Prescriptions for Reform

100 Billion Reasons to Reform Today's Medical Liability System

A Message from America's Hospitals

Rich Umbdenstock
President and CEO
American Hospital Association

$100 billion.

That's one estimate of how much money is spent on defensive medicine — care not expected to benefit the patient but provided to minimize the risk of a lawsuit. To help make health care more affordable and efficient, this is one area that needs urgent attention.

President Obama has called for demonstration projects, and we agree. But more must be done. If not, physicians will continue to close practices or move to states where reforms have taken place. The result? Some patients will lose access to care.

Physicians and nurses work hard to provide the right care at the right time. When things go wrong, people should be compensated. But today's system has run amok, with too much focus on jackpot cases and too little money getting to affected patients.

Instead, the legal environment should foster high-quality patient care. The respected Institute of Medicine agrees, and calls for a patient-centered and safety-focused system.

To achieve that, the AHA and others support a system in which decisions on compensation are made by trained, impartial adjudicators outside the regular tort system, based on whether injury was avoidable. These adjudicators would review the care provided and, if warranted, award compensation based on specific guidelines. Other alternatives to the current system could include protecting doctors and others from litigation if they were following clinical guidelines, and requiring a claim filed in court be validated by a medical professional.

Hospitals, physicians and others all must continue to improve the quality of health care. An alternative liability system should provide fair compensation to injured patients, while deterring unnecessary care and unsafe practices and systems.

This kind of positive change is a prescription for making care better and more affordable for all Americans, and now is the time to make it happen. To learn more visit: www.aha.org/Prescriptions.

America's Hospitals — Leading Change for Better Patient Care

American Hospital Association

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American Hospital Association

THE AHA'S FRAMEWORK FOR MEDICAL LIABILITY REFORM

What is our proposal?
An administrative compensation system (ACS) would be created to compensate patients for injuries that could have been avoided during medical care. Decisions would be made using nationally developed evidence-based clinical guidelines and schedules for compensation amounts. The system would be part of a comprehensive approach to address injuries sustained during care. Robust regulatory and oversight activities would complement the system to protect patients from individual practitioners who may place their safety at risk.

What are the expected benefits of this system?
- *Quality and patient safety improvements* – Providers would have additional incentive to adhere to clinical protocols and evidence-based care; the focus would be quality and safety, *not defensive medicine*.
- *Broader access to compensation* – The system would reach all eligible patients, not just a few; the amounts would be more consistent across similar cases, and awards would be reasonably predictable for patients; both the process and compensation would be faster.
- *Reasonable compensation* – Patients should be made "whole" for the economic and non-economic costs of injuries..
- *A more efficient system* – The claims process for patients would be simpler and less adversarial; compensation would be delivered with lower transaction costs; liability insurance should become more affordable.

What would an ACS look like?
- Claims for injury during medical care would be handled through an administrative process administered by the states and could not be brought directly to the courts. Intentional injuries and criminal acts would remain in the courts, outside of this system.
- Compensation would be provided for those injuries that could have been avoided and that meet a minimum threshold of harm. The standard would be whether the injury was avoidable; the negligence standard would not apply.
- Patients who believe they have been injured during medical care would submit a claim to a local panel which, using explicit nationally established decision guidelines and schedules, would make an initial decision about whether an injury was eligible for compensation and, if so, offer compensation. Hospitals, physicians and other providers could take the initiative before a claim is filed and offer compensation using the guidelines and schedules.
- Patients who question the local panel's decision could bring their claim to an expert panel or administrative law judge who is part of a state system' patients could ultimately seek review of the decision in court.

Other support for this framework
- Professor Michelle Mello, co-author of many of the articles referenced in the recent HHS/White House fact sheet on the issue, assisted in framing and shaping this approach.
- The Institute of Medicine has spoken favorably about replacing the tort system with a non-judicial compensation system that is patient-centered and safety-focused.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

October 9, 2009

Honorable Orrin G. Hatch
United States Senate
Washington, DC 20510

Dear Senator:

This letter responds to your request for an updated analysis of the effects of proposals to limit costs related to medical malpractice ("tort reform"). Tort reform could affect costs for health care both directly and indirectly: directly, by lowering premiums for medical liability insurance; and indirectly, by reducing the use of diagnostic tests and other health care services when providers recommend those services principally to reduce their potential exposure to lawsuits. Because of mixed evidence about whether tort reform affects the utilization of health care services, past analyses by the Congressional Budget Office (CBO) have focused on the impact of tort reform on premiums for malpractice insurance. However, more recent research has provided additional evidence to suggest that lowering the cost of medical malpractice tends to reduce the use of health care services. CBO has updated its estimate of the budgetary effects of proposals for tort reform to reflect that new information.

Background on Tort Reform

Under current law, individuals may pursue civil claims against physicians and other health care providers for alleged torts—breaches of duty that result in personal injury. The system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for losses they incur (including medical costs, lost wages, and pain and suffering) resulting from injuries that occur because of negligence.

