹⁹

¹³ See, e.g., Michelle Mello, "Understanding medical malpractice insurance: A primer," Robert Wood Johnson Foundation, Research Synthesis Report No. 8, January 2006, and Office of Technology Assessment, "Defensive Medicine and Medical Malpractice," 1994.

¹⁴ Michelle M. Mello, Amitabh Chandra, and Atul A. Gawande et al., "National Costs Of The Medical Liability System," *Health Affairs*, vol. 29, no. 9 (September 2010), pp. 1569-1577.

¹⁵ See CBO, "Budget Options, Volume 1: Health Care," December 2008.

¹⁶ Congressional Budget Office, "Cost Estimate of H.R. 5 Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011," March 10, 2011, available at <http://www.cbo.gov/ftpdocs/120xx/doc12095/hr5.pdf>.

¹⁷ See P. Danzon, "Liability for Medical Malpractice," *Handbook of Health Economics*, Culyer and Newhouse, eds., 2000; D. Kessler and M. McClellan, "How Liability Law Affects Medical Productivity," Working Paper No. 7533, National Bureau of Economic Research, February 2000, and "Do Doctors Practice Defensive Medicine?," *Quarterly Journal of Economics*, vol. 111, no. 2, May 1996; and F. Hellinger and W. Encinosa, "The Impact of State Laws Limiting Malpractice Damage Awards on Health Care Expenditures," *American Journal of Public Health*, August 2006.

¹⁸ Much of health care consumed in the private sector is provided through employer-sponsored health benefits that are not taxed as income for the employee. The JCT assumed that implementation of tort reforms would lead to lower health care costs, which in turn, would lead to higher wages, which are taxable. Thus, higher taxable income would result in greater revenue.

¹⁹ Congressional Budget Office, "Cost Estimate of H.R. 5 Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011," March 10, 2011, available at <http://www.cbo.gov/ftpdocs/120xx/doc12095/hr5.pdf>.

Challenges in Medical Malpractice Policymaking

Addressing problems in medical malpractice can be challenging, particularly due to the interactions of three different systems, each of which is complex in its own right: health care, tort, and insurance.

Health Care System

Medical errors can lead to injury, and injury is the medical basis on which a malpractice claim is made. Reducing errors through improved medical practices and effectuating penalties against poorly performing providers may benefit the overall performance of the medical malpractice insurance system by, for example, possibly lowering premiums or improving access to insurance.

States have the primary authority to define the process for granting and renewing a medical license, and regulating the medical practice. Currently, there is a lack of uniformity across states regarding both medical licensure and the medical practice. Moreover, states face financial challenges and many are likely to lack clinical expertise to fully implement patient safety strategies. For example, current state initiatives vary regarding the existence, scope, and robustness of data-collection efforts to track and analyze medical errors and possible instances of malpractice. Federal input may be implemented through a variety of approaches, both voluntary (e.g., support for research on evidence-based medicine, and toolkits to evaluate the adoption of patient safety efforts) and mandatory (e.g., “conditions of participation” standards for institutional providers under the Medicare program).

While reducing medical errors may be a worthy goal in its own right, it is unclear to what degree medical malpractice insurance will be affected if only patient safety concerns are addressed. Multiple older studies have found that the majority of malpractice claims filed involve medical injuries not caused by negligence.²⁰ Moreover, only a small proportion of patients whose injuries are caused by negligent medical care actually end up filing a malpractice claim.²¹ However, there is an emerging consensus in the academic literature that, while there are legal errors in paying undeserving individuals in addition to medical errors, “the merits of a claim are the best predictor of the likelihood of payment and the amount received.”²² These findings speak to the complexity of the existing medical liability system and difficulty in designing effective policies without consideration of the interrelated systems.

²⁰ See, e.g., David Studdert et al., “Negligent Care and Malpractice Claiming Behavior in Utah and Colorado,” *Medical Care* (March 2000); Paul Weiler et al., *A Measure of Malpractice* (1993); T. Brennan et al., “Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I,” *New England Journal of Medicine*, vol. 324, no. 6 (February 7, 1991).

²¹ David Studdert et al., “Negligent Care and Malpractice Claiming Behavior in Utah and Colorado,” *Medical Care* (March 2000).

²² David A. Hyman and Charles Silver, “Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid,” *Vanderbilt Law Review*, vol. 59, no. 4 (2006), p. 1100. “For instance, one major study of closed insurance claims found that injured (non-injured) individuals were compensated (not compensated) in a total of 73% of the cases. Moreover, it was 1.6 times more likely that an injured individual would not receive compensation than it was that a non-injured individual would receive compensation. Finally, the amount a non-injured individual received when compensated in error was almost half that received by those truly injured.”

