

Turning from Damage Caps to Information Disclosure: An Alternative to Tort Reform

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With the 2004 U.S. presidential election close at hand, George W. Bush and his Administration resurrected a previously-killed federal proposal to cap medical malpractice damage awards.¹ The Bush Administration once again claimed that the United States is experiencing a medical malpractice insurance crisis and that frivolous medical malpractice lawsuits are the cause of this crisis.² According to the current Administration, large jury awards lead to significant increases in medical malpractice insurance premiums, driving physicians from the practice of medicine.³ Indeed, an array of policymakers continue to argue that

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1. In March 2003, the House passed the Help Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003). The House version of the proposed legislation caps punitive damages at twice the economic damages or at \$250,000, whichever is greater, and limits attorney's fees in contingency cases. In July 2003, the Patients First Act of 2003, S. 11, 108th Cong. (2003) was proposed and defeated. If passed, the legislation would have placed an award cap of \$250,000 on non-economic damages and limited attorney's fees in contingency cases.

2. In a recent speech Vice President Richard Cheney argued that

Medical liability litigation is a serious problem in almost every state in the land, and it's not getting any better. Frivolous lawsuits are clogging the courts, and delaying justice for those with real problems. . . . We must protect the rights of those with real grievances, and we have to fix the medical liability problem at its source—the frivolous lawsuits that are filed solely with the hope of winning massive verdicts. That is why President Bush has set forth some responsible, practical reforms to put doctors and patients back in charge of healthcare in America The President has proposed a reasonable federal cap of \$250,000 on non-economic damage awards

Vice President Richard Cheney, Address to Dana Conference Center, Medical College of Ohio (July 19, 2004), <http://www.georgewbush.com/HealthCare/Read.aspx?ID=3006>.

3. *Id.* (quoting Cheney as arguing that “huge payoffs for personal injury trial lawyers”

damage caps will quell sharply increasing medical malpractice premiums, despite the fact that empirical evidence regarding the impact of damage caps on premiums is inconclusive.⁴

This Case Study argues that imposing statutory caps on medical malpractice damages is not an effective method of remedying the medical malpractice insurance crisis; therefore, policymakers should consider alternatives to damage caps. In particular, evidence suggests that implementing mandatory disclosure of the contract terms between managed care organization (MCOs) and physicians for the provision of services to enrollees reduces medical malpractice insurance premiums.

Part I of this Case Study reviews the controversy regarding the efficacy of damage caps in remedying medical malpractice insurance crises and discusses the state of empirical research investigating the effects of caps. Part II argues that a particular alternative—forcing disclosure of contract terms between MCOs and physicians—might more effectively reduce premiums. Policymakers interested in regulating medical malpractice insurance premiums should consider implementing MCO-physician contract disclosure requirements as a means to their desired end.

I. A POPULAR “SOLUTION”: MEDICAL MALPRACTICE DAMAGE CAPS

Several policymakers have proposed imposing medical malpractice damage caps to solve the current perceived medical malpractice insurance crisis.⁵ The proposals have reinvigorated a long-standing debate as to whether damage caps, in fact, significantly reduce medical malpractice premiums. Section A provides a short summary of the debate. In Section B, I discuss an important component of the analysis that has been largely missing from the debate: the effects of caps on treatment choices. Finally, in Section C, I briefly analyze the body of empirical research designed to study the relationship between caps, litigation, and medical malpractice insurance premiums.

and “massive increases in medical liability insurance premiums, for doctors across the country” have reached crisis proportions.) In the same address, Cheney claimed that imposing caps on damages would remedy the problem of increasing medical malpractice premiums. *Id.*

4. For a summary of the empirical literature studying the effects of damage caps on medical malpractice insurance premiums, see Kathryn Zeiler, *An Empirical Study of the Effects of State Regulations on Medical Malpractice Litigation Decisions* (July 2004) (unpublished manuscript, on file with author).

