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Medical Malpractice: Overview and Legislation in the 112th Congress

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Summary

As a policy area, medical malpractice involves issues related to its prevalence in the health care system; the market for provider liability insurance; 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 medical liability 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. The effectiveness of various public policy measures in addressing the issues in the medical malpractice liability market has been a matter of debate, in part because these difficulties have arisen at the intersection of the health care, tort, and insurance systems.

The overall medical liability insurance market is not currently exhibiting a comparable level of disruption to that in the “crisis” periods. Nonetheless, concerns persist regarding the affordability and availability of malpractice insurance in particular regions and for certain physician specialties (e.g., obstetricians). In addition, concern about medical malpractice claims may affect individual provider decisions and the cost of health care.

In terms of *direct* costs, medical malpractice insurance adds relatively little to the overall cost of health care. Medical malpractice premiums in 2010 totaled approximately \$10.2 billion, whereas overall health expenditures were \$2.6 trillion in 2010 according, respectively, to data from insurance rating firm AM Best and the National Health Expenditure Accounts. *Indirect* costs, particularly increased use of services by providers to protect against future lawsuits (“defensive medicine”), have been estimated to be higher than direct costs. CBO estimated that enacting federal tort reforms would reduce health care spending by approximately 0.4%-0.5% (roughly \$9 billion-\$11 billion) and the federal budget deficit by between \$40 billion and \$57 billion over a 10-year period.

The malpractice system also faces issues of equity and access. For example, some observers have criticized the current system’s performance with respect to (1) compensating patients who have been harmed by malpractice, (2) deterring substandard medical care, and (3) promoting patient safety. There are differing opinions as to the extent that each of these areas has been affected by the current malpractice system.

In the 112th Congress, the primary vehicle addressing medical malpractice has been H.R. 5, which focused on medical liability tort reform when introduced but was amended to include language similar to other legislation, specifically H.R. 157, H.R. 1150, H.R. 1943, and H.R. 3586. The amended version of H.R. 5 passed the House in March 2012. Language similar to the introduced version of H.R. 5 was included in H.R. 5652, the House budget reconciliation bill for FY2013, which passed the House in May 2012. The Senate has yet to consider H.R. 5 or S. 218 and S. 1099, companion bills to H.R. 5 as introduced. The President’s budgets for FY2012 and FY2013 both requested \$250 million for grants to test a variety of reform proposals, but this funding has not been appropriated by Congress.

Contents

Introduction	Error! Bookmark not defined.
Recent Action and Proposals on Medical Malpractice	1
The 112 th Congress.....	1
The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act (H.R. 5, S. 218, and S. 1099).....	2
FY2013 House Budget Resolution (H.Con.Res. 112)	4
Sequester Replacement Reconciliation Act of 2012 (H.R. 5652).....	4
FY2012 President’s Budget	5
FY2013 President’s Budget	6
The 111 th Congress.....	6
ACA and Medical Malpractice	6
Costs of Medical Malpractice.....	7
Challenges in Medical Malpractice Policymaking	8
Health Care System.....	8
Tort System	9
Insurance System	10
Recent Experience.....	10
The National Medical Malpractice Insurance Market.....	10
State-by-State Claims Experience.....	12
Recent Experience Among Providers.....	15

Figures

Figure 1. Nationwide Direct Losses Incurred.....	11
Figure 2. Nationwide Loss Ratio.....	12
Figure 3. Change in the Average Paid Medical Malpractice Claim.....	15

Tables

Table 1. Percentage Change in the Number of Paid Medical Malpractice Claims (2003– 2009) and Claims Per 100,000 Population (2009)	13
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Contacts

Author Contact Information	Error! Bookmark not defined.
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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, concern about claims for medical malpractice may affect individual provider decisions particularly through increased use of tests and procedures to protect against future lawsuits (“defensive medicine”), which may affect health care costs. 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

Public policy measures that have been effective in addressing the successive insurance market disruptions, and those that may be effective in the future, have been a matter of debate. Some proposals, such as the current Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act (H.R. 5, S. 218, and S. 1099), 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

The 112th Congress

The 112th Congress 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 “The 111th Congress”), was introduced by Representative Eric Cantor on January 5, 2011. This bill was passed by the House on January 19, 2011. Legislation addressing medical liability reform in greater depth passed the House, as discussed below.

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.

The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act (H.R. 5, S. 218, and S. 1099)

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 (H.Rept. 112-39, Part 1). The House Committee on Energy and Commerce marked up the bill on May 13, 2011, and reported it on May 23, 2011 (H.Rept. 112-39, Part 2). The House passed H.R. 5 on March 22, 2012, as detailed below.

In the Senate, S. 218 was introduced by Senator John Ensign on January 27, 2011, and S. 1099 was introduced by Senator Roy Blunt on May 26, 2011. Both bills were referred to the Senate Committee on the Judiciary, which has not acted on either. H.R. 5 and S. 218, as introduced, are identical bills. S. 1099 has slightly different wording in the findings portions of the bill, but is otherwise identical.

H.R. 5, S. 218, and S. 1099 as introduced would, with certain exceptions, preempt some aspects of existing state medical malpractice laws. Although the legislation seeks to address both medical malpractice and product liability, this report will discuss only provider medical malpractice. The legislation 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, all three bills 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, the legislation 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. The legislation 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.

House Committee Consideration

In the February 16, 2011, House Judiciary Committee markup of H.R. 5, 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 CBO’s cost estimate for this version of H.R. 5 foresees a 0.4%

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 quantifiable 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 (name redacted)

decrease in overall health spending and a reduction in the federal budget deficit of \$40 billion over the 10-year period from 2012 to 2021.⁸

In the May 11, 2011, House Energy and Commerce Committee markup of H.R. 5, the bill was amended to add a further exception to the prohibition on punitive damages for products that comply with Food and Drug Administration (FDA) standards. If enacted as reported, punitive damages would be allowed to be awarded in a health care lawsuit if the product which caused the harm was misbranded, adulterated, contaminated, mislabeled, or improperly stored. CBO's cost estimate for this version of H.R. 5 foresees a 0.5% decrease in overall health spending and a reduction in the federal budget deficit of \$57 billion over a 10-year period. This increased savings is largely due to the retention of the collateral source rule⁹ that was removed in the Judiciary Committee markup.¹⁰

House Floor Consideration

The full House considered H.R. 5 under the terms of H.Res. 591 on March 21-22, 2012. The base text of the HEALTH act, now Title I of a broader bill entitled the Protecting Access to Healthcare Act, largely followed the version reported by the Committee on the Judiciary, as it did not include the provision on collateral source benefits. The version considered on the floor also included an additional Title II, the Medicare Decisions Accountability Act of 2012. This new title would repeal provisions in the Patient Protection and Affordable Care Act¹¹ (ACA) establishing the Independent Payment Advisory Board (IPAB).¹² CBO estimates that this version of H.R. 5 would reduce the federal budget deficit by \$45.5 billion over the 10-year period from 2013 to 2022.¹³

During floor consideration, four amendments were adopted, two of which directly affect civil liability protections for health care providers. These two amendments are (1) H.Amdt. 989, introduced by Representative Charlie Dent,¹⁴ and (2) H.Amdt. 991, introduced by Representative Cliff Stearns. The first amendment—H.Amdt. 989—was adopted by voice vote. It would extend the Federal Tort Claims Act's¹⁵ (FTCA's) civil liability coverage to certain entities, health care providers that are subject to providing stabilization services in emergency departments under the Emergency Medical Treatment and Labor Act (EMTALA).¹⁶ Under this amendment, a claim for medical malpractice arising from health care services rendered pursuant to EMTALA would be

⁸ Congressional Budget Office, "Cost Estimate for H.R. 5 as ordered reported by the House Committee on the Judiciary on February 16, 2011," March 10, 2011, available at <http://cbo.gov/ftpdocs/120xx/doc12095/hr5.pdf>.

⁹ 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.

¹⁰ Congressional Budget Office, "Cost Estimate for H.R. 5 as ordered reported by the House Committee on Energy and Commerce on May 11, 2011," May 23, 2011, available at <http://www.cbo.gov/ftpdocs/122xx/doc12209/HR5.pdf>.

¹¹ P.L. 111-148, 124 Stat. 119 (2010).

¹² Title II to H.R. 5 was originally introduced as H.R. 542 by Representative David Roe.

¹³ Congressional Budget Office letter to Chairman David Drier, March 19, 2012, available at http://cbo.gov/sites/default/files/cbofiles/attachments/HR_5_Rules.pdf.

¹⁴ This is entitled the Health Care Safety Net Enhancement Act and is similar to H.R. 157 introduced by Representative Pete Sessions during the 112th Congress.