As noted above, some observers suggest that the current malpractice system encourages the practice of “defensive medicine,” that is, the fear of liability and the potential negative outcomes associated with malpractice claims lead providers to administer additional health care treatments or avoid high-risk services primarily to reduce their liability risk. The implication is that defensive medicine results in either an increase in overall consumption of and spending on health care services that may not be medically necessary or a decrease in access to certain services or for certain patients. Multiple studies have found some evidence of defensive medicine, but even providers acknowledge that it is a difficult concept to measure.²³ Moreover, some evidence suggests that factors other than defensive medicine, such as physician payment systems (e.g., fee-for-service vs. capitation) and financial incentives, may explain the over-provision of health services.²⁴

Tort System

The tort system acts as a mechanism through which a person suffering injury due to medical errors is monetarily compensated when he or she establishes that a provider provided substandard health care. Some argue that the tort system is an efficient way to both compensate those who suffer from an injury and to deter the errors that created the injury, and that the tort system is the primary way that the present system deals with such issues. However, there are those who argue that, in the case of medical malpractice, the current system does neither particularly well.²⁵ Some observers have suggested that the medical malpractice tort system is arbitrary in its outcome.²⁶ As noted above, many valid claims are never filed and many filed claims are not the result of negligence. Jury verdicts can vary significantly from case to case, with substantial variation also occurring among states and among counties within states.

Insurance System

Liability insurance insulates providers from the direct cost of medical malpractice. It acts as a buffer between the actual award for malpractice determined under the tort system and the provider who may have committed malpractice. The vast majority of providers have liability insurance, although there is anecdotal evidence about some providers practicing medicine without malpractice insurance. By its nature, insurance spreads the costs across a wide base of providers in a particular specialty or geographic area, so that the actions of a relatively small number of providers can have a wider impact.

Specific aspects of the insurance system can arguably catalyze or magnify crises. Medical malpractice claims tend to play out over an extended period of time, due both to the lag in recognizing that a claim might exist and to deliberations in the court system. Insurance is based on estimating future claims and estimating the investment returns on premium payments from the

²³ General Accounting Office, “Medical Malpractice: Implications of Rising Premiums on Access to Health Care,” GAO-03-836, August 2003.

²⁴ Ibid.

²⁵ See analysis presented by M. Mello and D. Studdert, “The Medical Malpractice System: Structure and Performance,” *Medical Malpractice and the U.S. Health Care System*, W. Sage and R. Kersh, eds., Cambridge University Press, 2006.

²⁶ “Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care,” Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, March 3, 2003.

time premiums are paid until the time claims are paid. The longer time period associated with liability insurance losses increases uncertainty in these estimations (both in terms of the frequency of claims and the dollar amount of awards), with such uncertainty possibly leading to increased volatility in premiums.

Medical malpractice liability insurance is regulated by the individual states under the federal McCarran-Ferguson Act of 1945,²⁷ which also provides a limited exemption from federal antitrust laws. This system of state regulation has resulted in variations in the structure of the markets as well as in the data generated. NAIC aggregates some insurance data; however, much potentially useful data is either not collected or not available. For example, data encompassing all the medical malpractice claims closed by insurers can give a broad picture of the situation in medical malpractice insurance; however, only a handful of states either collect such data or make it available to researchers.

Recent Experience

Recent experience in the medical malpractice insurance market, within the states with respect to the number of malpractice law suits and their average settlement amounts, and among providers that have embarked on quality improvement efforts that reduce malpractice exposure and premiums, can be described as encouraging. It is not yet clear whether these trends are long term or whether they reflect the trough of another cycle in the medical liability insurance marketplace.

The Medical Malpractice Insurance Market

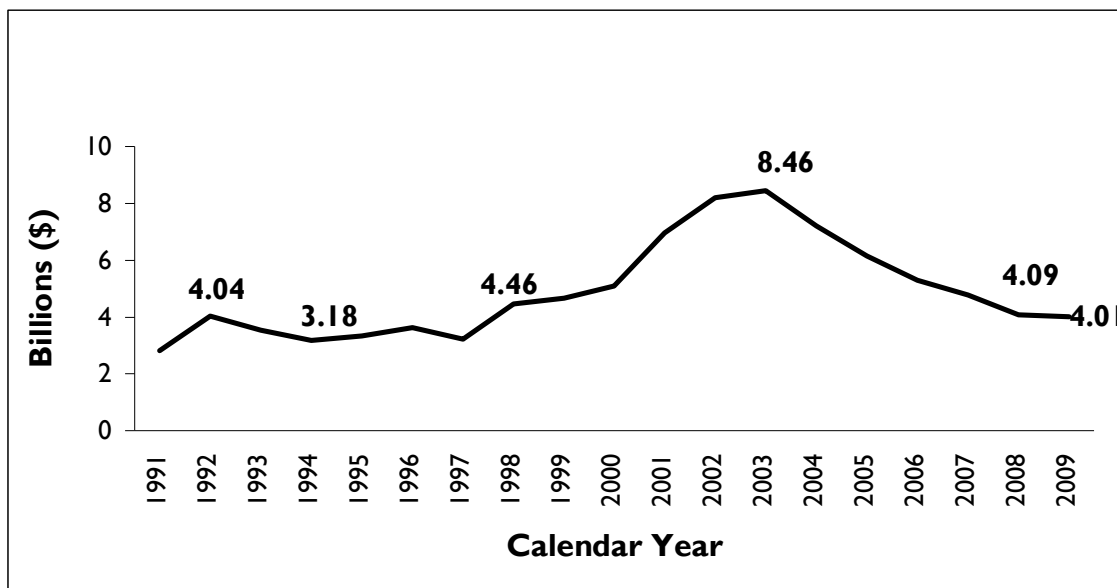
The cyclical experience of medical malpractice insurers is reflected in aggregate data about the industry compiled and analyzed by the NAIC (see **Figure 1**). From 1992 to 1998, direct incurred losses were relatively stable,²⁸ varying from a low of \$3.18 billion in 1994 to a high of \$4.46 billion in 1998. However, from 1998 to 2003, losses grew steadily year after year, to a high of \$8.46 billion in that last year, coinciding with the last crisis period. Since 2003, losses have fallen every year. In 2009, losses totaled \$4.01 billion, the lowest amount in more than a decade. (The loss data are in nominal dollar amounts.)²⁹

²⁷ 15 U.S.C. §1011 *et seq.*

²⁸ Incurred losses are payments for claims during a certain time period, in this case during a calendar year. Incurred losses for any given year include payments for claims submitted prior to that year, and account for outstanding claims at the end of the time period. The NAIC loss data is in nominal dollar amounts.

²⁹ The distinction between nominal vs. real dollars is significant when considered over the longer-time period. For example, while the 2008 loss of \$4.09 billion does not seem much more than the 1992 loss of \$4.04 billion, because these amounts do not reflect the effects of inflation, the 2008 losses are actually much lower than those in 1992.

Figure I. Nationwide Direct Losses Incurred
(Nominal)



Source: National Association of Insurance Commissioners.

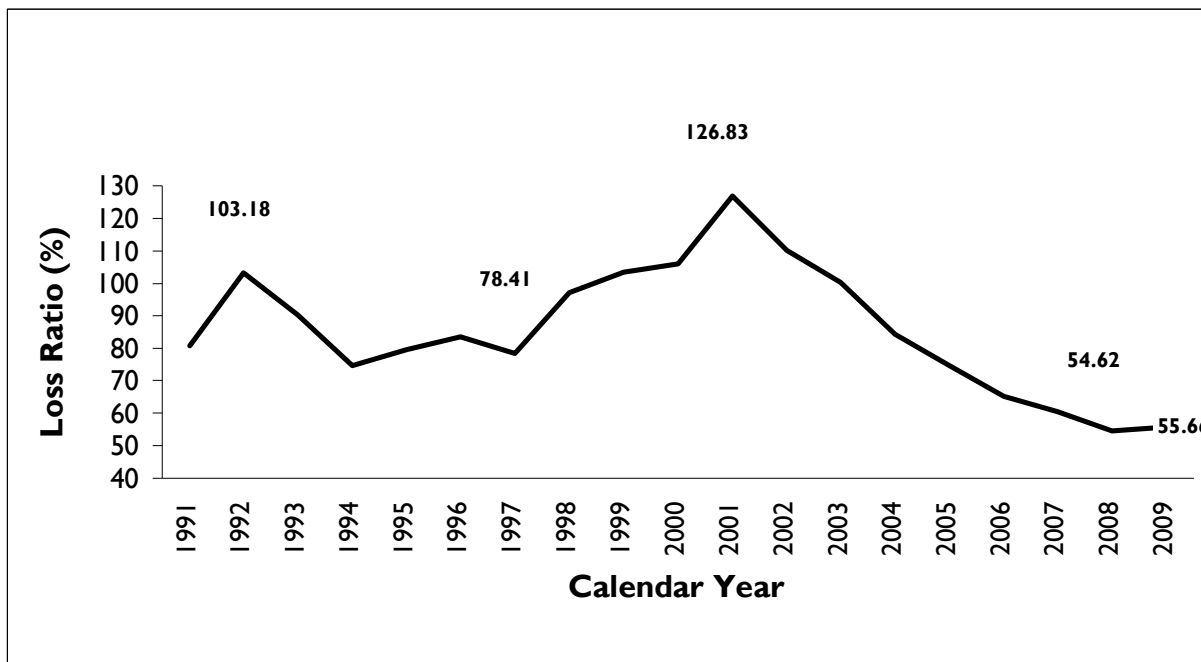
Malpractice insurance premiums roughly followed losses as those amounts increased.³⁰ However, premiums have not fallen nearly as much as losses in recent years as the trend reversed. The loss ratio, which compares losses to premiums, reflects this uneven trend (see **Figure 2**). A high ratio generally implies lower profits for insurers on the insurance portion of their operations. The loss ratio for the industry rose steadily from 78.41% in 1997 to 126.83% in 2001, tracking closely with the losses trend. Since 2001, the loss ratio has rapidly decreased. In 2008, the loss ratio of 54.62% was the lowest one in nearly two decades and the 2009 ratio was the second lowest at 55.66%, meaning that over the past two years, the industry experienced its highest profit margin on direct premiums earned in the calendar years analyzed.³¹

