MEDICAL MALPRACTICE INSURANCE AND THE EMPEROR'S CLOTHES

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INTRODUCTION

Tenured academics are not known for their firm grasp of reality. Medical malpractice policy seems to be an exception.

In the thirty years that have passed since California adopted its paradigmatic malpractice reform legislation, the Medical Injury Compensation Reform Act of 1975 (MICRA),[1] the health care system has changed dramatically. Annual spending on health care in the United States has risen from $300 billion to $1.6 trillion.[2] Medical technology has boomed, including new pharmaceuticals, diagnostic imaging techniques and other novel tests for disease, and lifesaving treatments such as coronary artery revascularization. Government dollars finance fifty percent of health care today, up from roughly thirty-five percent in 1975,[3] and the few prototype HMOs that existed then have given rise to a powerful managed care industry. Yet the fashion in tort reform remains unchanged. Essentially all the pro-reform stakeholders in the ongoing medical malpractice crisis continue to tout MICRA's caps on non-economic damages and limitations on lawyers' contingent fees as the ultimate in style, comfort, and durability.[4] The anti-reform stakeholders counter that the price of MICRA-style reform is not worth paying, and challenge the connection between legal claims and malpractice premiums, but ignore fundamental incompatibilities between conventional tort litigation and health care.[5] Only the

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1. Medical Injury Compensation Reform Act of 1975 (MICRA) (codified at CAL. BUS. & PROF. CODE § 6146 (West 2003), CAL. CIV. CODE § 3333 (West 1997), CAL. CIV. PROC. CODE §§ 340.5, 1295 (West 1982)).

2. Katharine Levit et al., *Health Spending Rebound Continues in 2002*, HEALTH AFF., Jan.–Feb. 2004, at 147, 148.

3. *Id.* at 151.

4. *See, e.g.*, Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2004, H.R. 4280, 108th Cong. (2004).

5. *See generally, e.g.*, J. ROBERT HUNTER & JOANNE DOROSHOW, PREMIUM DECEIT: THE FAILURE OF "TORT REFORM" TO CUT INSURANCE PRICES (2002).

academy—meaning law professors, public health professors, economists, and health services researchers—seems able to gaze at MICRA and see how shopworn it has become. Central to the academic perspective is an observation that is simultaneously obvious and startling: solving the current malpractice crisis and avoiding future ones will require restructuring medical liability insurance.[6] Why is this obvious? Because a malpractice crisis is defined as a period when liability insurance becomes scarce and expensive.[7] Why is it startling? Because the battle lines in medical malpractice reform were drawn between doctors and lawyers decades ago and have not budged.[8]

A. Blind Spots

The principal political stakeholders in malpractice reform have defined the conflict in terms of law and medicine. For over a century, American physicians have regarded malpractice suits as unjustified affronts to medical professionalism, and have directed their ire at plaintiffs' lawyers—whose wealth and reputation seem inversely proportional to their own—and the legal system in which they operate.[9] Lawyers have responded with similar cautionary tales, accusing physicians of sloth, greed, and incompetence. Neither side has offered a sophisticated vision of productive interaction between the twenty-first century health care system and contemporary legal, regulatory, and self-regulatory institutions in order to reduce medical error and compensate injured patients. Even more glaringly, neither side has

6. *See generally, e.g.*, William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, HEALTH AFF., July–Aug. 2004, at 10. For an effort to integrate malpractice policy with health policy, see INST. OF MED., FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS (Janet M. Corrigan et al. eds., 2003). For the gold standard summary of research on medical malpractice, see Patricia M. Danzon, *Liability for Medical Malpractice*, *in* HANDBOOK OF HEALTH ECONOMICS 1339 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000). For an important early article on liability insurance, see Gary T. Schwartz, *The Ethics and the Economics of Tort Liability Insurance*, 75 CORNELL L. REV. 313 (1990).

7. Many reports have been issued that look at malpractice insurance as a business line, but pay limited attention to the connection between malpractice policy and health care. *See generally, e.g.*, CONNING & CO., MEDICAL MALPRACTICE INSURANCE: A PRESCRIPTION FOR CHAOS (2001); U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES (GAO-03-702, 2003); Eric Nordman et al., *Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis* (Report presented to the NAIC's Property and Casualty Committee) (Sept. 12, 2004), *at* http://www.naic.org/models_papers/papers/MMP-OP-04-EL.pdf.

8. *See* William M. Sage, *The Lawyerization of Medicine*, 26 J. HEALTH POL. POL'Y & L. 1179, 1181–84 (2001).

9. For an historical perspective, see KENNETH A. DE VILLE, MEDICAL MALPRACTICE IN NINETEENTH-CENTURY AMERICA: ORIGINS AND LEGACY (1990); James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 JAMA 1731 (2000).

taken serious account of the third pillar of malpractice policy: liability insurance.

Both political constituencies—doctors and plaintiffs' lawyers—apply heuristics to liability insurance that misperceive its true nature and policy importance. Because blame for malpractice crises can be deflected onto insurers as well as physicians, trial lawyers frequently target liability carriers when opposing tort reform.[10] However, they do so generically rather than taking on the specific structure and financing of malpractice insurance. The trial bar seems to view malpractice insurers, like the insurance industry in general, simply as American business writ large. Most lawyer-commissioned reports on the current malpractice crisis, therefore, simply accuse liability insurers of pursuing profits rather than serving the interests of their customers.[11]

For their part, physicians fail to grasp the centrality of insurance reform to malpractice reform because they unquestioningly regard malpractice carriers as allies. This is true for reasons beyond the basic fact that insurers provide physicians with defense counsel when lawsuits are filed against them.[12] The exodus of many commercial companies during the malpractice crisis of the 1970s created a vacuum that was filled by insurers with state and local medical society sponsorship, many of which retain close financial and managerial ties to those orga-

10. *See, e.g.*, Stewart Eisenhart, *Condition Critical: Med Mal Liability Markets in Dire Need of Resuscitation*, INS. J., Sept. 30, 2002, http://www.insurancejournal.com/magazines/southcentral/2002/09/30/features/23715.htm.

11. *See, e.g.*, CTR. FOR JUSTICE & DEMOCRACY, A SHORT GUIDE TO UNDERSTANDING TODAY'S MEDICAL MALPRACTICE INSURANCE "CRISIS" (AND USEFUL QUESTIONS TO ASK) (Sept. 25, 2002), *at* http://www.centerjd.org/MediaGuide.pdf (presenting an advocacy document, the first section of which is titled "Unregulated Corporate Greed"). Other reports link the relatively slow rate of increase of malpractice premiums in California not to MICRA's damage caps, but to a voter initiative restraining price increases for insurance and a strongly pro-consumer elected insurance commissioner. *See generally, e.g.*, FOUND. FOR TAXPAYER & CONSUMER RIGHTS, HOW INSURANCE REFORM LOWERED DOCTORS' MEDICAL MALPRACTICE RATES IN CALIFORNIA, AND HOW MALPRACTICE CAPS FAILED (Mar. 7, 2003), http://www.consumerwatchdog.org/healthcare/rp/rp003103.pdf.