5. See *infra* Section I.A.

A. *The Controversy over Damage Caps*

Politicians and industry players claim that implementing medical malpractice damage caps will help end the medical malpractice insurance crisis. Recently, the media reported that “[damage] caps are being pushed nationally by Republicans including President Bush, who argue that excessive jury awards are largely responsible for escalating malpractice premiums.”⁶ The National Association of Mutual Insurance Companies (NAIC) supports medical malpractice caps on damages, arguing that caps would limit runaway jury awards of non-economic and punitive damages.⁷ Insurers also argue that caps reduce uncertainty, making it easier for them to set insurance premiums.⁸

On the other hand, opponents of damage caps argue that caps will not solve the medical malpractice crisis and that the cost of caps outweighs any potential benefits (if, indeed, they create benefits at all).⁹ Some commentators claim that caps are unconstitutional because they infringe on injured patients’ rights to trials by jury, to open courts, and to equal protection.¹⁰ Others note the potentially perverse effects of damage caps; for example, some claim that if caps are imposed, fewer legitimate medical malpractice cases might be filed because the costs of pursuing each claim might exceed expected awarded damages.¹¹ In addition, empirical evidence suggests that caps might lead to *larger* jury awards in some cases

6. John Wagner, *Doctors Wooed in Malpractice Insurance Fight*, WASH. POST, July 26, 2004, at B1.

7. Nat’l Ass’n of Mutual Ins. Cos., *Medical Malpractice Liability Reform*, at <http://www.naic.org/fedkey/04MedMal.asp> (last visited Nov. 10, 2004).

8. See W. Kip Viscusi, *Tort Reform and Insurance Markets*, 7 RISK MGMT. & INS. REV. 9, 20 (2004).

9. See *infra* notes 10-13 and accompanying text.

10. Ashley Stewart, Note, *Texas’ House Bill Four’s Noneconomic Damage Caps Impose the Burden of Supporting the Medical Industry Solely upon the Most Severely Injured and Therefore Most in Need of Compensation*, 57 SMU L. REV. 497, 503 (2004) (arguing also that damage caps “cause harm by preventing the most deserving victims from gaining compensation for their injuries”).

11. See ERIC NORDMAN ET AL., *MEDICAL MALPRACTICE INSURANCE REPORT: A STUDY OF MARKET CONDITIONS AND POTENTIAL SOLUTIONS TO THE RECENT CRISIS* 47 (2004), http://www.naic.org/models_papers/papers/MMP-OP-04-EL.pdf (draft report presented to the NAIC’s Property and Casualty Committee July 14, 2004) (arguing that “[s]ince the costs of researching and arguing a medical malpractice case can be very large, awards available once caps are introduced may not, in some cases, cover even the costs associated with pursuing a claim.”); see also Rachel Zimmerman, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, WALL ST. J., Oct. 8, 2004, at A1.

because jurors might perceive the cap as the correct amount to award to all injured plaintiffs.¹² Similar perceptions by negotiating parties can also skew settlement outcomes in unexpected ways.¹³

Importantly, neither proponents nor opponents of caps have considered how caps might affect treatment choices made by physicians and managed care organizations and how these choices influence patient injury rates. In the following Section, I extend the boundaries of the debate by arguing that caps, at least theoretically, affect treatment choices, which in turn impact injury rates and medical malpractice claim rates.

B. The Missing Component: The Influence of Damage Caps on Treatment Choices¹⁴

While proponents of damage caps frequently argue that excessive litigation increases the practice of defensive medicine by physicians,¹⁵ critics of caps might similarly assert that limits on damages may also adversely affect treatment decisions.¹⁶ An examination of how caps influence the behavior of a wider array of health care market actors reveals that they can produce perverse incentives at the treatment decision stage.

12. See Jennifer K. Robbennolt & Christina A. Studebaker, *Anchoring in the Courtroom: The Effects of Caps on Punitive Damages*, 23 LAW & HUM. BEHAV. 353 (1999). Of course, these results might be important only in regimes in which juries are informed of statutory damage caps prior to deliberating about damages. Currently, only courts in Massachusetts are required to instruct the jury that, if it finds the defendant liable, it may not (in most cases) award more than the statutory limit for non-economic damages. See MASS. GEN. LAWS ANN. ch. 231, § 60H (West Supp. 1995). West Virginia allows the court to instruct the jury in this manner. See W. VA. CODE § 55-7B-8 (1994).

