

Limiting Lawsuits

The Impact of Malpractice Damage Award Caps on the Healthcare Economy

Stephanie Dreifuss

Introduction

Previously, healthcare providers governed the health insurance economy. They decided what type of care their patients needed and how much it would cost. Today, with the rising frequency of medical malpractice litigation, physicians' liability insurers and those filing lawsuits against their doctors join physicians in determining the type of care patients should receive and the price that they should pay for it. The expensive premia physicians must pay to become insured continues to increase, especially for those specialties at higher risk of malpractice. Because of these rising costs, physicians have begun to relocate, retire, or alter the type of care that they provide.

Background on Damage Award Caps

In order to ameliorate this situation of reduced healthcare availability, states have begun to implement medical malpractice damage award caps. Damage award caps are a type of litigation instated by state

governments to limit the payouts permitted on medical malpractice cases. Physicians must pay awards to plaintiffs for three types of damages including noneconomic damages, economic damages, and punitive damages. Noneconomic damages are those that involve losses of non-financial assets. These may include discomfort, emotional distress, or decreased quality-adjusted life years. Economic damages are monetary losses. Some economic damages include lost wages due to absence from a job or the costs of healthcare. Finally, punitive damages act as a means of punishing a physician's negligent behavior.

Medical malpractice claims can potentially lead to inefficiencies, such as insurance companies paying costly and frequent awards for these lawsuits, and, therefore, charging often unaffordable premia for physicians to obtain coverage. This high cost to physicians acts as a disincentive to practice medicine, especially in higher risk specialties, causing care to become less accessible and affordable to American consumers. Governments have instated damage award caps as a means of limit-



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ing the incentive for weak claims by making the cost of less well-founded lawsuits nearly as large as the potential gain. As less necessary claims decrease in frequency, doctors enjoy reduced costs of compensating patients. Decreased costs to physicians allow them to reduce their use of defensive medicine, or extraneous tests and procedures that serve mainly to help create a stronger case in the event of a lawsuit. This practice may also involve turning away higher risk cases in order to reduce the risk of facing a malpractice lawsuit. These behaviors support the inefficiency of defensive medicine, as it results from the threat of being sued for not giving patients adequate care and forces doctors to administer unneeded care. Additionally, lower expenses allow physicians to decrease the cost of care to their patients' insurance companies. Because these health insurance

the frequency and cost of weaker medical malpractice cases; 2) lowering the liability insurance premia charged by insurance companies; and 3) evenly spreading the distribution of physicians and creating an incentive for more efficient practice of medicine.

Effect of Caps on Frequency and Cost of Malpractice Cases:

As the frequency and size of medical malpractice cases increase in the United States, physicians, insurance companies, and, subsequently, consumers observe a higher cost of healthcare. The cost of these claims varies according to both the magnitude of noneconomic or economic damages suffered by the plaintiff and by any enhancing or limiting factors, for example, a state-implemented cap. Because

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providers have reduced expenses, they may lower the premia that they charge their consumers. This reduction in costs allows more people to purchase health insurance and also decreases the drain on a consumer's disposable income. As state governments strive to increase the number of people with affordable health insurance, they use damage award caps as a tool to help reduce the cost of medical insurance coverage to society.

Summary of Paper

In this paper, I summarize and quantify the effect of malpractice damage award caps on both the frequency and cost of medical malpractice cases. I include data demonstrating the differences in costs per claim between states with and without caps and the impact of a cap on an individual lawsuit. Because these reduced costs call for fewer and cheaper payments from liability insurers, statistics across states show a decrease in the premia physicians must pay for coverage. Furthermore, I discuss how increasingly expensive insurance premia lead to decreased physician accessibility for certain geographical areas, under-representation of certain high-risk specialties, and increased use of defensive medicine as a precautionary measure should a lawsuit arise. The main conclusions of the paper are that caps on malpractice damage awards affect three main components of the healthcare economy by 1) reducing

damage award caps limit the financial incentive to file a malpractice lawsuit, they help to reduce the incidence and expense of claims. Therefore, certain state legislatures place a cap on awards for malpractice cases in order to decrease the detriment of these cases to physicians. Because caps limit the award a plaintiff may obtain, the plaintiff may deem certain, weaker claims not worth spending the money or the time in order to gain a limited reward. Therefore, these caps discourage weaker claims and encourage less severely injured patients to seek resolution out of court, thereby increasing the efficiency of the healthcare system by limiting the unnecessary costs of litigation. At the same time, because these caps primarily limit only noneconomic damage awards, injured parties may still receive unlimited compensation for lost wages and healthcare costs suffered.