12. Few day-to-day conflicts arise between physicians (the insured) and their liability carriers (the insurers). Plaintiffs rarely pursue physicians' personal assets, in large part because juries at trial tend to view physician defendants as well-intentioned even if negligent. *See generally* Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 LAW & SOC'Y REV. 275 (2001). It is also unusual for claims against physicians to fall outside the scope of coverage. The most pronounced conflict has been over the right to settle without the physician's consent, mainly because settlements must be reported to the National Practitioner Data Bank. *See* Lawrence E. Smarr, *A Comparative Assessment of The PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 LAW & CONTEMP. PROBS. 59, 71 (1997). However, state laws and accommodations by physician-sponsored mutual insurance carriers have made even this issue less contentious in recent years.

nizations.[13] Even when carriers that originated as physician mutuals sever those affiliations or are acquired by other companies, physicians often still feel professional kinship with the surviving entities. Because of the episodic nature of malpractice crises, physicians lobby in behalf of insurers' interests when a crisis hits and coverage becomes scarce, while simply ignoring insurance during non-crisis periods.

In recent years, the broader politics of tort reform has overtaken efforts by various constituencies to enact comprehensive changes that would apply only to medical liability.[14] In terms of both ideology and campaign contributions, a deep divide now separates Republican and business interests, who view litigation as an even greater threat than government regulation to personal freedom and economic growth, from Democratic and trial lawyer interests, who see entrepreneurial lawyers getting their clients a day in court before a jury of their peers as the last defense of individual rights against the predations of large corporations.[15] Tort reformers, who face the uphill battle of changing existing law, take every opportunity to plead their case for across-the-board restrictions on lawsuits. A medical malpractice crisis is irresistible because the public respects physicians, and worries about the cost and availability of health care. Opponents of tort reform refute these assertions using equally general techniques, such as illustrating the harshness of reform by identifying cases of egregious harm, or blaming the crisis, if not always the underlying injuries, on corporate greed. Neither side cares to debate the specifics of health care or the subtleties of liability insurance because a nuanced discussion would both threaten their political coalitions and take them off their core "lawsuits are bad" or "lawsuits are necessary" messages.

Physicians who wrap themselves in the mantle of tort reform tend to overlook changes in health care that have exposed significant weaknesses in the traditional liability insurance model. It should come as no surprise that people see the world selectively, and regard their

13. Organized medicine's opposition to the Clinton administration's enterprise liability proposal is attributable in part to these connections. *See* David Rogers, *Initial Clinton Medical Malpractice Reform Plan Pulled After Resistance by Entrenched Interests*, WALL ST. J., June 15, 1993, at A20.

14. The American College of Physicians (ACP), for example, supported radical innovations in liability policy in the mid-1990s. *See generally* American College of Physicians, *Beyond MICRA: New Ideas for Liability Reform*, 122 ANNALS INTERNAL MED. 466 (1995) (proposing trials of no-fault compensation and enterprise liability). By 2004, the organization had retreated to a pro-MICRA agenda. *See* ACP, *Affordable Professional Liability Insurance Necessary to Provide Care*, *at* http://www.acponline.org/hpp/menu/liability.htm (last visited Jan. 23, 2005) (supporting Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2002, H.R. 4600, 107th Cong. (2002)).

15. *See* Giovanna Fabiano, *Election 2004*, COURIER-NEWS, Aug. 16, 2004, 2004 WL 81172206.

usual surroundings and routines as optimal simply because they are familiar. Two important *idées fixes* for physicians involve fragmentation of medical practice and lack of external accountability for medical quality. American physicians regard themselves simultaneously as independent professionals, entitled to set up small businesses and receive generous, separate payment for their individual services, and as stewards of medical resources, empowered to control the hospital care, pharmaceutical treatments, and other items they believe their patients require.[16] Physicians carry a similar dualism over to quality assurance, insisting that medical facilities and medical products be subjected to strict legal and marketplace controls, but reserving to themselves the right to police their own colleagues through licensing boards, medical staff committees, and the like. As scholar Paul Starr details, the medical profession that received assurances of clinical and financial autonomy in exchange for supporting the enactment of Medicare in 1965,[17] and that persuaded many state legislatures to adopt MICRA-style tort reform in 1975 and again in 1985,[18] hoped it had secured such privileges for all eternity.

As it turned out, the two decades that have passed since the last malpractice crisis were a period of wrenching change for American medicine. Previous malpractice crises occurred at the high-water mark of financial success and professional independence for physicians. Even rapid increases in physicians' malpractice insurance costs could be passed on quickly and easily to health insurers in the form of higher medical fees.[19] This is probably no longer true. "Cost containment" has been the principal policy objective of both private insurers and the Medicare program since the 1980s. For example, the most successful tool of managed care is physician fee contracting,[20] and

16. *See generally* Lawrence P. Casalino et al., *Community Tracking Study: Benefits of and Barriers to Large Medical Group Practice in the United States*, 163 ARCHIVES INTERNAL MED. 1958 (2003).

17. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 375–77 (1982).

18. *See* AGENCY FOR HEALTH CARE POLICY & RESEARCH, U.S. DEP'T OF HEALTH & HUMAN SERVS., COMPENDIUM OF SELECTED STATE LAWS GOVERNING MEDICAL INJURY CLAIMS (1993); *see also* RANDALL R. BOVBJERG & BRIAN RAYMOND, KAISER PERMANENTE, PATIENT SAFETY, JUST COMPENSATION AND MEDICAL LIABILITY REFORM 28–29 (Jan. 2003), *available at* http://www.kpihp.org/publications/briefs/patient_safety.pdf.

19. *See generally* Patricia M. Danzon et al., *The Effects of Malpractice Litigation on Physicians' Fees and Incomes*, 80 AM. ECON. REV. 122 (1990).

20. *See* Robert A. Berenson, *Market Competition: Is That All There Is?*, HEALTH AFF., Nov.–Dec. 2003, at 274, 275 (criticizing GEORGE HALVORSON & GEORGE ISHAM, EPIDEMIC OF CARE: A CALL FOR SAFER, BETTER, AND MORE ACCOUNTABLE HEALTH CARE (2003), and arguing that the book is seemingly uncommitted to integrated health care apart from provider discounting).

health insurers are understandably reluctant to renegotiate these agreements every time physicians' input costs rise.

Third-party payers now emphasize cost containment because the generosity of their earlier coverage created a health care system that is both far better and far more expensive than it was thirty years ago. Medical advances have enabled many serious diseases to be detected at earlier stages, and treated more effectively, than was possible in 1970. Length and quality of life have improved for patients with chronic health conditions. To achieve these results, physicians frequently practice in interdisciplinary teams, and deploy an assemblage of technologically sophisticated supplies and facilities. This process of industrialization has brought corporate skills, and corporate risks, to the forefront of health care delivery. Patient and public expectations of health care have risen accordingly, as have salvage costs if something goes wrong. All of these factors increase the likelihood of malpractice litigation and worsen its financial implications for physicians.

The current malpractice crisis, therefore, is largely a product of medicine's success, not its failure.[21] In addition, longstanding safety problems in health care have been recognized and quantified, and new ones have arisen. Coordinating care among multiple providers increases opportunities for miscommunication, and corporate involvement raises the risk of systematic harm, whether or not financially motivated. Success has also bred self-awareness: professional acknowledgment (and therefore public recognition) of high error rates in medicine is largely the result of private employers' and insurers' insistence on applying standard industrial techniques of quality measurement and management to health care.[22] Further destabilizing the current environment is that the revolution in health care financing and

21. For a comprehensive analysis of the relationship between health care system change and medical liability, see William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, *in* 2003 HEALTH LAW HANDBOOK 1–32 (Alice Gosfield ed., 2003). *See also* Mark F. Grady, *Why Are People Negligent: Technology, Nondurable Precautions, and the Medical Malpractice Explosion*, 82 NW. U. L. REV. 293, 293 (1988) (stating that "[n]egligence law is fundamentally a creature of technology").

22. Although patient safety experts began applying industrial principles to the health care system in the 1980s, it was not until 1999 that the Institute of Medicine of the National Academies of Sciences brought the issue into public and political debate. *See generally* INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000). Significantly, much of the earlier work built on studies of the malpractice system, which had revealed substantial amounts of previously undetected error. *See generally* HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990); Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991); Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851 (1994).

delivery that began in the 1960s and 1970s remains incomplete, and suffers from internal tensions.[23] Health care is not yet fully industrialized, patient (or "consumer") focused, or universally accessible.[24] Whether these developments have stalled for political, commercial, or social reasons, the health care system that exists today is in disequilibrium, which itself magnifies the challenges the malpractice system faces during downturns of the insurance cycle.

B. Seeing the Obvious

The articles by Tom Baker and Mark Geistfeld in this Symposium make a strong case for insurance reform as a necessary component of malpractice reform.[25] Baker is a leading insurance law scholar; Geistfeld is a leading tort law scholar. Both write eloquently, and identify and analyze several fallacies and paradoxes that beset malpractice insurance markets. This Article attempts to distill from Baker and Geistfeld's contributions a few "take-home lessons" for malpractice policymakers. In keeping with this Article's metaphor of the emperor's clothes, these "revelations" turn out largely to be self-evident, at least in retrospect.

II. First Revelation: Malpractice Crises Are Insurance Crises

Connecting malpractice crises to liability insurance should not be rocket science. Malpractice came from nowhere to become "medicine's most serious crisis" in 1975 because large numbers of commercial insurers stopped or threatened to stop underwriting coverage.[26] The next crisis, in the mid-1980s, involved less upheaval among underwriters but an even more pronounced run-up in premi-

23. During those decades, the medical professional paradigm that governed health care for over a century was supplemented, though not replaced, by social communitarian programs such as Medicare and, simultaneously, by market-oriented reforms such as managed care. *See generally* Clark C. Havighurst, special ed., *Is the Health Care Revolution Finished?*, Law & Contemp. Probs., Autumn 2002, at 1; Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 Health Matrix 155 (2004).

24. *See* William M. Sage, *Unfinished Business: How Litigation Relates to Health Care Regulation*, 28 J. Health Pol. Pol'y & L. 387, 398–414 (2003).

25. *See generally* Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DePaul L. Rev. 393 (2005); Mark Geistfeld, *Malpractice Insurance and the (Il)Legitimate Interests of the Medical Profession in Tort Reform*, 54 DePaul L. Rev. 439 (2005).

26. *See* Frank A. Sloan et al., Insuring Medical Malpractice 4, 5 (1991); Glen O. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, Law & Contemp. Probs. Spring 1986, at 5; Matt Clark, *The Doctor's New Dilemma*, Newsweek, Feb. 10, 1975, at 41.

ums, particularly for certain medical specialties.[27] The current malpractice crisis has been marked by both unavailability and unaffordability of liability insurance.[28] Does anyone see a pattern here?

The conventional wisdom, by contrast, attributes malpractice crises to more frequent litigation and larger jury awards. Like much conventional wisdom, this account is basically true but grossly incomplete. As Baker explains, financial flows in liability insurance consist of premium payments and investment income entering, and claims payments and administrative costs leaving.[29] Of these components, claims are by far the most important. They should be—they are the *raison d'etre* for liability insurance. The main complicating factor (even more than fragile risk pools, discussed below) is that long periods of substantial uncertainty elapse between when premiums are collected and when claims are paid. As a result, trends in lawsuits and awards do not map cleanly onto trends in premiums or insurance availability.

That the malpractice crisis of the 1970s was seen as a litigation explosion is forgivable. Other than the medical profession itself, which had long resented the insult to reputation inherent in malpractice litigation,[30] nobody had paid much attention to the malpractice system before then, and certainly not to its insurance component. Moreover, litigation rates in the 1970s seemed to have risen dramatically from the near-zero baseline of the early 1960s,[31] before Medicare's huge infusion of cash into the health care system and the social and scien-

27. *See generally* John K. Iglehart, *The Professional Liability Crisis: The 1986 Duke Private Sector Conference*, 315 NEW ENG. J. MED. 1106 (1986).

28. Since 1999, liability insurance premiums have trended upwards nationally, and have increased markedly for certain specialties in certain states. *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 7. These premium increases were preceded by a prolonged "soft market" that ended with the insolvency or market withdrawal of many insurers, and an increase in physicians covered by joint underwriting associations and other government-sponsored insurers of last resort. *See* RANDALL R. BOVBJERG & ANNA BARTOW, UNDERSTANDING PENNSYLVANIA'S MALPRACTICE CRISIS: FACTS ABOUT LIABILITY INSURANCE, THE LEGAL SYSTEM, AND HEALTH CARE IN PENNSYLVANIA 7–10 (Report of the Pew Charitable Trust Project on Med. Liability in Pa., June 2003), *available at* http://medliabilitypa.org/research/report0603/UnderstandingReport.pdf; FRANK A. SLOAN, PUBLIC MEDICAL MALPRACTICE INSURANCE 23–26 (Research Report of the Pew Charitable Trust Project on Med. Liability in Pa., Mar. 2004), *available at* http://medliabilitypa.org/research/files/sloan0304.pdf; *see also* Rachel Zimmerman, *Insurers' Malpractice Helped Provoke Malpractice "Crisis"*, WALL ST. J., June 24, 2002, at A1 (describing insurance pricing practices during the 1990s). R

29. *See* Baker, *supra* note 25, at 396. R

30. For a speculative essay on the strong role reputation plays in malpractice policy, see William M. Sage, *Reputation, Malpractice Liability, and Medical Error*, *in* ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM 159 (Virginia A. Sharpe ed., 2004).

31. *See* Danzon, *supra* note 6, at 1355; *see also* Sage, *supra* note 8, at 1182. R

tific changes that both presaged and followed it. However, the argument that each subsequent malpractice crisis reflected surging litigiousness requiring legal restraint is false. Baker's analysis clearly shows that the shocks were insurance phenomena, while litigation merely followed a steady upward trend.[32] Malpractice liability is endemic to health care, not epidemic.

