Is No-Fault Insurance a Viable Alternative to Our Professional Liability Insurance System?

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A typical illustration of our failed professional liability ("medical malpractice") insurance system is a woman in poor health who loses her baby in childbirth, and who hires an attorney on a contingency fee basis to sue her obstetrician.

On the witness stand, the grieving mother's testimony is given between sobs, repeatedly interrupted to allow her to regain her composure, as she tells a sympathetic jury how much she loved her baby and how the loss of her baby has devastated her.

The physician's testimony counters this, accompanied by medical charts, test results, dry recitations from dictated medical records—frequently interrupted to explain the Latin medical terminology to an inattentive, disinterested jury—followed by diagnosis and treatment protocols from medical textbooks supporting the course of therapy.

The judge and jury, easily swayed by emotion and tears over logic and reason, are unwilling or unable to make the mental effort to understand the medical science involved. They follow the easier and more socially acceptable path of disregarding the facts of the case, siding with the emotionally distraught plaintiff, and condemning the professionally composed doctor.

Once the doctor is found liable for the death of the baby, the next task is to assess monetary damages. Because there are no legal or economic standards for valuing a human life, or assessing physical and mental suffering, there is no objective method or rationale to calculate a proper amount. The result is that these values, for all practical purposes, are numbers so large that neither the judge, jury, nor patient have ever experienced them, nor can comprehend them. The doctor's practice suffers irreparable damage, and his career can be ruined. The plaintiff's attorney reaps a financial windfall that will make him independently wealthy.

Now imagine the mirror image of this scenario, with a different set of laws and incentives. A pregnant woman who has had one miscarriage goes into a long and difficult labor in the early morning hours during a snowstorm. The doctor on call, at great effort and risk, comes to the scene and delivers a healthy baby girl. However, the patient refuses to pay the doctor's full fees, and under this imaginary alternate legal system, in the courtroom the doctor is the plaintiff, the patient is the defendant, and her lawyer is paid by the hour.

Using the same dramatic tactics, and evoking the same emotions as the plaintiff attorney in the first scenario, the doctor brings the newborn baby girl into the courtroom, allows the judge and each member of the jury the opportunity to hold and caress it, concludes his prosecutorial speech by getting everyone to agree that this is the most beautiful baby girl they have ever seen, and poses the following question: How much is this baby girl worth? To you? To the mother and father? And to the world?

Of course, the jury assigns an equally incomprehensible number to the value of the baby's life. Only this time, one-third of that amount doesn't go to the lawyer; it goes to the person who earned it: the bleary-eyed, sleep-deprived doctor who helped make this new life possible by rushing at great risk, expense, and inconvenience to deliver the baby.

How would our system work if the incentives for patients, doctors, lawyers, and juries were reversed? Since patients contend—and juries eagerly agree—that one cannot place a dollar value on a human life, and that burdens of pain and suffering are incalculable, shouldn't doctors be equally, and disproportionately, rewarded when they save a life or relieve physical pain and suffering?

The current practice of obstetrics is like a game of Russian roulette, with modest rewards, accompanied by the constant threat that the next pregnant woman in the delivery room holds the loaded chamber with a defective baby or an obstetrical catastrophe that endangers the mother's life and the doctor's career. In a system of reversed incentives, obstetrics would be like a high-stakes lottery, in which doctors could buy as many tickets as they wanted, and they were virtually assured of hitting a multimillion-dollar payoff at some point in their careers, just as lawyers do today.

These two stories show the lopsided incentives in our medical and legal systems. The result is that while there is a huge demand for physicians, and medical training programs strive to fill that demand, the legal system and the medical liability insurance market create shortages—especially of obstetricians in parts of the country plagued by irrational medical malpractice judgments. How can a market that serves at least one-seventh of the U.S. economy fail so miserably?