Cost per Claim Differences between States With and Without Damage Award Caps

To lessen these expenses associated with medical malpractice cases, governments instate caps on awards, because they have been shown to decrease average per-claim payments. These smaller payouts required of liability insurance providers allow for lesser premia that doctors must pay, a means of lowering costs across the spectrum. According to Frech et al (2006), implementing a cap in a state that currently does not limit awards on damages can re-

duce paid losses by up to thirty percent. Frech et al continue to show that removing all caps would lead to a \$206 million increase in loss payments, as opposed to a \$251 million decrease in loss payments if all states implemented a cap on damage awards. They obtain these numbers from a study by Pace et al (2004), who use data from jury awards under MICRA. MICRA is California's legislative reform that capped only noneconomic damages at \$250,000, without any restrictions on economic damages. Therefore, in any case in which the award for noneconomic damages exceeds the state-mandated cap, the jury would reduce that component of the award. For example, in a case in which the total award was \$1.6 million, with noneconomic damages amounting to \$1 million, the final judgment would reduce that amount and, thereby, reduce the final award to \$850,000. This equals a reduction of \$750,000. To complete their calculations, Pace et al applied this formula to every California medical malpractice

case on record. Table I displays their results, showing the impact of eliminating and imposing caps on states that do or do not currently have them. The figures also support the effectiveness of a cap in reducing payments, as the initial paid losses for states with caps is equivalent to nearly half of the paid losses for states without caps [1].

Guirguis-Blake et al also show the negative association between damage caps and payment per claim. On average, the mean payment per claim is 26% lower in states with damage caps, taking into account the 44,913 paid medical malpractice claims nationally between January of 1999 and December of 2001. Guirguis-Blake et al standardize these claims to account for the physician and total populations in each state. Table II shows the dollar amounts for mean malpractice payment, payment per physician, and payment per person between states with and without caps that they obtained from these data. All cost values in the table were higher for those states

States	Paid Losses	States without Caps	Paid Losses
Total	\$471,798,900	Total	\$825,977,500
Increase 43.75% (after caps removed)	\$678,210,919	Reduce 30.43% (after caps instated)	\$574,593,043
Change	\$206,412,019	Change	\$251,384,457

Table 1. NPDB Reported Paid Losses, and Effect of Eliminating Caps on States that Have Them, and Effect of Imposing Caps on States that Do Not Have Them (Pace et al 2004)

States	Average Malpractice Payment (\$)	Payment per Physician (\$)	Payment per Person (\$)
States with caps			
Median	190,174.62	10,833.56	20.95
Mean	196,495.34	11,504.69	24.38
States without caps			
Median	248,349.27	13,629.10	30.55
Mean	265,554.50	15,501.78	38.73

Table 2. Payment Characteristics of States With and Without Total Damage Caps (Guirguis-Blake et al 2006)

Total Damages (A)	Cap Value (B)	Prob. Of Win (C)	Gross Return (D)	Fixed Litig Cost (E)	Var. Litig Cost (5% of award) (F)	Expected Value (G)
Weak Claims (20% rate of success)						
\$1,000,000	NONE	20%	\$200,000	-\$100,000	-\$50,000	\$50,000
\$1,000,000	\$250,000	20%	\$130,000	-\$100,000	-\$32,500	-\$2,500
\$1,000,000	\$500,000	20%	\$180,000	-\$100,000	-\$45,000	\$35,000
\$1,000,000	\$900,000	20%	\$200,000	-\$100,000	-\$50,000	\$50,000
Strong Claims (80% rate of success)						
\$1,000,000	NONE	80%	\$800,000	-\$100,000	-\$50,000	\$650,000
\$1,000,000	\$250,000	80%	\$520,000	-\$100,000	-\$32,500	\$387,500
\$1,000,000	\$500,000	80%	\$720,000	-\$100,000	-\$45,000	\$575,000
\$1,000,000	\$900,000	80%	\$800,000	-\$100,000	-\$50,000	\$650,000

Table 3. Impact of Caps on Strong and Weak Claims (Frech et al 2006) - Equation: $G=A(\text{as limited by cap})^*C-E-F$

without caps, supporting the economic benefits of damage award caps. The payment per physician on malpractice claims was an average of \$3,997.09 higher in states without damage award caps, while the average payment per person is \$14.35 higher. The article also verifies Frech et al's data regarding an increase or decrease in loss payments if caps were implemented or removed [2].

