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Tort Reform: Examining the Current Environment (Part Two of a Three-Part Series)

On March 6, 2017, Republicans in the *U.S. House of Representatives* (House) introduced a bill designed to "*repeal and replace the Patient Protection and Affordable Care Act [ACA]*."[1] The bill (less than 60 pages in length), entitled the *American Health Care Act* (AHCA), contained little discussion related to tort reform, which, as discussed in Part One of this series, was a common theme of many of the initial "*repeal and replace*" proposals offered by Republican members of the House.[2] The AHCA was withdrawn prior to a scheduled vote in the House, and has been tabled for the near future. However, with the approval by the House Judiciary Committee of the "*Protecting Access to Care Act of 2017*,"[3] which seeks to implement a non-economic damages cap of $250,000 for medical malpractice actions,[4] Congress may still act on bills related to tort reform in the coming months, even if it is acted upon separate and apart from the AHCA.

As federal politicians consider tort reform, a consideration of the current medical malpractice environment may serve to place this political debate into context, including the prevalence of medical errors, the concentration of these lawsuits within the physician population, and tort reform efforts on the state level.[5] This *Health Capital Topics* article is the second installment in a three-part series examining the current state of tort reform in the U.S., and briefly discusses the present environment of medical malpractice and legislative initiatives across the U.S. addressing tort reform.

Significant increases in the volume of procedures performed by physicians over the past half century have contributed, in part, to the increase in both the risk of harm to patients and the liability exposure for physicians through *medical errors*, i.e., *deviations from the norms of clinical care*.[6] Since the 2000 *Institute of Medicine* (IOM) study that estimated that 44,000-98,000 patients die each year due to an adverse event,[7] of which 58 percent were preventable, (i.e., directly tied to *medical error)*,[8] numerous studies have sought to refine this figure. For example, a 2011 study published in *Health Affairs* found that deaths stemming from adverse medical events could range as high as 400,000 per year.[9] Additionally, a 2016 study published in *BMJ* by researchers from Johns Hopkins University estimated that 251,000 deaths occur annually due to *medical errors*, making medical error the third-leading cause of death in the U.S.[10]

Despite increased risk exposure, total indemnity payouts (i.e., damages awarded to injured parties from defendants) for instances of medical malpractice, as well as average premiums for medical malpractice insurance, have decreased since the early 2000s. According to *National Practitioner Data Bank* data analyzed by Diederich Healthcare, a professional liability insurer, the total amount of damages payouts in instances of medical malpractice in the U.S. fell nearly $1 billion over the past decade, from approximately $4.8 billion in 2003 to $3.84 billion in 2016.[11] The 2016 data reflects a decrease of 2.54 percent from 2015 levels, and serves as the first decline in medical malpractice payouts since 2012, which, at approximately $3.6 billion, marked the figure's lowest level since 2003.[12] Additionally, average medical liability insurance premiums for physicians have decreased over a similar timeframe. Data compiled from Medical Liability Monitor's *Annual Rate Survey Issue* demonstrates that average medical liability insurance premiums for the general surgery, internal medicine, and obstetrics and gynecology specialties have decreased each year from 2005 to 2014.[13] This trend is continuing into 2017, as Michael Matray, the editor of *Medical Liability Monitor*, stated to Kaiser Health News that "*[i]t's a wonderful time for doctors looking for coverage and it's never been better for insurers.*"[14]

Studies examining trends in medical malpractice payouts have revealed that a small cohort of physicians often provide a disproportionate share of payouts in cases involving medical errors. A 2016 study in the *Journal of Patient Safety* found that, from 1990 to 2015, an outlier group of 1.8 percent of physicians were responsible for half of the $83 billion in medical malpractice payouts over that time period.[15] Nearly three quarters of this outlier group faced multiple payouts, and 761 physicians (5 percent of the outliers) had 10 or more payouts.[16] Similarly, a 2016 study published in the *New England Journal of Medicine (NEJM)* found that, from 2005 to 2014, an outlier group of approximately one percent of physicians accounted for 32 percent of all paid claims.[17] The authors found an outlier group consisting of physicians with three or more paid claims, where 0.2 percent of all physicians accounted for 12 percent of all paid claims.[18] While not the sole contributing factor, membership in this cohort may be influenced by physician specialty, as a separate study published in the *NEJM* found that five of the top eight high-risk physician