13. See Greg Pogarsky & Linda Babcock, *Damage Caps, Motivated Anchoring, and Bargaining Impasse*, 30 J. LEGAL STUD. 143 (2001).

14. For a complete analysis of the effects of damage caps on treatment choices, see Zeiler, *supra* note 4 (presenting theoretical predictions regarding how damage caps affect medical malpractice claim rates).

15. See U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 19 (July 2002) (arguing that "[t]he excesses of the litigation system are an important contributor to 'defensive medicine'"). Defensive medicine refers to the practice of providing patients with an inefficient amount of medical care to avoid exposure to liability for medical practice. For example, a physician might order an excessive number of diagnostic tests to be sure that she meets the legal standard of care when treating a particular patient. For a discussion of defensive medicine, see CHARLES E. PHELPS, HEALTH ECONOMICS 442-45 (3d ed. 2003).

16. To the best of my knowledge, this has not been argued in the past by those who oppose caps on damages.

Consider, first, how damage caps might influence the decision of an injured patient (or her attorney who likely is employed by the patient on a contingency-fee basis) regarding whether to file a medical malpractice claim against her physician. Assume that a patient will file a claim only if expected damages exceed litigation costs.¹⁷ Estimates of expected damages depend on two variables: the anticipated damage award and the probability that the patient will succeed in recovering this amount from the physician. The probability of success (whether by court award or through settlement), in turn, depends on the likelihood that the physician provided non-compliant medical care. All other things being equal, as the likelihood that the physician provided non-compliant treatment increases, the probability of recovering damages increases, as does the probability that an injured patient will file a claim.¹⁸

The next step in the analysis is to consider how caps affect the probability that a physician will provide non-compliant treatment. In theory, when deciding whether to provide costly compliant treatment, the physician (in conjunction with the patient's MCO) weighs the costs and the benefits of providing such care.¹⁹ Costs refer to all the expenses incurred in providing compliant care; the benefits include the reduction in exposure to liability for medical malpractice. Damage caps reduce the exposure to liability; therefore, the imposition of caps makes it optimal, in some cases, for physicians (or MCOs) to face potential liability for medical malpractice rather than provide costly treatment that complies with the legal standard of care. Recent research does, in fact, indicate that

17. In other words, assume injured patients act perfectly rationally when deciding whether to sue for medical malpractice. Of course, in some cases, these decisions may be driven by factors other than the expected monetary costs and benefits of filing a claim (e.g., emotions, revenge and strategic behavior). However, since patients must convince lawyers to take on these cases in exchange for a cut of the pie, it is unlikely that filing decisions are driven significantly by emotional factors. In addition, physicians tend not to cave easily to patients' demands based on nonmeritorious claims because they highly value their reputations (and would risk sanctions). See Linda Oberman, *IG Asks Why More Hospitals Don't Report Adverse Actions*, AM. MED. NEWS, Feb. 13, 1995, at 4 (claiming that reputation effects, in part, drive physician reluctance to settle medical malpractice cases).

18. To obtain this result we need only assume that the court is better at verifying whether the physician provided negligent treatment than it would be if it flipped a fair coin. This assumption does not seem unreasonable.

