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Mark Geistfeld

MALPRACTICE INSURANCE AND THE (IL)LEGITIMATE INTERESTS OF THE MEDICAL PROFESSION IN TORT REFORM

*Mark Geistfeld**

INTRODUCTION

The cost of medical malpractice insurance has prompted the American Medical Association (AMA) to lobby, once again, for a cap on non-economic tort damages in malpractice claims.[1] Because the proposed reform would significantly limit the liability exposure of medical professionals, the AMA's lobbying effort appears to be little more than self-interested behavior by a professional organization. That conclusion, however, requires thorough analysis rather than superficial observation. Moreover, regardless of the merits of a damages cap, analyzing the type of reforms that can be supported by the legitimate interests of physicians should enhance the process of tort reform.

Malpractice insurance does give the medical profession a legitimate interest in tort reform, although the types of reforms that can be justified on this basis differ from those that have been favored by the AMA. At present, malpractice insurance may be priced in an indefensible manner by giving physicians an incentive to move from high-risk specialties and geographic locations. This dislocation is socially costly due to the way in which it reduces patient access to care, a social cost touted by the AMA as the reason for tort reform.[2] Some of the physicians who leave a specialty, though, will be part-time practitioners who typically are unable to provide the same quality of care as full-time practitioners. Whether this benefit offsets the cost of reduced access to care is an open question. But if the cost of access

* Crystal Eastman Professor of Law, New York University School of Law. For their very helpful comments, I am grateful to Jennifer Arlen, Tom Baker, David Hyman, Michelle Mello, and William Sage.

1. *See, e.g.*, Peter Eisler et al., *Special Report: Hype Outraces Facts in Malpractice Debate*, USA TODAY, Mar. 5, 2003, at 1A. The American Medical Association (AMA) has previously lobbied for a damages cap. *See infra* note 64 and accompanying text.

2. According to the AMA, "America's patients are losing access to care because the nation's out-of-control legal system is forcing physicians in some areas of the country to retire early, relocate or give up performing high-risk medical procedures. . . . That is why medical liability reform is the AMA's top legislative priority." AMA, *America's Liability Crisis: A National View*, *at* http://www.ama-assn.org/ama/noindex/category/11871.html (last updated Feb. 4, 2005).

looms as large as the AMA claims, then malpractice insurance is probably priced in a socially detrimental manner and the AMA would have legitimate grounds for complaining about malpractice premiums. The type of tort reforms that would make malpractice insurance more fair, however, do not involve damages caps, contrary to the AMA's lobbying position.

Part II of this Article defines the appropriate baseline for considering the relation between malpractice insurance and the legitimate interests of the medical profession in tort reform and then finds that the general level of malpractice premiums does not create any unfairness for the profession. The available data show that the tort system is not generating total liability costs in excess of the total cost of malpractice injuries—the outcome required in order for the general level of malpractice premiums to be unfairly high.

Although the general level of premiums is fair, Part III shows why many physicians may nevertheless pay unfairly high premiums. For any given policy limit, malpractice premiums typically depend only on the physician's medical specialty and geographic location within the state. Premiums are priced in a manner that gives physicians an incentive to avoid high-risk specialties and certain geographic locations in order to reduce their premiums. The relocation of physicians across specialties and geographic locales quite plausibly works to the net detriment of patient interests. In that event, the pricing of malpractice insurance violates the relevant legal, moral, and social criteria, creating unfairness for those physicians who must pay higher premiums only because of their specialty or geographic location.

Part IV discusses the obstacles to fairer malpractice premiums. The unfairness problem could be completely solved by insurance regulation, making tort reform unnecessary. Alternatively, malpractice premiums would be substantially fairer if based upon the policyholder's malpractice experience. A significant obstacle to the "experience rating" of medical malpractice involves the inherent uncertainty regarding the reliability of malpractice determinations, a problem that can justify tort reform.

Part V then evaluates various tort reforms in terms of their potential to promote fairer malpractice premiums. A damages cap does not facilitate experience rating or otherwise make malpractice premiums more fair. Other reforms would produce a better distribution of malpractice costs, most notably enterprise liability. Nevertheless, the AMA has previously resisted such a reform.[3] Thus, the medical pro-

3. *See infra* note 64 and accompanying text.

fession's interest in fair malpractice premiums justifies an approach to tort reform that differs markedly from that favored by the AMA.

II. THE GENERAL LEVEL OF MALPRACTICE PREMIUMS

Nearly all physicians purchase malpractice insurance.[4] Excessive malpractice liability therefore could result in medical professionals paying an unfairly high general level of malpractice premiums, thereby potentially necessitating tort reform.

Determining whether malpractice premiums are "too high" requires comparison to the relevant baseline by answering the following questions: What is the fair amount of liability that should be incurred by medical professionals? Further, how do current premiums compare to that baseline?

To understand the criteria for evaluating the fair amount of tort liability, it is useful to consider tort rules outside of the medical malpractice context, such as those governing risky interactions between drivers and pedestrians. An automobile driver typically desires transportation to pursue various economic and other liberty interests. As an unwanted byproduct of that activity, the driver exposes pedestrians to a risk of physical injury. A pedestrian also transports herself in furtherance of her liberty interests.

In the event of a crash that physically injures the pedestrian, by definition the pedestrian's interest in physical security has been harmed. The pedestrian also suffers emotional harms (e.g., pain and suffering) and intangible economic harms (e.g., medical expenses). If the driver were obligated to compensate those harms, the monetary damages would be detrimental to his economic interests. Any precautionary obligations that tort law imposes on the driver, such as a duty to drive slowly, would also be detrimental to his liberty interests. Similarly, any precautionary obligations that tort law imposes on the pedestrian (e.g., no jaywalking) would restrict her liberty. Therefore, the way in which tort law regulates the risky driver-pedestrian interaction means that at least one party's interests will be burdened: either the pedestrian's interests in liberty and physical security; the driver's liberty interests, including the economic interest; or the interests of both parties. How these conflicting interests should be mediated is the basic question of fairness that must be addressed by tort law.[5]

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4. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1616 (2002).

5. *See, e.g.*, OLIVER WENDELL HOLMES, THE COMMON LAW 144 (1881) (concluding that tort law "is intended to reconcile the policy of letting accidents lie where they fall, and the reasonable freedom of others with the protection of the individual from injury").

The fair mediation of interests poses a vexing question in the driver-pedestrian context. Should tort rules prioritize the security interest in order to protect the pedestrian's right to physical security? Or should tort rules instead compare costs and benefits in order to maximize social welfare and wealth? These difficult questions are not ordinarily posed by tort rules governing medical malpractice, making it easy to identify the principle of fairness relevant to the formulation of these liability rules.