Effect of Cap on Costs per Claim

In order to model the impact of a cap on the rising costs of lawsuits, Frech et al illustrate the expected value of strong versus weak medical malpractice claims with either no cap, a \$250,000 cap, a \$500,000 cap, and a \$900,000 cap. For their model, they assume that claims are valued at \$1,000,000 taking into account both economic (\$400,000) and noneconomic (\$600,000) damages. Then, to obtain the expected gross return of the claim, they multiply the probability of a win by the sum of the economic damages and the maximum noneconomic damage award allowed by the cap. From this number, they subtracted a fixed \$100,000 cost of litigating along with a variable cost of litigating, equaling 5% of the award. This final number equals the total expected value, shown in Table III.

The data they calculated show that for weak claims (those with a 20% rate of success), a \$250,000 cap is most effective in discouraging these inefficient cases. The calculated expected value of these cases is -\$2,500, signifying a monetary loss. Furthermore, cases in a state with either a \$900,000 cap or without any cap at all shared an expected value of \$50,000. This may show that too high of a cap will not effect weaker claims as it provides no disincentive for the plaintiff, leading to an expected value equivalent to that of a system without a cap. For stronger claims (those with an 80% chance of success), the expected values of claims with a \$900,000 cap and without a cap still share equal expected values. This time, the expected gain is an estimated \$650,000. Once again, a cap of \$250,000 corresponds to the lowest expected value of \$387,000 for strong, and more efficient, claims [3]. The findings of Frech et al show that a \$250,000 cap is most effective in discouraging weak claims that drain the time and money of lawyers and physicians; this cap best reduces the costs to physicians and their liability insurance providers of pursuing stronger claims. Furthermore, if a law caps malpractice damage awards at too high of a value, the legislation will not successfully reduce the costs of medical malpractice cases.

Discussion

These data show that caps on malpractice damage awards lead to decreased costs of medical malpractice cases, especially those that attempt to assert weaker claims. Because they bring about a higher proportion of strong cases with higher expected payouts, damage award caps lead to heightened efficiency. To further this efficiency, the caps act as a disincentive that also decreases the frequency of claims. In addition, the data show that these caps decrease the average payments required of physicians. Some may argue that these decreased costs of malpractice claims mean that physicians have no incentive to increase their quality of care and that those patients severely injured by a physician would not receive adequate compensation. A severely impaired or handicapped patient, however, would warrant a stronger case, thereby leading to a higher expected value. Furthermore, most legislation regarding malpractice damage award caps does not limit economic damage awards, thereby allowing the patient full compensation for any lost wages or healthcare costs. Because the average cost of these cases decreases due to the implementation of damage award caps, as illustrated by the state comparison data, physicians may pay lower premia for their liability insurance. Eventually, these benefits of lower costs to physicians and insurance companies allow for lower costs to consumers as physicians would need to charge less and would be able to practice less defensive medicine.

Effect of Caps on Liability Insurance Premia

Because caps allow for reduced, less frequent expenses in medical malpractice litigation, they allow liability insurance providers to pay cheaper losses on a less regular basis, saving them money. In order to become more competitive with other medical malpractice insurers, these companies subsequently lower the premia that they charge physicians. In doing so, they become more attractive insurance providers and, thereby, gain more clients and increase their profit. This allows for additional risk pooling should payment on a claim be required. When physicians may enjoy these lower premia, they are able to practice less cautious, more efficient, and, potentially, more effective medicine without draining as great of a proportion of their incomes.

Increasing Cost of Malpractice Insurance Premia and Associated Risks

In reality, the costs of malpractice premia are rela-

tively high. Therefore, the healthcare economy cannot realize these above benefits. As stated in Mello et al's study (2003), there are 18 states in America in which physicians and other healthcare providers face decreased availability and affordability of medical malpractice coverage. This probably means that the cost of malpractice insurance constitutes too large a percent of their income for them to purchase it. Those physicians in higher risk specialties must pay even higher premia, causing a large drain on their incomes. Figure IV shows the number of states in crisis, showing signs of problems, or not showing signs of problems. A crisis or problem would entail a large enough of percentage of physicians not being able to purchase liability insurance for their patients to see a decline in accessibility. This occurs due to decreased affordability or availability of coverage. The United States Map shows that only six states are not currently showing signs of problems [4]. Furthermore, Deluke states that in a United States General Accounting Office Study, increased losses in medical malpractice lawsuits serve as the greatest contributor to increased premia. They came to this conclusion by reviewing data provided by medical malpractice insurers to the National Association of Insurance Commissioners [5]. These issues support that there is a problem with too many disincentives for physicians to practice.