19. For a detailed analysis of the physician's treatment choice, see Kathryn Zeiler, *Medical Malpractice and Contract Disclosure: An Equilibrium Model of the Effects of Legal Rules on Behavior in Health Care Markets 16-18* (Apr. 2004) (unpublished manuscript, on file with author).

physicians react to different sorts of financial incentives in this way.²⁰

To summarize, if damage caps reduce exposure to liability, physicians (and MCOs), on average, may be less likely to provide compliant treatment. This will result in an increase in patient injuries, and in turn, an increase in the number of injured patients who file claims for medical malpractice.²¹

This increase in the claims rate, coupled with the potential decrease in the average damage award (and settlements) due to the cap, is likely to yield indeterminacy: Because of these competing forces the influence of caps on ex ante calculations of expected damages from medical malpractice claims (and therefore medical malpractice insurance premiums) will depend on other variables, such as the cost of treatment relative to expected damages, the probabilities of injuries given compliant and non-compliant treatment, and the amount of the cap.²² Therefore, the claim that caps will decrease medical malpractice insurance premiums is arguably shortsighted because it does not account for the influence of caps on influence treatment choices.

20. While the effects of tort reform on treatment choices have not been studied empirically to date, some have investigated the effects of financial incentives on treatment choices and find that physicians do respond to financial incentives. See, e.g., Thomas S. Crane, *The Problem of Physician Self-Referral Under the Medicare and Medicaid Antikickback Statute*, 268 JAMA 85, 86 (1992) (citing government studies indicating that physicians respond to financial incentives in their treatment practices); David Hemenway et al., *Physicians' Responses to Financial Incentives: Evidence from a For-Profit Ambulatory Care Center*, 322 NEW ENG. J. MED. 1059, 1062 (1990) (showing that physicians react to bonus arrangements that reward them for ordering laboratory tests by significantly increasing the number of tests they order). In addition, studies have found that physicians who report that their contracts with MCOs include incentives to reduce referrals were "more likely than others to have felt pressure to limit referrals in a manner that compromised care." See Kevin Grumbach et al., *Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516 (1998).

21. It is important to note that physician exposure to liability likely will influence MCO behavior. If the costs of practicing medicine increase due to increased exposure liability, then physicians will demand more in compensation from MCOs. MCOs can influence physician treatment choices directly by approving or denying reimbursement for treatments and indirectly through financial incentives written into MCO-physician contracts. Therefore, changes in physicians' exposure to liability will influence MCO-physician contracts and MCO decisions regarding whether to approve particular treatments.

22. See Zeiler, *supra* note 4, for a complete characterization of the equilibria under various conditions. Despite the indeterminacy, "unless the cap is so restrictive that total damages fall below litigation costs, caps are likely to cause an increase in ex ante expected damages." *Id.* at 13.

With a more complete understanding of how damage caps might influence the choices of health care market actors, we are positioned to evaluate the empirical results, produced using field data, to study the effects of caps on medical malpractice insurance and litigation behavior. The following Section summarizes the state of the empirical literature and argues that the cumulative findings do not allow us to draw conclusions regarding how damage caps influence medical malpractice insurance markets or litigation behavior.

C. Empirical Evidence

Several researchers have employed field data to investigate whether caps significantly influence medical malpractice insurance premiums and losses incurred by insurers.²³ A review of this empirical literature reveals two general themes. First, the empirical results generally are mixed. Second, given the difficulties in directly measuring the influence of caps, reliance on the results of most studies is controversial.

Results vary significantly depending on the data employed, the specifications of the empirical models, and the time periods studied. For example, Professor Frank Sloan investigated the influence of damage caps on premiums paid by physicians in three specific fields.²⁴ The study incorporated data for the years 1974-1978. Using regression analysis, he found that damage caps significantly affected neither premiums nor annual percentage change in premiums for any of the three fields tested. Professor Kip Viscusi and his colleagues focused mainly on the effects of the second generation of tort reforms to be implemented by state legislators.²⁵ Using 1988 aggregated premiums by state, they considered the change in premiums from 1985 to 1987. The analysis controlled for differences in state regulation of insurers. The authors considered limits on non-economic damages and limits on punitive damages and, like Frank, found that limits on non-economic damages did not significantly affect premiums.