III. Second Revelation: The Insurance Cycle Is Behavioral

Physician perception has always been at the core of the medical malpractice debate.[33] In the years between insurance crises, for example, tort reform advocates often justify their position by citing widespread "defensive medicine," which wastes resources and may harm patients. Opponents counter that, even assuming that malpractice risk is indeed the cause of questionable medical decisions, physicians overestimate the chance of being sued and the likelihood of being held liable.[34] Similarly, physician hysteria during insurance crises is considered proof enough for tort reform by some, while others insist on empirical evidence that actual lawsuits are unjustified or that patients are being denied health care. Should opinion suffice to drive public policy? Or should "hard facts" be required?

Baker's article demonstrates that perceptions drive the insurance side of the malpractice system as much as the clinical (or legal) sides.[35] The insurance cycle is a flesh-and-blood phenomenon—what he calls "fear and greed"—not a mechanical and hence immutable conse-

32. Baker, *supra* note 25, at 415. One can explain the sharp peak and subsequent falloff in malpractice suits and awards that occurred during the two historical waves of tort reform legislation in various ways. For example, plaintiffs' lawyers may have rushed cases to the courthouse in anticipation of adverse changes to the law, or juries may have reacted to publicity regarding malpractice crises by displaying less sympathy for plaintiffs. R

33. The legal system's perceptions also matter. A continuing concern of the medical profession is that judges and juries lack the technical expertise to determine malpractice liability, and are ill-served by partisan expert witnesses. Certificates of merit, expert screening panels, and "medical courts" are among the reform proposals that have been offered to improve the factual underpinnings of malpractice litigation. *See generally* Catherine T. Struve, Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options (Report of the Pew Charitable Trust Project on Med. Liability in Pa., Oct. 2003), *available at* http://medialiabilitypa.org/research/struve1003/StruveReport.pdf. Damages caps themselves can be viewed as restraining jurors' "mere opinions."

34. *See* Paul C. Weiler et al., A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation 124 (1993) (reporting that physicians overestimate the likelihood of being sued by a factor of three).

35. *See* Baker, *supra* note 25, at 426. R

quence of economic forces beyond the control of policymakers.[36] At any point, pricing is determined by the incentives and objective functions of corporate managers, the competitiveness of particular markets, the division of power within organizations, and whether particular employees feel optimistic or pessimistic about their businesses. Only perceptions, for example, can explain prolonged soft markets for liability insurance.

Baker effectively refutes the notion that, following the 1970s exodus of "commercial" companies, malpractice insurance returned to its fraternal roots.[37] Capital market valuation, and therefore continued growth, matters as much to most liability insurers as it does to other public companies, while the regulatory environment (e.g., the managerial moral hazard of guaranty funds) offers special opportunities for gamesmanship.[38] When sales and marketing departments are the corporate darlings, pricing is aggressive and expansion unfettered; when actuaries hold the cards, premiums rise and risk underwriting returns. Actuarial estimates themselves are art as well as science, and a low-frequency, high-severity, long-tail line of insurance such as medical liability coverage is particularly prone to scatter in trend projections.

Recognizing that human fallibility drives all aspects of malpractice system performance, including insurance, can be liberating for policymakers. Among other things, it answers the question about emotion versus fact as a justification for reform. Opinions matter when opinions drive behavior. How should regulators and legislators respond? They should respond in the usual fashion: improve information, change incentives, and when all else fails, constrain behavior directly.

IV. THIRD REVELATION: SPECIALTY-BASED RISK POOLS ARE INEFFICIENT

A major contribution of Geistfeld's article is the argument that conventional class rating of malpractice insurance based on specialty and

36. Opponents of damages caps also attribute malpractice crises to insurers' greed, but tend to do so stridently and with uneven attention to internal inconsistencies in their arguments. Specifically, they berate insurers for mismanaging their assets in soft markets while simultaneously vilifying them for profiteering during hard markets. Baker makes clear that greed drives soft markets, while fear drives hard markets. *See* Baker, *supra* note 25, at 426. Insurers cannot simply refrain from increasing premiums in hard markets; they lowered them too much in soft markets. Regulators and consumers bear some responsibility for this pattern of behavior. A common characteristic of auto insurance and malpractice insurance is that purchasers like low prices and have sufficient political clout to discourage regulators from carefully scrutinizing premium discounting, particularly from new entrants. **R**

37. *See* STARR, *supra* note 17, at 111 (describing early malpractice insurance arrangements). **R**

38. Baker, *supra* note 25, at 427–28. **R**

geographic location is not preordained, and in fact is socially counterproductive.[39] Physicians who perform delicate procedures (e.g., orthopedists and neurosurgeons), diagnose life-threatening but potentially treatable conditions (e.g., radiologists and emergency physicians), or control health at birth (e.g., obstetricians), have the greatest likelihood of being assessed very high damages in malpractice litigation. Accordingly, a rational liability insurer in a competitive market will charge them a premium commensurate with that risk. As Geistfeld notes, however, this approach results in small, volatile risk pools, particularly in geographic areas with few physicians in high-risk fields.[40] If physicians in these specialties find coverage unaffordable and limit or abandon their practices, the entire health care system potentially fails. Further, class rating does not serve other plausibly efficient purposes. Society does not benefit if fewer physicians choose to be obstetricians or neurosurgeons. Risk segregation is not needed to avoid adverse selection because essentially all physicians buy malpractice coverage.[41] Finally, class rating does not reduce moral hazard—physicians are charged premiums based on average, not individual, loss experience.[42]

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39. Geistfeld, *supra* note 25, at 448–49. R

40. Geistfeld concludes that geographic rating is similarly undesirable because it induces physicians to move from higher to lower risk communities, where they may be less satisfied with their practices and less valued by the market. Geistfeld, *supra* note 25, at 447. Supporting R Geistfeld's position is the fact that physicians practicing in poor urban areas, who tend to be in short supply because of low earnings and harsh working conditions, are particularly likely to pay very high premiums using current rating categories. *See* BOVBJERG & BARTOW, *supra* note 28, R at 27–33 (discussing geographic distribution of malpractice risk in Pennsylvania). On the other hand, a longstanding problem in American health policy is physician scarcity in rural areas, which also tend to have lower claims rates and juries who are friendlier to physicians. Geographic rating therefore acts as a crude inducement for physicians to relocate where they are in fact needed, although Geistfeld makes a good point that rural markets remain volatile because of the small numbers problem. For an overview of physician supply challenges, see COUNCIL ON GRADUATE MED. EDUC., PHYSICIAN DISTRIBUTION AND HEALTH CARE CHALLENGES IN RURAL AND INNER-CITY AREAS (Tenth Report to Cong. and the Secretary of the Dep't of Health and Human Servs., Feb. 1998), *available at* www.cogme.gov/rpt10.htm.

