Mgmt 444

Malpractice

I worked with the Pediatric Faculty Foundation of Children's Memorial Hospital

During the period 2002-2005, their malpractice premiums increased by 50%, and now represent nearly 10% of total practice expenses!

- There were no extraordinary claims or awards during this time

- The result: reductions in bonus compensation and unprecedented discussions of potential cutbacks in uncompensated care

Of course, PFF is not alone – across the U.S. there have been dramatic increases in premiums over the past few years

The AMA has declared 20 states to be in "crisis"

The primary factor in the AMA analysis was the magnitude of patients losing access to medical care. The AMA analysis looked closely at data showing physicians are retiring early, moving out of state or stopping performing certain medical procedures such as delivering babies. Additional factors included a state's legal and judicial climate, the affordability and availability of professional liability insurance, the trend of jury awards and settlements, and other factors.

This is not the first malpractice "crisis" in this country

- Number of suits and average awards increased from 1975-85

- These numbers flattened for about a decade, but things have apparently gotten out of control in the past few years

The results:

- Lower MD incomes and higher provider prices

- Alleged migration of MDs away from "crisis states" and specific specialties (such as neurosurgery and obsetrics)

- Alleged problems with patient access to services

Reasons for increases in premiums

- There are no definitive studies of why premiums have increased, but here are a few possibilities, only some of which have been documented

- Increase in number of lawsuits?

. Perhaps not – closed claims appear to be flat

- Increase in propensity of juries to find for plaintiffs?

- Increase in size of awards, perhaps tied to rising medical costs

- Insurers raising premiums to recover from investment losses?

. Most malpractice coverage is through *mutuals* – companies owned collectively by the insured
. They set premiums to break even; if investments go south, premiums must go north
. This effect is fairly minimal, however, because laws require mutuals to make very conservative investments (usually bonds)

Why is rising malpractice expense a problem?

- To a certain extent, it represents a transfer of wealth from doctors to their injured patients, lawyers, and perhaps a few "lottery winners"

. Doctors do ultimately get higher fees (recall RBRVS)

- But consumers might feel the effects as well

. Doctors might practice defensive medicine, driving up costs with little or no improvement in quality
. Doctors might curtail their practices or even move out of state
. Patients may be unable to obtain care, or have to travel further for care

- Frivolous lawsuits are a waste of societal resources

  . Perhaps half of all suits are without merit
  . But we may only know the merits after the fact
  . Suits are filed to begin "discovery process", a necessary step to determine merit

- System seems to reward the "wrong" people; Lawyers and experts receive 50% of awards

There are lots of proposals to rein in malpractice premiums, many of which have already been implemented in some states

- Some states cap "noneconomic" damages (e.g. pain and suffering, loss of consortium, and punitive damages)

- Many of the same states, as well as a few others, have other "reforms", such as caps on attorneys' fees and mandatory pretrial screens

- The conventional wisdom is that these reforms are working to reduce malpractice premiums, and there is some evidence of this

- They may help make the negligence system more efficient as well, by reducing defensive medicine

- There have been numerous studies of how reforms have affected defensive medicine and malpractice costs.

- A study by Kessler/McClellan is perhaps the most influential

Kessler/McClellan malpractice studies

KM I

In their first paper, KM examine trends in spending and outcomes in states that enacted a variety of tort reforms

- They focus on two conditions, AMI and IHD

- They use Medicare claims data and Social Security death records

- To control for general trends, they perform a difference in difference analysis

- They include dummies for each state (i.e., state "fixed effects") to measure *average* spending and outcomes in each state

. Their methods therefore examine how tort reforms affect *trends*

Results

- Direct reforms are associated with lower spending growth. No apparent effect on outcomes

- Nuances: Results are not consistent across all models, and the reforms that matter most don't seem to be the strongest

- Model does not control for other cost drivers, notably growth of managed care

KM II

This study compares diagnostic and therapeutic expenditures in states with and without malpractice "pressure"

- Again, KM focus on AMI and IHD

- To measure malpractice pressure, K/M obtain data on malpractice claims, in dollars, as well as the number of claims filed

They do not use malpractice claims as predictors in their model

- These data could reflect malpractice pressure, which is what we would like

- But they might instead reflect bad doctoring (in which case we have a third factor affecting "pressure" and medical practice)

- They use a variant of TSLS, in which they use various laws as instruments to predict claims

. Caps on awards
. Abolition of punitive damages
. Limits on attorneys fees
. Restrictions on joint and several liability (which permits going after "deep pockets"

- Again, they include state "fixed effects" to measure average diagnostic and therapeutic expenditures in each state

- Remember, with this fixed effects research design, K/M are effectively studying changes over time within each state

- By using TSLS, they are determining whether changes in the value of *predicted claims* over time, within each state, are due to changes in the laws, not due to changes in doctoring.