Conversely, Stephen Zuckerman of the Urban Institute and his

23. See Zeiler, *supra* note 4 (reviewing the empirical literature).

24. Frank A. Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment*, 9 J. HEALTH POL. POL'Y & L. 629, 637-643 (1985).

25. See, e.g., W. K. Viscusi et al., *The Effect of 1980s Tort Reform Legislation on General Liability and Medical Malpractice Insurance*, 6 J. RISK & UNCERTAINTY 165, 186 (1993) (analyzing the effects of reforms such as modifications of joint and several liability, limits on liability and establishments of immunities, limits on noneconomic and punitive damages and provisions for structured and periodic payments of damage awards).

colleagues found that damage caps significantly reduced medical malpractice insurance premiums.²⁶ The study uses data covering a thirteen-year period—1974 through 1986—and including data for most states. Likewise, Professor Vasanthakumar Bhat examined the influence of damage caps on several indicators including claim rates, severity of claims, and premiums.²⁷ Using data on the payment rate per physician of each state for the period 1991-1995, Bhat found that caps on economic and non-economic damages, taken together, significantly decreased premiums. However, similar to the results of some others, Bhat found that caps on non-economic damages, considered alone, had no effect on premium levels.

These mixed empirical results are most likely due to the difficulties in measuring the influence of caps on medical malpractice insurance and litigation.²⁸ These difficulties arise for a variety of reasons. First, isolating the effects of caps in the presence of other sorts of tort reform is complicated. Second, the uncertainty generated by legal challenges claiming, for example, that reforms are unconstitutional makes it difficult to measure the direct effect of caps on insurance and litigation.²⁹ Third, the availability of data is limited and the data that is available presents challenges in the design of empirical studies. For instance, data on actual losses paid aggregated by state are generally unavailable, although some researchers have obtained data of this sort directly from insurers.³⁰ Furthermore, using proxies for losses paid (e.g., losses incurred) presents additional concerns, including the danger that accounting adjustments might substantially reduce the correlation between losses paid and the proxy.³¹ Specifically, the managers of insurance companies have incentives

26. Stephen Zuckerman et al., *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167 (1990).

27. VASANTHAKUMAR N. BHAT, *MEDICAL MALPRACTICE: A COMPREHENSIVE ANALYSIS* (2001).

28. CONG. BUDGET OFFICE, *THE EFFECTS OF TORT REFORM: EVIDENCE FROM THE STATES* (June 2004) (discussing the difficulties in evaluating the results of the empirical studies on the factors discussed in this Section of the Case Study).

29. See Heidi Li Feldman, *Harm and Money: Against the Insurance Theory of Tort Compensation*, 75 TEX. L. REV. 1567, 1568 n.4 (1997) (discussing cases in which tort reforms have been held unconstitutional on theories of violation of equal protection, violation of right to court access and violations of rights to due process).

30. See Albert Yoon, *Damage Caps and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the South*, 3 AM. L. & ECON. REV. 199, 209 (2001).

31. See Zeiler, *supra* note 4 (analyzing data on losses incurred gathered by the National Association of Insurance Commissioners). Of 550 observations of state-level losses incurred

to manipulate the reserves to manage the bottom lines of their companies. Thus, if we observe lower incurred losses in regimes which cap damages, this may not reflect the true effects of the caps, but rather the effects of earnings manipulations that might be unrelated to manager expectations regarding future losses. In fact, managers might use the fact that damage caps are in place to justify decreasing reserves. Finally, as cogently explained by Professor Albert Yoon, employing simple regressions to study the effects of damage caps on medical malpractice insurance premiums can be problematic if the implementation of caps is endogenous to perceived market conditions related to premiums. In other words, if caps are implemented in response to rising medical malpractice insurance premiums, then it becomes difficult to measure the influence of the caps on premiums.³² This problem is referred to as endogeneity³³

In a recent study, Yoon demonstrated empirical modeling techniques that can be used in the face of potential endogeneity.³⁴ By using a difference-in-difference approach, Yoon was able to account for conditions present before and after the implementation and repeal of damage caps. Employing this technique and others to control for various additional modeling concerns, Yoon found that caps decreased the average relative recovery by medical malpractice claimants. This study offers an important step toward determining the actual effects of caps on insurance and litigation. The results, however, do not allow us to make claims about whether total losses paid out to claimants increase or decrease when caps are imposed because the results do not provide insights into how caps