Actuarial and Economic Factors

From actuarial and economic perspectives, the six major problems with the medical liability system in the United States are:

- ***Risk Assessment:*** *estimating the inherent risk of the insured entity in order to determine the insurance premium.* Patients with complex and dangerous conditions, who pose a greater medical liability risk, are not charged proportionally higher fees by doctors, nor are their exceptional circumstances sufficiently considered by juries when weighing the facts of the case.
- ***Insurable Interest:*** *the investment by the insured parties of the equivalent of the economic value of the items for which they purchase insurance.* Patients make no defined investment in their health (as they do when they buy insurance for a house or car they own), nor do they place a predetermined value on their health (as they do when they purchase life insurance to cover their financial obligations).

- ***Morale Hazard:*** *the insurance industry term for insured parties' lack of incentives to take reasonable precautions to prevent losses for which they are insured.* Patients are often noncompliant and exhibit self-destructive behaviors that undermine the best efforts of doctors to treat them.
- ***Incompetent Decision Mechanism:*** *flaws in the legal process that result in wrong decisions, for example, because of inability to assess the facts.* Jurors, who have been selected specifically for their lack of medical knowledge, decide innocence or guilt and award monetary damages. Blaming doctors for defective babies—because they happen to be present at the scene—is often like blaming local weather forecasters for damage wrought by hurricanes and tornados.
- ***Depreciation and Inevitable Failure:*** *bundling the natural inevitable outcomes of disease and death with the potential man-made risks of medical malpractice.* While people logically recognize that some babies will be born with genetic defects and that everyone will die, the practice of medicine and of law often ignores these realities. Auto mechanics do not have this problem. When they diagnose a failed transmission on 17-year-old car with 189,000 miles, they know the cost of the repair exceeds the value of the vehicle, and the owner rationally agrees to cut his losses and send the car to the junkyard. Emotionally, people don't think of human life this way. Logically, they know that aging, disease, and death are inevitable for everyone and are beyond the powers of medical science to prevent—but court decisions often deny this reality.
- ***Moral Hazard:*** *the incentive for insured parties to engage in malicious destructive behavior to profit from the proceeds of their insurance policies.* Although lawyers are not the insured parties in medical liability insurance, they still disproportionately benefit from it. Instead of billing by the hour or by the service, which is usual for the legal profession, medical malpractice cases offer the lucrative option of the contingency fee. This resembles a lottery in which the lawyers' odds are unfairly stacked in their favor. As long as the legal system rewards lawyers with lottery-sized windfalls, they will be tempted to exploit its flaws, not so much to compensate injured patients or delicense incompetent doctors, but to disproportionately enrich themselves. This further distorts the traditional practice of medicine, which dictates that the best heart surgeon in town should attract referrals of the most difficult and severe cases. However, the medical malpractice system provides increasing pressure to avoid such referrals and the additional malpractice risks they pose, and to place asset protection above the practice of medicine and the patient's best interests.

Notice that none of the above six insurance problems would be solved by role reversal—with the minor exception that doctors, not lawyers, would be the ambulance-chasers. And patients in ambulances have a more pressing need for a doctor than for a lawyer.

The problems are not caused by lawyers—who are drawn from the same genetic pool as doctors, politicians, and used-car salesmen, and respond to economic incentives in the same way. Pay them to do something, and they will generally do more of it. Penalize them for doing something, and they will generally do less of it. Lawyers are no more responsible for outrageously high professional liability premiums than doctors are responsible for outrageously high medical costs.

Dilemmas for Doctors

Doctors unable to pay their escalating professional liability premiums have four unattractive options: (a) change their specialty; (b) scale back their practice; (c) move to a state with a friendlier legal environment; or (d) cancel their policy, roll the dice, and self-insure their risk.

