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Medical Malpractice Compensation Reform

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Abstract

Tort reform legislation is a topic that has been discussed and studied heavily in the states of Texas and California. This is because it has been claimed that these states have had success in bringing more doctors into the states. This thesis studies those states, as well as the state of Arkansas. It examines Arkansas because tort reform legislation was an issue brought up in the most recent election in November 2018 in that state. Although Arkansas' tort reform ballot measure was removed from the ballot by the Supreme Court of Arkansas, a similar measure could still be brought forth in coming years. The analysis in this thesis finds that tort reform legislation is successful in meeting its goals in some ways, but not in others. Despite the assertions of supporters of tort reform measures, tort reform legislation does not prevent a state from seeing its doctors leaving the state. Tort reform legislation does, however, lead to fewer medical malpractice payouts in a state.

Introduction

State-level tort reform legislation has become a popular topic nationwide. It is claimed to have been successful by decreasing the number of medical malpractice cases and increasing the number of doctors. The successes of some states in these areas have led other states to implement their own similar legislation. Medical malpractice compensation is primarily affected through this type of legislation, which places a cap on monetary awards to plaintiffs in these types of cases. Such a measure was on the ballot for the November 2018 election in Arkansas, but has since been struck down by the Arkansas Supreme Court, meaning that the votes will not be counted. The court ruled that the ballot measure, as a whole, violated the Arkansas Constitution (*Morris Dean Davis v. State of Arkansas* 2018 Ark. 288).

The main purpose of tort reform legislation is to prevent judges and juries from awarding excessive awards to plaintiffs. This legislation also aims to lower the cost of medical malpractice insurance for doctors and maintain their numbers in a state, specifically preventing them from leaving the state to seek lower medical malpractice insurance premiums. By analyzing data regarding the number of doctors in a state over time and the amount of medical malpractice cases in selected states over time, this thesis will assess the effectiveness of tort reform legislation in meeting its goals.

Arkansas Issue 1 was divided into three parts, with the second part placing a cap on personal injury compensation, including accidental death. According to that ballot measure, non-economic damages are defined as “damages that cannot be measured in money, including without limitation any loss or damage, however characterized, for pain and suffering, mental and emotional distress, loss of life or companionship, or visible result of injury.” This would be capped at $500,000 without death or, in the instance that there is a death, an additional $500,000

to each beneficiary. Punitive damages are defined as “damages to punish and deter wrongful conduct” and will be capped at $500,000 or three times the amount of the compensatory damages (Arkansas Senate Joint Resolution 8 2017).

Personal injury cases have been affected in a multitude of ways due to tort reform. Cases such as *Simpkins v. Grace Brethren Church of Delaware, Ohio* (2016) have been brought forth by individuals who have suffered personal injuries that also result in mental illnesses. In this case, Brian Williams pled guilty to two counts of sexual battery against Jessica Simpkins. Simpkins was awarded economic and noneconomic damages but was not given the adequate funding for the counseling needed to recover from the mental trauma she faced (Trevas 2016). Unhappy with the cap on non-economic damages in tort cases set by the Ohio legislature, Simpkins brought the case to the Ohio Supreme Court claiming that the law was unconstitutional denies her due process. The Ohio Supreme Court ruled that the law was, in fact, constitutional, stating that this was a “single occurrence.” The court ruled that since this case was so unusual, the law should stay in place. Cases, such as this one, emphasize the need for an alternative solution to tort reform legislation.

In Arkansas’s proposed amendment to the state constitution, the original maximum amount set in awards was $250,000 but was revised (Arkansas Senate Joint Resolution 8 2017). This section of the amendment was written to protect big businesses from losing money in cases, such as was the case in *Liebeck v. McDonald's Restaurants* (1994). Even though the plaintiff in that case was ultimately awarded $2.7 million, Stella Liebeck only requested her medical services be paid (approximately $20,000). The decision, as in most cases, was left to the jury. The jury chose the highest amount it could possible award in punitive damages since there was a record of previous “hot coffee” incidents involving McDonald’s. However, the judge

significantly reduced the amount McDonald's owed in this case (Gerlin 1994).Tort reform legislation such as the previously proposed amendment to Arkansas's constitution, are created to protect big businesses in cases such as this and will ease the stress of big business owners when they commit wrongdoings against customers. Damage caps are also used to protect doctors from the "excessive" awards as well.

California was the first state to implement tort reform legislation in 1975. It was passed in response to the increasing cost of insurance premiums and the number of malpractice suits being filed along with a loss of doctors (Todd 2002). Advocates behind the measure stated that it was necessary to pass this legislation before the citizens' medical options further slimmed as doctors left the state, seeking lower insurance premiums for their practice. California's Medical Injury Compensation Act (MICRA) consists of eight sections.[1] This legislation was passed in hopes to lower the number of medical malpractice lawsuits, the cost of medical insurance premiums for doctors, and lower the cost of medical services to the public. Since MICRA's passage, other states began to look at it as a model to write their own tort reform legislation.

