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Non-Economic Medical Malpractice Limits: What They Mean for All Players

by Bart LeFan

Introduction

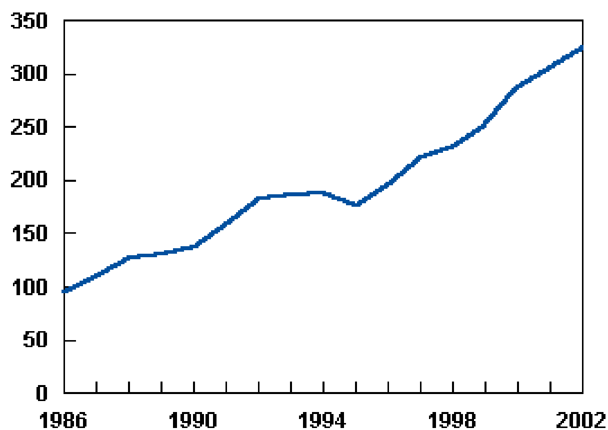
One popular explanation for reduced patient access and rising healthcare costs has been the soaring increase of medical malpractice insurance premiums due to large jury awards in malpractice cases. The most frequent and highly-publicized judgments have come in the form of non-economic damages – awards for suffering, emotional distress, and other intangible damages. Many physicians – particularly specialists – must carry significant insurance to cover potential judgments. In response, many states have attempted to limit the amount of jury awards for medical malpractice cases. These state statutes, or "tort reforms," have had both positive and negative effects on all players in the healthcare system. Several possible alternatives are being discussed nationwide, including "Early Offer Rules," patient indemnity insurance, and Health Courts.

Background

During the 1980s and 1990s, plaintiffs received record judgments in medical malpractice cases. The amount of these judgments forced some providers to cut services and causing some physicians to relocate or close their practice altogether. These judgments also had significant effects on the cost of malpractice insurance – the end of the 1990s and the beginning of the century saw a "sharp increase in premiums for medical malpractice insurance" (CBO 2004, 1). In Pennsylvania alone, over 150 physicians – mostly surgeons – claimed to have relocated, retired, or closed their practices due to "malpractice pressures" between 2001 and 2003 (GAO 2003, 17). The graph below shows the steady increase in the average award payment for closed malpractice claims from 1986-2002.

Graph 1: Average Insurance Payment for Closed Malpractice Claims, 1986-2002

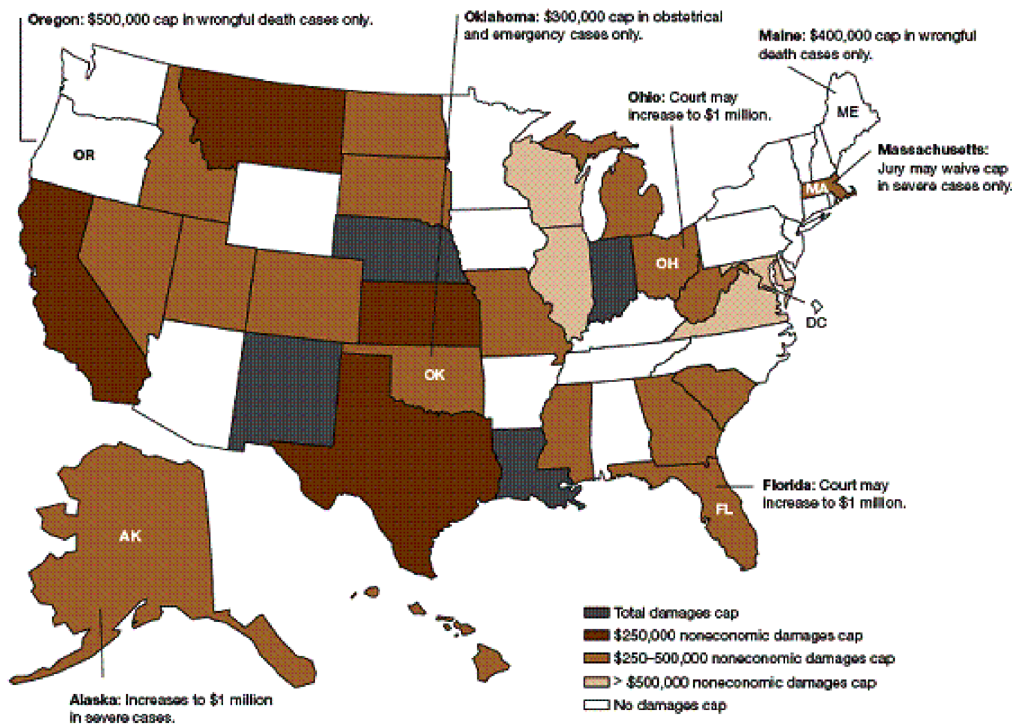
(Thousands of dollars)



Source: Physician Insurers Association of America.
Note: These averages exclude closed claims that did not result in payments.