Many observers have proposed nationwide curbs on medical malpractice torts. As CBO outlined in its 2008 report *Key Issues in Analyzing Major Health Insurance Proposals*, reforms to the tort system generally fall into one of two categories: caps on the payments that may be made and limits on who may be found liable. Broader reforms, such as the establishment of specialized courts or different standards of evidence, have also been discussed, but they have not featured as prominently in legislative proposals.

Caps on tort awards could take a number of forms. One common proposal would limit awards for noneconomic damages, such as pain and suffering. Other proposals would limit the amount awarded for punitive damages, or the situations in which a plaintiff could receive awards for punitive damages, or both. Still other proposals would cap the contingency fees that claimants' attorneys could collect as a percentage of the total

damages recovered. Additionally, some proposals would allow compensation that plaintiffs received from other sources—including payments from health and life insurance, workers' compensation, and automobile insurance—to be introduced at trials (juries presumably would take that information into account in determining awards); some proposals would also prevent those other sources from receiving any portion of awards for damages.

The two most common ways of imposing limits on liability are to shorten the statute of limitations on malpractice claims and to change the rules regarding joint-and-several liability. The principle of joint-and-several liability allows a claimant to recover the entire amount of a damage award from any one of the parties found to be responsible for an injury, regardless of the party's degree of responsibility for that injury. Replacing joint-and-several liability with a "fair-share" rule would limit each defendant's financial liability to his or her percentage share of responsibility for the injury.

Several times over the past decade, CBO has estimated the effects of legislative tort reform proposals. Typical proposals have included:

- A cap of $250,000 on awards for noneconomic damages;
- A cap on awards for punitive damages of $500,000 or two times the award for economic damages, whichever is greater;
- Modification of the "collateral source" rule to allow evidence of income from such sources as health and life insurance, workers' compensation, and automobile insurance to be introduced at trials or to require that such income be subtracted from awards decided by juries;
- A statute of limitations—one year for adults and three years for children—from the date of discovery of an injury; and
- Replacement of joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury.

The Effect of Tort Reform on Premiums for Medical Liability Insurance

National implementation of a package of proposals similar to the preceding list would reduce total national premiums for medical liability insurance by about 10 percent, CBO now estimates. That figure reflects the fact that many states have already enacted at least some of the proposed reforms. For example, about one-third of the states have implemented caps on noneconomic damages, and about two-thirds have reformed their rules regarding joint-and-several liability.

CBO estimates that the direct costs that providers will incur in 2009 for medical malpractice liability—which consist of malpractice insurance premiums together with settlements, awards, and administrative costs not covered by insurance—will total approximately $35 billion, or about 2 percent of total health care expenditures. Therefore,

lowering premiums for medical liability insurance by 10 percent would reduce total national health care expenditures by about 0.2 percent.

Recent Evidence on the Broader Effects of Tort Reform

On the basis of newly available research, CBO has updated its analysis of the effects of tort reform to include not only direct savings from lower premiums for medical liability insurance but also indirect savings from reduced utilization of health care services. Many analysts surmise that the current medical liability system encourages providers to increase the volume or intensity of the health care services they provide to protect themselves against possible lawsuits. (An example of increasing intensity would be ordering a computerized tomography scan rather than a simple x-ray.) In earlier analyses, CBO did not incorporate such effects in its estimates because research on the impact of tort reform on the use of health care services produced inconsistent results. For example, Kessler and McClellan (1996) and CBO (2006) both observed reductions in Medicare's hospital spending in states that had enacted a cap on noneconomic damages (for the full citations, see the attached list of references); however, those studies also reported *increases* in Medicare's spending for hospitals and for physicians' services in states that had changed their joint-and-several liability rules to fair-share rules.

More recent research has yielded additional evidence that tort reform reduces the use of health care services. Lakdawalla and Seabury (2009) and Baicker, Fisher, and Chandra (2007), using data on hospitals' total expenditures and Medicare's spending for Part A and Part B services, found that reductions in the cost of medical liability lowered health care expenditures.[1] In addition, Avraham, Dafny, and Schanzenbach (2009) found that several types of reform significantly lowered the costs of health plans offered by self-insured employers.

Other recent research seeks to reconcile some earlier results that appeared to be contradictory. Currie and MacLeod (2008) have suggested that certain components of tort reform, such as changes in the rules on joint-and-several liability, create different financial incentives for physicians than do other reform components, such as caps on noneconomic damages. Caps on damages unambiguously reduce financial liability for all providers. Reform of joint-and-several liability rules, however, is likely to increase the financial liability of the providers assigned the greatest share of responsibility in malpractice cases—typically, physicians. Therefore, physicians may reduce the volume and intensity of the services they provide in response to caps on damages, but they may increase volume and intensity in response to reform of joint-and-several liability rules. As a result, the inclusion or exclusion of specific components in a legislative tort reform proposal could affect the proposal's likely impact on health care spending.