Since the initial medical malpractice wave occurred in the 1970s, there have been multiple successive waves of malpractice suits filed in each state, leading more states to pass tort reform legislation. Texas has become another staging area for this, as government officials of the

[1] "1) Limit recovery for non-economic losses, such as pain and suffering, to $250,000.
2) Allow periodic, rather than lump sum, payment of damages for future losses.
3) Allow the defendant to introduce evidence of third party (i.e. collateral source) benefits, such as health insurance, that the plaintiff is entitled to receive as a result of the injury.
4) Eliminate the reimbursement, or subrogation, rights of third parties (collateral sources) who might claim part of the judgment.
5) Shorten the statute of limitations to one year in most cases, and up to a maximum of three years in others from the time of the original act of malpractice.
6) Require the plaintiff to give 90 days' notice to the defendant before filing suit.
7) Limit contingent attorney fees to 40 percent of the first $50,000 recovered, 33 1/3 percent of the next $50,000 recovered, 25 percent of the next $500,000 recovered, and 15 percent of the recovery over $600,000.
8) Encourage and facilitate arbitration." (Todd 2002)

state believe that their version of MICRA, passed in 2003, has been successful, (Kilgore et al. 2006). One main concern in Texas was the loss of several physicians, whether they retired early or had to move to another state in order to keep their practice. The loss of doctors, researchers concluded, was due to the increased number of medical malpractice suits being filed during the early 2000s (Stewart 2012). Texas tort reform has been proclaimed to have been successful, and legislatures have been content with the number of doctors that have flooded the state since the passing of tort reform (Kilgore et al. 2006).

Punitive damage caps set in some states, such as Kansas and Missouri, have been struck down by state supreme courts. Although this case in not related to medical malpractice specifically, it is important to explain why the Missouri Supreme Court struck down the punitive damage cap. The plaintiff in *Lewellen v. Franklin*, No. SC 92871, 2014 Mo. LEXIS 211 (Mo. banc Sept. 9, 2014) appealed their case to a higher court since the punitive damage caps were reduced due to tort reform legislation (Clark, Weinberg, and Wake 2014). The court emphasized that a person's right to a jury trial is diminished by a damage cap, meaning, when an award is capped, the jury cannot carry out their duty to decide how much a defendant should pay to rectify the situation (Clark, Weinberg, and Wake 2014). Some state legislatures fear that the logic applied in this case will also apply to other forms of tort reform, but some challenges before state supreme courts have been unsuccessful in striking down this legislation.

This thesis examines empirically the impact of tort reform legislation, and whether or not it is the case that such legislation does what it is said it will do. In what follows, this thesis compares the number of doctors in states that have passed tort reform laws and compares them to states that have not passed such legislation. It makes these comparisons over time to determine if it can be argued that such legislation effects the number of doctors within each state. The thesis

compares the number of medical malpractice suits filed in states that have passed tort reform with those states that have not. It conducts an in-depth analysis of California and Texas through an examination of the research on these two states. Such an examination is important because some researchers claim that tort reform has significantly reduced payouts in medical malpractice suits, specifically in those states. Overall, by examining each state, it can be determined how successful tort reform legislation efforts will be in accomplishing its goals.

Literature Review

Tort reform legislation has been researched in several ways, with a number of studies examining the impact tort reform legislation has had in states that have passed it. This paper focuses on tort reform as it relates to the area of medical malpractice. It examines how the passage of state-level tort reform legislation can impact the size of a state's medical community (specifically, the number of doctors within a state), medical malpractice insurance premiums over time, and the amount of medical malpractice case payouts over time. Understanding the impact this legislation is important to study this since the citizens of Arkansas could possibly be voting on a similar issue in the future. The previous Arkansas ballot measure, in part, was written to place a cap on noneconomic and punitive damages in medical malpractice cases. Studying how tort reform has affected the public, doctors, and attorneys in other states that have passed this type of legislation can provide insight into how tort reform will affect those in Arkansas if it were to pass in a future election.

The potential that doctors will move from a state without tort reform legislation to a state with that legislation is a major reason for considering this as a solution to the medical malpractice crises that have occurred over time (Stewart et al. 2012; Roser 2012; Frazier 2004). Reportedly, there have been several "medical malpractice crises" since the 1970s, the first triggering California to become the first state to pass tort reform legislation in the 1970s (Kilgore et al. 2006). The three known medical malpractice crises were approximately 1974 to 1976, 1984 to 1986, and 2001 to 2006, when the article was published (Kilgore et al. 2006). California's MICRA has become an outline for states wishing to implement medical malpractice reform legislation of their own. Since its passage in 1975, other states have adopted California's model

in order to halt rising insurance premiums that some argue have caused doctors to leave the state to seek lower insurance premiums elsewhere (Todd 2002).

Researchers have examined the effects of tort reform legislation in other states such as Texas. The Texas law was implemented in 2003 and closely resembles California's MICRA. In order to determine if tort reform legislation can affect an individual's access to health care, one group of researchers studied the fluctuation in the number of doctors leaving and coming to the state (Stewart et al. 2012). Although they find the number of doctors in the state did indeed increase after the law's passage, the authors note that there could be other reasons that account for the increase in the number of the state's doctors, specifically that the growth in the number of doctors could be a reflection of the state's overall growth. However, they argue their findings show that the Texas law's passage is directly associated with the increase in doctors within the state. This is because the influx of Texas doctors occurred at the same time as the law's passage.