¹⁵ The Federal Tort Claims Act is a limited waiver of the United States' sovereign immunity for some tort suits. It effectively makes the federal government liable for "injury or loss of property, or personal injury or death caused by the negligent or wrongful act or omission of any employee of the government while acting within his scope of office of employment, under circumstances where the United States, if a private person would be liable to the claimant in accordance with the law of the place where the act or omission occurred." 28 U.S.C. § 1346(b).

¹⁶ P.L. 99-272, 100 Stat. 164 (1986), codified at 42 U.S.C. § 1395dd *et seq.*

brought against the United States in lieu of the entity or health care provider. In other words, the federal government would become responsible for any monetary damages if an entity or provider would have been found liable under the laws of the state where the act or omission occurred.

The second amendment—H.Amdt. 991—was adopted by a vote of 251-157.¹⁷ It would grant limited civil liability protection to health care professionals who volunteer and provide services in response to certain federally declared disasters or public health emergencies as defined by the amendment.

The other two amendments adopted by the House are (1) H.Amdt. 987, introduced by Representative Rob Woodall, and which struck the original findings;¹⁸ and (2) H.Amdt. 990, introduced by Representative Paul Gosar, which would remove McCarran-Ferguson Act's antitrust exemption as it applies to health insurers.¹⁹ H.R. 5, as amended, passed the House by a vote of 223-181 with four Members voting present.

FY2013 House Budget Resolution (H.Con.Res. 112)

The report accompanying H.Con.Res. 112 (H.Rept. 112-421) includes language relating to reforming medical malpractice insurance. Specifically, the report states that “the budget supports several changes to laws governing medical liability, including limits on noneconomic and punitive damages.”²⁰

H.Con.Res. 112 includes instructions to various committees to submit legislation reducing the federal deficit in the committees' areas of jurisdiction, including \$39.7 billion in deficit reduction from the Committee on the Judiciary and \$96.8 billion in deficit reduction from the Committee on Energy and Commerce over the period from FY2012 through FY2022. In response to the budget resolution, the Committee on the Judiciary submitted a committee print that consisted of their version of the HEALTH Act on April 25, 2012,²¹ and the Committee on Energy and Commerce approved their version of the HEALTH Act as Title III of a committee print on April 25, 2012.²²

Sequester Replacement Reconciliation Act of 2012 (H.R. 5652)

H.R. 5652 was introduced by Representative Paul Ryan on May 9, 2012. It included many of the various committees' recommendations pursuant to H.Con.Res. 112. The HEALTH Act as passed by the Judiciary Committee was included as Title IV of H.R. 5652. CBO estimated that Title IV of H.R. 5652 would reduce the deficit by approximately \$48.6 billion for the period from 2012-

¹⁷ This is entitled the Good Samaritan Health Professionals Act and is similar to H.R. 3586, also introduced by Representative Stearns during the 112th Congress.

¹⁸ It was adopted by a vote of 234-173, with two Members voting present.

¹⁹ This amendment was adopted by voice vote, and it is entitled the Health Insurance Industry Fair Competition Act. Representative Gosar introduced this bill as H.R. 1150. It is also similar to H.R. 1943 introduced by Representative Peter DeFazio during the 112th Congress. While health insurance and medical malpractice liability insurance interact, medical malpractice liability insurance is considered part of property/casualty insurance and is specifically excluded under the language of Representative Gosar's amendment. For more information, see CRS Report R40968, *Limiting McCarran-Ferguson Act's Antitrust Exemption for the "Business of Insurance": Impact on Health Insurers and Issuers of Medical Malpractice Insurance*, by (name redacted) and (name redacted)

²⁰ U.S. Congress, House Committee on the Budget, *Concurrent Resolution on the Budget - Fiscal Year 2013*, report to accompany H.Con.Res. 112, 112th Cong., 2nd sess., March 23, 2012; p. 98.

²¹ Full details of the markups can be found at http://judiciary.house.gov/hearings/Markups%202012/mark_04172012.html and http://judiciary.house.gov/hearings/Markups%202012/mark_04252012.html.

²² Full details of the committee action can be found at <http://energycommerce.house.gov/news/PRArticle.aspx?NewsID=9475>.

2022.²³ The bill was passed by the House on May 10, 2012, on a vote of 218-199 with one Member voting present.

FY2012 President's Budget

The President's FY2012 budget made general reference to reforming medical malpractice.²⁴

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 FY2012 budget specifically requested funding for "\$250 million in grants to states to reform the way they resolve medical malpractice disputes." These grants were to be awarded by the Department of Justice in consultation with the Department of Health and Human Services.²⁵ The variety of reforms to be supported by the grants included the following:²⁶

Health Courts: States could use grants to help create specialized health courts, which would use specially-trained judges and medical experts to review evidence and determine the cause(s) of injuries. These courts could use pre-specified ranges of compensation for injuries and collect data that could be analyzed for patterns of problems in order to improve the quality of health care. Funds could be used to establish health courts, train judges, and employ medical experts.

Safe Harbors: States could use grants to support efforts to provide physicians, hospitals and other providers who adhered to certified clinical practice guidelines and installed electronic health records with a rebuttable presumption—or "safe harbor"—that they are adhering to the standard of care and therefore are non-negligent. Funding could be used toward the process for identifying and certifying practice guidelines.

Early Disclosure and Offer: States could use grants to help establish rules requiring physicians, hospitals, and other providers to implement a protocol after a medical error occurred. The protocol could include reporting the medical error to a safety officer, disclosing the incident to the patient, apologizing to the patient, and offering fair compensation established in a schedule. If the patient decided to litigate the case, the provider's disclosure and apology could not be used as evidence of liability. Grant funding could support safety officers, training of health care personnel in disclosure and apology protocols, and mediation programs for compensation.

Other Legal Reforms: States could use grants to adopt one or more of the above or other legal reforms. These reforms could include a number of those proposed by the President's National Commission on Fiscal Responsibility and Reform such as modifying the "collateral source" rule so that malpractice awards take into account other compensation or replacing joint-and-several liability with a fair share rule that would allocate responsibility for malpractice payments in proportion to responsibility for the damages.

²³ Congressional Budget Office letter to Chairman David Drier, May 9, 2012, available at http://www.rules.house.gov/Media/file/PDF_112_2/PDF/HMTG-112-RU00-HHRG-20120509-SD001.pdf.

²⁴ 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>.

²⁵ 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>.

²⁶ U.S. Department of Justice, *FY2012 Performance Budget: Office of Justice Programs*, February 2011, p. 190, <http://www.justice.gov/jmd/2012justification/pdf/fy12-ojp-justification.pdf>.

These grants were dependent on appropriations by Congress and were ultimately not funded in FY2012.

FY2013 President's Budget

The President's FY2013 budget does not include language on general medical malpractice reform, which is similar to the budget for FY2012. It does, however, include a request of \$250 million for Department of Justice grants to the states to reform the way medical malpractice disputes are resolved, as did the FY2012 budget.²⁷ As in FY2012, these grants are dependent on congressional appropriations legislation, which has yet to be completed.

The 111th Congress

ACA and Medical Malpractice

The ACA included two provisions related to medical malpractice reform.

ACA Section 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.

Prior to the passage of the ACA, in September of 2009, President Obama directed the Secretary of HHS to award grants to states to implement and evaluate patient safety approaches and medical liability reforms. In June 2010, the Agency for Healthcare Research and Quality (AHRQ) awarded \$25 million to states for this purpose under the authority of this directive as well as the agency's general authority.²⁸ ACA Section 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 insurance, (6) informs the patient about the differences between the alternative and tort litigation, (7) allows the patient

²⁷ U.S. Department of Justice, *FY2012 Performance Budget: Office of Justice Programs*, February 2012, p. 144, <http://www.justice.gov/jmd/2013justification/pdf/fy13-ojp-justification.pdf>.

²⁸ See 42 U.S.C. 299a(a). On April 3, 2012, Republican Senators Chuck Grassley and Orrin Hatch as well as Representative Lamar Smith issued a letter to the Secretary of HHS calling attention "to the fact that none of the [grants awarded under the President's 2009 initiative] has gone to researching or implementing 'traditional' medical malpractice reforms." The letter lists several questions for HHS asking for specific details about why and how the grants were distributed. See Letter to Secretary of HHS, Kathleen Sebelius, April 3, 2012, <http://www.grassley.senate.gov/judiciary/upload/Med-mal-04-03-12-signed-letter-with-Hatch-Smith-on-med-mal-grants-being-diverted.pdf>.

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 these grants have not been appropriated as of this time.