41. Adverse selection is selective purchasing of insurance based on differences in risk that are unobservable by insurers. *See generally* Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371 (2002–2003). "Going bare" (practicing without insurance where legally permissible) is a desperation measure of high-risk physicians during crisis periods, and typically involves both financial necessity and political maneuvering. *See, e.g.*, THE FLA. INS. COUNCIL, GOVERNOR'S SELECT TASK FORCE ON HEALTHCARE PROFESSIONAL LIABILITY INSURANCE 108 (Jan. 2003), *available at* www.doh.state.fl.us/myflorida/DOH-Large-Final%20Book.pdf (describing Florida physicians who decline liability insurance).

42. Moral hazard is behavioral change resulting from the possession of insurance that is unobservable by insurers. For an overview of moral hazard in insurance law and regulation, see Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996).

Geistfeld's solution is surprisingly simple: Insurance regulators should reject class rating under established insurance law as unfairly discriminatory.[43] Oddly, physicians who detest malpractice suits rarely question the universal practice of charging premiums in accordance with "legal risk." Why? There are several possible explanations. First, both training and temperament lead physicians to exaggerate the degree of control each individually exerts over his or her patients. They see themselves, and only themselves, as responsible for care.[44] Second, physicians who bridle at suggestions about their own malpractice often have little trouble believing that other doctors are much worse than they, and should pay for the injuries they inflict. Third, physicians by and large remain small businesspeople, notwithstanding the overall industrialization of health care, and view liability insurance as an individual cost of practice much like any other rather than as a collective resource. Fourth, the physicians charged the most for liability coverage in a class-rated system are often well-paid surgical specialists, and generalist physicians resent the idea of "subsidizing" the practices of their wealthier colleagues. Fifth, the inadequacies of specialty-based risk pooling tend only to be noticed during insurance crises, when proposals for insurance reform are seen as buying off the trial lawyers rather than eradicating the perceived problem of excessive litigation.

Geistfeld correctly asserts that the aggregate level of malpractice risk is less problematic than the distribution of risk.[45] Even in crisis times, malpractice premiums and self-funded reserves equal less than two percent of national health care expenditures.[46] An important qualification, however, is that growth and industrialization in the health care sector over the past thirty years has created roughly a trillion dollar annual gap between the revenues flowing through the health care system, often at the direction of physicians, and those di-

43. *See, e.g.*, TEX. INS. Art. 21.21-6 (2004) (prohibiting "unfair discrimination," including differential rates based on geographic location, except where justified by "sound underwriting or actuarial principles").

44. At a contentious 1993 meeting of the Physician Insurers Association of America, one irate medical leader condemned the Clinton administration's enterprise liability proposal—which would have held health plans rather than physicians responsible for malpractice—as "violating [his] constitutional right to be sued." *See* William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROBS. 159, 170 n.46 (1997). This outburst, which is still widely recalled by those present, demonstrated that physicians see allegations of negligence as personal attacks to be personally defended. The resulting dynamic is destructive for both plaintiffs and defendants. Plaintiffs want their health restored; physicians want their reputation vindicated. Litigation accomplishes neither.

45. Geistfeld, *supra* note 25, at 444. R

46. *See generally* THE URBAN INST., MEDICAL MALPRACTICE: PROBLEMS & REFORMS (1995); Danzon, *supra* note 6, at 1369–70 (discussing costs of the malpractice system). R

rectly available to physicians to fund malpractice premiums.[47] Hospital services, medical devices, pharmaceutical, and the like are all potential sources of injury and therefore liability, but physicians are not paid to provide them. Nonetheless, tort law still holds physicians primarily responsible for the consequences of their ordering and referral decisions (it also increasingly imposes direct liability on institutional and corporate defendants).[48] A serious question is whether physicians in small-group practice are adequately capitalized to insure so great an overhang of liability risk and potential premium volatility, particularly now that medical fees have become constrained by regulation and competitive contracting.[49]

V. FOURTH REVELATION: POORLY STRUCTURED INSURANCE "MISDETERS" PHYSICIANS

The relationship between malpractice liability and quality assurance in health care remains unsettled. Tort reformers invoke a supposed epidemic of "junk and frivolous lawsuits," not limited to medical malpractice, as justification for across-the-board measures to discourage claims and reduce recoveries.[50] On this account, the threat of malpractice litigation is unlikely to improve safety, and may in fact harm medical quality through defensive medicine if physicians perform costly tests and procedures without scientific justification or avoid caring for seriously ill patients who might have poor clinical outcomes. The Harvard Medical Practice Study (HMPS), still the most comprehensive research on medical error and malpractice litigation, confirmed a substantial mismatch between actual negligence and the initiation or successful resolution of legal claims, which substantially

47. Physician and other clinician fees typically account for less than twenty percent of national health expenditures. *See* Levit et al., *supra* note 2, at 148. R

48. For a review of institutional liability in health care, see BARRY R. FURROW ET AL., HEALTH LAW 372–417 (2d ed. 2000).

49. The future medical care component of economic damages, little of which represents physician services, has grown rapidly as the health care system has expanded. In this respect, malpractice liability has become far more than a warranty of physician performance (putting aside the question of non-economic damages). A physician who causes injury would not only be pledging his or her personal services to make things right, but would also be promising to arrange or acquire an expensive array of outside products and services. *Cf.* William S. Brewbaker III, *Medical Malpractice and Managed Care Organizations: The Implied Warranty of Quality*, 60 LAW & CONTEMP. PROBS. 117 (1997).

50. This is the tenor of most of President Bush's calls for malpractice reform. *See, e.g.*, President George W. Bush, Remarks at the University of Scranton (Jan. 16, 2003), *at* http://www.whitehouse.gov/news/releases/2003/01/20030116-1.html. *See also* U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM (July 24, 2002), *at* http://aspe.hhs.gov/daltcp/reports/litrefm.pdf.

weakens the deterrent effect of malpractice law.[51] On the other hand, doctors who committed true malpractice were much more likely to be held liable than doctors who did not,[52] which accords with other studies concluding that jury determinations of liability are generally accurate.[53] Furthermore, the most surprising finding of the HMPS was rampant *under*claiming despite unexpectedly high rates of iatrogenic injury and even negligence.[54] Proof of an actual epidemic of unprevented, uncompensated medical error, however, did not rehabilitate malpractice liability as an aid to quality. To the contrary, the medical profession interpreted the Institute of Medicine's (IOM) attribution of medical error to system failure, rather than individual incompetence, as further evidence that malpractice litigation should be scrapped in favor of voluntary reporting and self-regulation.[55]

How does malpractice insurance influence deterrence and hence quality? Some effects are well known. Insurance in general undercuts deterrence by relieving bad actors of financial responsibility, especially where there is first-dollar coverage. Countering this moral hazard for physicians' malpractice insurance is the existence of substantial uninsured costs associated with incurring and defending legal claims, including time spent, emotion invested, and reputation harmed. As previously noted, malpractice insurance as currently priced also fails to spur performance improvement because, for both statistical and political reasons, physicians are not individually experience-rated. The best neurosurgeon in town pays the same for coverage as the worst neurosurgeon, and substantially more than the worst psychiatrist or endocrinologist. On the other hand, insurance risk management recommendations may promote quality, particularly if insurers use aggre-

51. HARVARD MEDICAL PRACTICE STUDY, *supra* note 22, at 7; *see generally* A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245 (1991). Only 1/8 of events judged negligent in the study led to malpractice litigation, and only half of those were eventually compensated. For every valid claim filed, roughly six were filed with respect to non-negligent care. *See* Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1618–20 (2002). R

52. *See generally* Michelle M. Mello & David Hemenway, *Medical Malpractice as an Epidemiological Problem*, 59 SOC. SCI. & MED. 39 (2004).