Another journalist claims that tort reform legislation is not as beneficial to citizens as some researchers state (Roser 2012). Roser notes that tort reform does indeed seem to bring in more doctors to the state. However, she finds the influx of doctors does not have an impact on the cost of medical care. Healthcare costs are rising since doctors feel the need to run more tests, sometimes being more than necessary, to prevent a malpractice from occurring. She also finds that such laws have another unanticipated consequence: malpractice attorneys are leaving the state. This means the amount of access medical malpractice victims have to legal representation in the courtroom actually decreases (Roser 2012). Tort reform legislation attracts doctors to states with this legislation, but also pushes away attorneys that can represent the victims of medical malpractice cases when such representation is needed.

It has been claimed that over time, medical malpractice insurance premiums have increased at a faster rate in states without tort reform legislation than is the case in states with such legislation. For example, medical malpractice insurance premiums increased by up to 500% during the medical malpractice crisis from 1974 to 1976 (Posner 1986; Kilgore et al. 2006). Other "crises" during other periods have seen similar spikes in the cost of premiums. Kilgore (2006) and his colleagues found that malpractice premiums in states that passed tort reform legislation rose, but did so at a rate more slowly than states that had not passed such legislation (Kilgore et al. 2006; see also Posner 1986).

As seen with several other states, the advocates for the tort reform measure in Arkansas claim that there is a need to implement tort reform legislation in order to improve the availability and cost of medical liability insurance, bring doctors into the state, and improve the affordability of medical care and health insurance within the state (Frazier 2004). If passed, this would not be the first tort reform measure in the state.

Such a measure would not be the first for Arkansas. In 2003, the state passed the Civil Justice Reform Act (CJRA), also known as Act 649. This piece of legislation contains provisions that are distinct from other states' reform efforts. These include a provision requiring the need for a higher burden of proof for punitive damages. This burden of proof requires that "a plaintiff must … establish, by 'clear and convincing evidence,' that the defendant 'knew or ought to have known...that his or her conduct would... result in injury or damage and that he or she continued the conduct with malice or in reckless disregard... [or t]hat the defendant intentionally pursued a course of conduct for the purpose of causing injury or damage" (Frazier 2004). Act 649 established that plaintiffs are required to produce expert testimony during the case and must have an expert sign the affidavit before filing, which was not previously included in medical

malpractices cases. According to Frazier, Act 649 also requires that cases must be brought in the county that the act occurred in, making it impossible for plaintiffs to "venue shop" for a sympathetic judge. The law banned joint liability, and instead limits the parties to several liability, meaning that the plaintiff is awarded the amount for which each individual defendant is at fault only. Lastly, Act 649 capped jury awards at $1 million for punitive damages, an award amount which is common in other states' tort reform legislation (Frazier 2004). It is important to note that the provisions included in Act 649 are unique tort reform provisions since Arkansas Issue 1 included normal provisions that would place more caps on the outcome of medical malpractice cases, creating double reform on tort cases.

It is worth noting that Arkansas Issue 1 was appealed to the Arkansas Supreme Court earlier this year and was struck down due to unconstitutionality of the ballot measure (*Morris Dean Davis v. State of Arkansas* 2018 Ark. 288). Although the issue is no longer on the ballot, tort reform may be brought forth on the next ballot, and it is still important to consider opinions passing tort reform in Arkansas. The measure is controversial since the results of tort reform legislation could be unstable. For example, in a law review article, the former chief judge for the U.S. Court of Appeals for the Eight stated, "[a]s a practical matter, non-economic damages help working-class and lower-class litigants cover the expenses of hiring an attorney" (Burk 2017). This could be a negative affect brought forth by tort reform legislation since lawyers base a contingency fee on the potential winnings of a case. This relates back to Roser's newspaper article when she stated that lawyers are leaving the state (Roser 2012).

Not all states have needed to implement tort reform to decrease the amount of medical malpractice payouts that occur within a state over time. Several articles establish that only a fraction of individuals report negligent actions who endure them (Localio et al. 1991; Sloan and

Chepke 2008). In New York state, almost half of those who suffered an injury from negligence reported, it since their insurance companies provided them with the adequate funds to support them (Localio et al. 1991). Other research supports this finding. One article explains it in a different way: not all medical malpractice cases are being reported due to the good bedside manner of physicians and the personal relationship a patient creates with a doctor (Sloan and Chepke 2008). If the patient were to sue a doctor that she needed to see later, she would risk the relationship they have with that doctor. As such, she is hesitant to pursue legal action against the doctor.

The goal of this thesis is to determine whether tort reform legislation has been successful. Such measures of "success" include ensuring that doctors no longer fear getting sued, fear that is preventing some from coming to the state or causing those that are already there to leave. These measures also include preventing a rise in the cost of medical malpractice insurance premiums and lowering the size and number of medical malpractice awards to plaintiffs over time. The overarching goal of such as examination is to determine how another tort reform law will possibly affect Arkansas were to pass it in the future. Other aspects, such as the affordability of healthcare, have been analyzed as well. The research discussed in the literature shows some evidence that tort reform serves its intended goals. There appears to be evidence, based on the fact that the implementation of tort reform legislation leads to some of these. But, it also appears the legislation does not impact the cost of health care (Roser 2012). It also has also had unexpected consequences, such as lowering in the number of medical malpractice attorneys in the state. The works referred to throughout this paper have yielded mixed conclusions in each one of those areas, making it difficult to come to a conclusion about the overall outcome of tort reform legislation based solely on literature alone.

