

Malpractice System Needs Reform, Too

To truly achieve health care reform, medical malpractice costs must be addressed. In New York alone, tort reform could save hundreds of millions of dollars in unnecessary health care for patients, providers, and the State. This issue of *Health Care News In-Depth* explores the failures and costs of the current malpractice system and how it can better meet its goals.

The two main goals of the medical malpractice system are to deter unsafe health care delivery practices and to compensate individuals who have been injured by providers' negligent acts or omissions. By design, the current tort system is one that assigns blame, often through lengthy, acrimonious proceedings—thereby operating contrary to recommendations for promoting safety.¹ The most effective way to improve patient safety, experts say, is to create a “culture of safety” that promotes teamwork, transparency, and discussion of adverse events without blame in order to identify and address system failures and barriers to providing safe care.

The current system also fails to effectively compensate injured patients. The system's high costs and long delays dissuade many patients injured by negligence from filing claims. At the same time, studies indicate that 40% of claims involve no error, yet 28% of such no-error claims result in payments, with the degree of patient disability—not the presence of negligence—as the key predictor of payment.

Direct and Indirect Coverage Costs

The current malpractice system also diverts enormous resources from the health care system. According to a recent Congressional Budget Office study, providers nationwide will incur \$35 billion, or about 2% of total health care expenditures, in direct costs of malpractice liability in 2009. In New York State, hospitals incur at least \$1.6 billion annually in medical malpractice costs, repre-

senting more than 3% of their operating costs. Obstetricians in certain areas of New York pay medical malpractice premiums of close to \$200,000 per year. Studies attribute an exorbitant share of the system's costs to “overhead,” with litigation costs equaling 54% of compensation paid to plaintiffs, and 22% of these administrative costs being attributable to claims with no error.

Besides direct costs, the current malpractice system also encourages unnecessary tests and treatment to fend off potential claims. Studies indicate that a high proportion of physicians order diagnostic tests and con-

sultations due to fears of litigation and that such behavior correlates with a physician's perceived burden of his or her premiums. While the projected cost of defensive medicine varies, the figures are staggering. McKinsey & Company estimates that defensive medicine may cost as much as \$150 billion to \$190 billion per year. Even conservative estimates put the annual cost of defensive medicine to be at least \$25 billion, which translates to \$350 billion over a decade, with inflation.

Huge Impact on OB

Obstetrical (OB) services often bear the highest share of these costs, due in great part to large settlements and awards related to neurologically impaired newborns. In New York, coverage for OB care can represent 35%–50% of a hospital's total coverage costs, regardless of declines in the frequency of OB-related claims or whether the hospital has implemented aggressive perinatal safety programs. These coverage costs contribute to significant operating losses for OB services at most hospitals. As a result, the availability of OB services in New York is in serious jeopardy. Most states and their Medicaid programs have a large interest

PROPOSALS TO REDUCE NEW YORK HOSPITAL COVERAGE COSTS

PROPOSAL	% REDUCTION	COST DECREASE/YEAR
No-fault fund for neurologically impaired newborns	40%	\$640M
Fault-based medical indemnity fund for neurologically impaired newborns	20%–25%	\$320M–\$400M
\$250,000 caps on non-economic damages	24%	\$384M
Improved dispute resolution systems, including health courts and arbitration	5%	\$80M

and “investment” in resolving this problem. This is particularly true in New York, where Medicaid covers nearly 50% of the deliveries.

However, OB services may be unfairly targeted. More and more evidence suggests that the most expensive OB cases involving neurologically impaired newborns are often not sensitive to medical intervention or due to obstetricians' errors. Studies have concluded that the prevalence of cerebral palsy has not decreased

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though perinatal medicine has improved, suggesting that birth injuries do not necessarily equal medical negligence.^{2,3}

Ways to Improve the System

Given the high cost of OB coverage and the fact that many adverse outcomes are not caused by poor obstetrical care, it is necessary to consider an alternative compensation system for these cases. A no-fault system that would provide payment based solely on defined injuries and eliminate the adjudication of causation would permit injured parties to receive expedited payments without lengthy litigation. Such a system would reduce coverage costs for New York hospitals by 40%, or \$640 million, annually. An alternative is to maintain the fault-based system, but create a medical indemnity fund to cover future medical care for any cases in which a settlement or award might be reached. Although this alternative would not eliminate litigation costs, it would avoid the overcompensation that often occurs now while also spreading the cost of care more broadly and fairly. This model would reduce New York hospitals' coverage costs by 20% to 25%, or \$320 million to \$400 million, per year.

