

Testimony for  
“The Cost of the Medical Liability System Proposals for Reform, including H.R. 5, the Help  
Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011”  
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## **Introduction**

Mr. Chairman and Members of the Committee, I thank you for the opportunity to testify today. It is a privilege to be here. I am here today because I was asked to testify with regard evidence concerning the need for malpractice reform and measures that are currently being considered in Congress.

I plan to cover three main points: what we know about the evidence on performance of our malpractice system, what reform needs we have, and what the evidence tell us about traditional tort reform measures that have been enacted.

I will base my testimony on both my clinical and research experience. I am a physician at Brigham & Women's Hospital and Harvard Medical School where I have clinical, administrative, research, and teaching responsibilities. I see patients as a general internist practicing hospital medicine. In my administrative role, I am the Medical Director for Quality and Safety for my hospital. I also have a law degree and conduct research and teach in legal matters in medicine, including our malpractice system.

## **System Performance and Problems**

I'd again like to thank you for the opportunity to speak today. It is exciting to see that Congress is considering tort reform, especially given need we have today to improve our health care system in a comprehensive fashion.

First, I'd like to start by discussing why we need malpractice reform.

Health care today is not always delivered without error and can result in preventable injury. This creates the need for a well functioning system that will compensate eligible medical injuries and also help prevent errors from initially occurring or recurring (driving improvements in quality and safety).

We indeed have a malpractice system that theoretically exists to serve these two functions: to compensate patients and provide accountability for substandard care. However, the general perception and agreement among many experts is that the system is not serving these functions well and, in fact, may also be generating other unwanted secondary consequences such as defensive medicine.

If we turn to frequently cited evidence on the performance of the malpractice system, patients claim compensation in a very small number of negligent injuries (in some estimates, it is about 2% of all negligently injured patients) and an even lower number receive payment.<sup>i</sup> The problem is not just from the patient perspective though. If we look at the claims that are filed, there is concern that too low a number of claims (approximately 1 in 6) actual contain a negligent injury.

More recently generated evidence, however, shows that approximately 60% of filed claims likely have an error in them, but that the system may still not be properly adjudicating claims about a quarter of the time.<sup>ii</sup> This means that in about a quarter of the claims in which there is an error, patients may not be receive payment and in a quarter of the claims in which there is no error,

patients may still receive payment. This type of inaccuracy can undermine both patient and physician faith in the malpractice system.

Compounding this problem is data that show that the majority of premium dollars are paid to fund overhead costs of administering the system. In one estimate, about 54 cents on every dollar in premium is spent on attorney fees, other litigation related expenses such as expert witness fees, and running insurance companies.<sup>2</sup> Only about 46 cents is making it to injured patients.

All of this occurs in the context of very high insurance premiums for physicians, depending on the state and specialty of practice. Also, we cannot ignore the emotional cost that can be associated with a lawsuit—whether or not the suit has merit.

The problems with the malpractice system do not stop with its direct effects. There are also many indirect effects. The most notable is that of defensive medicine. While extremely difficult to quantify, the potential downstream consequences of defensive medicine may be considerable and include: limited access to care for patients and overutilization of resources. The latter has received tremendous attention with regard to the cost and quality implications. The threat of litigation and the perception that physicians are taking defensive measures can also undermine the quality of the patient-physician relationship.

### **Reform Needs**

In light of these findings, I'd like to turn to what we need from reform:

We need improvements that will not only fix the liability-related shortcomings for both physicians and patients, but also perform these functions much more efficiently (including lower overhead costs). These needs are directly related to how well the system performs its compensation function.

However, reform improvements should not stop there. Reforms should also address how well the malpractice system improves the quality and safety of care. There is more than one way in which this can be accomplished and includes: leveraging the claims-related information that comes in to help prevent injuries from recurring, providing a better signal and deterrent effect, or reducing defensive practices. All of these methods also carry the potential to reduce costs by reducing unnecessary care.

Therefore, as Congress considers any reform, it first becomes important to determine what the primary goal of the legislation is--whether the legislation will tackle multiple issues (patient compensation, physician liability risks and costs, overhead costs, or efficiency and quality of care) at once or start in one domain. A limited approach may be easier to pass and implement and perhaps bring quicker change in a targeted area or areas. However, tackling only one problem area may come at the expense of the others. Comprehensive reform options (such as health courts, safe harbors, or encouraging disclosure-and-offer programs) may be more appealing in this regard, but it may be more difficult to design or to take too long to enact. Regardless of the approach, it is important to consider any new reforms based on what the current evidence on reforms tells us.

## **Evidence on Reforms**

As a number of states have enacted tort reforms over the years, there has been a growing evidence base on their effects. The focus of the evaluations has often been on the liability-related effects (particularly that of claims, costs, and premiums) of these reforms. This has not been an unreasonable approach because the intent of many of these reforms was often to improve the liability insurance crisis for providers.

However, this has left a relative gap with regard to what we understand will happen to patient access to due compensation and the overall cost and quality of care when tort reforms are enacted.