Costs of Medical Malpractice

Medical malpractice insurance premiums add little to the direct cost of health care relative to total health care spending, but medical malpractice tort reform may still result in savings over time by reducing indirect costs to the system. Medical malpractice insurance premiums written in 2009 totaled approximately \$10.2 billion,²⁹ whereas health expenditures were \$2.6 trillion in 2010 as reported by the National Health Expenditure Accounts (NHEA).³⁰ Indirect costs, particularly increased use of tests and procedures by providers to protect against future lawsuits ("defensive medicine"), have been estimated to be higher than direct costs, and particularly, medical malpractice insurance premiums. These conclusions have been controversial, in part because some synthesis studies have found that national estimates of the cost of defensive medicine are unreliable.³¹ A recent analysis on the subject estimated that the total cost of defensive medicine in 2008 was \$45.6 billion.³²

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.³³ The recent CBO analyses of H.R. 5 estimated that federal tort reforms would reduce national health care spending by 0.4%-0.5% (equivalent to approximately \$9 billion to \$11 billion in 2010) depending on the exact provisions included.³⁴ This estimate represents the cumulative impact of federal tort reform on lowering medical malpractice insurance premiums and reducing use of health care services. In addition, it takes into account the fact that many states have already implemented tort reforms, and therefore, some proportion of potential cost savings already has been realized. Other earlier studies estimated the reduction in 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. One set of studies found a 4%-9% reduction in hospital spending for Medicare patients with heart disease in states that

²⁹ AM Best, "U.S. Medical Professional Liability –2010 Direct Premiums Written," *Best's Statistical Study*, July 25, 2011.

³⁰ See Centers for Medicare & Medicaid Services (CMS), Historical Data; National Health Expenditure Accounts (NHEA), at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

³¹ 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.

³² 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.

³³ See Congressional Budget Office, "Budget Options, Volume 1: Health Care," December 2008.

³⁴ See Congressional Budget Office, "Cost Estimate for H.R. 5 as ordered reported by the House Committee on the Judiciary on February 16, 2011," March 10, 2011, <http://cbo.gov/ftpdocs/120xx/doc12095/hr5.pdf>, and Congressional Budget Office, "Cost Estimate for H.R. 5 as ordered reported by the House Committee on Energy and Commerce on May 11, 2011," May 23, 2011, at <http://www.cbo.gov/ftpdocs/122xx/doc12209/HR5.pdf>.

implemented tort reforms, whereas another study found that state tort reforms reduced personal health care expenditures by 3%-4%.³⁵

CBO also estimated the effect of federal tort reform on the federal budget. In its analyses of H.R. 5, 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 to \$48 billion from 2011 to 2021. In addition, the Joint Committee on Taxation (JCT) estimated that such reforms would lead to an increase in federal revenues of \$6 billion to almost \$10 billion over the same 10-year period.³⁶ By combining the impact of federal tort reform on mandatory health spending and tax revenues, CBO estimated that such reform could reduce the federal budget deficit by approximately \$40 billion to \$57 billion over 10 years.³⁷

Challenges in Medical Malpractice Policymaking

Addressing problems in medical malpractice can be challenging, particularly due to the interactions of three different relevant 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 serves as the basis for a malpractice claim. Policies that aim to improve patient safety through the reduction of medical errors and effectuating penalties against poorly performing providers may therefore reduce injuries that might serve as the basis of medical malpractice claims. This could potentially lead to a reduction in medical malpractice claims, which may benefit the overall performance of the medical malpractice insurance system by, for example, improving access to medical malpractice insurance through the lowering of premiums.

Both states and the federal government have a role in reducing medical errors and improving patient safety. States have the primary authority to define the process for granting and renewing a medical license and regulating the practice of medicine. Currently, there is some degree of lack of uniformity across states regarding both medical licensure and the regulation of the practice of medicine; less rigorous regulatory standards, as well as variability in the robustness of regulatory standards, may have an adverse effect on patient safety. Moreover, the existence, scope, and

³⁵ 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.

³⁶ 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.

³⁷ Congressional Budget Office, "Cost Estimate for H.R. 5 as ordered reported by the House Committee on the Judiciary on February 16, 2011," March 10, 2011, available at <http://cbo.gov/ftpdocs/120xx/doc12095/hr5.pdf> and Congressional Budget Office, "Cost Estimate for H.R. 5 as ordered reported by the House Committee on Energy and Commerce on May 11, 2011," May 23, 2011, available at <http://www.cbo.gov/ftpdocs/122xx/doc12209/HR5.pdf>.

robustness of data collection efforts to track and analyze medical errors vary between and among the states.