Insurers, who are regulated by state insurance regulators, may also profit, or lose, from their investments. In general, with such low loss ratios, theory would suggest that there is an increase in competition because insurers are entering the market in search of profits. This, however, may not be happening as quickly as expected in medical malpractice if prospective insurers are wary due to past variations in medical malpractice losses, or if prospective insurers' capital has been depleted due to losses incurred during the recent financial crisis.

³⁰ This aggregate national data does not include, among other things, the number of policies written or the number of providers covered. As such, other trends such as consolidation of providers within hospitals or changes in the number of providers self-insuring or changes in the level of self insurance can impact the aggregate figures.

³¹ Other factors, such as returns on investments and administrative costs, in addition to losses, are likely to impact the total profitability of insurers.

Figure 2. Nationwide Loss Ratio



Source: National Association of Insurance Commissioners.

Notes: Loss Ratio = (Direct Losses + Direct Defense and Cost Containment Expenses Incurred)/Direct Premiums Earned.

State Reform Efforts

Over the past 35 years, many states have adopted various tort reform proposals, including, among other things, caps on non-economic damages, caps on punitive damages, reform of the collateral source rule,³² and changes in statutes of limitations. These reforms were designed in part to reduce the number of claims, the dollar amount of claims, or both.

In 2009, there were 10,739 paid medical malpractice claims in the United States—27.6% fewer than in 2003.³³ Some of these claims were paid without a trial. Paid claims represent only a part of total claims and a majority of claims were either dropped or settled through litigation in which the defendant provider was not found liable. At least one study found that in roughly 80% of the cases that went to trial, the alleged wrongdoer in a medical malpractice case has been exonerated.³⁴ **Table 1** shows the percentage change in the number of paid medical malpractice claims between 2003 and 2009. Only two states, Massachusetts and New Mexico, experienced an increase in the number of paid claims over this time period. Six states (Connecticut, Delaware,

³² A collateral source rule provides that the benefits received by an injured party from a source wholly independent of the wrongdoer, such as the injured party's insurer, will not operate to lessen the damages recoverable from the wrongdoer.

³³ See <http://statehealthfacts.kff.org/comparemtable.jsp?ind=436&cat=8>.

³⁴ David A. Hyman and Charles Silver, "Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid," *Vanderbilt Law Review*, vol. 59, no. 4 (2006), p. 1107.

Indiana, Kentucky, Ohio, and Texas) and the District of Columbia experienced a 50% or greater percentage decline in the number of paid claims.

Table 1. Percentage Change in the Number of Paid Medical Malpractice Claims (2003 – 2009) and Claims Per 100,000 Population (2009)

