The medical malpractice system: Review of the evidence

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April 1, 2010

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Outline

- Goals of malpractice system
- Impact of system
- Efforts to change the system
  - State tort reforms
  - Innovative reforms
- Ideas for changes within Medicare

Medicare has a stake in the medical malpractice system

- Payments to providers include liability costs
- Medicare may also incur costs associated with defensive medicine
- Link to health care quality and safety
- Important to physicians

Goals of malpractice system

- Compensate patients who are injured by medical negligence
- Deter medical errors/negligence through threat of litigation and financial penalties
- Evidence that system falls short of its goals, has unintended consequences

Performance of malpractice system

- Evidence that it does not compensate patients equitably, rapidly, or efficiently
- Does not appear to reduce medical errors
- May hamper efforts to improve patient safety
- Cyclical premium increases affect affordability of malpractice insurance
- Direct and indirect costs

Malpractice system associated with direct and indirect costs

- *Direct costs*: premiums and legal costs
  - $35 billion in 2009 (CBO)
- *Indirect costs*: additional services ordered by physicians in response to liability risk (defensive medicine)
  - Difficult to quantify defensive medicine
  - Studies have produced varying estimates; most findings are limited to specific conditions and populations

Review of efforts to reform malpractice system

- Study performed for Commission by Michelle Mello and Allen Kachalia
- Reviewed state tort reforms and innovative reforms
- Evaluated effects of each reform on
  - Frequency and costs of claims
  - Administrative costs
  - Malpractice premiums
  - Defensive medicine
  - Supply of services
  - Quality of care

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Existing state tort reforms

- Caps on noneconomic damages
- Pretrial screening panels
- Certificate of merit
- Attorney fee limits
- Joint-and-several liability reform
- Collateral-source rule reform
- Periodic payment
- Statutes of limitations or repose

Caps on noneconomic damages

- Only state tort reform that has significant effects
- Evidence that caps
  - Reduce average payment per claim
  - Modestly constrain growth of liability premiums
  - Modestly improve physician supply
  - Reduce defensive medicine for some services
- Impact on horizontal equity and vertical equity

Innovative malpractice reforms

- Limited or no implementation in U.S.
- Very small evidence base
- Based on limited evidence and theoretical predictions, many of these reforms appear promising
- Each has pros and cons and design issues

Two types of innovative reforms

- Modifications to current system
  - Schedule of noneconomic damages
  - Safe harbor for adhering to clinical guidelines
  - Subsidies for malpractice reinsurance
  - Enterprise medical liability
- Alternative compensation systems
  - Administrative compensation or health courts
  - Disclosure and offer programs

Schedule of noneconomic damages

- Tiered system of medical injuries ranked by severity
- Assign dollar value for noneconomic damages to each tier
- Schedule could be used by juries/judges as advisory document or binding guideline
- No state malpractice system uses schedule, but other compensation systems do (SSDI, workers' comp)

Safe harbor for adhering to evidence-based guidelines

- Strengthens weight of guidelines in litigation
- Could help prevent/dismiss claims that lack merit
- Could reduce defensive medicine
- Concept tested in Maine and Florida in 1990s
  - Difficult to evaluate because scope was limited
  - Only 1 claim in Maine invoked guideline

Government-subsidized malpractice reinsurance

- Providers who met certain conditions (e.g., patient safety) would receive reinsurance subsidies
- 10 states cover payments in excess of providers' primary coverage
  - Participation not conditioned on patient safety goals
- Lack of evidence that it would reduce claims frequency or costs
- Could reduce cost burden on providers

Enterprise medical liability

- Legal definition: requires hospitals to bear full liability for injuries that occur in the facility
  - Not the standard in any state
- But some organizations voluntarily provide malpractice coverage for employed physicians (channeling)
  - E.g., self-insured academic medical centers
- Incentive for hospital and physicians to work together to reduce errors

Health court or administrative compensation system

- *Health court*: jury replaced by specially-trained judge who determines negligence
- *Administrative model*: court replaced by administrative agency that decides claims
- Administrative model could resolve claims faster with less overhead, could generate more claims
- 2 states have administrative programs for birth-related neurological injuries

Disclosure and offer programs

- When medical error occurs, clinicians disclose error to patient
- Institution conducts rapid investigation, may offer compensation to patient
- Patient may refuse compensation offer and file lawsuit
- Limited to handful of self-insured hospitals and malpractice insurers

Ideas for changes within Medicare

- Provide reinsurance to organizations that meet certain requirements
  - E.g., reducing errors, disclosing errors to Medicare patients, offering fair compensation
  - Similar idea proposed by Institute of Medicine (2003)
- Create administrative compensation system
  - Could improve speed and equity of compensation for beneficiaries, reduce risk of large claims
  - Similar ideas proposed by PPRC (1992) and William Sage (2006)

For Commissioners' discussion

- Questions about reform strategies?
- Should Medicare play a role?