- Implicitly assume that there is no systematic relationship between changes in the laws in particular states/years and changes in other factors that might affect expenditures (e.g., managed care penetration)

- This seems like a reasonable assumption

Results

- There is an inverse relationship between the various reforms and both the probability of a claim and, to a lesser extent, the size of the claim

- Using TSLS, we see that expenditures for treatment of both AMI and IHD are positively related to the probability of a claim occurring, the time until resolution, and the probability of a nonzero payout

- Reforms have mixed effects on patient outcomes

  . Chances of subsequent AMI are positively related to malpractice pressure
  . Chances of subsequent HF readmit are negatively related

- Most of the expenditure effect is for diagnostics (Table 5)

These are seminal papers, but other scholars find weaker effects

- E.g., Dranove and Watanabe on C-section rates

What about the other effects? Are doctors abandoning their practices? Can patients no longer get access to care?

Several researchers have examined the effect of malpractice premia on physician migration

- Despite numerous anecdotal reports, there is little systematic evidence

- Nor is there evidence that patients are travelling further

The AMA rejects these findings, arguing very strongly that the "crisis" has had far larger effects in concentrated areas

To better understand the merits and drawbacks of our present system, we need to answer a broad question: why do we have a negligence system?

Any negligence system has two goals

- **Compensate for losses** – it is an insurance system

- **Deter negligence** – it is a quality assurance system

Negligence system as an *insurance system*

- There are substantial risks to undergoing medical treatment

  . We value the assurance that if something goes wrong during the course of treatment, we would be compensated.
  · Health insurance might compensate for medical costs, but what about losses to human capital and the intrinsic value of life?
  . The malpractice system could be seen as insuring against these unpredictable losses
  . E.g., High malpractice premiums for neurosurgeons reflects the high stakes; If unsuccessful treatment is really so costly, then perhaps we really should have fewer neurosurgeries!
  . *We would value this protection even if the harm was no fault of the provider*

- The current system is not very effective as an insurance system

    . One Harvard study found that only 1 out of 8 negligent acts that resulted in patient injury resulted in a lawsuit
    . Even when patients sue, there is little guarantee of recovering damages
    . Even if damages are recovered, lawyers and experts receive a large percentage of the award

- At its best, the current system provides insurance with no guarantee of recovery, and a 100% "loading fee" (recall that lawyers and experts get half the total award)

- Malpractice reforms would have mixed effects on the insurance component of the negligence system

    . Recall that if there are no fees, individuals at risk prefer full insurance
    . Caps on damage awards would imply less than full insurance
    . Caps on legal fees would reduce the loading fee
    . But would caps limit efforts of plaintiff's lawyers?

- If our main goal is to compensate victims, then a *no-fault system* would be preferred to the current system

    . Provide compensation to all victims, regardless of negligence (this provides proper "insurance" to victims)
    . Provided the intervention caused the harm, of course
    . Minimizes loading fee
    . High number of claims and large awards would reflect the fact that we all face large risks when we receive medical treatment

Negligence system is also a *quality assurance system*

- The aforementioned Harvard study found substantial negligence

  . Researchers examined every hospital discharge in NYS for one year in the late 1980s.
  . Found negligent acts resulting in patient injury in 1 percent of hospitalizations
  . Negligence implies preventable – perhaps a more stringent negligence system could lead to greater prevention

- System does a fairly poor job of deterrence, because insurance is *community rated*

  . MDs do not pay the financial costs of the damages they inflict
  . They bear time and inconvenience costs, but is this sufficient?
  . Should malpractice insurance be more strongly experience rated?

- For negligence system to assure quality, it is essential that jury awards are not random – juries must be able to distinguish true negligence from bad luck

Do juries punish innocent providers?

- Evidence is mixed

- E.g., Farber/White study

  . They obtained detailed information about 252 lawsuits filed against a single hospital during the late 1970s-1980s.

  . This hospital, like most, obtained the opinion of an independent expert who evaluated whether the hospital provided "good quality", "ambiguous quality", or "bad quality"

  . The hospital settled nearly every case where quality was bad (suggesting that the plaintiffs got less than they might have if they had gone to trial)

. The vast majority of cases where quality was good were dropped or dismissed (suggesting the discovery process worked effectively)

- Only 13 of 252 cases went to trial.

. 9 when the hospital had good quality; 1 when quality was bad
. The hospital won every trial!

- They regressed award and settlement amounts on care quality and extent of injury. Amounts were higher when quality was lower

Other retrospective studies find jury "error" is not uncommon

Bottom Line on Malpractice System

- If medical care does cause harm, and we want to compensate victims, then the price of medical care should increase to assure such compensation

. E.g., if neurosurgery often results in terrible harm, then price of neurosurgery should increase, as it has
. This may deter supply (higher costs of doing business) and demand (higher prices, lower access)

- The current system is inefficient in providing this compensation and drives up costs through defensive medicine

- Even so, tangible supply/demand effects remain no more than anecdotes, with few exceptions

- Allegations of irrational juries and "lottery" effects remain open to debate