(fifty states over eleven years), thirteen observations are negative. *Id.* This suggests that adjustments to reserves might swamp losses incurred and reduce the correlation between losses incurred and losses paid. See also *Patient Access Crisis: The Role of Medical Litigation*, House Comm. on the Judiciary, 108th Cong. 2-3 (2003) (statement of Jay Angoff, Counsel, Roger G. Brown & Associates) (reporting testimony describing insurance company manager incentives to inflate or understate estimates of losses incurred).

32. See Yoon, *supra* note 30, at 202 (arguing that if “the policy is a codification of underlying conditions . . . that actually caused the policy to be implemented in the first place,” then determining the causal connection between the implementation of caps and indicators, such as losses, becomes difficult).

33. For an explanation of the problems resulting from endogeneity, see STEPHEN J. SCHMIDT, *ECONOMETRICS* 263-81 (2004). See also HOWELL E. JACKSON ET AL., *ANALYTICAL METHODS FOR LAWYERS* 565-566 (2003) (illustrating endogeneity, which they refer to as “two-way causation,” by pointing out that it is difficult to understand the influence of increasing the number of police on crime rates because more police tend to be sent to particular areas: namely, those with high crime rates).

34. See Yoon, *supra* note 32, at 203.

influence the number of patient injuries and the number of claims filed. If caps result in an increase in the number of claims filed, then despite the fact that average recoveries decrease, caps could increase the total losses paid.

Despite the fervent push to implement damage caps as a solution to the medical malpractice insurance crisis,³⁵ more research clearly is needed to determine how caps and other sorts of tort reform actually affect behavior in health care markets. Not only is more empirical research necessary, but also it is important that the empirical research be grounded in sound theoretical models of the effects of tort reform on behavior in health care markets. In the meantime, turning our attention to other possible remedies might prove useful. Part II presents an alternative remedy yet to be addressed by policymakers.

II. AN ALTERNATIVE REMEDY: MANDATORY CONTRACT DISCLOSURE

As of 2001, twenty-one states required MCOs to disclose to their enrollees or prospective enrollees the terms of their contracts with physicians.³⁶ While the goal of forcing contract disclosure is simply to provide information to consumers during the health plan selection process,³⁷ evidence suggests that disclosure of contract terms might result in lower medical malpractice insurance premiums.

The relationship between contract disclosure and medical malpractice insurance premiums is not intuitive. To understand the relationship, one must consider how the revelation of MCO-physician contract terms influences two types of decisions: litigation decisions made by injured patients and contract decisions made by MCOs.³⁸

First, consider how contract disclosures affect whether an injured patient pursues a medical malpractice claim against her physician. As discussed above, patients considering whether to file a medical malpractice

35. See *supra* Section I.A.

36. For a list of states that force disclosure of contracts between MCOs and physicians, see Zeiler, *supra* note 4.

37. Cf. William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1825 (1999).

38. For a more complete game-theoretic analysis of the influence of mandatory contract disclosure rules on MCO-physician contracts, compliant treatment rates and medical malpractice litigation rates, see Zeiler, *supra* note 19; see also, Kathryn Zeiler, *Medical Malpractice and Contract Disclosure: An Equilibrium Model of the Effects of Legal Rules on Behavior in Health Care Markets* (Apr. 2004) (Working Paper presented to the Am. L. & Econ. Ass'n Annual Meeting, 2004).

claim frequently must do so under conditions of imperfect information. The injured patient is not always able to observe whether her injury was truly caused by negligent behavior on the part of her physician.³⁹ Injured patients (and their attorneys) benefit from information that helps to resolve this uncertainty when deciding whether to pursue costly litigation.⁴⁰