Data and Analysis

To better understand whether tort reform legislation been successful in meeting its goals, I examined the patterns over time, comparing states that have passed the legislation with those that have not. Specifically, I look at the number of doctors within states. I also looked at the size of medical malpractice payouts (the amount of cases and how much is awarded). If tort reform is considered "successful," then states that have passed tort reform legislation should see a significant increase in the number of doctors over time compared to those states that have not. States that have passed it should also see a decrease in the amount of medical malpractice payouts.

California passed the first law, the Medical Malpractice Compensation Reform Act, in 1975. It was passed in a time when medical malpractice case payouts started increasing. These payouts led researchers to conclude that medical malpractice premiums were increasing. These increases, in turn, caused doctors to leave the state. Other states have turned to this legislation for help since it has been claimed that doctors have been leaving states without tort reform legislation (Stewart et al. 2012). I hypothesize that the number of medical malpractice payouts in the states of Texas and California have dropped due to the implementation of tort reform. I also hypothesize that the number of doctors in both respective states has significantly increased as well.

Whether or not a state has passed tort reform legislation is the independent variable (and if so, what year). Whether or not a state has passed tort reform legislation (placing a cap on economic, noneconomic, punitive, or other damages) will also be included when analyzing the independent variable. Dependent variables include: the number of medical malpractice cases that resulted in a payout over time, the number of doctors within a state from 1990-2016, and the

average payout that resulted from a medical malpractice case. Ideally, data for medical malpractice insurance premiums would have also been presented in this thesis, but unfortunately, that information is not made public. The dependent and independent variables discussed above are publicly available and will be presented in line graphs since they represent results over time.

Figures 1 and 2 show Texas's statistics that were also discussed in the literature review. A significant claim from one of the articles states that the increase in the number of doctors within the state can be attributed to the implementation of tort reform legislation of 2003 (Kilgore et al. 2006). Figure 1 shows that the number of physicians per 100,000 state residents has been increasing in the state from 1975-2013, that is, the increase occurred both *before* and *after* the 2003 tort reform measure was passed in the state. In 1975, there were 12.5 physicians in Texas per 10,000 Texas residents. A few years prior to the reform measure's passage, the number rose to 20.3. After the act's passage in 2003, the number continues to grow (albeit at a slower rate) for the next 10 years to 23 doctors per 10,000 residents in 2015.

Still, the results presented in Figure 2 show that the Texas measure was, in fact, successful when it comes to curbing the number of malpractice suits. Prior to the act's passage, roughly 1,250 suits were decided in Texas' courts in 2002. After the implementation of tort reform legislation, medical malpractice case payouts in Texas plummeted, dropping to less than 776 cases in 2006, and continuing drop for the next several years. The most recent year for which we have data shows less than 500 cases were decided in 2016, reflecting a decrease of more than half of the pre-reform number of suits.