The Effects of Tort Reform on Total Health Care Spending and the Federal Budget

CBO now estimates, on the basis of an analysis incorporating the results of recent research, that if a package of proposals such as those described above was enacted, it would reduce total national health care spending by about 0.5 percent (about $11 billion in 2009). That figure is the sum of the direct reduction in spending of 0.2 percent from

[1] Part A of Medicare pays for hospital care and related services; Part B pays for care by physicians and related services.

Table 1.
Effects of Tort Reform on Mandatory Spending and Tax Revenues

											Total	
(Billions of dollars)	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2010-2014**	**2010-2019**
Change in Mandatory Spending[a]	0	-0.7	-1.8	-3.2	-4.6	-5.4	-5.9	-6.0	-6.3	-7.0	-10.3	-41.0
Change in Revenues	0	0.2	0.6	1.0	1.5	1.7	1.8	1.9	2.1	2.2	3.2	13.0
Net Effect on the Deficit[b]	0	-0.9	-2.4	-4.2	-6.1	-7.1	-7.7	-7.9	-8.4	-9.2	-13.5	-54.0

Sources: Congressional Budget Office; Joint Committee on Taxation.

a. Includes Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits program. Numbers do not include potential effects on payments made through the Federal Tort Claims Act and effects on other, small mandatory programs.

b. Negative numbers indicate a reduction in the deficit.

lower medical liability premiums, as discussed earlier, and an additional indirect reduction of 0.3 percent from slightly less utilization of health care services. (That reduction is the estimated net effect of the entire package listed earlier, although some components of that package might increase the utilization of physicians' services, as has already been noted.) CBO's estimate takes into account the fact that because many states have already implemented some of the changes in the package, a significant fraction of the potential cost savings has already been realized.

In the case of the federal budget, enactment of such a package of proposals would reduce mandatory spending for Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits program by roughly $41 billion over the next 10 years (see Table 1).[2] That figure includes a larger percentage decline in Medicare's spending than in the other programs' or in national health spending in general, a calculation based on empirical evidence showing that the impact of tort reform on the utilization of health care services is greater for Medicare than for the rest of the health care system. One possible explanation for that disparity is that the bulk of Medicare's spending is on a fee-for-service basis, whereas most private health care spending occurs through plans that manage care to some degree. Such plans limit the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as "defensive" medicine); in that way, plans control costs and keep premiums lower than they otherwise would be. In research reported in 2002, Kessler and McClellan found that when tort reform was introduced, health care spending in regions with relatively more enrollees in managed care plans did not fall as much as it did in regions with relatively fewer enrollees. Presumably, the managed care plans had already eliminated some of the defensive medicine that would otherwise have been diminished by tort reform.

[2] Spending in some discretionary federal programs could also be reduced, but funding for those programs is subject to future appropriation action and is not included in the estimates in Table 1. For example, some savings could be realized if the amounts appropriated to such federal agencies as the Department of Defense and the Department of Veterans Affairs were reduced because of lower health care costs as a result of tort reform. In CBO's estimation, that reduction would be less than $1 billion during the 2010–2019 period. The impact on federal agencies would be proportionally smaller than the impact on the overall health care system because medical malpractice costs are already lower than average for entities covered by the Federal Tort Claims Act.

By reducing spending on health care in the private sector, the package of proposals discussed here would also affect federal revenues. Much private-sector health care is provided through employment-based insurance that represents nontaxable compensation. Lower costs for health care arising from those proposals would lead to higher taxable wages and thereby increase federal tax revenues by an estimated $13 billion over the next 10 years, according to estimates by the staff of the Joint Committee on Taxation (JCT). Combining the effects on both mandatory spending and revenues, a tort reform package of the sort described earlier in this letter would reduce federal budget deficits by roughly $54 billion over the next 10 years. That estimate assumes that a change enacted in 2010 would have an impact that increased over time, achieving its full effect after four years, as providers gradually changed their practice patterns. Of course, the estimated effect of any specific legislative proposal would depend on the details of that proposal.

The Effects of Tort Reform on Health Outcomes

Because medical malpractice laws exist to allow patients to sue for damages that result from negligent health care, imposing limits on that right might be expected to have a negative impact on health outcomes. There is less evidence about the effects of tort reform on people's health, however, than about its effects on health care spending—because many studies of malpractice costs do not examine health outcomes. Some recent research has found that tort reform may adversely affect such outcomes, but other studies have concluded otherwise. Lakdawalla and Seabury (2009) found that a 10 percent reduction in costs related to medical malpractice liability would increase the nation's overall mortality rate by 0.2 percent. However, Kessler and McClellan (1996 and 2002) and Sloan and Shadle (2009) concluded that tort reform generated no significant adverse outcomes for patients' health.

I hope you find this information useful. If you have any further questions, please contact me or my staff. The primary staff contact is Stuart Hagen.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

cc: Honorable Patrick J. Leahy
Chairman
Senate Committee on the Judiciary

Honorable Jeff Sessions
Ranking Member
Senate Committee on the Judiciary

Honorable John Conyers Jr.
Chairman
House Committee on the Judiciary

Honorable Lamar Smith
Ranking Member
House Committee on the Judiciary

Attachment: References

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