53. *See* STRUVE, *supra* note 33, at 37–41. R

54. Until the Harvard Medical Practice Study, it was thought that little actual malpractice occurred. *See generally, e.g.*, Louis J. Regan, *Medicine and the Law*, 250 NEW ENG. J. MED. 463 (1954) (arguing that suits are groundless and urging doctors not to testify against colleagues).

55. The Institute of Medicine (IOM) report itself was more optimistic about systematic improvement from legal accountability, urging consideration of capped strict liability systems based on enterprise liability. INST. OF MED., *supra* note 22, at 109–11; *see also* INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 218–19 (2001). R

gate data to identify systematic quality problems, and communicate best practices to their insureds.[56]

Baker and Geistfeld take this analysis a step further. Baker shows that volatility in the insurance cycle is likely to swamp any deterrent signal, however attenuated, that malpractice liability might send individual physicians about quality improvement.[57] When premiums rise, they rise significantly and regardless of risk; when underwriting standards tighten, they do so quickly and catch both good and bad physicians in their net.[58] A prerequisite for safer health care, therefore, is a lower-amplitude, less volatile insurance cycle, with better modulated incentives for insurers to reward clinical quality.

Neither Baker nor Geistfeld, however, offers a confident vision of how malpractice insurance might be reformed so as to improve deterrence of poor medical care. Both struggle with the large number of negligent injuries that currently go uncompensated and therefore undeterred. Baker even speculates that periodic medical malpractice crises might be desirable because they provoke physicians into taking the threat of malpractice liability far more seriously than objective evidence regarding claims rates and outcomes would suggest.[59]

Research into health care quality and efficiency helps explain why this speculation misses the mark. One persistent problem in health policy is maintaining incentives for health insurers to manage (i.e., improve) health care delivery for members when they can profit more directly merely by managing insurance risk.[60] The analogy in the mal-

56. Two recent examples are anesthesia monitoring and vaginal birth after cesarean section (VBAC). Standardization of equipment and procedures for delivering surgical anesthesia greatly reduced anesthesiologists' malpractice exposure and liability insurance premiums. *See generally* John H. Eichhorn et al., *Standards for Patient Monitoring During Anesthesia at Harvard Medical School*, 265 JAMA 1017 (1986); Lori A. Lee & Karen B. Domino, *The Closed Claims Project: Has It Influenced Anesthetic Practice and Outcome?*, 20 ANESTHESIOLOGY CLINICS OF N. AM. 485 (2002). In part because of studies of malpractice claims, uterine rupture is now a recognized, though uncommon, complication of VBAC. *See generally* Suneet P. Chauhan et al., *Maternal and Perinatal Complications with Uterine Rupture*, 189 AM. J. OBSTETRICS & GYNECOLOGY 408 (2003).

57. Baker, *supra* note 25, at 435. R

58. State-administered joint underwriting associations have made matters worse. Established when repeated allegations of malpractice were regarded as victimization by plaintiffs' lawyers rather than an indication of poor quality, and before the extent of medical error was generally appreciated, these high-risk pools allow physicians who have been turned down by private carriers, even in soft markets, to continue to practice. States are beginning to revise these arrangements, as by requiring physicians with poor malpractice histories to be evaluated by the state medical board before Joint Underwriting Association (JUA) coverage is approved. *See generally* SLOAN, *supra* note 28. R

59. *See* Baker, *supra* note 25, at 435. R

60. *See generally, e.g.*, Sandra Shewry et al., *Risk Adjustment: The Missing Piece of Market Competition*, HEALTH AFF., Spring 1996, at 171 (describing managed competition in California).

practice context is the likelihood that physicians whose liability coverage is rated according to specialty and geography will respond by seeking patients who are unlikely to suffer bad outcomes or file claims rather than by practicing better medicine across-the-board.

A second problem—which played a central role in the IOM's attribution of medical error primarily to "systems failure"—is physicians' limited ability to improve safety even if they have financial incentives to do so.[61] Ever since Wennberg and colleagues identified pronounced variations in patterns of medical care from community to community in the United States, health care purchasers and health policy researchers have sought to explain these differences and establish benchmarks for high-quality medical practice.[62] Chassin and colleagues made this very large problem substantially more tractable by dividing health care quality failures into three classes: undertreatment, overtreatment, and mistreatment.[63] While physicians' financial incentives contribute significantly to quality failures, a large portion of them—particularly in the third category—derive primarily from shortcomings in how the health care system disseminates information about clinical "best practices" and translates physician knowledge into actual patient care.

Assessments of deterrent effect in malpractice scholarship would benefit from a similar framework. Certainly, gross underdeterrence or overdeterrence of physician malpractice would be problematic. Even more worrisome, however, is the degree to which the malpractice system creates "misdeterrence": clinical responses to the perceived risk of liability that fail to advance quality of care. Studies of "defensive medicine," for example, reveal that physicians who are preoccupied with liability risk—particularly in an ongoing liability insurance crisis—order or perform large numbers of superfluous diagnostic tests on some patients, while avoiding other patients entirely.[64] Neither pattern of behavior benefits the public. Moreover, as with quality of care generally, the fundamental problem is neither unskilled nor uncaring physicians, but physicians who do not understand how to

61. INST. OF MED., *supra* note 22, at 49–68 (describing why medical errors happen). **R**

62. John E. Wennberg, *Practice Variations and Health Care Reform: Connecting the Dots*, HEALTH AFF. (Oct. 7, 2004), *available at* http://www.pnhp.org/news/2004/october/practice_variations_.php (discussing practice variation and patient safety); David E. Wennberg & John E. Wennberg, *Addressing Variations: Is There Hope for the Future*, HEALTH AFF. (Dec. 10, 2003), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.614v1? (discussing variation and Medicare policy).

63. *See generally* Mark R. Chassin et al., *The Urgent Need to Improve Health Care Quality: Institute of Medicine National Roundtable on Health Care Quality*, 280 JAMA 1000 (1998).

64. *See generally* DAVID M. STUDDERT ET AL., DEFENSIVE MEDICINE AMONG HIGH-RISK SPECIALISTS DURING A MALPRACTICE CRISIS (2005).

respond appropriately to liability risk and who do not practice in an environment capable of translating perceptions of liability risk into superior patient care.