Figure 1: Number of Physicians in Texas over time per 10,000 citizens, 1975-2013

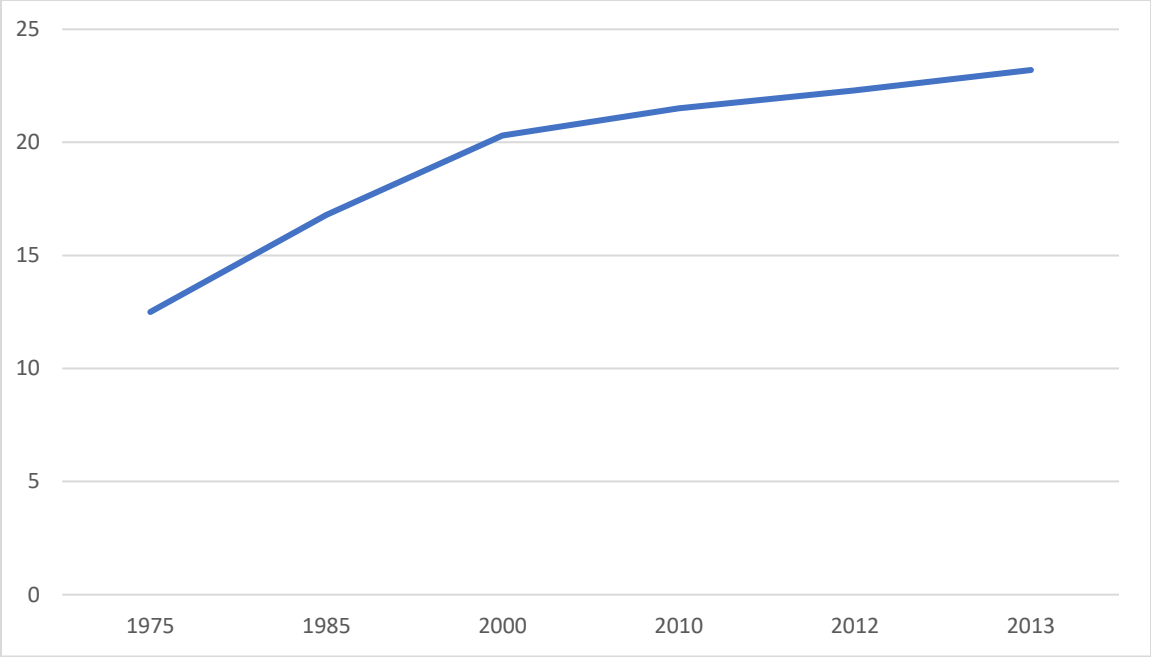
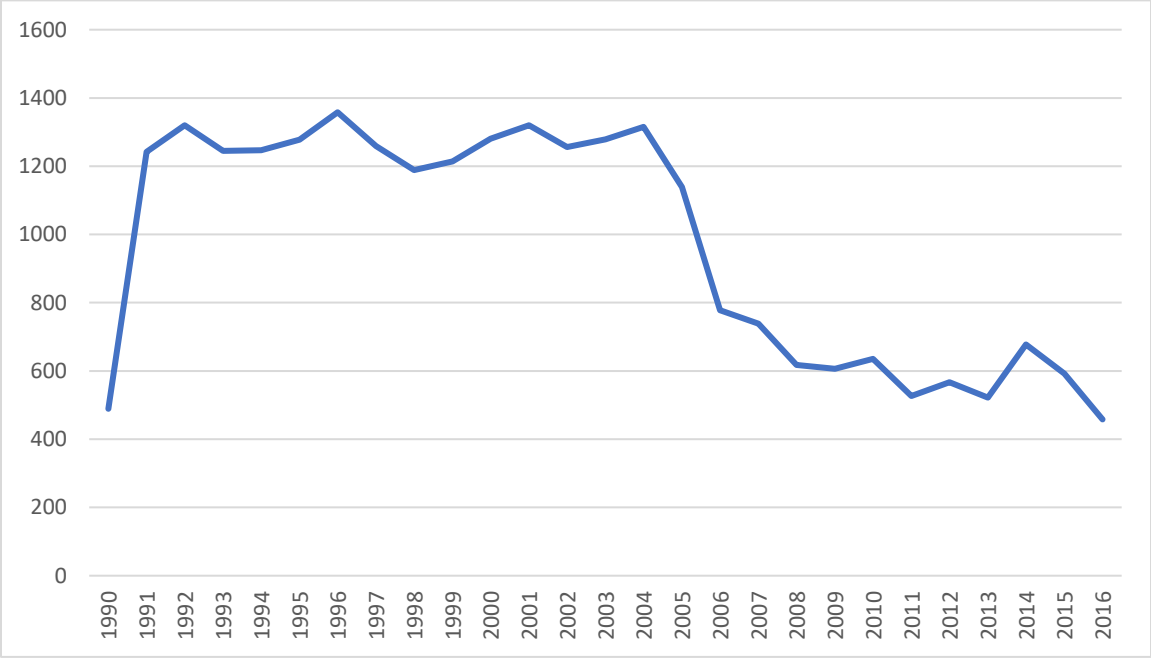


Figure 2: Number of Medical Malpractice Payouts in Texas, 1990-2016



Figures 3 and 4 present California's statistics in respect to the number of physicians in the state and medical malpractice case payouts over time. California was the first state to pass tort reform legislation in 1975. It was passed in response to the concerns that the state's doctors were leaving and medical malpractice insurance premium costs were rising, both caused by a large number of medical malpractice payouts (Todd 2002). Since data are only available starting 1975, it is difficult to say whether doctors were leaving the state prior the measure's passage. Although doctors are increasing in the state, between 1985 and 2000, the number of physicians per 10,000 citizens increase by a tenth of a decimal. This is unique since Texas and Arkansas, states that did not have tort reform at the time, had significant increases during the same time period. Figure 3 shows the number of doctors per California resident grows after 1975. On the other hand, California, much like other states had a significant increase in medical malpractice case payouts starting in the 1990s. This occurs regardless of the fact the state's tort reform legislation was implemented in 1975, as seen in Figure 4.

Figure 3: Number of Physicians in California over time per 10,000 citizens, 1975-2013