Furthermore, these rising insurance premia show

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that insurance providers face a decline in profits and, therefore, a decline in availability. For example, the St. Paul Company, the largest provider of liability insurance to physicians in all of the United States, left the market in 2001 after suffering losses of \$900 million. Their decision to close left 42,000 doctors and 750 hospitals without insurance [5]. The St. Paul Company was not the only carrier to face substantial losses. According to Thorpe, the net after-tax income of liability coverage providers fell from 23% to -11%, exceeding a 30% decrease in profitability [6]. The providers that remain, in an attempt to avoid losses of the magnitude suffered by the St. Paul Company, are increasingly selective in deciding which physicians to cover, taking on only those with perfect records or closing their companies all together [4]. Because insurance companies are suffering losses due to large, frequent malprac-

tice claims, they have increased the premia that they charge physicians by an average of 23% [6]. This large rise serves as an added expense to physicians and decreases the affordability of liability insurance.

Data Showing Impact of Caps on Malpractice Insurance Premia

Several studies show that caps on medical malpractice awards successfully lower these expensive insurance premia. Hellinger and Encinosa state that premia in states with caps are an average of 17.1% lower than those in states without these caps, according to averages compiled by the National Association of Insurance Commissioners [7]. According to Frech et al, caps on medical malpractice damage awards would reduce these premia by between 33 and 43 percent in those states that currently have no cap. They obtained their 33-43 percent range, taking into account data from the Congressional Budget Office after removing a cap from a state in which one was already in place. The same estimate for instating a cap in a state where one did not exist approximated that premia would decrease by between 25 and 30 percent [3].

Oregon supports the efficiency of a cap on awards, because a \$500,000 cap was implemented in this state and then removed, leading to a 155% increase in liability insurance premia. Average premia

went from a peak of about \$17,000 to a low of under \$5,000 upon implementation of the cap, only to increase to a current nearly \$13,000 since the caps removal. Graph I depicts these numbers, with cap instatement in 1987 and removal in 1999. The subsequent decision of the Oregon legislatures to, once again, place a cap on noneconomic damages further supports the benefits of a cap on these awards [3]. The peak after legislatures implemented the cap most likely resulted from the lag time required for insurance companies to feel the impact of decreased costs and payout frequency.

Hellinger and Encinosa found similar results with premia rising 10% in states with caps of \$250,000, as opposed to 29% in states with more limited tort reforms. These numbers apply to higher risk specialties including general surgery, internal medicine, and obstetrics/gynecology between the years 2001

and 2002. They obtained these numbers using data from a United States General Accounting Office Report that compared data from 12 states. Those with caps included 4 states with a \$250,000 cap and 8 with one of \$500,000 [7]. Because the states with caps of \$250,000 were not as well-represented in the sample, these results may be compromised in their reliability. The conclusion shown by this limited data is that malpractice premia still rise despite stricter reform, but a lower cap will help to decrease the magnitude of this cost increase and allow for increased liability insurance affordability and availability.

Effect of Caps on Physician Behavior and Distribution

The expensive costs of liability insurance influence the behavior and distribution of physicians, leading them to move away from more rural areas, close or relocate their practices, chose specialties in order to have lower coverage costs, and alter the types of care that they provide. These changes in physician accessibility present a problem to health-care consumers by increasing travel time for specific types of care or making certain procedures unavailable. Caps on malpractice damage awards have favorably changed the healthcare economy's physician market by allowing doctors to enter higher risk specialties without worrying about expensive premia. Furthermore, state-implemented caps help physicians become more evenly distributed geographically and allow them to provide care to suit their patients rather than the economy. Overall, states with caps on damage awards enjoy 2.2% more physicians per capita in suburban areas and 3.2% more physicians in rural areas, as well as 5.4% more obstetricians-gynecologists and 5.5% more surgeons. These numbers illustrate the direct impact of paid losses in a malpractice case on a physician's decision of location and specialty.