The fairness question in the driver-pedestrian context involves an interpersonal conflict of liberty and security interests. The driver's exercise of freedom threatens physical injury to the pedestrian. The interpersonal conflict of interests does not arise in most malpractice cases. Like the driver, the physician is the potential injurer creating the risk of physical injury to which the potential victim (patient) is exposed. The similarities between the driver and physician end there. Any tort burdens incurred by the physician—the cost of health care and injury compensation—can be passed on to the patient in the form of higher prices. In malpractice cases, any conflict between economic and safety interests is internal to the patient. Malpractice liability rules that provide for the best protection of patient interests therefore fairly mediate the interests of concern to tort law.[6]

In principle, the liability standard for medical malpractice is formulated in these terms. Each physician has an ethical duty of absolute fidelity to the patient.[7] This ethical duty should translate into medical custom that provides for the best protection of patient interests. Medical custom in the relevant community also defines the standard of care for medical professionals.[8] By providing health care that violates the standard of care, a medical professional presumably has not acted in the best interests of the patient, justifying the imposition of malpractice liability for injuries caused by the substandard care.

The full cost of injuries caused by malpractice accordingly determines the fair amount of tort liability. Consequently, if total malpractice liability exceeds the total cost of malpractice injuries, the general

6. *See generally* Mark Geistfeld, *Negligence, Compensation, and the Coherence of Tort Law*, 91 GEO. L.J. 585 (2003) (describing the importance of interest analysis in tort law and showing how the important tort doctrines can be derived from an interpersonal priority of the security interest over other interests); Mark Geistfeld, *Reconciling Cost-Benefit Analysis with the Principle That Safety Matters More than Money*, 76 N.Y.U. L. REV. 114 (2001) (showing why a principle of fairness that prioritizes the security interest is compatible with cost-benefit analysis in contractual settings like products liability and medical malpractice).

7. *See, e.g.*, TROYEN BRENNAN, JUST DOCTORING: MEDICAL ETHICS IN THE LIBERAL STATE 35 (1991).

8. *See* DAN B. DOBBS, THE LAW OF TORTS § 242, at 631–34 (2000).

level of malpractice premiums would be unfairly high. Otherwise, there is no ground for concluding that the tort system generates excessive liability and an unfairly high general level of malpractice premiums for medical professionals.

The relevant empirical studies clearly show that total malpractice liability is significantly less than the total cost of malpractice injuries. The first study covered the hospital records of approximately 20,000 patients in California in the mid-1970s, finding one tort payment for every ten potential tort claims.[9] The Harvard Medical Practice Study subsequently studied 30,195 records of patient stays in fifty-one New York hospitals in 1984, finding only one tort payment for every three potential tort claims involving the most serious or costly injuries.[10] With respect to all negligently caused injuries, the study found an estimated one tort claim for every 7.6 negligent injuries.[11] Further, "[i]n a third study, conducted in Utah and Colorado in the late 1990s, the injury rates detected were similar to those in New York, and the disconnections observed between injury and litigation were virtually identical, suggesting that the core problems were neither regionally nor temporally idiosyncratic."[12]

In addition to finding fewer malpractice claims than malpractice injuries, empirical studies have shown that the most severely injured malpractice claimants are undercompensated for their injuries. One study found that "a 1 percent increase in loss yields about a 0.1 to 0.2 percent increase in compensation on average."[13] In general, the tort system "tends to undercompensate large losses and overcompensate small losses."[14]

The substantial gap between potential malpractice claims and paid claims, coupled with the tendency of the tort system to undercompensate large losses, implies that medical professionals are not paying for

9. *See* PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 12 (1991) (summarizing Harvard Medical Practice Study (HMPS)).

10. *See id.* at 13 (summarizing HMPS study with respect to "iatrogenic injuries to patients under seventy that produced disabilities (including death) lasting six months or more").

11. PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 70 (1993).

12. David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 285 (2004). The study found one tort claim for every 5.1 negligent adverse events. *See id.*; *see also* David M. Studdert et al., *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 IND. L. REV. 1643, 1682 (2000).

13. Frank A. Sloan & Chee Ruey Hsieh, *Variability in Malpractice Payments: Is the Compensation Fair?*, 24 LAW & SOC'Y REV. 997, 1019 (1990); *see generally* FRANK A. SLOAN ET AL., SUING FOR MEDICAL MALPRACTICE (1993).

14. Marc Galanter, *Real World Torts: An Antidote to Anecdote*, 55 MD. L. REV. 1093, 1116 (1996) (summarizing various empirical studies).

the full cost of malpractice injuries. The general level of malpractice premiums is substantially lower than it would be if the tort system functioned perfectly and if physicians were liable for all malpractice injuries and absolved of liability in all other cases. Tort reform cannot be plausibly justified on the ground that the general level of malpractice premiums is unfairly high for the medical profession.

III. The Determination of Individual Malpractice Premiums

Even if the general level of premiums is fair, the amount paid by an individual policyholder or class of policyholders can be unfair. Premiums depend on the expected value of loss (probability of loss multiplied by severity of loss), which is determined by reference to a class of policyholders.[15] Within each class or risk pool, the policyholders should share similar risk characteristics. Different classifications then reflect differences in risk, enabling insurers to charge different premiums for different risk classifications. The differential in premiums can be unfair for an individual policyholder who is treated unfairly by the underlying risk-classification scheme.

Malpractice insurers typically define risk pools in terms of clinical specialty and known geographic differences in claims risk.[16] Physicians in high-risk specialties, such as obstetrics, pay higher premiums than those practicing low-risk specialties, like dermatology. The premium within each specialty then depends upon the scope and frequency of malpractice liability within the state or smaller regions, like counties, for the specialty in question. The premium does not depend upon the volume of health-care services provided by the medical professional, nor does it depend upon the claims or malpractice experience of the individual policyholder. Malpractice premiums, in other words, are not experience rated. A part-time obstetrician usually pays the same malpractice premiums as a full-time obstetrician in the same area, even if she has never been sued. Aside from the policy limits, the premium only depends on the physician's risk characteristics pertaining to specialty and geographic location.

This risk-classification scheme yields substantial differences in the premiums paid by medical professionals within a state. For example,

15. *See* Kenneth S. Abraham, *Efficiency and Fairness in Insurance Risk Classification*, 71 VA. L. REV. 403, 407–08 (1985).

16. For good descriptions of the risk-classification schemes commonly used by malpractice insurers, see FRANK SLOAN ET AL., INSURING MEDICAL MALPRACTICE 148–50, 165–69 (1991); Lori L. Darling, Note, *The Applicability of Experience Rating to Medical Malpractice Insurance*, 38 CASE W. RES. L. REV. 255, 261–65 (1987).

in 2002 "a large insurer in Florida charged base premium rates in Dade County of $56,153 for internal medicine, $174,268 for general surgery, and $201,376 for OB/GYN, and $34,556, $107,242 and $123,924, respectively, for these same specialties in Palm Beach County."[17] The substantial differences in the malpractice premiums paid by medical professionals create a distinct possibility that the underlying risk-classification scheme produces substantial unfairness.

The fairness of a risk-classification scheme can be evaluated by reference to the following five criteria, which involve the degree to which the classifications: (1) *separate* risk classes on the basis of differences in the expected value of loss; (2) depend upon risk characteristics that are *reliable* and not susceptible to administrative error or fraud; (3) have *incentive value* by basing the premium differential on variables within each policyholder's control; (4) are *homogenous* with respect to the amount of variation in the expected losses posed by policyholders within each classification; and (5) depend upon socially, legally, and morally *admissible* variables or risk characteristics.[18] For each criterion, the question is one of degree. No risk-classification scheme will perfectly satisfy all five criteria.

To illustrate, consider a risk-classification scheme used by many life insurers that requires smokers to pay higher premiums than nonsmokers, all else being equal. This classification is not commonly considered unfair for reasons that can be clarified by applying the aforementioned criteria:

> (1) The scheme adequately *separates* policyholders based on the documented difference in the life expectancies of the two classes. Smokers have a shorter life expectancy than nonsmokers, all other risk characteristics being equal.
> (2) The scheme is only partially *reliable*, however, insofar as smokers are able to hide this characteristic from the insurer and purchase the insurance at the lower, nonsmoker premium.
> (3) The scheme has *incentive value* since a smoker can choose to quit and lower her premium to the nonsmoker level.
> (4) Within each classification, the degree of variation in the expected losses posed by individual policyholders would be roughly equivalent or *homogenous*, except for the possibility that some smokers will conceal this characteristic from the insurer and be mistakenly grouped into the nonsmoker class. As a result, the nonsmoker class has wider variation in the expected losses than the smoker class. No unfairness arises, however, because the lack of

17. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 8 (GAO-03-836, 2003), *available at* http://www.gao.gov/new.items/d03836.pdf.

18. *See* Abraham, *supra* note 15, at 410–20.

homogeneity poses a problem of fairness only if the high-risk class has greater variability than the low-risk class.[19]

(5) The classification depends upon an *admissible* variable. There is nothing legally, morally, or socially problematic about forcing smokers to pay for the costs of smoking. Additionally, the higher premium gives smokers an incentive to quit, an outcome that is not legally, morally, or socially problematic.

We can now consider how these criteria apply to the risk-classification scheme for malpractice insurance that defines risk pools in terms of specialty and geographic location. These risk characteristics clearly *separate* one risk pool from another. The malpractice premium depends upon the risk that the insured will incur liability for malpractice claims during the policy period. The liability risk is comprised of various factors, including the probability that the insured will be sued for malpractice, the probability that the insured will be required to pay damages pursuant to a judgment or settlement, and the amount of potential damages. These risk characteristics depend upon the medical specialty of the insured. For example, an obstetrician who commits malpractice ordinarily pays greater damages than a dermatologist who commits malpractice. The risk characteristics also depend upon geographic location within the jurisdiction. Damages for lost wages will be higher in some locations than others. A risk-classification scheme based entirely on specialty and geographic location, therefore, *separates* medical professionals into different groups facing different amounts of liability risk.

The liability risk faced by an individual insured also depends upon the quality of health care she provides. But due to the absence of experience rating, a medical professional usually cannot control the level of her premiums by providing quality care. Malpractice premiums typically do not depend upon the malpractice experience of the physician.

The absence of experience rating may make the risk-classification scheme unfair for medical professionals classified in the high-risk

19. The true nonsmokers pay the same premium as the higher-risk deceitful smokers, a variation among group members absent from the smoker group. Whereas the true nonsmokers partially subsidize the premiums for the deceitful smokers, the truthful smokers are not subsidizing anyone else. The greater variability or more extensive subsidization that occurs within the group of nonsmokers does not pose an issue of fairness, however, because the risk-classification scheme benefits the nonsmokers by enabling the insurer to charge lower premiums for the group. In exchange for the benefits of lower premiums, the nonsmokers must incur the subsidization costs created by the deceitful smokers. Such an exchange does not make the classification scheme unfair. Instead, the classification might be unfair if it both increased premiums for the individual and increased the amount of subsidization required of the individual—an outcome possible only for those in the high-risk category.

pools. In order for the associated malpractice premiums to be fair, the risk-classification scheme should depend only upon risk characteristics that are *admissible* in terms of the relevant legal, moral, and social criteria. A risk-classification scheme that depends only on the insured's specialty and geographic location might not satisfy these criteria for reasons involving the *incentive value* of the scheme.

Most obviously, malpractice insurance that is not experience rated undermines the incentive of medical professionals to avoid malpractice liability. A physician who has incurred malpractice liability is not ordinarily penalized by an increase in premiums, reducing the incentive to avoid malpractice liability. Malpractice insurance lacks *incentive value* in this respect, although the problem is not a sufficient reason for concluding that the risk-classification scheme is unfair or undesirable. Medical professionals have other incentives for avoiding liability, provided by ethical obligations, professional reputation, and the time and hassle of litigation. Moreover, virtually any form of liability insurance undermines the incentive of the policyholder to avoid liability. That incentive effect (i.e., moral hazard) is a necessary cost for obtaining the social value of liability insurance.

Instead, the unfairness stems from the other incentives created by a risk-classification scheme defined solely in terms of specialty and geographic location. One scholar states, "[u]nder the competitive conditions that now prevail, medical care providers rather than consumers will often bear the lion's share of increased insurance costs."[20] The steep increases in malpractice premiums that have been occurring will likely have the greatest impact on the net profits of specialists like obstetricians who pay the highest premiums, providing a significant economic incentive for these physicians to reduce malpractice premiums in order to increase profits.[21] Physicians can reduce premiums by moving from socially valuable, though risky, specialties such as obstetrics into less risky specialties. Any resultant shortage of obstetricians can be detrimental to patients. Physicians can also reduce premiums by relocating to geographic regions with a reduced scope or frequency of malpractice liability. The concentration of medical professionals in such areas forces patients in other areas to travel long distances for

20. William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, HEALTH AFF., July–Aug. 2004, at 10, 17.

21. Malpractice premiums can account for as much as twenty percent of an obstetrician's gross revenues. *See* Diane Levick, *Insurers Squeeze State Doctors: Malpractice Rates Increasing Dramatically*, HARTFORD COURANT, Nov. 17, 2002, at A1. On average, physicians spend 3.2% of their revenue on malpractice insurance. *See* Eisler et al., *supra* note 1.

treatment—a significant safety concern for health problems requiring immediate treatment. Again, obstetrics provides a good example.

Predictably, medical professionals are making these socially problematic choices as a result of their malpractice premiums: "Nationwide, the American College of Obstetrics and Gynecology reported in 2002 that 73 percent of obstetricians in the 12 states worst hit with premium increases have either retired, relocated or limited their practices to reduce their potential liability risks."[22] The impact of malpractice premiums on the physician choice of specialty is not a new development. During the malpractice insurance crisis of the 1980s, a "considerable number of family physicians who serve low-income and rural communities [were] reported to be giving up or cutting down on obstetrics because of liability concerns."[23] Physicians have made these decisions for myriad reasons, and it is unlikely that the supply of physicians has been dramatically reduced by rising malpractice premiums.[24] Nevertheless, malpractice premiums are influencing the decisions of a number of physicians with respect to specialty and geographic location.[25]

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22. *Medical Malpractice Litigation Raises Health Care Costs, Reduces Access and Lowers Quality of Care*, ISSUE BACKGROUNDER (Employment Policy Found., Washington D.C.), June 19, 2003, at 1, 6 [hereinafter *Medical Malpractice Litigation*], *available at* http://www.epf.org/pubs/newsletters/2003/ib20030619.pdf.

23. Maxwell J. Mehlman, *Bad "Bad Baby" Bills*, 20 AM. J.L. & MED. 129, 130 n.8 (1994) (citing INST. OF MED., 1 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 42–48 (1989)).

24. *See* KATHERINE BAICKER & AMITABH CHANDRA, THE EFFECT OF MALPRACTICE LIABILITY ON THE DELIVERY OF HEALTH CARE 17 (Nat'l Bureau of Econ. Research, Working Paper No. 10709, 2004). The influence of factors other than malpractice premiums is reflected in a U.S. General Accounting Office report which found

> instances in the five states where actions taken by physicians in response to malpractice pressures have reduced access to services affecting emergency surgery and newborn deliveries [that] were not concentrated in any one geographic area and often occurred in rural locations, where maintaining an adequate number of physicians may have been a long-standing problem.

U.S. GEN. ACCOUNTING OFFICE, *supra* note 17, at 5.

25. *See, e.g.*, Editorial, *The Doctors Are Leaving*, CHI. TRIB., Apr. 18, 2004, at C8 ("Illinois doctors are fleeing across the border to states such as Wisconsin, Indiana and Missouri, where insurance costs are much lower."); *Medical Malpractice Litigation*, *supra* note 22, at 6 (citing reports from Oregon and Washington concerning the large number of surgeons, obstetricians, and other critical specialists "moving to neighboring California to find a lower risk climate for their practices"). *See also* BAICKER & CHANDRA, *supra* note 24, at 17 (empirical study finding that "[o]verall, a 10% increase in malpractice premiums results in a 1% decrease in all rural MDs per capita, and almost a 2% decrease in older rural MDs"). Further evidence of the incentive effects created by malpractice premiums are provided by studies finding that the existence of a damages cap, which presumably reduces malpractice premiums, increases the number of physicians in a state. *See generally* FRED J. HELLINGER & WILLIAM E. ENCINOSA, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE IMPACT OF STATE LAWS LIMITING MALPRACTICE AWARDS ON THE GEOGRAPHIC DISTRIBUTION OF PHYSICIANS (July 3, 2003), http://www.ahrq.gov/research/

These social costs are not a necessary incident of malpractice insurance. Malpractice premiums could be uniform for all medical professionals within a jurisdiction, regardless of specialty or geographic location. As compared to the current menu of malpractice premiums, a system of uniform premiums would increase the premiums for some physicians while decreasing premiums for others. Each physician, though, could still purchase malpractice insurance at the uniform premium. Physicians would still have access to malpractice insurance if premiums were not based on specialty and geographic location, so the social costs created by these premiums must find justification elsewhere.

Any justification for these social costs must reside in the *admissibility* criterion, which evaluates the risk characteristics of specialty and geographic location in terms of the relevant legal, moral, or social criteria. As previously discussed, these criteria reduce to a principle of fairness that requires the best protection of patient interests.[26] This group incurs the social costs that arise when physicians change specialties or relocate in order to reduce their malpractice premiums. Due to this social cost, the risk-classification scheme can be justified under the *admissibility* criterion only if it creates a sufficient social benefit for medical patients.

To determine the social benefits provided by the risk-classification scheme, first consider medical patients with health insurance. These individuals pay a premium for health insurance that is based upon the expected cost of medically necessary health care—an amalgam of costs throughout various health-care specialties. The medically necessary health costs incurred by insured medical patients already involve a substantial collectivization of cost across specialties and locations, eliminating any benefit these patients might otherwise derive from a risk-classification scheme that makes malpractice premiums dependent on an individual physician's specialty and geographic location. The scheme merely individualizes malpractice prices for various specialties and locations, an effect that is then largely lost by the collectivization of costs inherent in the calculation of premiums for health insurance. All else being equal, malpractice premiums based upon

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tortcaps/tortcaps.pdf; Jonathan Klick & Thomas Stratmann, Does Medical Malpractice Reform Help States Retain Physicians and Does It Matter? (Oct. 2, 2003) (unpublished paper), *at* http://mailer.fsu.edu/~jklick/Reform9.pdf. *See generally* Stephen Zuckerman et al., *Effects of Tort Reforms and Other Factors on Medical Malpractice Premiums*, 27 INQUIRY 167 (1990) (empirical study finding that physicians in states with a damages cap have lower malpractice premiums than physicians in states without a damages cap).

26. *See supra* note 6 and accompanying text (explaining why the relevant principle of fairness is framed in terms of patient interests).

specialty and geographic location confer no apparent benefit on insured medical patients.

This conclusion also applies to uninsured medical patients. Most of these individuals would prefer to purchase health insurance in order to reduce the risk of incurring health care expenses, but they cannot afford to do so because of the high premiums.[27] These individuals, therefore, would benefit from any arrangement that enables them to reduce risk without increasing their expected cost of health care. If malpractice premiums were not based on specialty or geographic location, the resultant equalization of malpractice premiums across specialties and locations would effectively turn the malpractice risk for each specialty into a collective malpractice risk borne by the group of uninsured patients. The equalization of malpractice premiums, in other words, would serve as a form of malpractice insurance for uninsured patients, which indicates that it would benefit most of them.[28]

Both insured and uninsured patients accordingly prefer that malpractice costs be collectivized across specialties and geographic locations, unless there is some offsetting benefit created by malpractice premiums based on specialty and geographic location. The benefit must be significant given that some patients are harmed by the way in which these premiums induce physicians to leave high-risk specialties and geographic areas.

The only identifiable benefit involves the reduction of physicians who practice a specialty on a part-time basis. As some scholars conclude, "[t]wenty years of research have established that, for some procedures and conditions, higher volume among hospitals and physicians

27. A risk-averse individual will be willing to pay the actuarially fair premium in order to insure fully against a monetary loss. *See* STEVEN SHAVELL, ECONOMIC ANALYSIS OF ACCIDENT LAW 192–94 (1987). An individual is risk-averse if "the party's utility increases with the level of his wealth, [and] it does so at a decreasing rate (the interpretation being that the value to him of having more wealth falls as he fulfills his more important needs)." *Id.* at 186. This characteristic is presumably shared by most individuals, which implies that most everyone would benefit from the provision of actuarially fair insurance.

28. In determining the preferred distribution of malpractice costs, the preference of an uninsured individual can be defensibly framed from an *ex ante* perspective that evaluates the matter prior to the time at which the individual needs any particular health care service. Not knowing of any particular health vulnerabilities requiring medical attention, the individual would reasonably evaluate expected health care costs in terms of the average characteristics within the relevant population. If these same characteristics then determine the actual distribution of malpractice costs, the expected welfare of the individual would not decrease unless she was risk-loving. The individual would be guaranteed to experience the average outcome rather than be forced to experience the variable outcome (with the same expected value) associated with the payment of malpractice costs by specialty. Only risk-loving individuals would prefer the variable outcome.

is associated with better outcomes."[29] This finding suggests that the quality of care may increase as the proportion of full-time practitioners within a specialty increases, a dynamic that is currently being facilitated by malpractice premiums. When premiums depend only on specialty, the volume of care does not affect the premium amount. A full-time specialist pays the same premium as a part-time specialist. On a per patient basis, however, the malpractice insurance is significantly less costly for the full-time specialist, giving her a competitive advantage over part-time specialists. Malpractice premiums therefore are predictably increasing the proportion of full-time practitioners within a specialty, which in turn is likely to increase the quality of care to the benefit of patients.

Malpractice premiums based upon specialty and geographic location accordingly create incentives that are both beneficial and detrimental to patient interests. If the beneficial increase in the quality of care does not offset the cost of reduced access to care, then malpractice premiums would be priced in a manner that ultimately is detrimental to patient interests. The premiums would be based upon risk characteristics (pertaining to specialty and geographic location) that violate the relevant legal, normative, and social criteria and are not *admissible*, implying that the risk-classification scheme unfairly treats those medical professionals who must pay higher premiums only because of their specialty or geographic location. For this reason, physicians and the AMA can justifiably complain about malpractice insurance by relying upon the way in which malpractice insurance reduces patient access to care.[30]

The problem is then compounded by the way in which the risk-classification scheme affects the spreading of risk. Dividing medical professionals into risk classes based on specialty and geographic location substantially reduces the number of individuals within each risk pool:

> The actuarial consequence of the small size of malpractice insurance risk pools is that insurers cannot spread among a large number of physicians the risk that a few will be the subject of a significant number of claims, some of which may produce extremely large verdicts. Instead, a comparatively small number of physicians compris-

29. Ethan A. Halm et al., *Is Volume Related to Outcome in Health Care? A Systematic Review and Methodological Critique of the Literature*, 137 ANNALS INTERNAL MED. 511, 517 (2002).

30. *See supra* notes 1–3 and accompanying text. It seems plausible that any beneficial impacts on the quality of care are less than the cost of reduced access. The relationship between higher volume and better outcomes is complicated, depending on individual procedures and conditions. Not all procedures are subject to this effect. *See* Halm et al., *supra* note 29, at 514. Moreover, the "relative contribution of hospital versus physician volume is largely unknown." *Id.* By incentivizing only physician volume, malpractice premiums are not necessarily promoting better outcomes.

> ing each pool is charged with the aggregate cost of this risk . . . . [Consequently], inevitable changes in the frequency or severity of claims against a particular specialty in a particular state—changes that might result in modest rate changes for the members of a large risk pool—have an exaggerated effect on a small pool. The result is that physicians practicing high-risk specialties pay malpractice premiums that are many times the premiums paid by physicians practicing low-risk specialties [within] the same jurisdiction.[31]

It should now be evident why malpractice insurance has drawn the ire of the medical profession. The issue matters most to those physicians facing the highest premiums, and these individuals are the ones who may be paying unfair premiums. Someone who makes socially valuable choices—to practice obstetrics in a poor neighborhood, for example—is penalized (via higher premiums) for doing so. When that person continues to make socially valuable choices regarding the provision of quality health care, the penalty (the higher premium) stays in place due to the absence of experience rating. There is no socially valuable choice the individual physician can make to reduce premiums. In these circumstances, the malpractice premium is an understandable source of frustration for the physician, frustration that predictably mounts as the premium rises.

IV. Obstacles to Fairer Malpractice Premiums

The unfair risk-classification scheme currently employed by malpractice insurers is a consequence of market competition. The classification depends on risk characteristics that adequately *separate* individuals into different risk classes in a *reliable* manner. Obstetricians as a group incur higher average liability costs than dermatologists. The lower cost of insuring dermatologists enables insurers to charge lower premiums to that group. If an insurer placed obstetricians and dermatologists in the same risk pool, the premium for each dermatologist would increase (to reflect the greater liability exposure of the obstetricians within the pool). An insurer that priced premiums in this manner would lose the business of dermatologists, as another insurer could offer that group lower premiums by basing premiums on specialties. Price competition accordingly forces insurers to base premiums on specialties, even if such a risk characteristic is not *admissible*.

This problem could be solved without tort reform. The unfairness could be eliminated by the adoption of insurance regulations banning

31. Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 Harv. L. Rev. 381, 401–02 (1994).

the use of specialty and geographic location in the setting of individual malpractice premiums. These regulations could be promulgated by insurance regulators in virtually every state. Insurance regulators are almost always empowered by state law to ensure that premiums are not "excessive, inadequate, or *unfairly discriminatory*."[32] Thus, regulatory inaction poses one obstacle to fairer malpractice premiums.

A different obstacle can also be identified. A system of fair malpractice premiums does not necessarily require uniform premiums for all medical professionals, regardless of specialty or geographic location. Uniform premiums may be more equitable than the individualized premiums in the current system, but individualized premiums would become defensible if the policyholder's malpractice experience were incorporated into the current risk-classification scheme. A physician's malpractice experience is an *admissible* risk characteristic, because each physician should be responsible for the quality of health care she provides. Such responsibility is the underlying rationale for malpractice liability, and basing premiums on this risk characteristic would create a beneficial incentive effect. Experience rating gives medical professionals another reason to provide quality care—to avoid malpractice and thereby reduce premiums. These choices translate into a claims experience that may then make relevant the individual's specialty and geographic location, each of which also affects the individual's malpractice experience.[33] The incorporation of experience rating into the current risk-classification scheme, therefore, is another way to achieve fairer malpractice premiums. This approach, however, faces an obstacle that may be insurmountable.

Medical malpractice insurance is not experience rated, in part, because of the weak statistical correlation between the filing of a malpractice lawsuit and the occurrence of malpractice. The probability that patients who file claims were the victims of malpractice has been estimated by four different empirical studies. The estimated probabilities were seventeen percent, twenty-nine percent, forty-six percent, and fifty-four percent.[34] Similarly, another study found that the likelihood of a patient filing a malpractice claim against a physi-

32. KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION: CASES AND MATERIALS 97 (3d ed. 2000) (emphasis added).

33. The conclusion is qualified because specialty and geographic location continue to affect premiums and therefore could create socially problematic incentives. The force of such incentives depends on how claims experience otherwise affects premium levels, making it difficult to determine whether experience rating justifies inclusion of specialty and geographic location as additional risk characteristics.

34. *See* Michelle J. White, *The Value of Liability in Medical Malpractice*, HEALTH AFF., Fall 1994, at 75, 77.

cian depends at least as much on her personal relationship with the physician as on the quality of treatment.[35]

The statistical correlation between the occurrence of malpractice liability and the occurrence of malpractice has similar properties. Patients who have been injured by malpractice are more likely to receive tort damages than other malpractice claimants.[36] Many claimants, however, receive tort compensation even though independent review shows that they were not injured by malpractice.[37] Similarly, "[s]tudies of obstetric care have failed to identify any differences in the quality of care rendered by obstetricians with varying histories of malpractice claims."[38]

A weak correlation between the occurrence of malpractice liability and the occurrence of malpractice does not make experience rating infeasible. The weak correlation only makes it harder to solve an otherwise difficult predictive problem. The difficulty stems from the infrequency of malpractice claims for individual policyholders.

> [T]he degree of autocorrelation in most physicians' claims experience over time is low. Arguments for experience rating find support in statistics showing that most physicians have very little experience of being sued, while a small number of "bad apples" experience a large number of claims. The distribution of actual losses (payouts to plaintiffs) is even more sharply skewed. However, most physicians' claim experience fluctuates dramatically from year to year, so the number of claims (or total losses) from one year, or even a five-year period, is not a reliable predictor of their claims in years to come.[39]

The problem is then exacerbated by the length of time ordinarily required for resolving malpractice claims.[40] As the New York Department of Insurance concluded in its unfavorable assessment of experience rating: "Due to the length of time claims are open, it is

35. *See* Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1362–63 (1992).

36. *See* White, *supra* note 34, at 77–81 (summarizing studies that have examined the negligence system in medical malpractice).

37. The data from the HMPS, for example, found that "about thirty to thirty-five of every 1,000 malpractice victims use the legal system to obtain compensation for their losses. . . . At the same time, twenty-five to thirty people who were probably not victims of malpractice nevertheless receive payment from the system." Stephen D. Sugarman, *Doctor No*, 58 U. CHI. L. REV. 1499, 1501 (1991). *See generally* Frederick W. Cheney et al., *Standard of Care and Anesthesia Liability*, 261 JAMA 1599 (1989) (empirical study finding that claimants received compensation in forty-seven percent of cases not involving negligence).

38. Mello & Brennan, *supra* note 4, at 1607.

39. *Id.* at 1616–17 (footnotes omitted).

40. One study, for example, found that "[f]ifty percent of claims were closed more than 5.5 years after the date of the medical accident, 25 percent more than 7.5 years later, and 10 percent more than 10 years later." WEILER ET AL., *supra* note 11, at 68.

difficult to have enough meaningful data for merit rating of medical malpractice."[41]

Despite these problems, experience rating is feasible. Some studies have shown that malpractice insurance can be experience rated.[42] Limited forms of experience rating have also been used by private insurers:

> The programs were limited in the following dimensions: First, very few physician insureds were typically affected. In several cases, less than 1 percent of physician enrollees paid more than standard rates because of adverse prior claims experience. Second, the surcharges were generally not substantial. They ranged from around 10 percent to 200 percent of the base premium. Although 200 percent may seem a large number, the variation in paid losses per exposure year within specialties tends to be far greater than this. Surcharges tended to be imposed on policy-holders for a two- or three-year period. Third, rather than affecting premiums through a strict mechanistic formula, the physician's track record was often modified by peer review with an appeals mechanism in the event of an adverse decision.[43]

The statistical difficulty of experience rating, therefore, does not appear to be insurmountable. The source of the problem lies elsewhere. The efforts by private insurers to adopt limited forms of experience rating for medical malpractice have been resisted by physicians.[44] A similar outcome has occurred in New York and Massachusetts, each of which has made a limited form of experience rating mandatory.[45] After reviewing how this form of rate setting worked, the New York Department of Insurance concluded that "[p]hysicians are unalterably opposed to merit rating."[46] Massachusetts never adopted its experience-rating plan due to political opposition.[47]

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41. SLOAN ET AL., *supra* note 16, at 172 (quoting N.Y. STATE INS. DEP'T, A BALANCED PRESCRIPTION FOR CHANGE: REPORT ON MEDICAL MALPRACTICE 46 (1988)).

42. *See generally* Gary M. Fournier & Melayne Morgan McInnes, *The Case for Experience Rating in Medical Malpractice Insurance: An Empirical Evaluation*, 68 J. RISK & INS. 255 (2001); Frank A. Sloan & Mahmud Hassan, *Equity and Accuracy in Medical Malpractice Insurance Pricing*, 9 J. HEALTH ECON. 289 (1990); *see also* Gail A. Jensen et al., *Physicians and the Risk of Medical Malpractice: The Role of Prior Litigation in Predicting the Future*, 39 Q. REV. ECON. & FIN. 267 (1999) (finding through theory and empirical study that malpractice liability is significantly more likely when the defendant has a prior poor litigation record).

43. SLOAN ET AL., *supra* note 16, at 177 (citation omitted).

44. *Id.* at 178.

45. Darling, *supra* note 16, at 265–71 (describing the statutory mandates in New York and Massachusetts).

46. SLOAN ET AL., *supra* note 16, at 172 (quoting N.Y. STATE INS. DEP'T, A BALANCED PRESCRIPTION FOR CHANGE: REPORT ON MEDICAL MALPRACTICE 46 (1988)).

47. *Id.* at 173.

The medical community is concerned about experience rating for reasons attributable to the inherent uncertainty regarding malpractice determinations. The paucity of malpractice claims incurred by the typical policyholder forces insurers to rely upon all relevant data to establish the individualized premium, including open and closed claims. The more recent claims typically are open or unresolved—an outcome attributable to uncertainty[48]—and require evaluation of the merits by peer review. And even for closed claims resulting in malpractice liability, the high rate of legal error requires peer review to ensure that the liability determinations properly relate to the quality of care.[49] In effect, peer review substitutes for the lengthy, unreliable legal determination of malpractice. But even though the relevant malpractice experience is determined by medical professionals, the medical community has resisted efforts to base premiums on the malpractice experience of the policyholder. Apparently, the medical community believes that peer review does not adequately reduce the uncertainty regarding malpractice determinations.

This concern about peer review finds support in various empirical studies seeking to estimate the rate of medical errors among hospitalized patients: "These statistics are generally based on peer review using structured implicit review instruments. Physicians are trained to review hospital medical records and give their opinion on the occurrence of adverse events and the quality of hospital care and its impact on patient outcomes."[50] These studies have yielded similar statistics regarding the rate of medical error experienced by hospitalized patients.[51] The similar statistics produced by the studies does not mean,

48. Uncertainty most likely increases the length of time required to resolve malpractice claims. The settlement range for any claim is determined by the minimum price the plaintiff would accept to settle the claim and the maximum price the defendant would pay. Uncertainty can cause the two prices to diverge so that there is no settlement range—the plaintiff's minimum price exceeds the defendant's maximum price—forcing the case to trial. And even if the parties similarly evaluate the merits of the malpractice claim, uncertainty will increase the settlement range. A larger settlement range has indeterminate effects on the likelihood of settlement. "Perhaps the best guess is that the larger the settlement range the likelier a settlement is, but the longer the negotiation of the settlement is likely to take. With more at stake, the optimal amount of negotiation is greater." RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW § 21.4, at 567 (6th ed. 2003).

49. *Cf.* Randall P. Ellis et al., *Should Medical Professional Liability Insurance Be Experience Rated?*, 57 J. RISK & INS. 66 (1990) (showing that experience rating based only on the number of claims filed or paid would create a significant risk of inappropriate surcharges due to the large number of invalid claims).

50. Rodney A. Hayward & Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors: Preventability Is in the Eye of the Reviewer*, 286 JAMA 415, 415 (2001).

51. *Id.*

though, that peer review reliably identifies particular instances of malpractice.

> In all general medical and surgical chart review studies to date, reviewers have had a difficult time agreeing on whether an error caused by an adverse event or even on whether something was an error at all. Reviewer agreement is usually even worse when specific processes of care are evaluated (as opposed to overall care) and attempts at improving the true reliability of implicit review by discussion between reviewers have been unsuccessful.[52]

In one study, for example, "[i]f one reviewer rated a death as definitely or probably preventable, the probability that the next reviewer would rate the case as definitely not preventable (18%) was actually slightly higher than the probability that the second reviewer would agree with the first (16%)."[53]

These studies portray a troubling situation in which almost all active-care injuries could plausibly lead to a tort suit with evidence sufficient to go to the jury. As long as the plaintiff continues to search for an expert opinion supporting the malpractice claim, the diversity of medical opinions on malpractice makes it likely that there will be at least one medical reviewer who believes that the injury was caused by medical error.[54] While the expert opinion may be an outlier, it is also presumably based on medical expertise and therefore is ordinarily sufficient to satisfy the plaintiff's burden of proof. And when experts frequently disagree about the merits of a malpractice claim, medical professionals are understandably skeptical of most legal findings of malpractice.

The reliability of malpractice determinations thus poses the real obstacle to experience rating and the attainment of fairer, individualized malpractice premiums. A policyholder's premiums should be based on her claims experience only if that experience is a good indicator of the individual's ability to provide high-quality care. The imposition of malpractice liability on the policyholder is, however, not a reliable indicator nor is an independent finding by peer review. The uncertainty undermines the ability of insurance companies to establish individualized premiums on a fair basis, which exemplifies the more general problem that uncertainty poses for well-functioning insurance mar-

52. *Id.* at 419–20 (footnotes omitted); *see also* Eric J. Thomas et al., *The Reliability of Medical Record Review for Estimating Adverse Event Rates*, 136 ANNALS INTERNAL MED. 812, 814 (2002) (study finding "moderate to poor inter-rater reliability among physicians trying to identify adverse events and negligent adverse events by medical record review").

53. *See* Hayward & Hofer, *supra* note 50, at 417.

54. *See id.* at 418 (concluding that "given enough reviewers, almost all active-care deaths would have some reviewers who believe that an error caused the death").

kets.[55] As long as malpractice determinations are subject to uncertainty and differing interpretations, malpractice insurers will have difficulty experience rating premiums.[56]

This obstacle to fairer malpractice premiums implicates tort reform, as the problem stems from the malpractice determination that triggers tort liability. What, then, are the types of reforms that would make malpractice premiums fairer? Further, how do these reforms compare to those advocated by the AMA?

V. FAIRER MALPRACTICE PREMIUMS VIA TORT REFORM

The medical profession's interest in fair malpractice premiums can help justify tort reforms that facilitate experience rating by reducing the uncertainty associated with malpractice determinations. The unreliability of peer-review findings, however, might mean that uncertainty is inherent in any legal regime that ties liability to malpractice. For example, efforts to improve the reliability of medical record review have been unsuccessful.[57] Similarly, studies have found that medical review panels do little to improve the accuracy of legal determinations of malpractice liability.[58]

Assuming there is no tort reform capable of significantly improving upon the reliability of malpractice determinations, the damages cap proposed by the AMA has superficial appeal. A damages cap effectively reduces the potential scope of tort liability and therefore the amount of uncertainty created by the tort system. With respect to compensatory damages, the component attributable to pain and suf-

55. *See* Mark Geistfeld, *The Political Economy of Neocontractual Proposals for Products Liability Reform*, 72 TEX. L. REV. 803, 839–42 (1994). This article provides various reasons why "[i]ncreased legal uncertainty . . . translates into higher costs for insurance companies even if the mean value of the loss stays constant." *Id.* at 841. For more recent studies showing how uncertainty undermines insurance markets, see J. David Cummins & Christopher M. Lewis, *Catastrophic Events, Parameter Uncertainty and the Breakdown of Implicit Long-Term Contracting: The Case of Terrorism Insurance*, 26 J. RISK & UNCERTAINTY 153 (2003); Kenneth A. Froot & Paul G.J. O'Connell, *The Pricing of U.S. Catastrophe Reinsurance*, *in* THE FINANCING OF CATASTROPHE RISK 195 (Kenneth A. Froot ed., 1999) (providing and testing model in which the equilibrium price of insurance increases with increased volatility of the policyholder's loss distribution due to the insurer's increased need to raise costly, external capital).

56. *See* Patricia M. Danzon, *Liability for Medical Malpractice*, *in* 1B HANDBOOK OF HEALTH ECONOMICS 1339, 1361 (Anthony J. Cuyler & Joseph P. Newhouse eds., 2000) (concluding that "if judicial error is significant, risk aversion would explain the lack of demand for experience-rated policies").

57. *See* Timothy P. Hofer et al., *Discussion Between Reviewers Does Not Improve Reliability of Peer Review of Hospital Quality*, 38 MED. CARE 152 (2000).

58. *See* Patricia M. Danzon & Lee A. Lillard, *Settlement Out of Court: The Disposition of Medical Malpractice Claims*, 12 J. LEGAL STUD. 345, 373–74 (1983); Stephen Shmanske & Tina Stevens, *The Performance of Medical Malpractice Review Panels*, 11 J. HEALTH POL. POL'Y & LAW 525 (1986).

fering creates the most uncertainty.[59] Hence, a cap on nonmonetary damages can be justified as a means of reducing uncertainty, although other reforms like improved jury instructions or scheduling are a more effective means of achieving this result.[60]

Whatever the merits of a damages cap may otherwise be, the reform cannot be supported by the legitimate interests of the medical profession. A damages cap would reduce uncertainty without facilitating experience-rated malpractice premiums. The reform would not improve the quality of data required for experience rating; malpractice determinations would continue to be as unreliable as they were prior to reform. Instead, a damages cap would reduce the extent of liability and the general level of malpractice premiums. The general level of malpractice premiums, though, is not unfairly high for the medical profession.[61] A damages cap would not make malpractice premiums fairer for physicians.