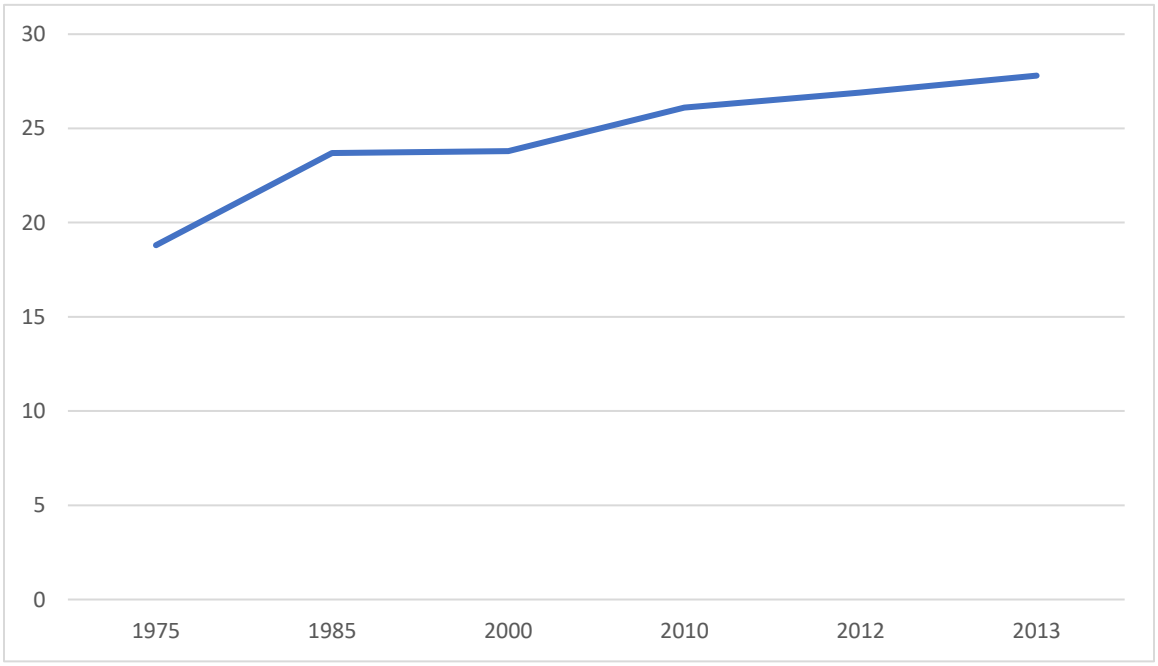
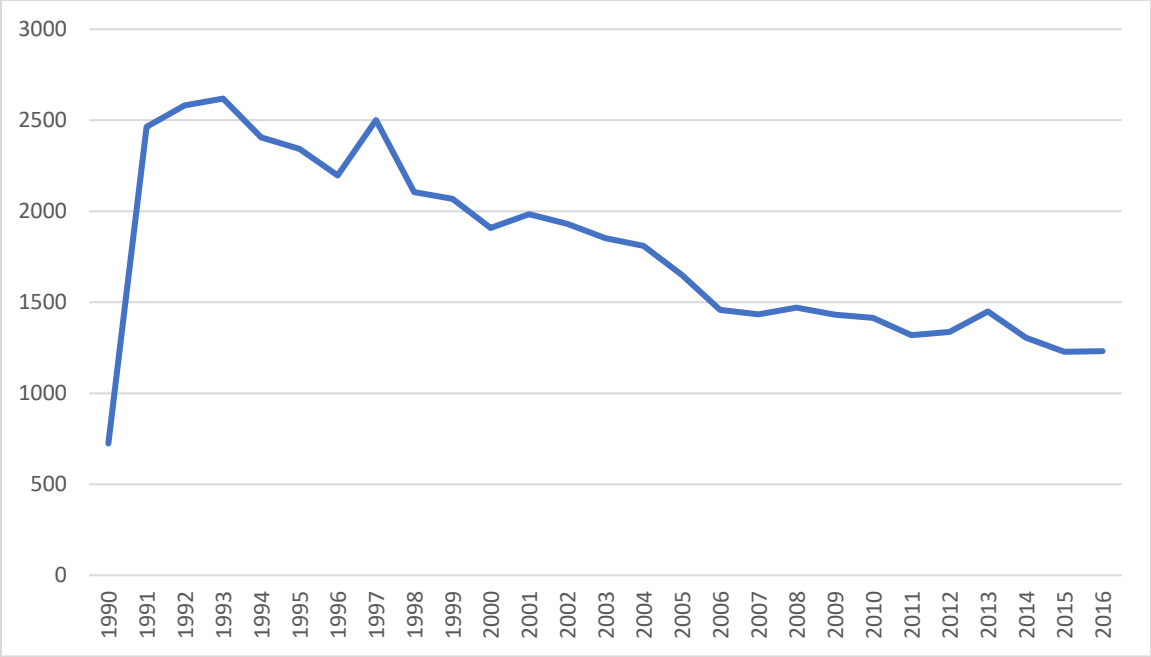


Figure 4: Number of Medical Malpractice Payouts in California, 1990-2016



Figures 5 and 6 show Arkansas's statistics. In 2003, Act 649 was implemented in the state of Arkansas, placing a cap on medical malpractice payouts, as mentioned before. Figure 5 shows that the amount physicians per 10,000 citizens were increasing, similarly to that of Texas. The motivation behind Arkansas's representatives proposing tort reform legislation was passed in response to the contention the number of doctors within the state was dropping (Frazier 2004). Much like what was presented above regarding Texas' number of doctors, the number of Arkansas' doctors is not declining. Between 2000 and 2013, the number of physicians per 10,000 Arkansas residents increases from roughly 19 to 21.5. Figure 6 shows that the amount of medical malpractice case payouts is unstable, which is unusual since Act 649 placed a cap on punitive damages. Nonetheless, the graph suggests the overall number of suits decreases after the act's passage.