The likely solution is reducing fragmentation and improving coordination of care through a greater institutional role in both liability risk-bearing and clinical practice. In other words, the solution is enterprise liability.[65] As Geistfeld recognizes, moreover, better health care organizations will generally have better structured malpractice coverage.[66] Assigning liability to health care organizations that can hedge the portion of coverage cost attributable to the insurance cycle (or separate it from the portion attributable to risk experience) is potentially safety-enhancing as long as the responsible enterprise (e.g., a hospital or physician group practice) also has tools at its disposal to measure and improve system-level safety. Physicians currently in academic practice, for example, enjoy a much more sensible liability environment despite the higher acuity of their caseload. Academic health centers—which in essence bear enterprise liability because their physicians are salaried employees—are diversified across a range of clinical services. Aggregate coverage for academic health centers is negotiated with commercial liability carriers on an experience-rated basis that includes substantial risk retention (self-insurance) by the institution. Furthermore, liability costs for individual physicians are imputed by the institution and incorporated into overall compensation arrangements that factor in case volume and quality rather than being charged directly to those physicians.

65. Several articles have been written about enterprise liability. *See generally, e.g.*, Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381 (1994); Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7 (2000); William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROBS. 159 (1997); William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1 (1994). Although early advocates of enterprise liability urged legislative reform, recent voluntary trends toward including physicians in hospital-based self-insurance programs or risk retention groups lead in the same direction. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, *supra* note 7, at 39–41; Michelle M. Mello et al., *Hospital Behavior in a Tort Crisis: Lessons from Pennsylvania*, HEALTH AFF., Nov.–Dec. 2003, at 225, 231–32 (describing market trends that are compatible with enterprise liability principles). R

66. Geistfeld also supports further efforts to individually experience-rate physicians, which (unlike class rating by specialty and geography) he regards as a legitimate form of discrimination among insureds. Geistfeld, *supra* note 25, at 453. A more workable first step might be to expand premium discounts using process-based quality indicators, which are being developed by health insurers as part of "pay-for-performance" initiatives. *See generally* David A. Hyman & Charles Silver, *You Get What You Pay For: Result-Based Compensation and Health Care*, 58 WASH. & LEE L. REV. 1427 (2001). R

VI. Fifth Revelation: A Better Liability System Needs Speed

Delay is a very serious problem for medical malpractice policy. Both Baker and Geistfeld describe the "tail" of malpractice coverage as uniquely long.[67] Malpractice claims take, on average, two years to resolve, and large dollar claims typically take more than five years.[68] Patients often do not know immediately that they have been injured by medical care, and seldom suspect negligence. The extent of their injuries, and therefore their incentive to sue, may not be apparent for still longer. Legal discovery is complex and protracted, particularly the process of engaging and debriefing expert witnesses. The expense incurred by plaintiff's counsel in order to prepare a case for trial creates strategic incentives for further delay by defense counsel. Navigating procedural mechanisms such as pretrial screening panels may slow things down even more. Finally, many of the most serious malpractice claims relate to newborn or early childhood injuries, making the tail even longer, because state law generally allows suit to be brought many years after the fact so as not to prejudice the rights of minors.

The long tail of malpractice coverage makes premium pricing uncertain, even for claims-made policies.[69] Baker describes significant "developments risk"—much of it systematic—that makes malpractice insurance underwriting a tough business.[70] Claiming behavior may increase, as some commentators believe happened after the IOM's 1999 report heightened public awareness of medical error.[71] Jurors may become less sympathetic toward physicians when determining liability, and more generous to plaintiffs when awarding damages. Medical advances may create new opportunities for missed diagnoses or botched treatments.[72] The cost of caring for injury may increase. A change in

67. *See* Baker, *supra* note 25, at 422; Geistfeld, *supra* note 25, at 454. R

68. *See* Danzon, *supra* note 6, at 1369. R

69. Until the malpractice crisis of the 1970s, malpractice insurance covered liability arising from events of negligence that occurred during the policy year, regardless of how long it took for a claim to be filed or a payment to be made. *See* Sloan et al., *supra* note 26, at 5–6. In response to that crisis, many carriers began writing coverage that applied only to claims filed during the policy year, which eliminated the uncertainty associated with the passage of time between the occurrence and the filing (often many years for newborn or childhood injuries). Most, though not all, malpractice coverage is currently written on a claims-made rather than occurrence basis. *See id.* at 8. R

70. Tom Baker, *Insuring Liability Risks*, 29 Geneva Papers on Risk & Ins. 128, 130–39 (2004).

71. *See generally* Troyen A. Brennan, *The Institute of Medicine Report on Medical Errors—Could It Do Harm?*, 342 New Eng. J. Med. 1123 (2000).

72. *See* Sage, *supra* note 21, at 7; *see generally* Mark F. Grady, *Better Medicine Causes More Lawsuits, and New Administrative Courts Will Not Solve the Problem*, 86 Nw. U. L. Rev. 1068 (1992) (book review). R

the law, either procedural or substantive, may open new avenues of attack for plaintiffs. Because liability insurers hold premium dollars for many years before paying them out to claimants, the long tail also makes current pricing depend to a greater extent on investment income than is typical of other forms of insurance. According to most accounts, declining investment yields were a precipitating factor in the "crisis of affordability" that threatened malpractice insurance markets in the 1980s.[73]

Delay resolving claims also impairs health care delivery and compromises patient safety. Insurers' financial interest in defending third-party liability claims, combined with physicians' natural resistance to confessing failure, typically keeps patients and their families in the dark when medical errors occur.[74] Monetary payment is rarely offered until a formal claim is filed and discovery has commenced, even though it is often needed much sooner.[75] The adversarial legal process, once initiated, is alienating for both physicians and patients. When a case is finally resolved, so much time has passed that there is little chance that the health care providers involved will learn from what happened. Considering these effects as a whole, it is fair to say that malpractice reform proposals that speed up the process of surfacing and resolving claims should be embraced, and those that hide claims and further delay resolution should be rejected.

VII. SIXTH REVELATION: MALPRACTICE INSURANCE AND HEALTH INSURANCE ARE CONNECTED

Most health care delivered in the United States is covered by health insurance. Therefore, health insurers indirectly finance malpractice coverage when they reimburse physicians, hospitals, and other providers. In addition, a significant amount of defensive medicine—particu-

73. *See* SLOAN ET AL., *supra* note 26, at 7. R

74. The advantages of early disclosure for patient well-being, quality improvement, and dispute resolution are beginning to be appreciated. *See generally* Gerald V. Hickson et al., *Patient Complaints and Malpractice Risk*, 287 JAMA 2951 (2002); Carol B. Liebman & Chris Stern Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients*, 23 HEALTH AFF., Jul.–Aug. 2004, at 22; Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609 (1994).