Although controversial, one of the most effective ways to reduce coverage costs is to impose caps on non-economic damages, such as pain and suffering. Many states have enacted such caps to eliminate some of the unpredictability, variability, and inequities associated with large pain and suffering awards. A 2004 Milliman study estimates that a \$250,000 cap on non-economic damages would reduce medical malpractice costs for New York hospitals and

physicians by 24%, or \$384 million, per year. Studies suggest such reforms would significantly reduce defensive medicine costs without negatively affecting the quality of care.^{4,5}

Meaningful reforms to the dispute resolution system could also improve access and reduce

coverage costs. The most compelling proposal is health courts, which, in their purest sense, would be administrative in nature but that could also operate in the Federal or state judicial systems. Such courts could have specially trained judges and apply identified clinical practice and compensation guidelines. Studies indicate that a more efficient, faster, and less rancorous system for adjudicating claims can reduce both costs and defensive medicine.

Regardless of the reforms pursued, providers should participate in meaningful initiatives to reduce adverse events. GNYHA and its members have undertaken initiatives designed to increase patient safety, improve outcomes, and identify best practices. For more information regarding these initiatives, please see the Quality Section of GNYHA's Web site, www.gnyha.org.

Proposals That Increase Costs

While the nation is trying to reduce health care costs, some New York State legislators have proposed bills that would increase malpractice

costs. Among them is a bill that would eliminate the current graduated fee schedule so that plaintiff attorney fees can be one-third across the board. For example, an attorney winning a \$6 million award for a plaintiff would be entitled to a \$750,000 fee in the current system. As proposed, the attorney would be entitled to a 167% increase in that fee, or \$2 million. This proposal, if enacted, would increase hospital

PROPOSALS THAT WOULD INCREASE NEW YORK HOSPITAL COVERAGE COSTS			
PROPOSAL	% INCREASE	COST INCREASE/YR.	BILL
Eliminate graduated plaintiff attorney contingent fee schedule to permit 1/3 attorney fees across the board	25%–40%	\$400M–\$640M	S. 2040
Adjust current plaintiff attorney contingent fee schedule by increasing fee bands	15%	\$240M	No bill introduced yet
Extend statute of limitations to run 2 1/2 years from when one knows/should have known of negligence and that negligence caused injury (vs. current 2 1/2 years from act or omission); includes one year revival of claims	15%–25%	\$240M–\$400M	S. 1729 and A. 4627-A
Prohibit ex-parte interviews of later treating physicians; overturns Court of Appeals decision in <i>Arons</i>	5%	\$80M	A. 8964/S. 3203-A and A. 1254/S. 1514
Amend General Obligations Law to require non-settling defendants to elect the method of calculating share of future recovery before trial	5%	\$80M	A. 2579/S. 2390

coverage costs by 25%–40%, or \$400 million to \$640 million, per year.

Another proposal would amend the 2.5 year statute of limitations, which currently runs from the date of an act or omission, so that it would run from when one knows or reasonably should have known of the negligent act or omission and that the act caused an injury. This bill would increase hospital coverage costs by 15%–25%, or \$240 million to \$400 million, per year. Other states with such liberal discovery rules generally also cap damages.

A third bill would eliminate a defendant's right to interview, ex-parte, the plaintiff's later treating physicians, a right that plaintiffs have and that the State Court of Appeals has upheld. This would increase hospital coverage costs by 5%, or \$80 million, per year.

None of these bills would improve the State's dispute resolution, and all would unnecessarily increase health care costs. GNYHA continues to advocate for meaningful tort reform that reduces unnecessary costs, improves patient care, and appropriately compensates patients who have been harmed. ■

For additional information on medical malpractice issues, contact Susan Waltman or Rebecca Urbach at GNYHA.

¹Kohn, Linda T., Corrigan, Janet M. and Donaldson, Molla S. "To Err Is Human: Building a Safer Health System." Washington, D.C.: National Academy Press, 2000.

²Nelson, Karin B. M.D. "Can We Prevent Cerebral Palsy?" *New England Journal of Medicine*, 349 (2003), pp.1765-1769.

³MacLennan, A., Nelson, K.B., Hankins, G., and Speer, M. "Who Will Deliver Our Grandchildren? Implications of Cerebral Palsy Litigation." *JAMA*, 2005 Oct 5; 294(13):1688-90.

⁴Kessler, Daniel P. and McClellan, Mark B. "How Liability Law Affects Medical Productivity." *Journal of Health Economics*. Amsterdam: November 2002. Vol. 21, Iss. 6: 931-955.

⁵Kessler, Daniel P. and McClellan, Mark B. "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*. May 2006. Vol. 111, No. 2: 353-390.