Distribution Across Specialties

In order to avoid more expensive premia and earn a higher income, physicians favor lower risk specialties. This presents a problem, however, when a specific type of doctor is unavailable to perform a needed procedure. The threat of litigation has become so prevalent that, according to White, even medical students feel its impact. A reported 48% of medical students claimed that the risk of malpractice litigation factored in their decision as to what specialty to pursue [8]. This may explain the decrease in number of entrance into obstetrics. To lower premia and make higher risk specialties more appealing to physicians, states implement caps on damage awards.

To further explore the issue of liability insurance premia differences between higher and lower risk specialties, Guirguis-Blake et al calculated that if those 44 states without caps shared the same premium rates as states with caps, the annual savings for internists, general surgeons, and obstetricians would be \$711 million, \$270 million, and \$815 million respectively.

These results take into account all physicians in states without caps and the difference between their premia and the premia of a physician in the same specialty, but in a state with a cap. Further analysis of the premia differences between these specialties in states with and without caps is shown in Table VII. It indicates that as the risk associated with a specialty increases, so does the premia that physician must pay. This increase is even greater in a state in which malpractice damage awards are unlimited. Bivariate analysis shows that total damage caps are associated with lower mean annual premia for all three of the specialties in the table – internists, general surgeons, and obstetricians [2].

As Table VII shows, obstetricians feel the impact of rising malpractice insurance costs especially strongly, but enjoy the greatest savings of any specialty under a system with a cap. According to Frech et al, obstetrics is one of the most cost-effective fields of medicine as an individual benefits from

Impact of Noneconomic Damage Caps on Medical Liability Insurance Premia in Oregon

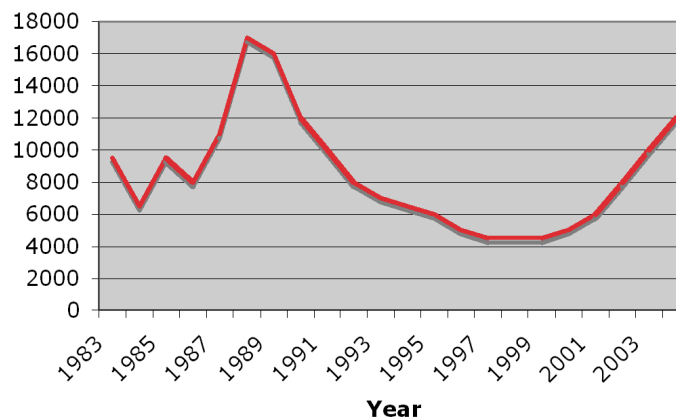


Figure 2. Cap instated: 1989, Cap removed: 1999 (Frech et al, 2006)

the treatment throughout his or her entire lifetime. These physicians, however, are at the highest risk for malpractice lawsuits, demonstrating the inefficiency of the medical malpractice litigation system and the need for legislative reform. In a study by Dranove and Glon, they found that, of the doctors performing high-risk deliveries, 256 left their careers in 2003, as opposed to 195 in 2000. On the other hand, 227 obstetricians entered the specialty in 2003, compared with 242 in 2000. These lead to a net entry of 47 in of these doctors in 2000 and a net loss of 29 in 2003 as insurance premia continue to rise. These changes signify the decreasing appeal of obstetrics, consistent with the results of White's study, and present a threat to what has been deemed the most efficient specialty. Without reform, women run the risk of having to travel for an extended period of time to find a physician to deliver their babies.

In addition to changes in distribution across specialties, physicians have changed their geographical distribution due to the variable costs of practicing medicine in rural, suburban, and urban areas. If a change of location still does not seem an affordable option, some doctors opt to retire, closing their practice and eliminating additional physicians from the market. As Mello states, the frequency of emergency room closures has increased, pregnant mothers have lost their obstetricians, and hospital services have been terminated [4]. White claims that hospitals have eliminated some neurosurgery, emergency care, and prenatal care units [8]. These occurrences lead to a conflict of physician accessibility. Because malpractice damage award caps decrease the cost of claims in both high and low litigation areas, physicians will tend more toward an even geographical distribution. Furthermore, legislation that allows physicians to keep more of their income discourages

Physical/Geographical Distribution

Number of Doctors per 100,000 Residents			
All Rural Physicians	1975	2000	% Increase
Cap equals \$250,000	60.61	89.65	48
Cap above \$250,000	49.34	71.26	44
Rural Surgeons			
Cap equals \$250,000	19.23	27.09	41
Cap above \$250,000	16.81	22.00	31
Rural OB-GYNS			
Cap equals \$250,000	23.87	38.30	61
Cap above \$250,000	24.61	36.57	49