In 2002, Dr. Shelby Wilbourn, an obstetrician/gynecologist in Las Vegas, Nevada, was so desperate that he chose both options (b) and (c). First he scaled back his practice to gynecology, and ceased delivering babies. When that proved to be insufficient, he uprooted himself and moved to the other end of the country, where his liability premium dropped by more than 90%.[1]

For Dr. Wilbourn, the rationale for his decision was simple, appealing, and obvious. For the privilege of delivering 200 babies in 2002, his liability insurer charged him $56,000. That works out to $280 in liability insurance costs per delivery. When his insurer informed him that his premium would nearly double to $108,000, or $540 per delivery the following year, Dr. Wilbourn folded his tent and moved his practice to Belfast, Maine.

If Dr. Wilbourn charged $1,400 for a delivery in 2002, he would have to add a 20 percent surcharge to his bill to cover his malpractice premium. Had he continued to practice in Las Vegas, he would have had to increase this to almost a 40 percent surcharge in 2003. This logic is equally simple, appealing, and obvious from the patient's perspective. Imagine consenting to pay $25,000 for a new car, and as you're about to sign on the dotted line, the salesman softly whispers, "and for an extra $10,000 we'll guarantee that it works."

Naturally, the cost of providing the warranty (liability insurance) contract for a new car is included in the purchase price. However, few products or services have warranty costs that approach even 5 percent of the purchase price, much less the 40 percent professional liability tax on having a baby in Las Vegas.

In the auto industry, the standard 3-year bumper-to-bumper warranty comprises less than 1.5 percent of the cost of the vehicle for Japanese automakers, and about 3 percent for U.S. automakers.[2] If a new car dealer offered an additional $350 off the price of a $25,000 car in exchange for waiving the warranty, how many new car buyers would agree? And if the dealer increased the offer to $700, how many new car buyers would change their minds?

Dr. Wilbourn has two economic and legal problems he can't resolve. First, he knows that few patients—young expectant mothers in his case—would be willing or able to spend an extra $560 for the liability insurance premium to protect themselves against the natural genetic risks of birth defects and the man-made risk of their doctor's incompetence. To compound this problem, he also knows that while his patients will not, or cannot, pay the premium, he must.

His second problem is that he knows his professional liability insurance premium is grossly overpriced, but he doesn't know what the market price should be. He is confident that if he were so

incompetent as to warrant an annual $108,000 malpractice premium, he would never have graduated from medical school. Even worse, the actuaries who calculate the cost of his premium don't know what that price should be either, because incompetent and unpredictable juries compound the risk assessment problem.

Actuarial Calculations

The basic actuarial calculation for an insurance premium is the *odds of an event occurring* multiplied by the average *value of the loss*. The problem for actuaries is that both of these previously predictable variables have become unpredictable. First, when juries make the wrong decision by impulsively and routinely assigning fault to the doctor, irrespective of the facts, actuaries are unable to calculate the true odds of an event occurring for the risks they are attempting to price. Second, when juries assess randomly large and unrealistic damages with their verdicts, actuaries don't know what amount to use for the value of the loss for the second variable in their equation. Thus, a reasonably stable system of predictable outcomes is transformed into an unstable system of unpredictable outcomes.

Increasing the odds of an event occurring, or increasing the value of the loss, will naturally increase an insurance premium. This is exacerbated by another actuarial principle, which holds that increased uncertainty further increases insurance premiums. The less certain an actuary is about either the odds of an event occurring or the value of the loss, the higher the premium should be. In other words, premiums for competent, predictable juries will be lower than premiums for incompetent, unpredictable juries.

Patient-owned, No-fault Insurance

One proposed alternative to our current liability insurance system is a no-fault, "bad outcomes" policy, purchased before a surgical procedure to financially protect the patient from an adverse result. It exists today in the form of flight or travel insurance, which offers the customer a policy prior to traveling for a predetermined amount at risk. At first glance, it appears to be the preferred answer because it solves all six problems of the current system by assigning values and prices, which the patient consents to pay, to the two primary insurance variables.