Figure 5: Number of Physicians in Arkansas over time per 10,000 citizens, 1975-2013

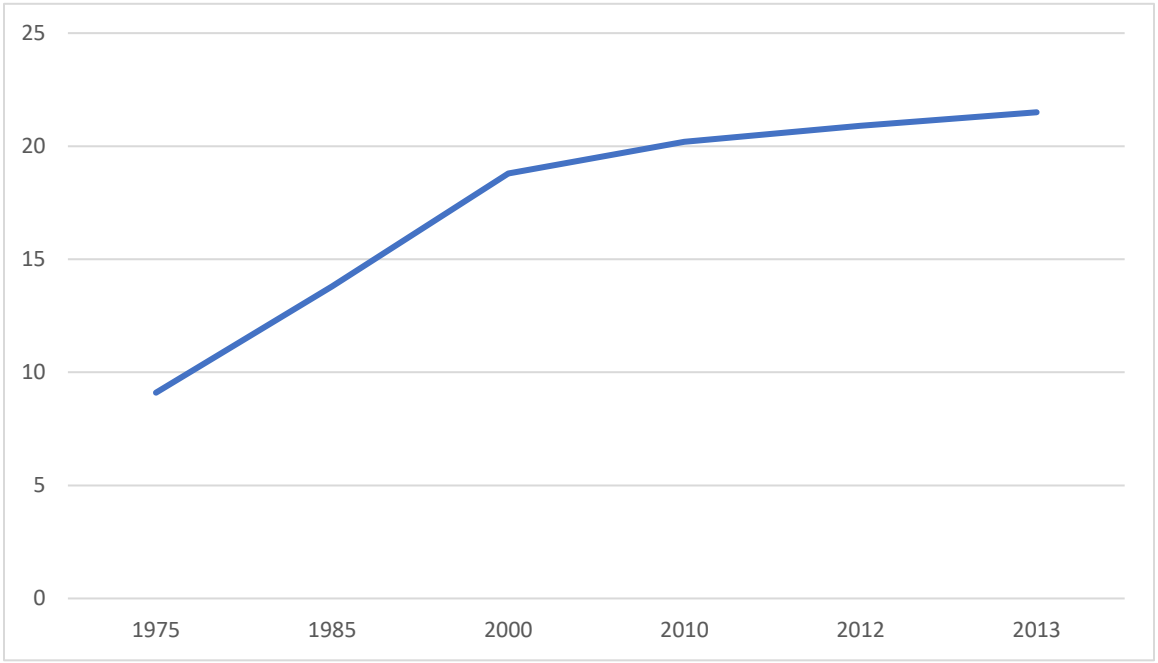


Figure 6: Number of Medical Malpractice Payouts in Arkansas, 1990-2016

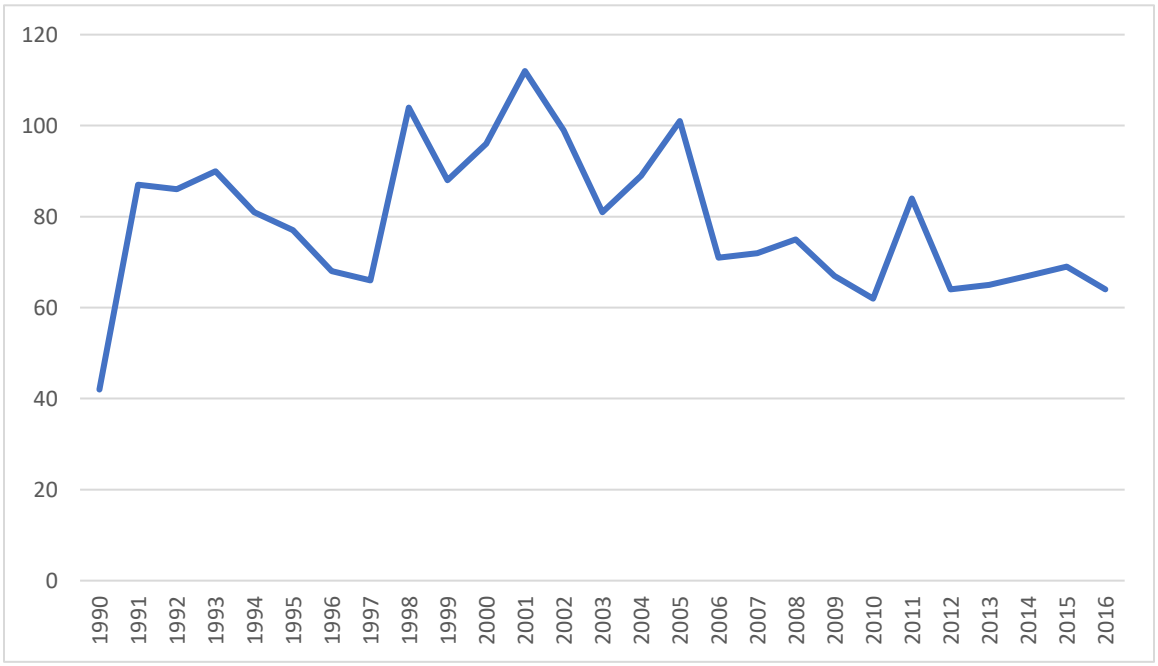
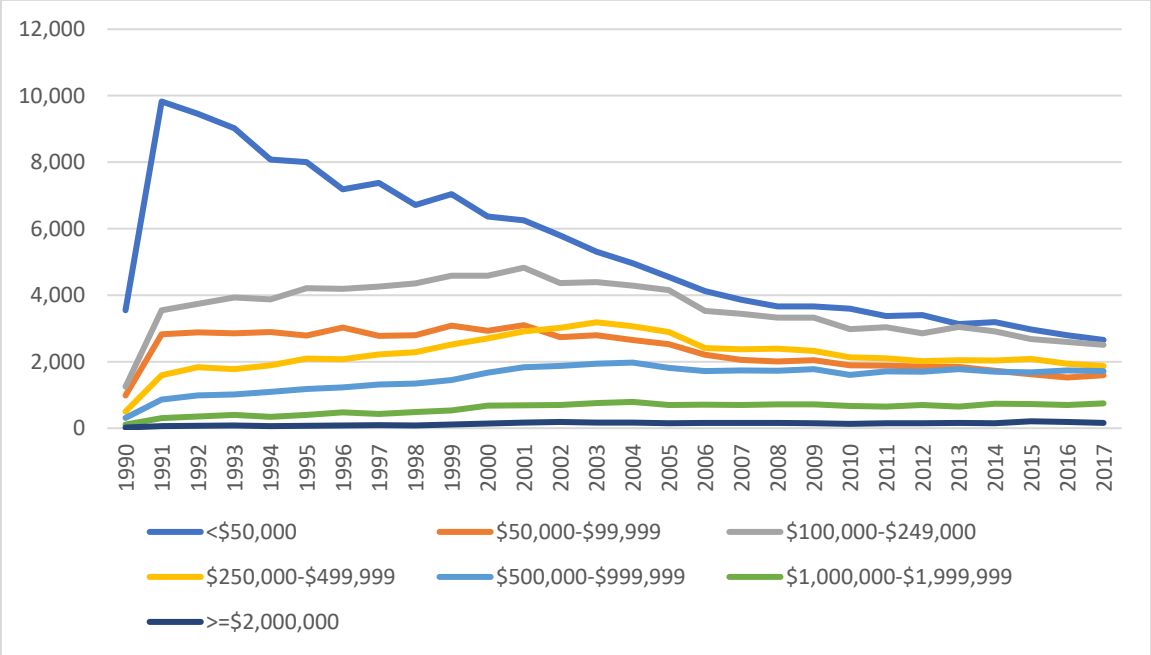