Table 5. Trends in Rural County Physician Supply In States With \$250,000 Caps on Malpractice Awards (Encinosa and Hellinger 2005)

	Full Sample			Rural Only		
	1997	2000	2003	1997	2000	2003
Neurosurgery						
No craniotomy	25.0	25.0	26.6	49.7	49.0	50.5
Craniotomy	35.3	36.8	41.4	65.0	68.9	69.5
	Full Sample			Rural Only		
Delivery						
Not high risk	20.7	21.0	21.4	41.2	41.2	41.0
High risk	21.1	21.4	22.0	42.0	43.7	42.8

Table 6. Travel Times for Neurosurgery and Deliveries in Florida (Dranove and Gron 2005)

Specialty	With Caps	Without Caps
Internal Medicine	\$4,519.86	\$7,447.00
General Surgery	\$16,912.14	\$24,516.93
Obstetrics	\$22,371.57	\$42,728.68

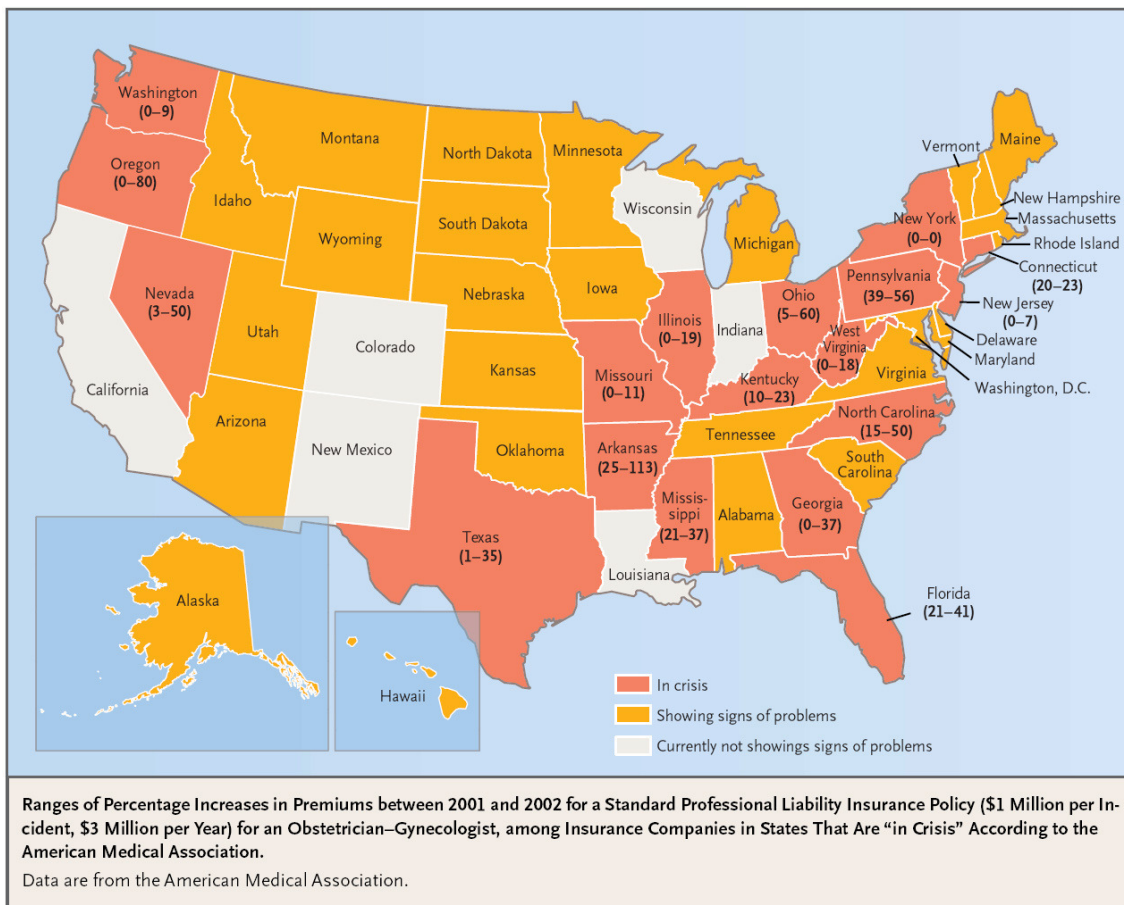
Table 7. Annual Premia by Specialty for States With and Without Caps (Guirguis- Blake et al 2006)

the closing of practices and allows for more accessible physicians.