Travelers purchasing flight insurance assess their risks in advance when they buy the policy. They define their insurable interest in advance, paying proportionally more for higher-level coverage. There is no morale hazard because the airline has no way of knowing who purchased flight insurance. The incompetent decision mechanism is eliminated, because the question is no longer, "Who was at fault?" but rather, "Did the passengers arrive safely?" The inevitable fact of death is acknowledged and valued in advance. And the moral hazard is removed because travelers cannot affect the outcome of the flight, and thus contract disputes rarely result.

For Dr. Wilbourn, a no-fault bad-outcomes policy, purchased by the patient in advance of the delivery due date, appears to solve these problems. Patients define in advance how dearly they value their life and health, and how much a bad outcome is worth to them.

Actuaries have ample statistics on maternal and infant mortality rates to calculate reasonably accurate and competitive premiums with a high degree of confidence. Insurers will charge arithmetically more for policies with a higher face value, and exponentially more for policies covering patients with high-risk pregnancies as opposed to routine ones.

The cost of the risk of the patient's condition is properly transferred from the doctor, who cannot control it, to the patient, who cannot escape it. The doctor can now properly and honorably focus his efforts on achieving the optimal outcome for the patient, rather than on minimizing his legal liability and protecting his net worth. In the event something goes wrong, the legal issue is no longer the difficult and subjective question of, "Who was at fault?" but instead the more simple and objective question, "What was the outcome?"

In fact, warranty contracts for consumer products are routinely written with similar provisions, which limit the manufacturer's liability to the purchase price. For example, if someone pays $1,000 for refrigerator that proves to be defective, he is legally entitled to a $1,000 refund from the manufacturer. However, the manufacturer is not liable for the value of the food that spoiled when the cooling unit failed. But if a restaurant serves poultry products tainted with salmonella, customers can recover both the cost of their "defective" meal, along with monetary damages for the illnesses they suffer.

Legal and Economic Barriers

The restaurant example illustrates the four legal and economic barriers that also prevent implementation of "no-fault" bad-outcomes medical liability contracts:

- ***Inalienable rights***: People cannot waive their rights to their physical bodies.
- ***Personal responsibility***: People cannot absolve themselves of responsibility for the consequences of their actions.
- ***Unequal bargaining power***: Doctors have vastly more knowledge and experience with the risks involved with (a) the patient's condition, (b) their recommended course of treatment, and (c) their professional competence, than their counter-parties—i.e. patients with whom they contract.
- ***Economic efficiency***: It's more economically efficient and socially advantageous for the knowledgeable and responsible parties to bear the cost of the risks of routine implicit contracts of daily social intercourse.

The first problem with no-fault bad-outcomes professional liability insurance is that, while it defines in advance the exchange of money based on the possible outcomes (as with any common wager), it ignores the legal liability for bodily harm. While doctors and patients can agree to ignore this liability, the U.S. legal system will not allow them to, and the laws of economics make it inefficient to do this. The failure of no-fault auto insurance and the gradual demise of flight insurance over the past several decades provide the evidence.

A fundamental principle of the U.S. legal system is that a citizen, in most cases, cannot waive or be denied his rights, which are deemed to be inalienable. For example, a person can agree to sell himself into slavery to a master. They can even sign a contract to codify the terms. However, if at some point the slave decides to

quit and run away, and the master files a lawsuit against him for breach of contract, the courts will refuse to enforce it.

The practical application to professional liability insurance is that patients cannot waive their rights to sue their doctors for bodily harm. If a patient signs a contract with a surgeon in which she waives her right to sue him, it is not enforceable in the courts. It might be enforceable in cases in which the doctor can prove that he took all precautions and did everything correctly, but it would not be enforceable if, say, the doctor operated while intoxicated, acted out of malice (e.g. if the patient was having an affair with the surgeon's spouse), or was otherwise professionally negligent.

In such cases of incompetence, malice, or negligence, the malpractice problem would not go away, because the insurer of the no-fault bad-outcome policy would then sue the doctor in an attempt to recover its losses, in the same way that an auto insurer sues the driver of the car that hit one of its policyholders to recover the losses it paid.