Federal patient safety policies may be implemented through a variety of approaches. These approaches include voluntary policies, for example, support for research on evidence-based medicine, national-level medical error reporting systems, or toolkits to evaluate the adoption of patient safety efforts. They also include mandatory policies, for example, “conditions of participation” quality and safety standards for institutional providers under the Medicare and Medicaid programs.³⁸

As noted above, some observers suggest that the current malpractice system encourages the practice of “defensive medicine”; that is, concern about liability and the potential negative outcomes associated with malpractice claims may lead providers to administer additional health care treatment or avoid high-risk services primarily to reduce their liability risk. The implication is that defensive medicine may result 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. In addition, however, the provision of unnecessary health care services may also directly harm patients. Multiple studies have found some evidence of the practice of defensive medicine, but even providers acknowledge that it is a difficult concept to measure.³⁹ Moreover, factors other than defensive medicine, such as physician payment systems (e.g., fee-for-service vs. capitation) and financial incentives, contribute to the over-provision of health services; additionally, the contribution of this and other factors to the overutilization of health care services, for example failure to adhere to evidence-based practices, is likely larger than that of defensive medicine.⁴⁰

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.⁴¹ Some observers have suggested that the medical malpractice tort system is arbitrary in its outcome.⁴² 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.

³⁸ For more information about Conditions of Participation (CoPs), see <https://www.cms.gov/CFCsAndCoPs/>.

³⁹ General Accounting Office, “Medical Malpractice: Implications of Rising Premiums on Access to Health Care,” GAO-03-836, August 2003.

⁴⁰ Ibid.

⁴¹ 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.

⁴² U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care*, March 3, 2003.

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 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 1945,⁴³ 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. The National Association of Insurance Commissioners (NAIC) aggregates some insurance data; however, many potentially useful data are 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, and their link, if any, to state or federal policies is also unclear.

The National Medical Malpractice Insurance Market

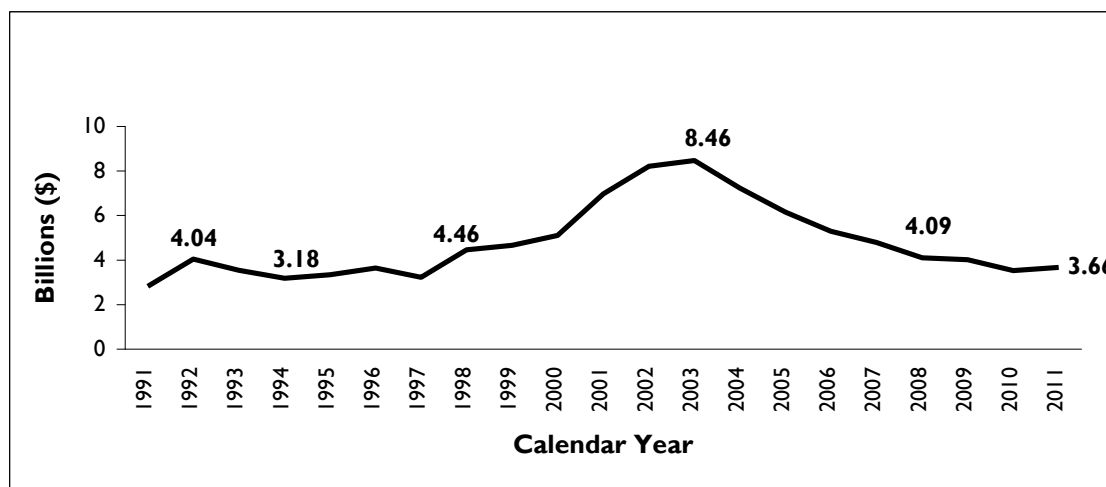
The cyclical experience of medical malpractice insurers is reflected in aggregate data about the industry compiled and analyzed by the NAIC (see **Figure 1**). From 1992 to 1998, direct incurred losses were relatively stable,⁴⁴ varying from a low of \$3.18 billion in 1994 to a high of \$4.46 billion 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. From 2003 to 2010, losses fell

⁴³ 15 U.S.C. §1011 *et seq.*

⁴⁴ 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.

every year to a low of \$3.52 billion with the 2011 losses of \$3.66 billion only slightly higher than 2010. (The loss data are in nominal dollar amounts.)⁴⁵

Figure 1. Nationwide Direct Losses Incurred
(in billions of nominal dollars)



Source: National Association of Insurance Commissioners.

