MALPRACTICE REFORM: WHAT'S THE BOTTOM LINE?

Malpractice reform is on the way in Texas. The 78th Legislature recently passed legislation that caps non-economic payouts in medical malpractice cases. The caps are, in essence, $250,000 per provider and $750,000 per suit. This legislation could be part of a larger trend: nationwide, malpractice reform is being considered at the federal level and in a variety of states, including California, Connecticut, Florida, Georgia, and Washington.

But what exactly is the crisis? Are there more claims than there used to be? Have jury awards gone up a lot? Are there more bad doctors than there used to be? Or is the malpractice system causing large increases in health care costs? The answer, as far as we can tell from the available data, is surprising: none of the above. The malpractice crisis is mainly about insurance and access–insurance for providers and access for consumers.

There is no denying the large increases in the premiums physicians and hospitals must pay for malpractice insurance. The lucky ones have kept their annual percentage increases to two digits. Those less fortunate have seen their premiums double from one year to the next. Not surprisingly, this pushes some providers out of the market, limiting consumers' access to care.

These changes in premiums are not caused by changes in insurers' underlying financial risk so much as by changes in market dynamics. During the 1990s, insurers kept premiums down in order to compete for business. They could also afford to keep premiums down because the premium revenues, invested in the market, paid healthy dividends. Poor returns in the financial markets have now eliminated that opportunity, and weak profits in the insurance industry have thinned the number of insurers competing for providers' business. The consequence: higher malpractice premiums for providers.

Still, no matter what the cause of the crisis, by limiting damage awards malpractice reform should help restore profitability to malpractice insurers and, eventually, reduce providers' malpractice premiums. What other consequences are likely to follow?

For one, I foresee little change in the quality of care. Simply put, the malpractice system, as it stands, is not a very effective quality-assurance mechanism. Suits are too random, and providers are insured against the financial repercussions anyway. Capping payouts is unlikely to put patients at measurably greater risk.

I also foresee little overall change in health care costs. Malpractice costs, at 1-2% of total health care revenues, are simply too small to have much influence on overall health care costs.

There might be a change in the number of claims, however. The considerable costs of discovery, negotiation, and litigation are borne, on the plaintiff's side, mostly by the plaintiff's attorney, in the hope of being rewarded by a large settlement or payout. Therefore a cap on payouts will reduce attorneys' willingness to accept cases, and can lower the total number of malpractice claims.

This could be good or bad, depending on whether these claims are viewed as socially constructive or socially destructive. In the words of my colleague, UTA Economics Professor Roger Meiners, "Many expensive lawsuits involving health care providers are due to lack of proper legal procedure. Health care managers must understand HIPPA and other federal rules, as well as the general standards of the law, in order to help minimize destructive litigation."

So what's the bottom line? The real tragedy of the malpractice system is that it does not create strong incentives to provide good quality care. Perhaps it is not fair to expect it to. I'm sure the system encourages diligence at the more routine aspects of health care delivery, but many aspects of quality are too subtle, too intangible, or too hard to measure to be well regulated by the malpractice system. We would be well served if a cap on damages was accompanied by increased efforts to find effective, alternative mechanisms for ensuring the quality of health care.

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