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Does Tort Reform Reduce Health Care Costs?

With the U.S. Congress actively debating health reform bills that could extend insurance coverage to millions of Americans, the need to identify strategies to contain health care costs has become an ever more pressing issue. Tort reform has been proposed by leaders of both political parties as one possible strategy to reduce health care costs.

In “**The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums**” (NBER Working Paper 15371), researchers **Ronen Avraham**, **Leemore Dafny**, and **Max Schanzenbach** exploit state-level differences in tort laws to explore the potential cost savings associated with tort reform.

The authors begin by observing that tort reform must have an impact on medical practice — as opposed to solely on medical *malpractice* — in order to yield nontrivial reductions in healthcare costs. Direct costs of malpractice, which include premiums, damage awards in excess of premiums, and associated litigation costs, represent no more than two percent of health care costs. Thus, tort reforms can have a substantial effect on health care costs only if they affect the amount of healthcare services provided.

The authors explain that the effect of tort reform on health care costs is theoretically ambiguous. On the one hand, providers’ sensitivity to liability may lead them to provide excessive care, resulting in higher health care costs. Eliminating this practice of “defensive

medicine” is a primary justification for tort reform. On the other hand, however, liability creates incentives for providers to take greater precautions and avoid unnecessary risks. By this logic, reducing liability could increase costly medical errors and encourage providers to recommend profitable but unnecessary and even risky treatments, increasing health care costs and lowering the quality of care. Thus the effect of tort reform on costs is an empirical question.

The previous literature on this topic has largely focused on the effect of tort reform on treatment intensity for particular medical conditions with a large number of malpractice claims, such as pregnancy. These studies may not be representative of the effect on health care at large and have led to wide variations in the estimated impact of reform. The current study is the first to look at the aggregate effect of reform on costs.

To do so, the authors use a database of employer-sponsored health plans covering over 10 million non-elderly Americans annually for the period 1998 to 2006. The authors focus on four types of reforms — caps on non-economic damages (such as for pain and suffering), caps on punitive damages, collateral source reform (which reduces plaintiffs’ awards if they receive public or private insurance benefits), and joint and several liability reform (which limits plaintiffs’ ability to go after those parties with “deep pockets”).

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The authors’ basic approach is to make use of differences in the timing of adoption of these reforms by the states to identify the effect of reform on premiums. In their first key set of results, they find that each of the reforms except for the cap on punitive damages lowers health insurance premiums by 1 to 2 percent. This result applies to self-insured plans, those health plans for which the sponsoring employer directly pays realized health care costs of enrollees rather than paying an insurance carrier to bear this risk.

By contrast, the authors find that tort reforms have no effect on premiums of fully-insured plans. Since almost ninety percent of fully-insured plans in their data are managed by Health Maintenance Organizations (HMOs), this finding suggests that HMOs may reduce defensive medicine

without tort reform through monitoring of care. The authors test this hypothesis directly by comparing the effect of the reform by insurance plan type within the sample of self-insured firms. They confirm that responses to the reforms are concentrated among plan types other than HMOs, such as Preferred Provider Organizations (PPOs).

Another interesting hypothesis the authors test is whether post-reform premium reductions are steeper in more competitive insurance markets, as measured by the number of insurance carriers. They find that this is the case. This suggests that when insurers possess market power, the pass-through of cost reductions due to tort reform will be incomplete.

A potential concern with the

authors' analysis is that tort reforms may be adopted by states that are experiencing a rapid increase in health insurance premiums, generating a correlation between reforms and premiums that may not represent a true causal effect. When the authors test whether the implementation of a reform is associated with any change in premiums prior to the reform, however, they fail to find any evidence of this. They also find that the effect of reforms strengthens slightly with time.

In sum, the authors find that caps on non-economic damages, collateral source reform, and joint and several liability reform reduce self-insured premiums by 1 to 2 percent each. These findings indicate that tort reform reduces treatment intensity, as the drop in premiums is larger than the sav-

ings that would arise from reduced direct liability costs. These reductions are concentrated in PPOs rather than HMOs, suggesting that HMOs can reduce "defensive medicine" even in the absence of tort reform.

The authors observe that their findings "constitute the first evidence that tort reform reduces healthcare expenditures broadly (albeit not in a managed-care environment)." However, they caution that "to understand the social welfare implications of these reforms... additional research on health outcomes and long-run costs is needed."

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What Determines Movement Across Health Care Plans?

Most non-elderly Americans who have health insurance receive their coverage through an employer. Many workers are offered a choice among several employer-sponsored health insurance plans. These plans can be characterized as more or less generous, where the more generous plans offer greater freedom in selecting providers, and/or more complete coverage of health care expenditures. Such plans, however, have higher premiums.

What factors determine a worker's choice of a particular plan, either initially, or to remain or change plans if previously enrolled? Those decisions and the resulting dynamic features of insurance plan populations are the subject of a new conceptual and empirical study by researchers **David Cutler, Bryan Lincoln, and Richard Zeckhauser**, "Selection Stories: Understanding Movements across Health Plans" (NBER Working Paper 15164).

The authors begin with a theoretical discussion of the factors affecting workers' choice of plan. Traditional economic theory suggests that workers consider price, including both premi-

ums and out-of-pocket costs, as well as future expected spending when choosing a health insurance plan. Expected spending is related to both age and current health status, and can differ dramatically across individuals. Average health care costs rise rapidly with age once workers reach their 40s. The distribution of health care costs at any age is highly skewed; thus, a relatively small share of the insured population accounts for a large fraction of total expenditures. The premiums that workers pay for employer-sponsored health insurance typically are not related to their own expected spending.

This choice setting is likely to generate adverse selection, the tendency of those with higher expected spending to select the more generous plan. Such choices render the more generous plan a poor deal financially for healthier workers with lower expected spending, since the plan will have to charge high premiums to cover the costs of the less healthy workers it has attracted. Thus, too few of the healthier workers will enroll in the more generous plan relative to what their risk preferences alone would dictate. In some cases the

more generous plan may be forced out of business through a phenomenon known as a "death spiral."

The authors identify other factors that may affect plan choice as well. The costs of switching from one health insurance plan to another are potentially important. Suppose that workers with higher spending are less likely to switch plans, for example because they are concerned about changing doctors in the middle of treatment, or because there is transaction cost or insecurity associated with transferring medical records to a new doctor. In this case, adverse retention will result, meaning that sicker workers would be less likely to move, regardless of the generosity of their current plan.

If switching costs are sufficiently high, workers will rarely or never switch plans. The authors call this phenomenon aging in place. If the initial demographics of the two plans differ substantially, aging in place could result in an increasing premium differential over time, due to the rapid rise in health care costs after age 40.

Having established that these three phenomena — adverse selec-