75. The largest physician insurer in Colorado, COPIC, recently began a pilot program called "3Rs," in which physicians immediately report errors to the insurer and disclose them to the patient. The insurer promptly offers the patient compensation without requiring a release of claims. *See* COPIC, 3Rs PROGRAM NEWSLETTER (March 2004), *available at* http://callcopic.com/publications/3rs/vol_1_issue_1_mar_2004.pdf. Thus far, incidents compensated under the program have not given rise to lawsuits. An additional advantage of this approach from the physician's perspective is that, because payment is made before a claim is filed, the payment need not be reported to the National Practitioner Data Bank.

larly extra diagnostic tests and referrals to specialists—likely happens only because health insurers pay the bills. At a deeper level, then, private health insurance benefits, government financing of Medicare and Medicaid, and state health insurance regulation determine how much health care society considers "enough," while malpractice law and malpractice insurance determine what society considers appropriate to invest when "enough" isn't good enough. In other words, the same health care dollars pay for care received before something goes wrong and care received afterwards.

Yet malpractice insurance and health insurance act like two ships that pass in the night. Health insurance is first-party insurance; customers who suffer losses file claims. Result? Health insurers offer a product that people with illness or injury value.[76] By contrast, malpractice insurance is third-party insurance. Physicians who buy malpractice insurance do not suffer losses; patients do. Result? Malpractice insurers have no reason to care about illness or injury as long as they can avoid or delay having their customers held responsible for it.[77] Furthermore, it is nearly impossible for health insurers to stick their heads in the sand when patterns of supply and demand change in health care, while malpractice insurers adapt to the same changes slowly and erratically at best.[78]

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76. This is an oversimplification, of course. Health insurance is often considered an aberrational form of insurance, dealt with separately if at all in books on insurance law. *See, e.g.*, ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 25–40 (2d ed. 1996). Users of health insurance are not always the same as payers, which creates various tensions. *See, e.g.*, MARK V. PAULY, HEALTH BENEFITS AT WORK: AN ECONOMIC AND POLITICAL ANALYSIS OF EMPLOYMENT-BASED HEATLH INSURANCE 15–35 (1997) (discussing the economic incidence of health insurance costs). In addition, health care involves small, predictable expenditures as well as occasional, catastrophic needs. This leads health care consumers to seek to "use" their health insurance in ways that would be hard to imagine for fire insurance or other property-casualty coverage. *See* SHERRY GLIED, CHRONIC CONDITION: WHY HEALTH REFORM FAILS 83 (1997) (describing disagreements over the benefits package for the Clinton administration's failed Health Security Act). Where insurance is concerned, moreover, keeping customers happy may include tolerating fraud. *See* Richard V. Ericson & Kevin D. Haggerty, *The Policing of Risk*, *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 238, 255–57 (Tom Baker & Jonathan Simon eds., 2002).

77. Automobile insurance is an interesting intermediate case. Traditional auto insurance is third-party insurance, but claims are frequent and typically small, making it easier to assess risk and harder to avoid payment. *See* SLOAN, *supra* note 28, at 13–16. In addition, any particular insured driver is equally likely to enter the system as a plaintiff or a defendant. This reduces support for damages caps and other simple tort reforms, and channels attention instead into no-fault or similar systems, usually with exceptions for severe or egregious cases. For malpractice insurance, of course, a no-fault system that excludes the most expensive cases accomplishes little. R

78. Health insurance has a much shorter "tail." Physicians and other health care providers request payment as vociferously for health insurance as they resist it for malpractice insurance. State legislation and settlements reached in class action litigation have also assured prompt payment for services rendered by health care providers to members of managed care organizations.

Baker and Geistfeld begin to confront these issues, though more must be done to build a rational connection between liability insurance and health insurance. For example, Geistfeld analyzes specialty-based class rating from the perspective of an insured patient, and concludes that beneficiaries with comprehensive health coverage are poorly served by liability insurance practices that result in small, volatile, undiversified physician risk pools.[79] Furthermore, as Geistfeld notes, health insurance regulators regularly—and for the most part successfully—require carriers to combine different levels of risk in order to widen access to coverage.[80] Geistfeld also sensibly frames the malpractice issue as "safety versus dollars," which recognizes the commonalities between malpractice policy and other regulatory policy (including health insurance) rather than indulging the persistent fiction that cost is irrelevant to the standard of care in malpractice litigation.[81]

What are the next steps? First, because medical expenses comprise a growing portion of malpractice damages, policymakers need to reevaluate the exercise of subrogation claims by health insurers against malpractice insurers to avoid further burdening the liability insurance system with costs it is ill-prepared to bear.[82] Second, policymakers should link financial relief for the malpractice crisis to selective improvements in safety and accountability within the health care system, such as voluntary error reporting and analysis, better communication with patients and families, and pay-for-performance mechanisms.[83] The most straightforward way to accomplish this is through health insurance, particularly the Medicare and Medicaid programs,

See generally, e.g., 2002 Mich. Pub. Act 316; 2002 Mich. Pub. Act 317 (codified at M.C.L. 500.2006 (2004)); Michael Chu, *Cigna Settles with Health Care Providers*, 32 J.L. MED. & ETHICS 177 (2004). As a result, health insurers have little opportunity to invest premium dollars between receipt and payout, and health insurance premiums depend almost entirely on estimating risk and managing treatment.

79. Geistfeld, *supra* note 25, at 449–50. **R**

80. *See* Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1256 (2004) (describing the overall success of New York's community rating law).

81. Geistfeld, *supra* note 25, at 442. **R**

82. States that have adopted collateral source offset reforms, which preclude malpractice plaintiffs from recovering damages payable from health or disability insurance, already have limitations in place on subrogation claims. *See, e.g.*, CAL. CIV. CODE § 3333.1(b) (2004). More generally, the affordability of comprehensive malpractice reform that would replace litigation with a "no-trial" administrative approach depends on maintenance of effort from health insurers. *See generally* David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225 (2001).

83. *See* INST. OF MED., *supra* note 6, at 81. The authors propose that the U.S. Department of Health and Human Services should fund state-based demonstration projects for "patient-centered and safety-focused non-judicial compensation." *Id*. at 83. **R**

which for various reasons have never played a role in malpractice policy. Medicare-led malpractice reform would not only serve the interests of Medicare beneficiaries, but would also uproot decades of political entrenchment during which government has ignored both the insurance and the health policy aspects of the malpractice problem.[84]

VIII. CONCLUSION

Tom Baker and Mark Geistfeld's contributions to this Symposium offer detailed and persuasive analyses of medical malpractice insurance. Their principal contribution to the malpractice reform debate, however, is simple: confirming that liability insurers should not be left to their own devices between malpractice crises or appeased during crisis periods. Instead, liability insurance must be consciously designed to help the health care system work toward its core goals of high quality, broad access, and affordable cost.

In 2000, the IOM issued a follow-up report to its earlier indictment of medical error, calling upon the health care system to become safe, effective, patient-centered, timely, efficient, and equitable.[85] The medical malpractice system possesses none of these qualities, in large part because of the incentives created by third-party liability insurance. The inadequacy of the current insurance system should be readily apparent to both market participants and malpractice reformers. History and politics, however, have blinded them to the obvious. In the topsy-turvy world of medical malpractice policy, grassroots constituencies seem to have their heads in the clouds, while scholars peering out of the ivory tower somehow manage to see the lay of the land.

84. *See* Sage, *supra* note 6, at 20. **R**

85. *See* INST. OF MED., *supra* note 55, at 5–6. **R**