Another fundamental principle of the U.S. legal system is that a citizen, in most cases, cannot be absolved of the responsibility for the consequences of his actions. When owners of parking lots post signs that read, "Not responsible for damaged or stolen vehicles," this is generally valid because they are stating that the terms of their contracts are for providing a parking space, and not for security. However, a person cannot extend this legal principle by putting a bumper sticker on his car that reads, "Not responsible for my reckless driving," and then claim immunity for crashing into another vehicle because the other drivers on the road were properly informed in advance.

Third, doctors know a great deal more about the risks their patients face than their patients do. Patients place their trust in their doctors' medical expertise and make their decisions based on their doctors' professional recommendations. When contractual disputes arise in cases of asymmetric knowledge of the parties involved, legal precedent holds that ambiguities and unforeseen circumstances are interpreted against the party with the superior knowledge, because that party is in a much better situation to have been aware of such potential outcomes, and is assumed to be in a position to take unfair advantage of the other party in such a contract.

Even if these legal barriers did not exist, the best argument against no-fault medical outcomes insurance is economic. It's much more efficient for one doctor, who knows the risks, treatment options, and surgical procedures, to sign one liability insurance contract at the optimum price, than it is for many patients, who have little or no knowledge of the risks, to negotiate, sign, and pay for a huge number of contracts—with prices inflated because insurers take advantage of the insured's unfamiliarity.

This is why automobile drivers purchase a single insurance policy against the risk of a collision with anyone, not individual policies covering the risk of colliding with every other potential licensed driver. Similarly, building owners buy liability insurance against risk of structural failure, rather than having all who enter the building buy their own insurance for the same risk.

When the Hyatt Hotel walkway in Kansas City collapsed in 1981, killing 114 people, none of the victims had purchased—or thought to purchase—insurance against such an unforeseen event. The property owner and architect were legally liable. And it would be practically, legally, and economically absurd for every person contemplating walking into a hotel lobby to consider negotiating and purchasing such insurance.

Patients regularly place defined dollar values on their untimely death, and pay a premium accordingly when they buy life insurance. The typical family man, who wants to provide for his wife and children in the unlikely event of his untimely death, purchases life insurance for this purpose. He doesn't care what might cause his untimely death—heart attack, auto collision, building collapse, or botched surgery; his only concern is that his family is provided for. But just because people don't think to, or bother to, purchase such insurance in advance doesn't mean either that (a) they place no value on their life, or (b) that injuring or killing them should not result in legal liability.

The gradual demise of flight insurance, more popular in the 1950s and 1960s, is due to both (a) the legal precedents for liability of bodily harm have been firmly established over time (the airline is legally liable and pays compensation to the victims and hence purchases liability insurance protecting itself for the financial risk of such catastrophes), and (b) air travel has grown exponentially safer over time to the point that travelers, and even insurance companies (which used to classify airline pilots and flight attendants as high-risk occupations), no longer consider air travel riskier than other forms of travel.

Reducing all this to one sentence: *The U.S. professional liability insurance market is economically efficient, but the U.S. legal system—as it is applied to medical malpractice—is not effective.* The proposal for no-fault bad-outcomes medical contracts is an attempt to sacrifice the economic efficiencies of professional liability insurance in exchange for the privilege of circumventing the ineffective U.S. medical malpractice legal system.

To illustrate why this is generally undesirable, consider the legal precedents that would be set—and the resulting social consequences—if people were able to avoid or severely restrict their liability for the consequences of their actions. Men would have an incentive to coerce women they date, or even marry, into signing contracts stating they are not liable for child support if they get them pregnant. Projecting this scenario into other areas of routine social discourse will generate sufficient examples that would shake the foundation of our legal system and ultimately our civilization.

The linchpin of the problem with the U.S. professional liability insurance system is the defective decision mechanism. Fixing this problem will generally solve the other five. And success will be measured when malpractice premiums are reduced to 2-3 percent of the costs of a doctor's practice, instead of the current 20-30 percent.

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