Last year, we completed a review of the evidence with regard to the effect of many traditional tort reforms.<sup>iii</sup> Here is what we learned about measures that are contemplated in the current bill:

**Caps on damages:** Several states have passed caps, most of them being non-economic caps. It is also worth noting that recently two states struck down caps as unconstitutional. However, evidence indicates that caps can lower the average size of claims payments (as would be theoretically expected) and this appears to translate into lower premiums for physicians. Interestingly, though, caps do not seem to lower the number of claims filed. There is good evidence to suggest that caps may lower the amount of defensive medicine that occurs, but their effect on the overall quality of care is unknown.

**Statute of limitations:** There is reasonable evidence that statutes of limitations may lower malpractice insurance premiums but it is unclear what they do with regard to claims frequency. They do not appear to change the average award size. The evidence on the effects of statutes of limitations on defensive medicine and other care related metrics is limited.

**Attorney fee limits:** This intervention may seem appealing for a couple reasons. Limiting contingency fees may reduce the overhead costs and place more compensation in the hands of patients and also decrease the number of non-meritorious suits. However, this has to be balanced against patient access to the number of attorneys that will take cases for a lower contingency fee. Overall, the evidence shows that fee limits do not seem to translate to lower claims frequency, costs, or premiums. There is little evidence on what happens with regard to defensive practice or overall quality of care.

**Collateral source rule reform:** This reform seeks to limit plaintiffs from “double recovery” (e.g., collecting subsequent care costs from both health insurance and the defendant). This reform’s appeal is in the fairness of award amounts. The evidence indicates that there is no effect on claims frequency, claims costs, or premiums. There also appears to be no effect on defensive medicine or the overall quality of care.

## **Conclusion**

In summary, as we continue to focus our attention on how to lower costs and improve quality in health care, our medical malpractice system is an area ready for reform. The system is currently falling short for both patients and providers at a high overhead price, and also causing unwanted indirect effects that raise cost and reduce quality, especially with regard to defensive medicine.

As we consider how to reform the system, it becomes important to evaluate reforms not just on the liability consequences for providers, but also to evaluate or consider the effects on patient access to compensation and the overall cost and quality of care.

As a practical matter, Congress may opt for incremental reform that addresses one area at a time, but it is also important to keep in mind that the ultimate goal should be reform that addresses all the ails of the malpractice system. In that vein, consideration of comprehensive reforms has also been recommended by members of Congress.<sup>iv</sup> I would like to emphasize that regardless of the types of reform passed, it will be critical to measure their impact and to have plans that call for proper and timely adjustments. Just as we continue to seek better data and evidence in the medical care we deliver, we should ask the same of our medical liability system.

## **Brief Summary**

1. Research indicates that our medical malpractice system is not achieving its goals for both patients and providers. Very few negligently injured patients receive compensation and a substantial number of claims against physicians do not contain an error.
2. A significant number of meritorious claims do not receive compensation and significant number of non-meritorious claims receive compensation. This inaccuracy can undermine patient and provider faith in the malpractice system.
3. The malpractice system generates high overhead costs with the majority of every premium dollar being spent on litigation-related and insurance company expenses.
4. The malpractice system has also generated unwanted secondary effects that include defensive medicine, which can raise costs and reduce quality.
5. Reform needs include improvements in system performance for both patients and providers with lower overhead costs. Reforms should also be evaluated for their impact on care-related metrics such as defensive medicine, cost, and quality.
6. The current base of evidence on traditional tort reforms shows that, with the exception of damage caps, in general there is little to no effect on many liability system measures. The evidence on the effect of tort reforms on overall cost, access, and quality is limited. Damage caps, however, do appear to lower claims payments and liability premiums and reduce defensive practices.
7. As Congress debates incremental or comprehensive reform, it is important to plan to ultimately address all of significant shortcomings of our malpractice system. In addition, measurement and rigorous evaluation of all new reforms should be sought so that proper and timely modifications and adjustments can be made.

## **References**

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<sup>i</sup> Localio AR, Lawthers AG, Brennan TA, et al. Relation between malpractice claims and adverse events due to negligence: results of the Harvard Medical Practice Study III. *New England Journal of Medicine* 1991; 325: 245-251.

<sup>ii</sup> Studdert DM, Mello MM, Gawande AA, et al. Claims, errors, and compensation payments in medical malpractice litigation. *New England Journal of Medicine* 2006; 354: 2024-2033.

<sup>iii</sup> Mello MM, Kachalia A. Evaluation of options for medical malpractice system reform. Washington, DC: Medicare Payment Advisory Commission, 2010. Available at: [http://www.medpac.gov/documents/Apr10\\_MedicalMalpractice\\_CONTRACTOR.pdf](http://www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf).

<sup>iv</sup> The moment of truth: report of the National Commission on Fiscal Responsibility and Reform. December 2010. Available at: [http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12\\_1\\_2010.pdf](http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf).