Some Facts and Concepts Related to the Malpractice Crises

by Jay Hutchins

According to a Congressional Budget Office (CBO) issue brief dated January 8, 2004, the available evidence suggests that malpractice premiums have risen for primarily two reasons. The first is that the costs for claims (awards and legal fees) have risen at twice the rate of inflation since 1986. The second is that insurance providers' income from investments has fallen, a factor not easily influenced by reforms.

More than 40 states have legislated restrictions on claims and a widely respected study conducted by Kenneth Thorpe, M.D., of Emory University found malpractice insurance rates in these states to be, on average, 17 percent lower. In Oregon, which does not restrict awards, some specialists such as obstetrician-gynecologists have seen their rates rise as much as 300 percent since 1999 when the Oregon Supreme Court struck down a law that capped awards for economic damages. One thing that complicates this issue is that specialty and region determine the cost of professional liability insurance (PLI) premiums. Therefore, a state that has caps could still have inordinately high PLI premiums for some specialties.

While a major concern for doctors is lowering their PLI premiums, this unfortunately won't address everyone's concerns about lowering the cost of healthcare. Malpractice costs account for less than 2 percent of total spending on healthcare. A reduction of even 25 percent to 30 percent of PLI premiums will lower healthcare costs by only about 0.5 percent, so the likely effect on your health insurance premiums will also be small.

Fear of litigation, however, may indirectly have a much greater affect on the cost of healthcare than PLI premiums. The costs of defensive medicine, decreased access, and unreported errors are major concerns.

Defensive Medicine

Colin Cave of the Oregon Medical Association (OMA) believes that doctors order unneeded tests and procedures to protect themselves from lawsuits and that this increases the cost of healthcare. In certain areas of the country, according to the CBO brief, a few small studies have found a correlation between performance of specific procedures and the costs of litigation. However, a comprehensive study (Harvard Medical Practices Study) that used 1984 data from the state of New York did not find a strong relationship between the threat of litigation and medical costs. Using a different set of data, CBO also found no statistically significant difference in per capita healthcare spending between states with and without limits on malpractice claims.

According to Dr. William Hersh, Director of the Informatics Department at OHSU, one reason extra tests and procedures are performed may be that information technology is not being used efficiently to integrate patient histories or the development of evidence-based best practices.

Access to Care

Advocates of restricting malpractice awards argue that high professional liability rates discourage doctors from practicing medicine and this restricts access to care. While it is true that the U.S. Department of Health and Human Services (HHS) found much anecdotal evidence supporting this view, the General Accounting Office (GAO) investigated the situation in five states and found the evidence mixed. (GAO report: *Medical Malpractice: Implications of Rising Premiums on Access to Healthcare, GAO-03-836 (August 2003))* The GAO confirmed a reduction of access to emergency surgery and newborn delivery in rural areas where other factors also affected the availability of services, but the GAO also found that many reports of reduced access could not be substantiated.

In Oregon, there appears to be a direct link between the number of obstetrician-gynecologists and the cost of PLI. A 2003 OHSU study indicated that Oregon lost 122, or nearly 25 percent of all OB providers in this state in the three years following the Oregon Supreme Court's decision against caps. According to the Health and Human Services (HHS) report, there are doctors in regions of other states who have never been involved in a claim and still cannot purchase PLI, which is definitely a barrier to access.

Medical Errors and Reporting

While deterrence is the rationale for our malpractice tort system, the rising incidence of medical errors has led policy makers to question its effectiveness. Of all malpractice claims, only four percent lead to awards even though insurance companies incur costs defending all of them. Because specialty and location determine the overall cost of PLI premiums, not the competency of individual doctors, the dollar costs of claims are shifted to all policyholders. According to the HHS report mentioned above there also is evidence that many events for which claims are paid do not constitute malpractice.

The Institute of Medicine has calculated that each year medical errors kill between 44,000 and 90,000 people and a number of studies indicate that only two percent of cases of medical negligence are reported. High healthcare premiums and out of pocket expenses absorb the costs of these unreported adverse events. Initiatives to distribute costs more fairly and improve care include pay-for-performance plans that utilize experience ratings to set rates for PLI.

Because the fear of malpractice lawsuits chills reporting of adverse events, the tort system itself may be one of the causes of medical errors. Many researchers and physicians believe that a legally protected non-punitive reporting system similar to the type the aviation industry uses may be the answer. The point is that more errors need to be reported to systematically improve patient safety and ultimately help reduce the cost of access to care. However, in the halls of Congress and many state assemblies the current healthcare battle lines are forming over the cost of professional liability insurance (PLI), specifically on caps for non-economic damages.

Meanwhile, the Oregon Patient Safety Commission, along with stakeholders such as the Oregon Medical Association and the Oregon Nurses Association, has been instrumental in passing a bill that has created a voluntary adverse events reporting system in Oregon. If hospitals and other health centers choose to participate, they must report all medical errors to the commission and the commission will notify affected patients in writing. The information reported to the commission will be exempt from public disclosure laws and legal subpoenas, and will be used to disseminate evidence-based prevention practices to improve patient outcomes. According to the Department of Human Services, Oregon's system is unique because it creates an independent commission to collect and use patient safety data. It also combines voluntary reporting with mandatory financing by those who participate.

(In this issue of Oregon's Future *Dr. William Hersh explains the need to reform the use of Information Technology in both public health and clinical care and Colin Cave makes the OMA's argument for Tort Reform)*

Comments by Colin Cave, President OMA

While I know the goal of Jay's sidebar is to be objective and fair, there is a point about insurance profits I would like to clear up. In Oregon, insurance company profits have nothing to do with the problem. Northwest Physician's Mutual insures around 2,200 physicians and has never had a losing year investment-wise. By law, over 85 percent of their funds are placed in bond funds. CNA insurance has a profit-sharing arrangement with their approximately 2,400 physicians of the OMA (Oregon Medical Association). If CNA brings in more money than contractually agreed to, it is returned to the physician members. This has not been an issue since 1999 when the Supreme Court overturned caps on pain and suffering and costs for settlements shot through the roof. Since then, the combined payouts from NWP and CNA have risen from $15 million (1999) to $60 million (2002), a 400 percent increase. Physicians have seen their rates increase 200 to 300 percent.

Comments by Dr. William Hersh

A number of entities within the healthcare system have led the push for improved quality and safety. The major leaders have been the purchasers of health care, both in the federal government and the private sector. The former has considerable leverage as the payer of Medicare. Among the initiatives include plans for pay-for-performance where reimbursement will be provided based on a measurement of quality of care delivered. Medicare already has sponsored several large-scale quality initiatives that could form the basis for a pay-for-performance program (http://www.cms.hhs.gov/quality/). On the private sector side, the best-known advocate for healthcare quality and safety is the Leapfrog Group, which represents many large corporations who are the major purchasers of healthcare in the US. They advocate that their members only purchase insurance with entities that adhere to certain IT-based quality efforts, including computerized physician order entry, limiting high-risk procedures to institutions that perform large volumes of them, and providing adequately trained staffing of intensive care units.