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types (i.e., neurosurgeons, orthopedic surgeons, general surgeons, plastic surgeons, and obstetrician-gynecologists) had twice the risk of having multiple payouts than other physician specialties.[19] These studies concluded that identifying outlier physicians and developing tailored strategies to reduce the risk of medical errors within this cohort could help dissipate the high cost of medical malpractice actions.[20]

In consideration of current trends related to medical errors, medical liability insurance premiums, claim payouts, as well as the concentration of claim payouts among a disproportionately small number of physicians, industry stakeholders have responded in myriad ways. State legislators and insurers have historically sought to resolve issues surrounding medical malpractice through *tort reform* measures, most notably by enacting a *cap* on payments for non-economic damages, e.g., payments for *pain and suffering*, *loss of consortium*, and *emotional distress*. Since California first modeled this approach in 1975 by passing the *Medical Injury Compensation Reform Act* (MICRA), which enacted a cap of $250,000 for awards based on non-economic damages,[21] a majority of states have passed some form of cap on non-economic damages.[22] Additionally, state legislators have enacted a variety of other laws related to *tort reform*, including:

(1) Establishing statutes of limitations on claims made by plaintiffs;[23]

(2) Enabling or enhancing the ability of defendants to countersue claimants who file frivolous lawsuits;[24]

(3) Implementing compensation programs outside of the courts to handle malpractice cases;[25]

(4) Increasing the standards for admission of expert witness testimony;[26]

(5) Implementing reforms aimed at the healthcare delivery process in an attempt to reduce medical errors;[27] and,

(6) Establishing honesty policies for full disclosure of errors through "*apology laws*," which "*prohibit the use of a physician's apology as an admission of fault*" when a court adjudicates a medical malpractice case.[28]

Despite their prevalence, non-economic damage caps have faced scrutiny from state judicial systems, forcing legislators to readdress the issue. In particular, state supreme courts have struck down caps on non-economic damages in at least eight states,[29] with the Illinois Supreme Court striking down three separate statutes.[30] Ohio and Oklahoma courts have specifically struck down damages caps in medical malpractice cases involving wrongful deaths, but allowed other caps.[31] Additionally, five states have constitutional prohibitions on damage caps,[32] and Texas was forced to pass a constitutional amendment in order to enact a medical malpractice damage cap.[33] Missouri's original cap on non-economic damages, passed in 2005, was struck down in 2012 by the Missouri Supreme Court due to concerns about the law limiting a person's right to a trial by jury; in response, the legislature reenacted the cap in 2015, with the bill seeking to alleviate the concerns raised by the Court.[34]

Lawmakers often cite the need to curtail defensive medicine practices as a reason for *tort reform*.[35] *Defensive medicine* is defined as "*medical care provided to patients solely to reduce the threat of malpractice liability*," e.g., unneeded/redundant diagnostic testing and is often prevalent in high-risk specialties.[36] Defensive medicine practices are often viewed as either "*unnecessary*" or a sign of "*overuse*," raising questions as to the benefit to the patient of such practices.[37] However, recent studies have scrutinized the link between *tort reform* laws and reductions in defensive medicine practices. Although a 2015 *BMJ* study concluded that increases in defensive medicine coincide with a statistically significant decrease in medical malpractice suits,[38] physician utilization of defensive medicine practices generally do not decrease when states enact *tort reform* laws, and in some states, defensive medicine practices rose nearly four percent after the passage of *tort reform* measures.[39]

Despite disagreements regarding the practical utility and legality of *tort reform* measures, public deliberation on the issue may persist, and even expand, as the larger debate concerning the fate of the ACA and the ultimate path of healthcare reform continues. The third and final installment in this series will discuss the impact of the ACA on the medical malpractice environment, as well as examine the possibility of *tort reform* measures gaining traction at the federal level as part of healthcare reform deliberations.

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