Malpractice insurance premiums roughly followed losses as those amounts increased.⁴⁶ 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 2010, the loss ratio of 51.13% was the lowest one in nearly two decades, and the 2008, 2011, and 2009 ratios were the second, third, and fourth lowest at 54.62%, 54.66%, and 55.66%, respectively. This means that over the past four years, the industry experienced its highest profit margin on direct premiums earned in the calendar years analyzed.⁴⁷

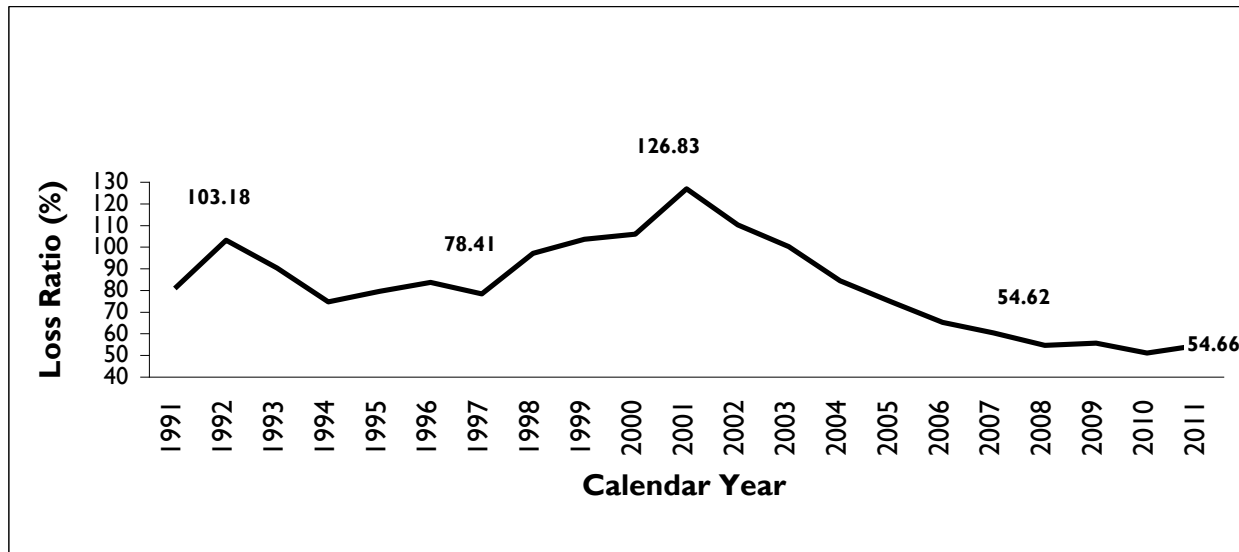
Insurers, who are regulated by state insurance regulators, may also profit, or lose, from their investments. In general, with such low loss ratios, theory would suggest increasing competition as other insurers enter the market in search of profits. This, however, may not be happening as quickly as expected 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.

⁴⁵ 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.

⁴⁶ 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.

⁴⁷ 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.

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

State-by-State Claims Experience

In 2009, there were 10,739 paid medical malpractice claims in the United States—27.6% fewer than in 2003.⁴⁸ 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.⁴⁹ **Table 1** shows the percentage change in the number of paid medical malpractice claims between 2003 and 2009.

⁴⁸ Kaiser Family Foundation from <http://statehealthfacts.kff.org>.

⁴⁹ 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.

Table I. 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.

Only two states, Massachusetts and New Mexico, experienced an increase in the number of paid claims over this time period. Six states (Connecticut, Delaware, Indiana, Kentucky, Ohio, and Texas) and the District of Columbia experienced a 50% or greater percentage decline in the number of paid claims.

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.⁵⁰ 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).

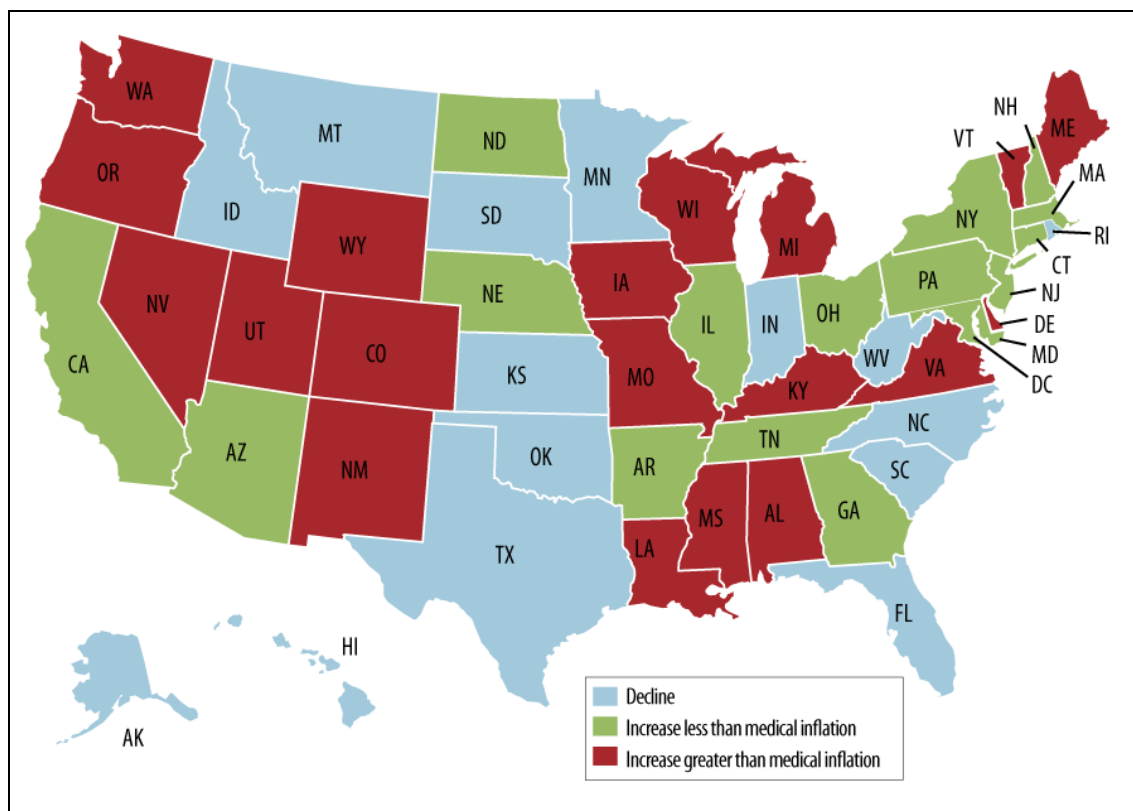
Figure 3 shows the change in the average total dollars in medical malpractice claims paid from 2003 through 2009.⁵¹ Sixteen states saw a decline in their average medical malpractice claims paid, ranging from roughly 5% to 50%. An additional 17 states saw their average total dollars in medical malpractice claims paid from 2003 through 2009 rise more slowly 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 appear to have *sticky* premiums, that is, premiums that have not fallen despite a reduction in the number of claims. In addition, some specialties experienced premium increases over the past decade well in excess of medical inflation.

⁵⁰ 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.

⁵¹ 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.

Figure 3. Change in the Average Paid Medical Malpractice Claim
(2003 – 2009)



Source: Kaiser Family Foundation from <http://statehealthfacts.kff.org>

Notes: *Decline* indicates that a state experienced an actual decline in the average total dollars in medical malpractice claims paid. *Increase less than medical inflation* indicates that a state experienced an increase in the average total dollars in medical malpractice claims paid, but the increase was less than the rate of medical inflation during the 2003-2009 period. *Increase greater than medical inflation* indicates that a state experienced an increase in the average total dollars in medical malpractice claims paid, and the increase exceeded the rate of medical inflation during the 2003-2009 period.

Recent Experience Among Providers

Providers, both physicians and institutional, appear to have been increasingly successful at identifying the causes of medical injuries and reducing them through quality improvement efforts. This appears to have reduced the number of medical malpractice law suits and to have lowered medical malpractice premiums. For instance, the American Society of Anesthesiologists (ASA) reports that the number of anesthesiology deaths has declined from 1 in 5,000 to less than 1 in 200,000, and real medical malpractice insurance premiums for anesthesiologists have declined by more than 40% in real terms since 1985.⁵²

Evidence of connections between quality improvement, improved patient safety, lower medical malpractice insurance premiums, and fewer law suits extends beyond anesthesiology. A recent RAND Corporation study found that “improvements in patient safety reduce malpractice claims.”

⁵² Karen B. Domino, *Professional Liability Insurance Premiums for Anesthesiologists: Stability Despite the Economic Crisis*, American Society of Anesthesiologists, 2010, http://depts.washington.edu/asaccp/prof/asa73_8_44_45.pdf.

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.”⁵³ Similarly, in 2010, Virginia Mason Medical Center, in Seattle, WA, 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 that,⁵⁴

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 outcomes while pursuing efforts to improve quality and reduce or prevent medical errors,⁵⁵ 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 solid business case for improving quality and reducing errors.⁵⁶

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⁵³ 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.

⁵⁴ E-mail from Dr. Craig Blackmore, Virginia Mason Medical Center, January 25, 2011.

⁵⁵ 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.

⁵⁶ 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.

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