State	% Change in Number of Claims (2003-2009)	Claims Per 100,000 (2009)	State	% Change in Number of Claims (2003- 2009)	Claims Per 100,000 (2009)
AL	-37.5	0.650	MT	-37.9	3.759
AK	-36.8	1.770	NE	-41.5	2.723
AZ	-43.6	2.630	NV	-35.0	2.490
AR	-29.4	1.694	NH	0.00	3.591
CA	-30.7	2.499	NJ	-19.9	5.441
CO	-23.0	2.515	NM	13.7	4.201
CT	-51.9	2.980	NY	-26.5	6.712
DE	-71.9	2.070	NC	-47.8	1.191
DC	-52.4	3.393	ND	-45.5	2.857
FL	-38.7	4.232	OH	-65.4	1.744
GA	-35.6	2.116	OK	0.00	3.677
HI	-35.4	2.517	OR	-34.2	1.931
ID	-28.1	1.513	PA	-38.3	6.203
IL	-42.4	2.225	RI	-40.8	4.057
IN	-56.4	2.913	SC	-28.3	2.559
IA	-39.7	2.367	SD	-35.1	3.027
KS	-29.4	2.612	TN	-12.3	2.182
KY	-53.2	2.414	TX	-56.5	1.910
LA	-02.9	6.080	UT	-08.8	3.012
ME	-16.7	2.306	VT	-34.6	2.763
MD	-36.0	3.184	VA	-35.5	1.544
MA	23.7	4.741	WA	-37.3	1.848
MI	-40.2	3.477	WV	-23.8	4.462
MN	-40.4	1.078	WI	-42.0	1.168
MS	-34.0	2.361	WY	-45.8	2.436
MO	-26.9	2.776			

Source: CRS analysis of Kaiser Family Foundation data, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=436&cat=8>.

The average claim paid in the United States in 2009 was \$323,273. Although the 2009 figure is up from \$289,891 in 2003, the rate of increase over this time period mirrors that found in medical inflation generally. These averages, however, mask considerable variance across states.³⁵ For instance, in Kansas the average claim paid in 2009 was roughly \$155,622 (72 cases) whereas in Wisconsin it was almost \$761,000 (65 cases). **Figure 3** shows the change in the average total dollars in medical malpractice claims paid from 2003 through 2009.³⁶ Sixteen states saw a decline in their average medical malpractice claims paid, ranging from roughly 5% to 50%. An additional 17 states saw their average total dollars in medical malpractice claims paid from 2003 through 2009 rise slower than medical inflation. Eighteen states saw their average total dollars in medical malpractice claims paid from 2003 through 2009 rise faster than medical inflation.

These statistics, while illustrative, still lend themselves to different interpretations. Averages may not fully reflect circumstances in particular states or among particular high-risk specialties. Some states appearing to have *sticky* premiums which have not fallen despite a reduction in the number of claims, and some specialties experienced premium increases over the past decade well in excess of medical inflation.

³⁵ There are also considerable year-to-year variations for some states both in the numbers of cases and the average dollar amounts of claims paid.

³⁶ The actual number of cases in some states, particularly those with a small number of cases each year on average, can vary considerably from year to year just as the average dollar amount of claims paid in **Figure 3** can be dependant on the nature of the claims settled in any one year.

“improvements in patient safety reduce malpractice claims.” Specifically, the study, conducted at the county level in California, found that a county that “saw a decrease of 10 adverse events (achieved through improvements in the quality of care provided) in a given year would also see a decrease of 3.7 malpractice claims.”³⁸ Similarly, in 2010, Virginia Mason Medical Center, in Seattle, Washington, was named Hospital of the Decade by the Leapfrog Group, along with the University of Maryland Medical Center, for “major achievements in reducing medical errors and other innovations in patient safety and quality.” Virginia Mason reports that³⁹

with improving quality of care and preventing errors, we have seen a decline in our medical malpractice premiums. We have seen decreases in medical malpractice premiums every year since 2005. As of 2011, our premiums have dropped by 52% since 2005, saving us literally millions of dollars.

Although other medical systems have also achieved similar improvements while pursuing efforts to raise quality and prevent medical errors,⁴⁰ some argue that enough is not being done to ensure that hospitals and other providers fully internalize the costs of their errors such that they have a good solid business case for improving quality and reducing errors.⁴¹

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³⁸ Michael D. Greenberg, Amelia M. Haviland, and J. Scott Ashwood, et al., *Is Better Patient Safety Associated with Less Malpractice Activity? Evidence from California*, Rand Corporation, Santa Monica, CA, 2010, http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR824.pdf.

³⁹ E-mail from Dr. Craig Blackmore, Virginia Mason Medical Center, January 25, 2011.

⁴⁰ One major integrated health care system reported a roughly 70% decline in malpractice costs between 2005 and 2010 and attributes the decline to both the soft insurance market and its quality improvement efforts.

⁴¹ Michelle M. Mello, David M. Studdert, and Eric J. Thomas, “Who Pays for Medical Errors? An Analysis of Adverse Event Costs, the Medical Liability System, and Incentives for Patient Safety Improvement,” *Journal of Empirical Legal Studies*, vol. 4, no. 4 (December 2007), pp. 835-860.