MCO-physician contract terms are just this sort of information. In theory, injured patients should be able to update their prior beliefs about whether the physician acted negligently by considering the contract terms. For example, if the patient observes that the MCO and the physician agreed to a traditional fee-for-service arrangement (i.e., the physician is reimbursed a fee by the MCO for each particular medical service provided), then the injured patient might be more likely to believe that expensive compliant treatment was provided than if the MCO and physician agreed to a capitated arrangement (i.e., the MCO pays the physician a fixed dollar amount per patient per month and the physician pays for overruns out of his own pocket).⁴¹

Still, how does a change in the way potential litigants make decisions about whether to file claims lead to lower medical malpractice insurance premiums? The next step in the analysis is to consider how behavior at the litigation stage affects contract choices. MCOs design physician contracts to provide incentives for physicians to choose treatments that maximize MCO profits. In regimes that force contract disclosure, MCOs must consider not only how the contract terms shape physician treatment decisions, but also how the contract terms will influence litigation decisions by injured patients. By observing disclosed contract terms, patients are able to update their beliefs about the likelihood that they

39. Whether the patient is able to infer that the injury was caused by the negligent actions of the physician or MCO depends on two probabilities: the probability that non-negligent treatment results in injury and the probability that negligent treatment results in injury. If these probabilities fall somewhere between zero and one, but are not equal to zero or one, then the patient will be uncertain about whether the injury resulted from negligent treatment. These probabilities, of course, will differ from case to case and will depend on the nature of the treatment, the characteristics of the patient and other such factors. *See Zeiler, supra* note 14.

40. This general concept is not novel: When principals are not able to observe behavior, they often turn to other sources of information, such as the number of hours the agent worked or whether the agent seemed intoxicated. *See* EDWARD P. LAZEAR, *PERSONNEL ECONOMICS* (1995).

41. *See Zeiler, supra* note 19, at 21-29 (predicting the manner in which MCOs will employ various contract types to influence physician behavior given a particular legal regime).

received compliant treatment. In fact, MCOs benefit from disclosing because they can use disclosures to signal the provision of compliant treatment and potentially reduce the number of claims filed.⁴² In other words, when injured patients receive the signal that compliant treatment was provided, they are less likely to file a costly medical malpractice claim because the likelihood of succeeding is low. Therefore, when patients can observe contract terms it is more likely that the MCO, when comparing the cost of compliant treatment to the expected damage award, will find it optimal to employ particular contract terms to encourage the physician to provide compliant treatment. This is because, in those cases, the cost of providing the level of compliant treatment necessary to ensure that very few medical malpractice claims are filed is less than the reduction in exposure to liability that results from the increase in the provision of compliant treatment.⁴³ As a result, in regimes that mandate contract disclosure, MCOs are more likely to use contract terms that encourage physicians to provide compliant treatment and patients are less likely to file medical malpractice claims.⁴⁴

Initial empirical tests of the theoretical predictions regarding how mandatory contract disclosure rules affect medical malpractice insurance premiums support claims that disclosure rules decrease *ex ante* expected damages arising from medical malpractice claims. A study using data on medical malpractice insurance premiums per physician in the fifty U.S.

42. That we do not observe MCOs voluntarily disclosing physician contract terms is most likely due to the fact that disclosure of this information is costly. Not only is the disclosure itself costly to produce, but an MCO might lose its competitive advantage if it discloses information about innovative contract terms that create efficiencies not enjoyed by competing MCOs. See Zeiler, *supra* note 4, at 28-29. In addition, that we do not observe consumers demanding disclosure of contractual arrangements might be due to market failures. See Bruce C. Greenwald & Joseph E. Stiglitz, *Externalities in Economies with Imperfect Information and Incomplete Markets*, 101 Q. J. ECON. 229 (1986). Market failures abound in health care insurance markets. In particular, given that a substantial number of consumers obtain their health insurance through their employers, most consumers of health insurance are not involved in the bargaining process. See KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2004 ANNUAL SURVEY (2004), <http://www.kff.org/insurance/7148/summary/index.cfm> (reporting that “[e]mployer-sponsored health insurance reaches more than three out of every five nonelderly Americans”). In addition, employers’ interests are not necessarily aligned with the interests of their employees.

