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IN THIS ISSUE

Liability Reforms Reduce the Practice of Defensive Medicine

The combined cost of administering the current malpractice system and of the actual compensation to plaintiffs represents less than 1 percent of total medical expenditures. However, the effects of the malpractice system on physicians' behavior are potentially much more important: physicians may respond to the threat of malpractice lawsuits by being "too careful," that is, by administering precautionary treatments with minimal expected benefit because they fear legal liability. The term often given to this practice is "defensive medicine." Yet for all the discussion, there has been virtually no direct evidence on the existence and magnitude of defensive medical practices until now.

In **Do Doctors Practice Defensive Medicine?** (*NBER Working Paper No. 5466*), **Daniel Kessler** and **Mark McClellan** show that malpractice reforms that directly reduce providers' liability lead to reductions of 5 to 9 percent of medical expenditures without substantial effects on medical complications or mortality. Their conclusion is based on data on hospital expenditures and health outcomes for Medicare patients who were admitted to the hospital with either acute myocardial infarction (AMI) or ischemic heart disease (IHD). They focus on patients with either of these two heart problems because cardiovascular illness is likely to be sensitive to defensive medical practices: AMI is the third most prevalent type of malpractice claim, only behind malignant breast cancer and brain-damaged infants.

Kessler and McClellan divide the malpractice reforms that they analyze into two categories: those that directly reduce expected malpractice awards and those that indirectly reduce awards. The "direct" reforms are: 1) caps on damage awards, whereby either pain and suffering or total damages payable are capped at a dollar amount specified in the law; 2) abolition of punitive damages; 3) no mandatory prejudgment interest, so that the plaintiff receives interest on a loss from the date of the judgment rather than from the time of the loss, or the time the plaintiff filed suit; and 4) collateral-source rule reform, whereby total damages payable in a malpractice tort are reduced statutorily by all or part of the dollar value of payments to the plaintiff from other sources, such as insurance companies. The "indirect" reforms are: 1) caps on contingency fees, which limit the proportion of an award that a plaintiff can agree contractually to pay to a contingency-fee attorney; 2) mandatory periodic judgments, which require that all or part of damages must be paid in the form of an annuity; 3) joint-and-several liability reform, which abolishes joint and

Correction

An inadvertent error occurred in the April 1996 *NBER Digest* article, "Who Gains from *Maquiladoras*?" The second paragraph should have read as follows:

Initially, Hanson recalls, maquiladoras were not conceived as standalone factories. When they were first permitted in 1965, proponents envisioned "twin plant" production, in which a factory in a U.S. border city would manufacture components and a sister plant across the border, under the same management, would assemble the components into finished goods. This type of formal arrangement has not occurred. Nonetheless, Hanson finds, Mexican assembly plants have had a major economic impact on the U.S. side of the border. Manufacturing employment in the 1980s was nearly flat, but it grew significantly in major U.S. border cities.

several liability for either noneconomic or total damages; and 4) patient compensation funds, under which doctors receive government-administered excess malpractice liability insurance, generally paid for by a tax on malpractice insurance premiums.

If liability reforms reduce defensive medical practices, Kessler and McClellan reason, then reforms lead to slower expenditure growth per case without affecting patient health outcomes. In fact, they find that in states that adopted direct reforms, expenditures per AMI case declined by 5.3 percent relative to those of nonreform states; expenditures per IHD case declined by 9 percent relative to those of nonreform states. These effects on expenditures occurred within three to five years of the reforms. The indirect reforms had much smaller effects, Kessler and McClellan find.

> "[M]alpractice reforms that directly reduce providers' liability lead to reductions of 5 to 9 percent of medical expenditures without substantial effects on medical complications or mortality."

They also find that neither type of reform led to any consequential differences in mortality or in the occurrence of serious complications. Combining the effects on expenditures with the effects on mortality, they compute the expenditure/benefit ratio for a higher-pressure liability regime to be over $500,000 (in 1991 dollars) per additional one-year AMI survivor. In other words, if applied nationwide, reforms directly limiting liability would have eliminated almost $600 million per year of the nation's approximately $8 billion Medicare tab for cardiac disease in 1991, without adversely affecting health outcomes. DRH

Immigrants and Welfare

Members of immigrant households are much more likely to receive some type of welfare benefit—Medicaid, food stamps, housing subsidies, or cash payments—than those born in the United States, according to a recent NBER study by **George Borjas** and **Lynette Hilton**. Moreover, immigrant households have more spells of welfare, and these spells last longer, than nonimmigrant households. In fact, the typical immigrant household has a much higher propensity of being "permanently" on welfare than a "native" household does.

In **Immigration and the Welfare State: Immigrant Participation in Means-Tested Entitlement Programs** (*NBER Working Paper No. 5372*), Borjas and Hilton indicate that the gap between immigrants and natives in the use of the many programs that make up the welfare state is relatively small if only cash benefits, such as Aid to Families with Dependent Children (AFDC, that is traditional welfare) or Supplemental Security Income, are considered. In 1970, immigrant households were slightly less likely than native households to receive cash benefits. By 1990, 9 percent of immigrant households received public assistance, as compared to 7 percent of native households.