In response to physician relocation and declining access, many states began instituting limits on non-economic damages. The first such law was California's MICRA law, passed in 1975, capping non-economic damages at $250,000 (Randolph, 2006). Following California's lead, 34 states currently have limits on non-economic damages. Most states with limits, including Utah, have capped non-economic damages at $500,000 or less (NCSL 2007).

Figure 1: Caps on non-economic and total damages by state as of April 2006



Source: Mello 2006.

Medical malpractice limits have historically been enacted solely by individual states, but the federal government is attempting to address the problem as well. On February 15, 2008, President Bush submitted a proposal to Congress in an attempt to address Medicare shortages. Title II of the bill addresses medical malpractice reform – implementing a $250,000 cap on non-economic damages and a limitation on punitive damages.

Malpractice limitations are also facing judicial review at the state level. In Alabama, the Supreme Court ruled that the state's $400,000 cap on non-economic damages was unconstitutional, leaving the state without any malpractice limits (PIAA, 2008). The Wisconsin Supreme Court held that limits on non-economic damages violated the Equal Protection clause of the Wisconsin Constitution. These recent decisions could spark a nationwide backlash against tort reforms, such as the overturn of Illinois' caps in November 2007.

Current Characteristics & Impact of Malpractice Caps
The impact of medical malpractice limits has been wide-ranging. Both supporters and opponents of limits agree on the resulting migration of physicians, but see differing effects on access and patient rights. The migration has increased patient access in some states, leaving non-cap states with fewer physicians per capita.

Proponents of the caps claim an increase in the supply of physicians in states with these limitations. Some states are experiencing a boom as a result of physician relocation. "We found that there was an 83 percent increase in the median number of physicians per 100,000 residents from 1970 to 2000 in the states that never had a cap on malpractice awards before 2000" (Encinosa 2005, W5-253). A Harris Interactive study showed that physicians shy away from high-risk specialties out of fear of greater malpractice liability (Harris 20002). Studies also show a 17% decrease in insurance premiums within those states with caps (Thorpe 2004).

Opponents of the malpractice limits argue that the caps are ineffective and reduce patient access and rights. Even in states with caps, malpractice insurance premiums still increased 83.3% between 1991 and 2002, often resulting in reduced physician services. In Florida, over half of the state's physicians have reduced or eliminated services – change attributed to increased liability premiums (Brooks 2005). Studies show that even with caps, the number of insurance companies writing malpractice policies has modestly increased since 1991 (Weiss 2003). The effect of "physician migration" can leave patients in non-cap states with reduced access to care – particularly in neurosurgery and obstetrics. Before Texas' tort reforms, 60% of counties did not have an obstetrician (Perry 2003). Opponents argue that malpractice caps limit patient recourse against physicians in cases of negligence. Many legitimate cases are never brought to trial due to the high costs of expert witnesses and lawyer fees.

Alternatives to Caps
There are several solutions that have recently been implemented as alternatives to traditional medical malpractice caps.

These include: 1) Early Offer Rule; 2) Patient Indemnity Insurance policies; and 3) health courts.

The use of full disclosure, or the "Early Offer Rule," is becoming a popular trend in medical malpractice cases. Under this agreement, a physician or facility admits an error has occurred and makes an initial offer to settle the case. By accepting the offer, the patient waves his/her right to seek additional damages through the judicial system. Illinois and Vermont both passed legislation for pilot programs to test full disclosure/early offer policies. If successful, other states are expected to follow suit (Geier, 2006). Early offer policies have also been considered on the federal level. The National Medical Error Disclosure and Compensation (MEDiC) Bill was submitted jointly by Senators Hillary Clinton (D-NY) and Barack Obama (D-IL) in 2005 (S. 1784), and included an early offer rule in an effort to "reduce the cost of medical liability for doctors."

Another alternative to malpractice caps is the creation of Patient Indemnity Insurance policies. These policies are issued to cover a patient against an adverse medical outcome. In the same way that many athletes insure their bodies against off-field injuries, patients would be able to purchase policies covering the outcome of medical procedures (Pate 2006).

A third alternative receiving bipartisan support is the establishment of Health Courts. Under this system, judges would receive topical medical training, expert witnesses would be court-appointed, and participants would be encouraged to forego jury trials in favor of "bench trials." Damages would be awarded on a previously arranged fee schedule. Specially trained judges could better analyze the technical evidence submitted in such cases. Court-appointed experts could help ensure the integrity of testimony. The use of "bench trials" could save time, legal fees, and ensure equality of damage judgments (Pate 2006). Health Court legislation was introduced to both houses of Congress in May 2007 (H.R. 2497 & S. 1481), and remains in committee review.

Conclusion
Though medical malpractice limits have been adopted by a majority of states, there remains significant debate regarding their effectiveness in mitigating rising healthcare costs. Many physicians have been stifled by the overwhelming cost of malpractice insurance, and have relocated their practices to other states with malpractice limits. Multiple alternatives to malpractice caps continue to be pursued at both the federal and state levels.

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