43. See Zeiler, *supra* note 19, at 21-31 for a detailed explanation of this result.

44. For a complete analysis of how mandatory contract disclosure rules lead to more compliant treatment and less litigation, see Zeiler, *supra* note 19, at 29-31 for a detailed explanation of this result.

states for the period 1991-2001 provides some support for the prediction that mandatory disclosure rules decrease ex ante expected damages from medical malpractice claims.⁴⁵ The empirical results indicate that medical malpractice insurance premiums are lower in states that force disclosure of contract terms.

Mandatory disclosure has some potential drawbacks as well. For example, by forcing MCOs to disclose information about physician contracts they are, in essence, forced to reveal trade secrets.⁴⁶ Innovative physician contracts arguably afford MCOs the opportunity to obtain an advantage over competitors. This benefit provides an incentive for MCOs to design creative, efficient physician contracts, an endeavor advantageous not only for the MCO but also for enrollees who enjoy lower prices and/or higher quality. Forcing MCOs to disclose information about these contracts might diminish the incentive to expend resources to develop innovative physician contracts. It is important to weigh these disadvantages against the benefits gained or consider ways to work around them before implementing such policies.

CONCLUSION

This Case Study focuses on the “best way” to address or improve the current state of malpractice insurance. Given the complexity of the industry, the solution likely will be complex itself, as it must address

45. See Zeiler, *supra* note 4, at 19-22, 24-26 (reporting regression results indicating that, under reasonable specifications, mandatory contract disclosure leads to lower medical malpractice insurance premiums). The effect of mandatory disclosure rules, however, becomes statistically insignificant when assuming (1) that a lag exists between the time statutes are passed and insurance rates reflect the new rule and (2) that current year premiums depend on prior year premiums. *Id.* At 24-26. While these empirical results provide some support for the theoretical prediction that mandatory disclosure rules lead to lower medical malpractice insurance premiums, it is important to note that these are preliminary findings. Further investigation is required before we can recommend policy prescriptions.

46. HMOs have argued that required disclosure of physician contracts is unfair because the contracts are trade secrets. They claim that contracts are the result of much time and effort spent negotiating with physicians, and forced disclosure will allow competitors to unfairly take advantage of the end product without contributing to the costs. See *Wilmington Star-News v. New Hanover Reg'l Med. Ctr.*, 480 S.E.2d 53, 56 (N.C. Ct. App. 1997) (discussing whether pricing information in HMO contracts constitutes a trade secret). Forcing disclosure of physician incentives might create an economic disincentive to expend resources constructing innovative incentive arrangements. It is important to consider this when evaluating whether mandatory disclosure is socially optimal.

information asymmetries, agency problems, the negative effects of adverse selection, and various other market imperfections resulting from the structure of health care markets. Likely, no one remedy will be a panacea. In addition, seemingly intuitive remedies often produce unintended, perverse effects.

The main point of this Case Study is to argue that damage caps, while a seemingly intuitive fix, might not be the cure-all touted by politicians and industry actors. Deeper analyses of the effects of caps reveal that they might affect health care markets in ways that make matters worse. In addition, given the nature of the inquiry and inherent methodological problems, we cannot draw strong conclusions from the body of empirical studies that investigate the effect of caps on medical malpractice insurance premiums.

Given these difficulties, we should focus on alternatives to damage caps. One such alternative—mandating disclosure of MCO-physician contract terms—appears promising. An analysis considering how the market will react to the mandate indicates that forcing disclosure will lead to lower medical malpractice insurance premiums. Preliminary empirical evidence suggests that it is worthwhile to explore this remedy further.

Patchwork remedies and politically-driven policies likely will not ameliorate the negative consequences of health care market imperfections. If we have any hope of structuring and regulating health care markets so as to reduce the probability of experiencing various sorts of crises, we must step back and take a comprehensive look at how market actors will adjust to regulations and how various regulations interact with one another.

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