Figure 7 shows the average amount that resulted from medical malpractice case payouts against physicians starting in 1990. Over time, lower awards ($499,999 or less) have become less frequent while higher awards ($500,000 or more) are becoming slightly more frequent. This could contribute to the support for tort reform legislation and the claim that juries are awarding "excessively." However, his could also be due to other reasons, such as an increase in the cost of medical care. The data presented below was provided by the National Practitioner Data Bank (medical malpractice case payouts and amounts) and the American Medical Association (number of physicians within states).

Figure 7: Average Medical Malpractice Payout Award Amounts across all States



As discussed in the literature review, researchers claimed that the raising medical malpractice payouts caused doctors within the state of Texas to leave during a 2002 medical malpractice crisis, but in fact, the number of physicians in Texas, was still increasing according to the results displayed in Figure 1 (Stewart et al. 2012). It was also claimed in the literature that

the increase in medical malpractice payouts caused an increase in medical malpractice insurance, which could also be a reason for why doctors left states (Posner 1986; Kilgore et al. 2006). Since this data shows a timeline of medical malpractice payouts, doctors within the states, and the amount rewarded through medical malpractice payouts, an assumption, based on the literature, can be made that medical malpractice insurance premiums over time will show the same results.

The general trends in the graphs show that the amount of medical malpractice payouts have been decreasing since approximately 1990 and physicians within the states has been slowly increasing. Despite the implementation of tort reform legislation in California, the state faced a steep increase in medical malpractice case payouts between 1990 and 1991. On the other hand, award amounts of $500,000 or more have slightly increased since approximately 2000, while award amounts of less than $500,000 have slightly decreased since then. This is significant because while the amount of medical malpractice payouts has been decreasing, the fewer plaintiff wins have resulted in higher payments.

Conclusion

There has been extensive research that examines how tort reform has affected the states of California and Texas since their legislation closely resembles one another, but little research has been done on states without tort reform legislation in comparison to those. This thesis, however, examines Arkansas's data and compares it to that of Texas and California in respect to physicians within the states, the number of medical malpractice payouts, and the average amount of payouts across the United States. It is important to compare those numbers since the Arkansas General Assembly recently attempted to implement tort reform legislation by referring such a measure on the ballot to Arkansas' voter. The measure only failed due to the way the ballot measure was listed.

The analysis in this thesis shows the amount of California and Texas medical malpractice payouts and number of physicians within the states are more stable, meaning that they have less fluctuation, than the graphs that show Arkansas's data respectively. Since there is a significant amount of fluctuation in the Arkansas medical malpractice payout amount graphs compared to the other states, it is difficult to claim whether or not the data supports or rejects the hypothesis. As previously stated, the trend lines in the graphs show that the number of payouts in Arkansas has been decreasing. Despite the fluctuation in the Arkansas payout graph, the number of physicians in all three states has been increasing.

Other research could be beneficial in concluding whether tort reform is successful or not, especially the data on medical malpractice insurance premiums. The claim commonly made throughout the literature reviewed for this thesis is that insurance premiums will decrease if tort reform legislation is implemented within a state. Since that information is difficult to find, it was not included in this thesis, but based on my analysis, it can be assumed that insurance premiums

have not changed, despite the implementation of tort reform legislation in the states of Texas and California.

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