But focusing on cash benefits alone gives a misleading picture of the extent to which immigrants receive welfare benefits, Borjas and Hilton write. When noncash transfers such as food stamps, Medicaid, and housing subsidies are considered, the immigrant–native "welfare gap" grows much larger. In the early 1990s, Borjas and Hilton find, 21 percent of immigrant households received cash benefits, Medicaid, vouchers (mainly food stamps), or housing subsidies, as compared to 14 percent of native households (and 11 percent of white non-Hispanic native households). The 9 percent of the U.S. population living in immigrant households accounted for 14 percent of the cost of these various welfare programs, or $26 billion out of a total of $184 billion.

> "[F]ocusing on cash benefits alone gives a misleading picture of the extent to which immigrants receive welfare benefits."

Borjas and Hilton further find that in 1990–1, the typical immigrant household had a 4 percent probability of being on AFDC, as compared to 3 percent for native households. Similarly, more than 9 percent of immigrant households received

food stamps, versus 7 percent of native households. And 15 percent of immigrant households were covered by Medicaid, as compared to 9 percent of native households.

Immigrants who arrived since the mid-1980s are more likely to use various welfare benefits, especially Medicaid, than those who arrived in the early 1970s, Borjas and Hilton observe. And, the longer they are in the country, the more likely these later immigrants are to receive welfare, especially Medicaid. One reason for this growing use of welfare by immigrants is the decline in their education and skill levels, Borjas and Hilton find.

This study is based on data from the government's Survey of Income and Program Participation taken in 1984, 1985, 1990, and 1991. DRF

What Becomes of Pension Rollovers?

Private pension arrangements have changed substantially in the last decade. Defined-benefit pension plans, which typically promise workers a retirement benefit based on years of service, final wage, and retirement age, and which grew rapidly in the early postwar years, have stopped expanding and even contracted in some years. Defined-contribution pension plans (including 401(k) plans), in which each employee and (in some cases) the employer make contributions to a set of specific pension accounts designed to provide income in retirement, have expanded rapidly.

The "pension portability" associated with defined-contribution plans is one of their important attractions relative to defined-benefit plans. When workers leave a job with a defined-contribution plan, they typically can withdraw at least some, and potentially all, of their accumulated pension assets and transfer them to the pension plan of a new employer, or "roll over" these assets into an Individual Retirement Account (IRA). Individuals also can withdraw the assets in defined-contribution pension plans and not roll them into a new retirement saving vehicle.

In evaluating the extent of retirement income security afforded by defined-contribution plans, one of the central issues is the degree to which assets will be withdrawn before plan participants reach retirement age. A withdrawal of the entire balance from an employer-provided pension account is known as a lump-sum distribution. These distributions have exceeded $100 billion in recent years, and have been greater than the flow of new contributions to IRAs and other targeted retirement saving programs.

In **Lump-Sum Distributions from Retirement Saving Plans: Receipt and Utilization** (*NBER Working Paper No. 5298*), NBER Research Associates **James Poterba, Steven Venti,** and **David Wise** ask what determines the receipt and utilization of lump-sum distributions. They find that many lump-sum distributions are not rolled over into IRAs or other retirement saving plans. The probability of such a rollover is much higher when the distribution is large. For example, in the government's Health and Retirement Survey, only 33 percent of respondents who received a lump-sum distribution reported that they rolled it over; 67 percent of all distribution dollars were rolled over. In the government's 1993 Current Population Survey (CPS), only 14 percent of all recipients of lump-sum distributions report rolling their distributions into an IRA or another employer's pension plan, but 31 percent of the distribution dollars were rolled over in this way.

> "[Lump-sum] distributions have exceeded $100 billion in recent years."

According to the CPS data, individuals who report having received a lump-sum distribution worth between $500 and $1000 have an 8 percent chance of rolling it into an IRA or another employer plan. Those whose distributions are valued between $25,000 and $50,000, however, have a 48 percent chance of such a rollover.

The probability of rolling over a lump-sum distribution also increases with the age of the recipient. For survey respondents between the ages of 25 and 34, the probability of rollover is 16 percent. For those between ages 55 and 64, that probability is 42 percent. The probability of rollover also rises with household education.

These results suggest that a simple analysis of how many lump-sum distributions are rolled over into other retirement saving plans may not be a reliable guide to the degree of leakage from the defined-contribution pension system. Because large distributions are more likely than small ones to be rolled over, the degree of leakage

is much smaller than an analysis of the *number* of distributions not rolled over would suggest.

Poterba, Venti, and Wise use data from the 1993 CPS, a representative sample of households of all ages, and the Health and Retirement Survey, which focuses on individuals between the ages of 52 and 61 in the early 1990s. Both datasets ask survey participants if they have ever received a lump-sum distribution, and if so, what they did with the proceeds. Neither dataset contains information on whether individual respondents were potentially able to receive lump-sum distributions but chose not to, instead allowing their defined-contribution balance to remain with their former employer. In the CPS, 9.9 percent of all respondents who are currently in the labor force or are retired report having received a lump-sum distribution at some point.

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