Because states vary in the litigation they place upon malpractice cases, physicians tend to gravitate toward those with a more stringent cap on malpractice damage awards. For example, as Frech states, that as the cost of liability insurance rose by 150% percent since 1999, patients have experienced more limited access to higher risk specialties [3]. These doctors migrated in order to reduce the percentage of their income used to pay for insurance. Mello's study on effects of malpractice premia differences between states indicates that 17% of Pennsylvania's orthopedic surgeons left the state or limited their services, further limiting patients' accessibility to physicians [4]. A study by Dranove regarding the necessary travel times for high-risk procedures in Florida shows a significant difference between travel times for procedures with high and low risks. The findings are shown in Table VI to illustrate the increase in travel times, especially those for higher risk procedures, between 1997 and 2003.

The distribution of physicians does not only differ across state lines, but also shows a difference across demographic regions. Between more rural or inner-

city and more suburban areas, physicians gravitate toward the suburban areas as these locations have a greater ratio of revenues to costs for doctors. This is because if physicians were to attempt to share more costs with their patients in a less demographically wealthy area, they would lose their business as patients could not afford medical care. Mantone (2005) believes that a move toward a rural area would be beneficial as it allows physicians to practice in less litigious areas, reducing their risk of becoming involved in a malpractice lawsuit [9]. Therefore, a cap would allow more physicians to move into underserved areas. Hellinger and Encinosa show, through Table V, the trends in physician supply in rural counties in states with greater than or equal to \$250,000 caps. The table shows that, while the number of doctors overall has increased in the past 25 years, this growth has been more rapid in those states with \$250,000 caps. This is probably because a cap over that amount would not act as a disincentive toward those looking to pursue litigation. Furthermore, Hellinger and Encinosa state that Ohio, Oregon, and Texas all had caps limiting noneconomic damages in effect for at least four years before their removal. In all of these states, during the four years in which the



caps were in effect, there was a positive, significant correlation with number of physicians per capita in a given geographical area [7].

Physician Behaviors and Administered Care

For the same reason that physicians avoid higher risk specialties, they refrain from administering higher risk procedures. Should this type of care cause any injury to the patient, the physician faces a greater chance of lawsuits. Therefore, these types of procedures, whether rare or highly invasive, have become less prevalent as the cost of malpractice insurance has grown continually. Furthermore, physicians will administer defensive medicine – a type of precautionary practice performed for the sole purpose of constructing a solid case if a lawsuit should follow. Defensive medicine becomes both costly and inefficient, leading to higher costs and a more expensive healthcare system [10].

For these reasons, the radiologists studied by Elmore et al (2005) reported an increased rate of biopsy recommendations after a mammogram. Over 70% of radiologist claimed that their rate of biopsy recommendations moderately increased [11]. This increase serves as an example of the prevalent use of defensive medicine, as many of these biopsy recommendations are purely precautionary. Unnecessary procedures act as an added cost that perpetuates the lack of insurance affordability for physicians and consumers.

While the frequency of defensive medicine has increased, that of high risk procedures has decreased. Dranove and Gron found a dramatic increase in travel times for patients seeking a craniotomy, as shown in Table VI. This could either be due to physicians' refusal to perform certain procedures or to physicians' relocation or retirement. Either way, this lack of accessibility supports the importance of legislative reform to decrease malpractice insurance costs for physicians, encouraging them to keep practicing and ensuring that they take home a deserved percentage of their incomes.

Conclusion

These findings support that damage award caps help to lower costs associated with healthcare. Caps help to decrease the average paid losses that liability insurers must incur, thereby allowing physicians to pay cheaper liability insurance premia. Furthermore, these decreased costs allow for the consumer to pay less for his or her own health insurance, as they will be receiving less of the inefficient defensive medicine and more of the necessary care. These

decreased costs in all areas of the healthcare market allow for greater insurance affordability for the general consumer and more widespread health insurance coverage. Furthermore, it helps makes it a more attractive option for businesses to increase coverage of their employees. Physicians will become more evenly distributed with a federal damage award cap implementation, as costs of malpractice insurance premia will be equal between states and demographic areas, and much less spread out between specialties.

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