

Medical Malpractice and Health Care Costs

Background Information Prepared for the Health Care Transformation Task Force by Minnesota Department of Health Staff December 3, 2007

Members of the task force have requested information on the impact of medical malpractice costs on overall health care spending. This background paper provides information on the market for medical malpractice insurance in Minnesota, the estimated impact of medical malpractice costs on overall health care spending, and the potential cost savings associated with malpractice reform proposals.

Malpractice Insurance Market Trends

Despite major problems occurring in the market for medical malpractice insurance elsewhere in the U.S., medical malpractice insurance has been a fairly profitable line of business in Minnesota. According to information from the Minnesota Department of Commerce:¹

- The overall loss ratio for medical malpractice insurers from 2002 to 2006 was 56%. In other words, malpractice insurers paid out about 56 cents in claims for each dollar of premium they collected.
- The market is fairly concentrated; one company has 53% of the market share.
- Malpractice premiums in Minnesota are among the lowest in the country.²

Medical Malpractice and Health Care Spending

There are *direct* and *indirect* costs to the health care system from medical malpractice. Some analysts think that reforming the malpractice system could reduce these costs. We discuss the impact of medical malpractice on health care costs and the potential cost savings from certain reform proposals below.

Direct Costs

Malpractice premiums are the best available measure of the *direct* cost of malpractice in the state of Minnesota. According to the Minnesota Department of Commerce, malpractice insurance premiums in Minnesota totaled \$100 million³ in 2006. This represents about 0.3% of the estimated \$31.4 billion in total health care spending in the state.

¹ Minnesota Department of Commerce, "Medical Malpractice Insurance in Minnesota", November 2007.

² *Medical Liability Monitor*, October 2006

³ Although malpractice premiums are the best available measure of the direct cost of malpractice in Minnesota, the data are incomplete because some organizations choose to self-insure for malpractice (the share of the market that is not included in the premium data reported to the Department of Commerce is unknown).

Indirect Costs

The *indirect* costs of medical malpractice are thought to result primarily from “defensive medicine,” which occurs when a health care provider decides to order additional services (e.g., diagnostic testing) to reduce exposure to malpractice litigation. It is very difficult to estimate the extent and cost of defensive medicine. Studies that rely on physician survey data suggest that the practice of defensive medicine is widespread and increases when physicians are concerned about their liability coverage.⁴ However, critics have noted that the surveys may not be representative because physicians who are concerned about malpractice are more likely to participate.⁵ Some studies have attempted to quantify the extent of defensive medicine by comparing rates of procedures that physicians are more likely to order due to liability concerns (such as caesarean sections and imaging) across states with different malpractice climates.⁶ The findings are mixed; some studies show small associations between the malpractice climate and use of these procedures, while others do not. Even if there were agreement on the association between the legal climate and defensive medicine, however, it would be difficult to estimate the full impact of defensive medicine on health care spending.

Reform Proposals and Impact on Health Care Spending

Many states have adopted tort reforms that attempt to contain malpractice costs by decreasing both the frequency and total cost of lawsuits. In Minnesota, these reforms include:

- A four-year statute of limitations on filing a claim.⁷
- A requirement that a plaintiff’s attorney file an “affidavit of expert review” within 180 days of filing a lawsuit. This law aims to discourage frivolous lawsuits or eliminate them at an early stage by requiring plaintiffs to state up front who they will call as expert witnesses and what those witnesses will testify to.⁸
- A “collateral source rule” that reduces a health care provider’s liability by the amount that the injured person receives from other sources such as workers compensation and insurance.⁹
- Proportional liability except in cases where one defendant is found to be more than 50% responsible for the injury. Proportional liability is a limit on “joint and several liability”, which allows a patient to collect the full amount of damages from any party regardless of their responsibility for the injury.¹⁰

⁴ Robert Wood Johnson Foundation (RWJF) Synthesis Project, “Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms”, May 2006

⁵ RWJF Synthesis Project; Congressional Budget Office, “Medical Malpractice, Tort Limits and Health Care Spending”, April 2006

⁶ RWJF Synthesis Project

⁷ Minnesota Statutes, section 541.076

⁸ Minnesota Statutes, section 145.682

⁹ Minnesota Statutes, section 548.36

¹⁰ Minnesota Statutes, section 604.02

Some states have enacted other reforms to limit malpractice costs. Caps on noneconomic damages, which have been adopted by 22 states¹¹, have received the most attention. Critics of caps on noneconomic damages argue that they are unfair to the most severely injured patients. Another common reform not in place in Minnesota is a limit on attorney fees, which 26 other states have adopted.¹²

Impact of Reforms

Direct Costs

Tort reforms could decrease the direct costs of medical malpractice by lowering the amount of damages awarded, decreasing claims frequency, and eventually lowering premiums. Several studies have shown that caps on noneconomic damages may lower direct malpractice costs. For example, studies show that caps on noneconomic damages limit growth in malpractice premiums by 6-13% and the size of the average malpractice award by 20-30%.¹³ There is less evidence about the efficacy of other reforms, but in 2003 the Congressional Budget Office (CBO) concluded that tort reforms resulted in a net decline in malpractice awards and premiums.¹⁴ However, given that direct malpractice costs account for less than 1% of total spending in the state, even significant reductions in direct malpractice costs would result in relatively small overall savings.

Indirect Costs

The potential impact of tort reforms on defensive medicine is widely debated. A frequently cited study about hospital costs for Medicare patients with certain types of heart disease showed a 4-9% reduction in hospital costs from direct tort reforms. However, the CBO determined that these results could not be generalized to all medical conditions.¹⁵ The CBO also recently attempted to estimate the impact of tort reforms on overall health expenditures.¹⁶ Its analysis provided some evidence of a link between tort reforms and reduced spending, but the results were inconsistent. The CBO concluded that it is extremely difficult to disentangle the effects of tort reforms from other factors that influence spending. Similarly, California's decision to cap noneconomic damages coincided with extensive insurance reform. The state has since experienced much slower growth in malpractice premiums, but it is difficult to determine how much of this was due specifically to the malpractice reforms.¹⁷

¹¹ As of April 2006, RWJF Synthesis Project

¹² National Conference on State Legislatures, 2007 Medical Malpractice Laws

¹³ RWJF Synthesis Project

¹⁴ Congressional Budget Office, *Cost Estimate for H.R. 5: Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003*

¹⁵ Congressional Budget Office, "Limiting Tort Liability for Medical Malpractice," Economic and Budget Issue Brief, January 8, 2004.

¹⁶ Congressional Budget Office, "Medical Malpractice Tort Limits and Health Care Spending", April 2006

¹⁷ RWJF Synthesis Project