Other tort reforms, by contrast, would make malpractice premiums fairer. Consider enterprise liability, which would replace the current malpractice system with a legal regime holding medical enterprises (hospitals or managed care organizations) strictly liable for the avoidable medical injuries incurred by their patients.[62] The medical enterprise, rather than the medical professional performing the service in question, would be responsible to the patient for all avoidable medical injuries, thereby eliminating the legal uncertainty and other problems created by individualized malpractice determinations. Freed from individual liability, physicians and other medical professionals would no longer need to purchase malpractice insurance. Instead, the medical enterprise would pay the collective cost of malpractice insurance for all of its medical professionals, yielding a sufficiently extensive claims experience to make feasible the experience rating of malpractice pre-

59. *See* Mark Geistfeld, *Placing a Price on Pain and Suffering: A Method for Helping Juries Determine Tort Damages for Nonmonetary Injuries*, 83 CAL. L. REV. 775, 783–89 (1995) (summarizing studies finding a high variability in pain and suffering awards and describing problems created by this uncertainty).

60. *See id.* at 803–18, 828–40 (describing how jury instructions can be improved and how scheduling could be defensibly implemented).

61. *See* discussion *supra* Part II.

62. *See generally* Abraham & Weiler, *supra* note 31. A more limited version of enterprise liability would make the enterprise jointly liable with the physician. *See* Mello & Brennan, *supra* note 4, at 1624–29. The limited version of enterprise liability would effectively require medical professionals to purchase individual malpractice insurance. Unless the shift to avoidability-based liability determinations makes experience rating more feasible, this reform would not produce fairer malpractice premiums for physicians.

miums.[63] The unfair malpractice premiums for individual physicians would be replaced by the more fairly determined malpractice premiums for medical enterprises.

As clearly revealed by a comparison of a damages cap with enterprise liability, different tort reforms have different impacts on the fairness of malpractice premiums. Nevertheless, this differential impact has not influenced the reforms preferred by the medical profession. For purposes of promoting more fair malpractice premiums, tort reform must reduce the uncertainty regarding malpractice determinations. The uncertainty could be eliminated by two different reforms: eliminating the requirement that liability depends upon malpractice (enterprise liability), or eliminating all malpractice liability (a cap on all damages). The medical profession is not indifferent between these two reforms. Unlike enterprise liability, a damages cap benefits all medical professionals, explaining why the AMA has lobbied against enterprise liability in favor of a damages cap within the current malpractice regime.[64] Such lobbying cannot be justified in terms of the medical profession's legitimate interests in tort reform, given that enterprise liability would eliminate the current unfairness faced by medical professionals, whereas a damages cap would not. The reforms that have been favored so far by the AMA do not reliably correspond to those reforms that would make malpractice premiums fairer.

VI. CONCLUSION

Malpractice insurance is an understandable source of frustration for medical professionals. Those who pay the highest premiums feel the most frustration, and these physicians are the ones who are treated unfairly. And since malpractice premiums are required only because of malpractice liability, the medical profession's frustration with malpractice premiums is understandably directed at the tort system.

The unfairness for medical professionals, however, stems from the manner in which malpractice premiums are priced. Premiums priced solely on the basis of specialty and geographic location may be detrimental to medical patients, on balance, due to the movement of some physicians out of high-risk specialties and geographic areas. In that event, the existing premium structure produces unfair malpractice premiums for those medical professionals, like obstetricians, who pay

63. *See* Abraham & Weiler, *supra* note 31, at 410–11; Mello & Brennan, *supra* note 4, at 1598, 1617–18.

64. *See* Abraham & Weiler, *supra* note 31, at 383 (describing the AMA's lobbying efforts in the early 1990s opposing the Clinton Administration's tentative proposal to adopt medical enterprise liability).

the highest premiums. These physicians are effectively penalized for making socially valuable choices regarding specialty or geographic location.

But because the ire of the medical profession has been understandably directed at the tort system, "the liability insurance system itself has been spared serious analysis from a health policy perspective."[65] Unless that perspective is adopted, most medical professionals will probably find the existing structure of malpractice premiums to be fairer than one of uniform premiums across specialties and locations. After all, obstetricians incur much more malpractice liability than other specialists, so it somehow seems right that obstetricians should pay higher premiums as a result of their choice to practice in such a high-risk specialty. This view is seemingly correct only because it fails to consider malpractice insurance from a health policy perspective. Once the health consequences of the existing premium structure are taken into account, the problem with the liability insurance system becomes apparent. Premiums individualized by specialty and geographic location are quite plausibly detrimental to patient interests. This possibility, easily missed when one's ire is directed at the tort system, obviously follows from the fact that the vast majority of health care consumers prefer insurance and its collectivization of health care risks as compared to individualized risk-bearing, all else being equal.

Of course, not all else needs to be equal. Individualized risk-bearing can have desirable incentive effects. Individualized malpractice premiums based on specialty, geographic location, and claims experience could create individual incentives that reduce the incidence of medical error and better protect patient interests. Such a system of individualized malpractice premiums may be more desirable than one of uniform premiums. The experience rating of malpractice premiums, unfortunately, is difficult. The occurrence of malpractice liability is not a reliable indicator of malpractice occurrence.

It is only at this point that tort reform should become a relevant consideration in evaluating malpractice insurance. Reforms that would improve upon the reliability of malpractice determinations can facilitate experience rating, which would then make the malpractice premium fairly dependant upon the physician's other individual risk characteristics, such as specialty and geographic location. By contrast, the tort reform currently favored by the AMA—a damages cap for pain and suffering—would not make malpractice premiums fairer.

65. Sage, *supra* note 20, at 10 (footnotes omitted).

The AMA, however, need not abandon the reform. A damages cap could be defensibly implemented within a system of enterprise liability. When medical enterprises are liable for avoidable injuries, malpractice risk is collectivized and individualized incentives for physicians can be maintained by the organization, resulting in a distribution of malpractice costs among physicians that is fairer than the distribution presently produced by malpractice premiums. Enterprise liability coupled with a cap on non-economic damages would be similar to workers' compensation, which is a no-fault liability regime designed to compensate workers only for monetary injuries.[66] The similarity with workers' compensation does not have to end there. The adoption of workers' compensation schemes in the early twentieth century showed workers that the managerial or scientific control of the workplace did not entail a lack of concern for worker safety.[67] So too, by lobbying for the adoption of medical enterprise liability coupled with a damages cap, the medical profession would show patients that the cost concerns now driving the industry need not be detrimental to patient safety.

66. For a description of the workers' compensation system, see 1 AMERICAN LAW INSTITUTE, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY: REPORTERS' STUDY 105–27 (1991). Even though workers' compensation is supposed to compensate only for financial harms, the scheduled benefits for permanent partial disabilities provide awards regardless of whether the disability impairs the victim's wage-earning capacity. *Id.* at 114. "Certainly, though, no [workers' compensation] program awards damages like those regularly paid in tort litigation for the purely non-financial consequences of personal injuries." *Id.*

67. *See* JOHN FABIAN WITT, THE ACCIDENTAL REPUBLIC: CRIPPLED WORKINGMEN, DESTITUTE WIDOWS, AND THE REMAKING OF AMERICAN LAW 103–51 (2004).